Pinnacle Care Ltd

Wolston Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Wolston Grange provides accommodation and personal care for up to 39 people living with dementia. The service consists of three separate units, the residential home (main house) which accommodates older people living with dementia, adjoined with The Lodge and a separate building called The Barn which accommodates primarily people living with alcohol related dementia. A total of 23 people lived at the service at the time of our inspection.

People's experience of using this service:

• Systems to identify people's individual safety risks and to promote people's safety within the home environment were not effective.

• No action had been taken when Health and Safety checks identified people could be exposed to unnecessary risk, such as potential scalds from excessive hot water temperatures. Fire safety measures had been taken following a fire authority visit in 2017, however staff responsible to check fire equipment such as doors and emergency lighting had not been trained. Where fire safety equipment was recorded as not working, this equipment remained defective.
• The general décor and maintenance throughout the service was poor and posed risks of injury to people because repairs were required. This included repairs to interior woodwork and window restrictors. Because of the overall disrepair of some areas of the home, this presented potential infection control risks.
• The provider's quality assurance systems were not effective in identifying, responding and maintaining a good standard of service that people deserved. Where some improvement actions had been recorded and raised with the provider, limited or no evidence showed what actions had led to improvements.
• Risk assessments were not always clear to show how risk scores were used to assess individual risks to people and risk management plans lacked important information to keep people safe.
• Medicines were not always managed and administered in a safe way which increased risks to people's health and wellbeing. Systems to store, record and dispose of medicines safely were inadequate.
• Improvements were needed to ensure people were supported to enjoy a wider range of activities which reflected their interests, and enhanced their lives. Staff sought ways for people to continue to do things they liked, whilst maintaining their safety, such as using outdoor spaces.
• People, their relatives, staff and other health and social care professionals worked together to assess people's needs and plan their care. This was done so people's needs and preferences would be met, and they would enjoy an enhanced sense of well-being.
• People were supported by staff to make decisions about their care. Staff used their knowledge of people's preferred ways of communicating, to assist people to make their own choices.
• Staff did not always promote people's right to independence, dignity and respect.
• Staff supported people to have timely access to external health care. This improved health and well-being outcomes for people living at Wolston Grange.
• Staff received an induction and on-going training to develop and maintain their skills, however this training was not always put into practice and for some staff, they told us it was ineffective.

• People, their relatives and staff were encouraged to make any suggestions through annual surveys. Staff had meetings which gave them a chance to share ideas and feedback.
• Most people were happy living at Wolston Grange and were cared for by staff who understood their preferences and were kind.

Following our inspection, we notified relevant stakeholders such as the Local Authority Quality Team, Local Clinical Commissioning Group (CCG) and the Fire Authority about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment.
Regulation 17 Regulated Activities Regulations 2014 - Good governance.

Rating at last inspection: Good. The last report for Wolston Grange was published on 9 March 2017.

Why we inspected: This was a planned inspection based on the rating at the last inspection. The previous 'good' service provided to people had not remained consistent. At this inspection the rating has now changed to Inadequate overall.

Enforcement: Action provider needs to take (refer to end of report).

Follow up: Due to level of risks identified from this inspection, we wrote to the provider under Section 64 of the Health and Social Care Act 2008, to request for provision of an action plan to address our concerns. We will continue to monitor progress made against the provider's action plan and any regulatory action as an outcome of this full inspection report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

Wolston Grange

Detailed findings

Background to this inspection

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

Inspection Team:
One inspector carried out this inspection, supported by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Wolston Grange is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.' A manager had been appointed on 10 January 2019 and was in the process of registering with us.

Notice of inspection:
The inspection was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse and information from the public, share your experience forms, whistle blowing concerns and from local commissioners. We did not send the provider a provider information return is a form which gives them an opportunity to tell us about their service and what they do well. Through our conversations we gave them an opportunity to tell us and show us. We used all this information to plan our inspection.

