Abbey Healthcare Homes Limited

Wrottesley Park House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection started on 6 January 2015 and was unannounced. We completed the inspection on 12 January 2015.

The home can provide accommodation and nursing care for up to 63 people with physical disabilities, learning disabilities and autistic spectrum disorders. At the time of the inspection there were 47 people living in the home. There were four units in the home; three on the ground floor leading from the central reception area. A fourth unit was upstairs and could be accessed by a passenger lift.

There were two people registered to manage this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

One of the managers of the service told us at this inspection that they had submitted their resignation and at the time were still in day to day control of the home. The other registered manager who was working in a more senior position was providing part time support to the home.

At the last inspection in October 2013 the service had become compliant with regulations. At this inspection we found that some legal requirements were not being met.

At our inspection we found concerns relating to the management of medications. The Clinical Commissioning Group (CCG) for Wolverhampton had visited the home in October 2014 and found that people were not receiving the health care and support that they needed. They had raised safeguarding concerns about two specific people's care and advised about their concerns including: people being restricted in movement, medication administration, pressure area care, people's nutrition, staff training and care planning. At our inspection we found that these concerns that had been raised by the CCG in respect of medication management remained and actions that had been taken had not fully addressed the issues. During our inspection some action was taken to address some of the immediate concerns.

We found that medication administration was not timely or in line with prescriber's instructions putting some people at risk. Medication management arrangements in the home were not robust or safe. Checks on the administration of medicines had been undertaken but these had not shown the concerns identified at the inspection so they were ineffective. You can see what action we asked the provider to take at the back of the full version of this report.

In addition to changes in the registered management of the services there had been some changes in roles and responsibilities of nurses within the home. There were vacancies amongst the permanent staff group and the provider had engaged agency nurses who were working to support the staffing rota on most day and night shifts.

There were inadequate systems in place to identify, monitor and plan for the risks to people's health and wellbeing in the home. People's health and care needs were not consistently met. Communication between staff was not effective and had failed to ensure that changes in health or care needs were appropriately shared. People were placed at risk that their health and wellbeing would not be protected or promoted.

The systems in place for reviewing and learning from people who used the service and their relatives together with reviews of trends identified through concerns or complaints were not robust. People told us they were unhappy with responses they received from staff when they had raised concerns or complaints.

The systems in place for assessing and monitoring the quality of the service and for responding to risks were not effective. Issues identified during the inspection had in some instances been known by the service but action to address the concerns not been timely and in some instances were incomplete. Action to address issues that had been noted by the CCG in October 2014 were still outstanding or incomplete at the time of the inspection in January 2015. Issues raised were related to the healthcare needs of people using the service. You can see what action we told the provider to take at the back of the full version of the report.

Safeguarding concerns about staff behaviour had resulted in some action by the managers with individual staff concerned. However managers were also aware of concerns about the night staffing in the home in November 2014. At our inspection some people we spoke with expressed concerns related to the same issue. Whilst we found there were enough staff on duty, at times the deployment of staff meant that people did not receive any opportunities for individual time with staff. Comments from people about staff varied but most people commented that staff had little time available to spend with them in any social way. Staff were seen to be kind in how they did support people. The privacy and dignity of people was protected by staff. You can see what action we told the provider to take at the back of the full version of the report.

The understanding of staff in respect of people's legal rights was good. This ensured that, where people did not have the capacity to make decisions that affected their safety or treatment, applications were appropriately

Summary of findings

made to the local authority to consider whether they should deprive the person of their liberty. People were not being deprived of their liberty and staff understood what action to take should this be considered necessary.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were unsafe.

People could not be certain that they had their medicines prescribed in a timely way and safely.

Risks to people's health were not always identified and improvements or changes in care provided to people following concerns being raised was slow.

People had been subjected to poor care and staff performance that had affected their wellbeing.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

People could not be certain that staff had the training and support to ensure their care.

People who needed support to have appropriate nutrition were not supported by staff who had received detailed guidance.

Assessments of care support needs were not reviewed routinely and did not take into account some people's recent care history or how their needs had changed and this meant appropriate care and changes in care were not always met.

People's legal rights were protected. The registered manager and staff we spoke with understood the principles and how to protect the legal and civil rights of people using the service.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

People told us that many of the staff showed kindness to the people using the service, however some people said that staff were not caring.

We saw that people were cared for in ways that protected and promoted their rights to uphold their privacy and dignity.

Staff did not spend much time speaking or interacting with people who used the service.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

People were supported and encouraged to provide information about how they wished to be supported and cared for so that care provided met their needs.

Summary of findings

The individual interests of people using the service were not always met through activities that were arranged by the service.

Management systems did not take into account all of people's dissatisfactions and confidence about using the complaints procedure was not high amongst people using the service.

Is the service well-led?

Requires improvement

The service was not well led.

Management systems within the home had at times been unclear to people using the service.

The systems to check on the quality and safety of the home were not effective and this left people at risk of receiving unsafe and poor care.

Methods of communicating between staff, people who used the service and managers about improving the service were not wholly effective and opportunities to gather views and opinions about how to make improvements were not frequently utilised.

Wrottesley Park House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and conducted over two days, 6 January 2015 and was unannounced we continued the inspection on 12 January 2015.

On the first day the inspection was undertaken by two inspectors and a pharmacist inspector. One the second day there was one inspector.

Before our inspection we reviewed information the provider had sent us since our last visit. We asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we checked the notifications about the home. Providers have to tell us about some incidents and accidents that happen in the home such as safeguarding concerns and serious accidents. We also considered information supplied to us from the local Clinical Commissioning Group that buy health care services in the service. We used this information to plan what areas we were going to focus on during the inspection.

We spoke with six people who lived in the home and three relatives. We observed the interactions between people and care staff. We had contact with two health workers from the Wolverhampton Clinical Commissioning Group and two social care workers. We spoke with the registered managers, three nurses, five care workers, a cook and an activities worker.

We looked at a variety of records to review the care people received, including parts of nine people's care plans and nine people's medicine administration records. We looked at the recruitment records for three newly appointed staff, staff rotas and training records.

Requires improvement

Is the service safe?

Our findings

On 6 January 2015 a pharmacist inspector reviewed the medication administration in the home and found that issues of concern remained as had been described by staff from the Clinical Commissioning Group. We had been informed that people's medical conditions were not always being treated appropriately by the use of their medicines. We found that the medicines administration records were not completed well enough to show if people were receiving their medicines as prescribed by their doctor. We found that the receipt of some medicines had not been recorded and staff initials were missing from the administration record so we were unable to establish if the medicines had been administered.

We found that the information available to the staff for the administration of 'when required' medicines were not clear enough to ensure that the medicines were given in a timely and consistent way by the staff. We found the lack of this information and knowledge of staff had contributed to one person being taken to hospital when they may not have needed to.

We looked at the records for people who were having pain relieving skin patches applied to their bodies. We found that the extra checks legally required for the administration of these controlled drugs were not being consistently undertaken. In addition records were not able to demonstrate that the skin patches had been applied safely and at appropriate intervals to minimise a person's pain. For example some skin patches were supposed to be changed every three days to provide continuous pain relief but was saw patches were changed at a range of intervals between two and 10 days. This could leave people in pain.

Some people needed to have their medicines administered directly into their stomach through a tube and the provider had not ensured that the necessary safeguards were in place to ensure that these medicines were administered safely. We spoke with a nurse who confirmed how a medicine had been administered, the method used as described was unsafe.

Some medicines were not being stored correctly so they remained effective. The refrigerator temperatures were not being measured correctly. Readings taken on the day of the inspection showed that the refrigerator temperature had dropped substantially below freezing but no action had been taken to ensure the safety of the medicines being stored. We asked the service to take immediate action and all stocks of a specific medicine which was not safe after freezing were replaced.

We had already received information from the Clinical Commissioning Group (CCG) in Wolverhampton following their visit to the service on 28 October 2014. They had raised concerns about how staff were administering medicines. They had asked the manager to provide action plans of how the administration of medicines would be improved and it was concerning that the practice had not changed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home and their relatives told us that the home was safe; but two people told us they felt less safe with night staff. Concerns had been raised with the service about the care people received at night and although the service had increased some checks, concerns were raised with us about the effectiveness of these measures. This was still being investigated at the time of our report.