During our inspection we spoke with seven people living at Wolston Grange to get their experience of what is was like for them. We spoke with the area manager, a marketing manager (previously a registered manager at this home), the home manager, a senior lead, three care staff, a cook, the housekeeper and two maintenance staff.

We reviewed a range of records. For example, we looked at three people's care records and multiple medication records. We also looked at records relating to the management of the home. These included systems for managing any complaints. We looked at the provider's checks on the quality of care provided that assured them they delivered the best service they could. Following our visit, we received further information from the home manager and marketing manager to inform us about the immediate actions they had taken, following our feedback to safety concerns.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not always safe and at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● There was a failure to ensure people were protected from the risks associated with inadequate fire safety systems and processes. Monthly fire checks were completed, but where faulty equipment had been recorded, limited or no action had been taken to make the required improvements. For example, fire emergency lighting had been identified as faulty since 27 August 2018, but no action had been taken to rectify this. Other audits such as 'fire door inspections' showed fire door closures were required or needed adjusting, but this work had not been completed. During our visit we asked the provider to investigate this urgently and to let us know, when action would be taken. Following our visit, we received assurance from the provider that work was planned to remedy these defects.

●Maintenance checks included monthly checks on water quality to ensure people were protected from water borne viruses. However, monthly temperature checks in people's bedrooms regularly recorded hot water temperatures as 56 degrees Celsius, which exceeded safe limits. This meant vulnerable people were at risk of scalding themselves. Following our visit, the marketing manager confirmed thermostatic temperature valves had been fitted to limit the potential for scalding.

●There was a failure to check windows had safety devices fitted to restrict opening. First floor bedroom windows had incorrect devices fitted to prevent them opening too wide in line with health and safety regulation. Some of these window restrictors had been identified as needing replacement on 18 September 2018, but the provider had not replaced them as they believed they were safe. One staff member told us someone had absconded from the house October or November 2018 through a window. The provider had sent us a statutory notification in November 2018 telling us someone had been found near a road. Following our visit, the marketing manager said they were investigating the correct tamper proof restrictors and would ensure they were fitted.

● District nurse staff kept paper records and medical supplies such as prescribed bandages and sterile solutions in a cupboard on a ground floor corridor. A poorly fitted lock meant we could open the door and take items from this locked cupboard. In this cupboard we counted at least 80 tubes of 20ml of sterile saline solution. This had potential to put people at risk if consumed in quantity. Staff had not identified this risk. This cupboard was secured before we left on day one of our visit.

●The provider' used risk assessment tools to assess individual risks. Their current risk assessments did not show, how some risk scores had been achieved which made it difficult to assess changing health needs had been considered.

● Where individual risks had been identified, people's plans of care did not consistently describe the action staff should take to minimise the identified risks. Risk management plans lacked specific details for staff to safely manage risk. For example, one person was assessed as a medium risk around their smoking routine, however records and staff conversations indicated this was a potential high risk because they smoked in their room and the person needed to be observed. We found this person smoking outside with no staff observation in place. Staff said, there were times the person was not observed.

● Risks for people spending time on their room, did not have the right equipment to seek help when needed. One person told us they had recently fallen from their bed, and they had remained on the floor, most of the night. They said, "I was cold, it was not very nice." An accident record showed this person was found by staff at 5.50am. The person told us and records showed, they did not have a call bell in reach, because their bed was too far away from the call bell point. This person told us they frequently had to shout or throw items at their bedroom door to summon help because staff had not considered the risks if the person could not use a call bell to get help quickly. The manager told us some people would not be able to use call bells due to living with dementia, yet care plans did not identify which people were unable to use call bells and there was no evidence to show other systems had been considered, to alert staff to when people needed assistance.