Staff we spoke with were able to tell us about the signs that may show that people were being abused and who they would report any concerns to within the home. They told us that they had received training about safeguarding and maintaining the safety of people. Staff knew the agencies involved in safeguarding people from abuse that they could contact if they were unhappy with action taken and at times staff had contacted safeguarding agencies direct. Staff's understanding of their responsibilities to report concerns helped to keep people safe.

The provider had suitable arrangements in place to respond to emergencies that may affect all people who live in the home. These included a management on-call rota and specific plans in case of fire or failure of the main utilities such as gas and electrical power. Individual plans had been written to ensure people could be moved from the building safely should they need to be evacuated. These plans were held on people's care files and in discussion it was explored that it would be more effective if the plans were together so they could be more easily found

Requires improvement

Is the service safe?

in the event of an emergency. Further fire safety checks were needed to ensure that risks associated with the storage of oxygen and electrical lift equipment were minimised.

The CCG raised concerns following their visit in October 2014 about the lack of suitable equipment that needed to be available for one person in the event of a medical emergency. The manager provided an action plan about this for the CCG as they had requested. We found that training had been undertaken to ensure that nurses in the staff team were able to provide the right care but we found that a part of the emergency equipment was not available in the person's room and this compromised the person's safety.

Risk assessments were in place for people, for example, in respect of people's nutrition, pressure area care and how to move people safely. However, three people we spoke with told us that they were uncomfortable because of problems with their skin. We checked people's risk assessments and care plans for information about these conditions. We found that one person's skin condition was healing and appropriate assessments and plans were in place. Although there were records of skin changes for the other two people recorded on body maps there were no recorded plans to monitor or help improve the person's skin condition. For one person there was no evidence that this concern had been passed on to a nurse in the staff team on duty and this lack of action presented a risk that person could develop more serious conditions. The managers confirmed that this was a gap in their processes. We saw a person being cared for on a pressure relieving mattress at a setting contrary to their care plan and we brought this to the attention of the manager. We were made aware of two recent incidents where pressure injuries following investigation were found to be avoidable indicating that the risks to people's skin were not being managed effectively.

People we spoke with told us that there were not enough staff available at night although they told us there were enough staff available during the day. For example one person told us, "On occasion there has been three care staff and one nurse at night. There are lots of people who need two care staff to hoist and there are not enough care staff; it means people's pressure areas [checks and treatments] do not get done." A relative told us that as care staff were assigned to a unit to work on rather than working across the units the staff level was better. A member of staff told us, "I love my job, but there are not enough staff." A social care professional told us, "At times the service is let down by the staffing levels for people with very complex needs." The staffing rotas showed that staffing was not always at the optimum levels as described by the manager. There were enough staff on duty during the day of our inspection. People, who were able to be supported out of bed, were generally up and dressed at a reasonable time. Two people who were not up and about told us this was line with their personal preferences. Some people told us they were assisted early in the morning by the night staff but also told us this was what they chose to happen. Call alarms were answered within a reasonable time.

Agency nursing staff had been used to cover absences from the home for both day and night shifts and on some occasions people were being supported by nurses who did not know them. Rotas did not always clearly identify which staff were allocated to provide one to one support for a person and at times the staff on duty to provide one to one care had been counted in the overall number of staff on duty to cover the rest of the home.

We checked three new staff records and details of checks made of nurse registration and found that improvements had been made since the CCG visits. Staff only commenced working in the home after comprehensive checks had been completed. This helped to ensure that staff were safe to work with people who lived in the home.

Requires improvement

Is the service effective?

Our findings

People we spoke with thought that staff knew what treatment and support they needed and why. We spoke to staff about some people who lived in the home and found that not all staff knew about the health conditions that affected specific people's day-to-day lives or how specific people needed to be supported. Some staff told us that they had not had training on a specific health condition that we asked them about and could not tell us how it affected people.

At times people had been assessed by one of the managers who was not trained as a nurse and this has led to some difficulty in determining a person's clinical needs and whether the home could adequately provide the care a person needed.

Staff were involved in a programme of e-learning to refresh knowledge of topics such as safeguarding people that the provider had deemed were mandatory. However, information supplied by the management of the home showed that some staff on nights had not completed significant amounts of the available training. The provider information return supplied to us in September 2014 showed that some appropriate training had not been undertaken and that there had only been a slow increase in the overall amount of training completed since then. The manager told us that some courses in continence, first aid and supporting people with positive behaviour had been arranged and we saw lists of staff who were proposing to attend. The on-going training opportunities for staff needed to improve.

Staff support such as induction and supervision were not consistently provided. Staff we spoke with who provided supervision and staff who received it did not have consistent expectations about how often and how supportive this was to them. Inconsistent opportunities for supervision meant that staff did not have opportunities to discuss individual learning needs or to raise any issues of concern to them. From the training and rota records provided not all staff had started the common induction standards although they were on the general staff rota providing direct care to people using the service.

People we spoke with were happy with the meals they received. Their comments included, "I like the food; the breakfast and evening meal are really good. The lunch time tends to be sandwiches and cake," "The food is alright. It depends who is cooking it" and, "The food is nice." People appreciated the choices of food available to them and the ability to choose when they eat.

The manager told us that the kitchen provided food from 7am until 7pm and this was confirmed by the chef. We saw people, who were able, choosing the time they had their meals and what they had to eat including having a cooked breakfast if they wanted. People who did not want any of the prepared choices of meal could ask for other quickly prepared options of food. A person told us, "If I don't like the food I can have scampi and salad."

Some people who lived in the home needed their meals specifically prepared. A relative told us, "Some staff cannot feed (person's name]. Some of the food is not appropriate for [person's name]." We found that not all care plans were detailed enough to ensure that people who had specifically prepared food and drinks were given these appropriately or that checks outlined in best practice guidelines were undertaken. We spoke with an agency nurse who told us that they had not been given any guidance about any person's specialised nutritional needs where they were working in the home and the lack of detail in people's care plans put those individual's health and wellbeing at risk. Prior to the inspection the provider told us that there were 20 people in the service who were at risk of malnutrition. Despite this we found that no staff had attended an appropriate course in nutrition in the preceding 24 months.

We saw two people being assisted to eat meals and noted the skills of staff providing the support, whilst it was predominantly good, it was varied. People were generally supported at meals in a caring and calm manner.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

Some people told us that they were supported to go out of the home whenever they wanted and some people told us that they would like to be supported to go out more often. We looked at the applications that had been made to the supervisory body to deprive people of their liberty. We

Requires improvement

Is the service effective?

found that these had been made appropriately and staff we asked were aware of people who had applications made and why. We did not see any other person being deprived of their liberty at the time of the inspection. Staff told us they had received training on MCA and DoLS recently or were due to attend this training shortly.

People we spoke with were confident that staff would contact health professionals when needed to keep them well. Their comments included, "Yes they got me a doctor when I had a cold and I have had my 'flu jab." A person told us that they had seen a GP recently but there was no evidence of this in their care plan or review of their medical care with the GP for two years. In addition, a person's care plan had the discharge letter for another person which could have resulted in inappropriate care being given and this also indicated that people's care documents were not being reviewed regularly.

Assessments were not routinely reviewed and the underlying causes of people's health conditions were not always recorded. For one person their assessment did not reflect that their abilities had diminished and some staff we spoke to did not know that the person was experiencing difficulties. Consideration had not been given to how this person's independence could be retained. For another person the cause of their health condition had not been fully exploited.

Where people declined contact with health professionals and had the capacity to make this decision this was recorded which helped to ensure that the wishes of individuals were respected. The service had ensured that essential information was available about people to give to the emergency services and hospitals if needed at short notice; this information was not always up to date. The health professionals and social care professionals we spoke with told us that staff were not always quick enough to identify health concerns. When these were pointed out to them plans were put in place to improve people's health but these plan were not always checked to see if they were effective.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us about specific staff who they found caring but told us they found others less so. They said, "[Two staff member's names] are fine but the night staff are rough," "[Staff's name] she is lovely and [pointing to another member of staff] she is my number two." Three people told us that they did not have much interaction with staff and our observations during the day found that staff were not always deployed in a way to meet people's social needs. Their comments included, "There is little interaction with staff and me," and "Most of the staff are okay, the night staff are not so okay. Staff do not come and sit and talk with me."