Staffing and recruitment

●We could not be assured staffing levels supported people's assessed needs because we were not confident those needs were assessed correctly. The provider told us they used an assessment tool to determine staffing levels required to meet people's individual needs safely, but this was not made available to us on the day. Following our request, we received it after our visit. This tool identified people's needs and risks but we were not confident, risks were recorded accurately. For example, one person used a wheelchair and staff said on occasions, two staff for transfers, but records showed they used a walking frame and one staff member. Our observations on the day were staff were not always easy to locate, given the layout of the home but we did not see people waited long for assistance.

●Agency staff were working in the home to cover staff vacancies. People said agency staff did not always know their preferred routines and staff told us they had to keep checking agency staff were supporting people safely. This impacted on their available time to sit and chat with people.

●The home layout presented challenges. Communal areas of the home were unstaffed at times and people had no effective system to summon staff support if needed.

●People's experience of requesting timely assistance through ringing call bells when in their bedrooms, was mixed. People's comments were that staff were timely, yet one person said they had waited 30 minutes for assistance.

● We did not look at all recruitment files, however we checked how the provider assured themselves, agency staff were of good character. The marketing manager said they had training and staff profiles, as well criminal record checks to ensure agency staff were of good character. For their own permanent staff, we checked to make sure staff had enhanced criminal checks and found these were in place.

Using medicines safely

● The management of medicines was not always safe and people were at risk of not being given them safely, consistently or as prescribed. Where people had been prescribed medication on an 'as and when needed' basis, for example pain relief or for agitation, there were no clear protocols for staff to know when to give this medicine.

●People receiving medicines in a patch, had their patch applied at the required intervals, however staff had not followed manufacturer's guidance for the application of the patch. This had potential for people's skin to become irritated or the medicines not to be absorbed at the prescribed safe rate. Daily checks were not completed to ensure the patch medicines remained in place.

● Medicines identified for destruction were not stored and managed safely. We entered a locked but vacant ground floor bedroom, and found six boxes and a black bag full of discarded blister packs, many containing medicines. All of these medicines, including other boxed medicines, liquid medicines and inhalers were discarded without being recorded and disposed of safely in line with NICE guidance. We found two upturned sharps boxes which had potential to put staff who accessed this room at risk of injury or infection.

●We raised our concerns with the management team. The area manager told us they knew about this issue,

but not the scale. Following our visit, the marketing manager confirmed actions had been taken to return all the unwanted medicines to the pharmacy.
●We checked a selection of people's medicines and found current stocks were correct and people received them as required.

Preventing and controlling infection
● Areas of the home were not well maintained which meant effective cleaning could not take place. For example, we were told by managers and staff that due to the type of drainage system, cleaning products such as bleach could not be used. We saw a number of communal toilets and toilets in people's own bedrooms, that were stained and unhygienic. The walls, windows and window sills in a communal room in the main house were in a poor state of repair which meant they could not be cleaned effectively. In a linen cupboard, we found some bedding was kept on the floor which meant it was difficult for staff to keep the floor clean, and the bedding free from contamination.
●On both days of our visit, a communal bathroom on the first floor contained a person's toiletries bag, a razor and a clothes brush, plus hand and bath towels which increased the risks of any infections spreading.
●We were told each person had their bedroom deep cleaned once a month, but we found these were not always carried out effectively. Maintenance staff told us they were told to paint over marks and stains instead of cleaning those areas with appropriate products or making good repairs.

Learning lessons when things go wrong
● The provider was responsible for analysis of accidents and incidents to identify patterns and trends and prevent a reoccurrence. Staff had reported and recorded accidents and incidents. The provider had undertaken an overall analysis to ensure risks of reoccurrence were mitigated. However, we checked the provider's falls analysis for December 2018 and found it was not accurate. Different accident logs, the managers accident analysis and accident and incident forms completed by staff, recorded different numbers for December 2018. Accident and incidents were either recorded as four, seven or 13. No one had identified these discrepancies and followed it through so we could not be confident all analysis led to further investigation.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff were trained and knew how to protect people from abuse and poor practice. Staff were confident to raise any concerns with senior staff, the manager or senior management within the organisation. If staff felt no action was taken, staff felt confident to 'whistle blow'. Staff told us they had not witnessed any poor practice they felt needed to be referred to the provider or to us. The registered manager knew the procedure for reporting safeguarding concerns to the local authority and to us (CQC).