Our observations confirmed that there were few people spending time in the communal areas and that most people were spending time in their rooms either due to their health needs or through personal preferences. We saw in one of the lounge areas for 40 minutes and found that although staff passed through they did not spend time with the one person in there except to change the music to a person's known preference. It was positive that they knew the person well enough to know this. During our first day of the inspection we saw that people sat for a long time doing nothing. Social interactions we did see were fleeting but kind. At one time we saw staff sitting together and not speaking or interacting with the people who live in the home. The management of the home told us that this had been raised with staff and that it was expected that staff should be talking to people who live in the home.

People who were able controlled some areas of their lives. People could choose whether to stay in their rooms or come out into the communal areas. They could choose when and where to have their meals and drinks. Some people were receiving support from the home's physiotherapy assistant to maintain their physical abilities to support their independence. Some people's rooms were set up so that they could undertake personal care tasks for themselves, enabling them to remain independent. One person told us that they had been supported to move to change bedrooms within the home which they had found was much better. We saw information displayed about advocates although we were told that no one had an advocate at that time.

We asked staff how they ensured that people's privacy and dignity were protected and maintained. Staff we spoke with were able to describe how they did this. During out observations people's privacy or dignity was maintained. We saw that people were dressed appropriately and appeared to have as much support as they wanted to maintain their appearance. Personal care was only provided in people's own rooms and observations were that doors were closed at these times. People did not raise any concerns about this with us. People we asked told us that their visitors were treated well and this helped to respect people's dignity.

Whilst delivery of care was conducted in private we found that people's care plans were kept in unlocked filing cabinets on each unit which failed to protect the documents from unauthorised access.

Requires improvement

Is the service responsive?

Our findings

People had an assessment of their health and social needs before they were admitted to the home. A social care professional told us that the management responded quickly to when people needed an assessment to determine whether they should be admitted to the home.

There was evidence that people were encouraged to give information about their personal history and their preferences prior to their admission to the service although this information was not always used to make the care plans as personal to the individual as possible. Whilst assessments were undertaken prior to admission some were not well detailed in the records. The lack of detailed records and shared information meant that some staff were not aware of some of the people's individual abilities or health conditions. Some care plans were written in a way that suggested that the individual person had written them, however in one care plan we looked at the language used and lack of a signature from the person would indicate that this was not the case. People we spoke with had mixed views about whether the arrangements for their care matched their expectations. One person told us, "They get me up at 5am [to give me my treatment] then wash and dress me and put me back to bed. I would rather remain up as otherwise I have to wait until 8am sometimes before they come again and I can get up and have breakfast." Another person told us, "They get me up at about 5am. This suits me, I find it difficult to sleep."

Staff we spoke with knew about people's life history. They knew people's religion, ethnic background, culture and important decisions in their lives. A new member of staff told us, "We are given information about equality and diversity in the staff handbook." Comments from other staff included, "All of the women in the wing where I work have chosen to have their care provided by female staff only" and, "Yes people are able to practise their religion here." They advised us of people who visited the home to support individuals with their faith.

Some people we spoke with wanted to have more activities and wanted to get out of the home more. Others thought they had enough to do. Their comments included, "There used to be music and movement that doesn't happen anymore and I would like to go out and see [events named]" and, "I spend time helping [member of staff's name]. I like doing that." One relative told us, "[Person's name] is bored, they just float around and now when we come in everyone seems to be in their bedrooms." We saw that two people had more detailed information about their social activities and evidence of being involved in individual interests. One person showed us some of the craft work that they had recently done. We saw that another person had items in their room to occupy their time. We also saw some people who sat on their own for long periods of time without any activity or interaction from the staff. The managers told us about, and we spoke with, a recently appointed activities co-ordinator who they hoped would make activities more individually suitable for people.

People we spoke with had mixed views about making complaints and raising concerns. One person thought they would be in trouble if they said anything about their concerns, another person thought it wouldn't change anything and two people told us that they felt confident about raising issues.

We looked at the management of complaints. There were appropriate procedures in place which help to ensure that appropriate steps should be taken if a complaint was made. In practice the records and outcomes of complaints did not always detail areas of the complaint and did not provide an itemised response which may cause people to be dissatisfied with the complaint process. We spoke to care and nursing staff about complaints and dissatisfactions with the service provided and how these were recorded. We were told that larger complaints were recorded separately and these were handed to the manager. Where people or their relatives had smaller concerns these were dealt with and recorded in the relevant person's care plan. This method missed an opportunity for these of dissatisfaction to be recognised and acted upon.