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- Care staff received training which they said equipped them with the skills they needed. People felt permanent staff had the right skills, but were less complimentary about how they were supported by some agency staff.
- We could not be confident staff always put their learning into practice. For example, we could not be confident staff followed their training to move people safely and effectively in their wheelchairs. We saw staff moved a person in a wheelchair that only had one footplate in place. The person being moved had a bandaged leg and told us their wheelchair was broken. This person told us, "I have to put this leg (bandaged) and rest it on my other leg when I am being moved. I don't feel safe, but it's a case of having to be." This person said the other footplate was in their room.
- Staff who completed health and safety and fire safety checks told us they had limited training to know what to look for and how to make effective and safe checks on equipment. Training schedules showed they had received training, but there was no follow up to ensure they understood and put it into practice. One staff member who carried out health and safety checks told us they learnt how to do some things from the internet.
- The number of concerns identified in relation to people's overall care and support meant training was not always applied or observed to prevent poor practice from becoming common practice. We found examples of poor staff practice when responding to the needs of people living with dementia, unsafe management of medicines and lack of infection prevention which impacted on the quality and safety of care provided.

Adapting service, design, decoration to meet people's needs

- The home environment needed further maintenance and redecoration in people's bedrooms and some communal areas to help provide a safer environment for effective care to be delivered.
- People living in 'The Barn' were unable to use the lift at the time of our visit because it had a sign that said, 'lift out of action'. The marketing manager told us the lift was in working order, but no one had questioned the sign. People living in The Barn could use the internal stairs, but restricted access to the lift had the potential to limit people's freedom of movement.
- Some doors had signs stating, 'Keep locked' but we found some of these doors were open which put people at risk. For example, one unlocked cupboard housed hot water tanks and hot pipework.
- The provider supported people living with dementia. No assessments had been carried out to assess what alterations and adaptations, including suitable use of signage and decoration, were required to assist people to find their way around the home independently. People's own bedroom doors had no memorable objects or prompts nearby to help them find their own room easily. The lack of intervention and actions of the provider to monitor and maintain the environment to an acceptable standard is further discussed in the

well led domain.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met."

● Staff worked within the principles of the MCA and explained to people what was happening and gained their consent, for example, before moving them or asking where they wanted to sit, and what they wanted to do. Staff said they offered people choice and respected their decisions. Where people were unable to make a choice, staff made choices for them knowing they were in the person's best interests.

● People said staff involved them in making daily decisions about their care and support.

● Some people's care plans recorded whether they had given consent, but this was inconsistent and not always relevant to wider aspects of care, such as agreement to care decisions, photography and for staff to hold a person's tobacco.

●The manager told us three people had some restrictions on their liberty and applications had been submitted to the local authority to ensure any restrictions were not unlawful.

Supporting people to eat and drink enough to maintain a balanced diet

● People's main meal was served at lunchtime and people said the food was nice. There were no plated options or pictorial cards to help those with a memory impairment choose what they wanted to eat.

● At lunch time in the main house, people were brought to dining tables 40 minutes before lunch was served, but people had nothing to keep them occupied while waiting, such as conversation or music to listen to. Staff served people, without knowing who had been waiting the longest which increased people's frustration.

●Prior to our visit, we received information some foods were out of date. We checked kitchen food items and found they were in date and the cook told us they had enough food in stock to provide people with alternative options if they did not like the menu choices.

● Nobody had specific or cultural diets that needed to be met, but the cook said this would be accommodated.

Staff working with other agencies to provide consistent, effective, timely care

● People received support from other healthcare professionals. One person told us they were visited by the district nurse and spoke positively about the district nurse service at the home. This person felt well supported and said of their treatment, "It's wonderful." Other people told us they saw the doctor, optician and a chiropodist. One person told us, "A dentist comes into the home, to check people's teeth, but if they need any work done, they would have to go to the practice."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

- Overall, people were treated well by staff during our visit and we did see some good interactions. Staff held people's hands or put an arm around them when they were upset or becoming anxious. Staff were patient and responded calmly to help prevent certain behaviours from escalating.
- However, we saw other interactions which were not so caring. When one person became vocal towards a member of staff, the staff member responded by turning their back on the person, saying 'we don't do that', then walked away.
- One person told us how they had a fall from bed and could not call for help because they had no call alarm bell in reach. During our visit we saw some people in bed, but they had no available call bell to hand to summon help. This impacted on people's ability to seek help when they wanted it could lead to them being socially isolated.
- Within other key questions within this report, we have reflected how the provider's lack of oversight, scrutiny and investing in people and their environment has impacted negatively on some people's experiences. Concerns around fire safety, maintaining equipment, monitoring infection control risks and other safety risks, showed us the provider were not always focussed on providing a caring service, despite staff's commitment to caring for people on an individual basis.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were not asked which gender of care staff they preferred to support them on a daily basis, or with more intimate care. Some people said they did not want certain staff and when they raised this, their views were respected, although this did not apply to everyone.
- Care evaluations were completed by staff, but it was not common practice to involve people or relatives. People's records included space to record their likes/dislikes, previous occupations and hobbies but most of these were left blank. This information would help staff and especially agency staff, get to know people.
- For some people whose tobacco or cigarettes were held by staff, there remained no evidence people's views and agreements had been obtained.
- The marketing manager told us recent quality questionnaires had been sent out to people, relatives and professional visitors, but all responses had not yet been returned. We were told early indications showed people were pleased with the service they received.

Respecting and promoting people's privacy, dignity and independence

- Everyone told us staff were caring, particularly complimenting permanent staff. Some people felt agency staff, although were kind to them, did not show the same levels of compassion. People said their own space and possessions were treated respectfully by staff.

●Staff understood the importance of privacy and showed their respect by knocking on people's doors and waiting, before they went in. For most of the time, staff were respectful when talking about people, however on occasions, staff would discuss people across a room which was not always respectful, although this did not involve confidential information.
One person shared a concern that their privacy and dignity was not always respected because they were always woken up at 5.00am for continence care. They told us, "I don't like this." They did not understand why this happened but said they had become used to it. We discussed this with the manager who was not aware of this and agreed to investigate this.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People had individual care plans but there was limited evidence or comments from people that showed they had been involved in how their care was planned and provided.

● Care plans gave minimal information around people's emotional support needs and focused on their physical needs.

●Where people had specific health conditions, additional information was not consistently provided to tell staff how they should ensure people's needs were met. Staff gave conflicting information about people's health conditions, such as a person's skin integrity or how the person mobilised, Staff told us they did not always have time to read the care plan and because agency staff provided care, people said they had mixed experiences.

● People's religious beliefs were sometimes recorded, but there was no information about how important it was to them and how they were supported to follow their faith, although two people said staff would take them to a place of worship.

● We found people lacked planned interaction and stimulation and told us they did not know when and what activities took place. By the main entrance was a notice board which showed 2018 upcoming events, nothing for January 2019. One person told us activities were not stimulating enough and explained they did not want to do 'colouring in' or jigsaws, but activities that tested their brain. They told us they liked a 'good quiz', but this was rarely accommodated. Throughout our visit, we saw people walking around the home but there were limited opportunities for them to speak with staff or to engage with tactile items or visual prompts to evoke memories and start conversations. These things are an important aspect of good dementia care, enabling people's memories to be stimulated. A staff member said one person had an engineering background and liked to touch things, but there was nothing that helped this person to do those things. The staff member told us this person removed radiator covers because they liked to play with the metal covering. The lack of tactile possessions meant this person put themselves and others at unnecessary risk by removing important safety measures.