Requires improvement

Is the service well-led?

Our findings

People who lived in the home and relatives we spoke with had reservations about the management of care being provided. Their comments included, "He [the manager] is very good, but not very strong" but they did not expand on what this had meant for them. One person told us that they thought the service was deteriorating. Other people spoken with did not make specific comments about the management of the home.

At the time of the inspection there were two people registered as managers of this service. One had become a more senior manager at the end of 2013 and she told us that she had retained her registration but had not been in day to day control of the home. She told us that had returned to the service and would be managing on three days per week. The other registered manager had become the manager in April 2014. He told us on the first day of the inspection that he had handed in his notice the day before our unannounced arrival. Prior to this there had been another manager involved in the home between December 2013 and March 2014; this person had not applied to be registered with us. Changes in management had disrupted the smooth running of the home and care of people because of changes in management styles and expectations.

The manager who was appointed in April 2014 was not a registered nurse and staff who had been responsible for the clinical leadership alongside the manager were no longer undertaking this role. This had left a gap in clinical leadership within the home. We were told that a new clinical lead was arriving the week after our inspection.

There had been failures in the care provided to people that had not been identified by the monitoring arrangements within the home. The monitoring of risks and delivery of quality care were not effective. Systems to monitor risks associated with medication administration, attitudes and behaviour of individual staff and clinical care to prevent pressure damage, the care of people who needed high level support were not effective. When failures had been identified this did not result in prompt action to minimise the possibility of these failures happening again. Where steps had been taken to improve, sufficient monitoring was not on place and we found that some of the failures were repeated. Examples of the lack of effective monitoring were clear in respect of the emergency equipment that had not been checked, and in respect of medication management audits. Concerns had been expressed about the performance of night staff in November 2014 and people we spoke with who live in the home were still unhappy about the care they received at night.

The service had relied on a survey undertaken with people who lived in the home in April 2014 to inform them about how people wanted to support the development of the service, promote good practice and enable people to share their ideas. Opportunities to review and learn from complaints and concerns that had been raised were not available to the home. The provider had conducted an overview of complaints but this was across the locations within the allied companies and not for this specific company and location.

Systems in place to check on and monitor the quality of recording systems in the home were not effective. We found that some records of people's care were not completed consistently. Some care plans had essential core sections that were incomplete and other care plans lacked details about people's health care and changes they had experienced. The safe retention of records had not been monitored and records of which staff had not been monitored and records of which staff had worked during what periods in the home were not all up to date.

Records for the effective running of the care home were in many instances not complete. Records that evidenced training and staff support had not been updated, and the system to demonstrate that the provider was assured that staff had the necessary skills to meet people's needs was not robust. People had funding for one to one care and it was not always clear on the rota which members of staff were providing this support.

Prior to the inspection we had been made aware of numerous safeguarding concerns that had been reported in the previous year. The management of the home only identified and advised us of five of these concerns. Some concerns had been raised about; medication administration, the behaviour of some staff, staff's lack of response to alarms and incidents of preventable skin damage. Where the provider was aware of concerns, these were investigated and measures were put in place but these measures were not always monitored. The lack of monitoring meant the actions taken were not always effective and concerns were repeated.

Requires improvement

Is the service well-led?

The arrangements for the monitoring the quality of the home and the management of risks were not effective. They failed to ensure that people were protected from the risk of inappropriate or unsafe care. There was a lack of arrangements to ensure that the views of people who used the service or people who were acting on their behalf were regularly sought. Such arrangements would enable the provider to utilise feedback to further improve the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not protecting people against the risks associated with the unsafe use of medicines because the systems for recording, safe handling and administration of all medicines were not in place. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who lived at the home were not protected because the systems to assess and monitor the quality of the service and identify, assess and manage the risks were not sufficiently in place. There was no evidence that changes had been made to reflect learning from incidents that had taken place or that risks had been managed. This was a breach of Regulation 10 (1)(a)(b) and (2)(b)(I)(iv) and (c)(I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.