●People living in The Barn told us they usually stayed in their part of the home and were able to lead more of an independent life. They told us they made their own drinks and prepared their own meals. They told us they got on well with each other.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place.

● The manager told us there had been one complaint since January 2019 but this had been responded to and closed.

●People told us they would raise a complaint if they had to, and they knew who to speak with.

End of life care and support

● At the time of our visit there was no one receiving end of life care. The manager and staff said if it was people's expressed wishes, this would be their home for life.

●People's wishes and preferences in the final stages of their life was not recorded. Staff told us they had previously supported people at the end of their life, and staff were confident they would be able to meet people's wishes and choices for their care in their final days.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Inadequate: There were widespread and significant shortfalls in service leadership. The provider and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's ineffective leadership and systems to monitor the quality and safety of the service and to act on those findings, meant people did not receive a good standard of service. Management and staff failed to take responsibility to identify the shortfalls we found, including risks to people's safety and welfare. For example, in relation to fire safety, medicines management, infection control, maintenance of the building, and suitably trained and skilled staff to meet people's needs.
- We found shortfalls in the accommodation, which included the maintenance of the building, its fixtures and furnishings. The lack of safe and suitable facilities directly impacted on people, which risked their safety, health and welfare.
- Some fire safety checks undertaken from August 2018 to January 2019 recorded essential equipment as faulty and unfit for use. Records did not show what actions had been undertaken and what was still required. Following our inspection visit we were told repairs were undertaken by an electrician on 8 February 2019 and fire door closures were to be fitted as soon as possible, with no exact date provided.
- Health and safety of the building had been audited and actions identified, but these had not been undertaken to drive and sustain improvements put people at risk. Checks made on hot water temperatures were not completed from March 2018 to July 2018. When checks began, those checks continually recorded high temperatures, but no action was taken, even when they exceeded safe limits. Radiator covers could be, and were easily removed, because of incorrect fixings. This exposed radiators too hot to touch because thermostats were set too high. Window restrictors were not to required legislation and infection control measures were not sufficient.
- Medicines disposal management was poor. Significant amounts of unreturned medicines had not been recorded and made safe for disposal. Reasons given were for unsafe disposal of medicines included, "We did not have a returns form" which demonstrated a lack of understanding and disregard for safe medicines practice. No one had taken responsibility even though management were aware.
- Our conversations with the area manager, manager and marketing manager showed a lack of clarity about whose role it was to take responsibility for checks and when checks were delegated to others, who ensured they had been completed.

The above concerns demonstrated this is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● In the last two months, the provider had undertaken a quality assurance survey but the results were not yet completed and analysed. Questionnaires had been completed by people living at the service, professional visitors and relatives. The marketing manager told us results recorded a high satisfaction rate across the service. The level of satisfaction reported was not reflected by our findings during our inspection visit.

● The provider facilitated opportunities for staff to share their views through staff meetings and the new manager had plans to involve staff further. The manager had plans to improve the team structure so staff had clearer ideas about their own roles and responsibilities especially when checks were to be completed. The manager said involving staff in this gave them a greater sense of ownership. The manager was planning to set planned supervision meetings and upon their appointment in January 2019, had introduced a 10.30am meeting for heads of department to share any concerns about the service.

Continuous learning and improving care; Working in partnership with others

● There was limited evidence to show how the provider assured themselves of what good dementia care was or how they kept themselves informed of current best practices. Discussions with the management team showed a lack of current knowledge of health and social care best practice, legislation and regulation. The manager upon appointment had identified a number of improvements and was in the process of completing an action plan to address the issues. They told us there was a number of competing priorities and it would take time, but they assured us they would make those improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to mitigate any such risks. The lack of risk management related to the management of the premises, fire safety, medicines management and infection prevention.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were not effective to monitor the service appropriately, including people's safety.