Castle Meadows (Dudley) Limited

Castle Meadows Care Home

Inspection report

112 Dibdale Road
Dudley
West Midlands
DY1 2RU

Tel: 01384254971

Date of inspection visit:
18 April 2017

Date of publication:
17 July 2017

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**

Summary of findings

Overall summary

The inspection took place on 18 April 2017 and was unannounced. The home was previously owned by a different provider and this was the first inspection of the service under the new provider registration.

Castle Meadows Care Home provides accommodation, personal and nursing care for up to 51 people who may be living with dementia or a physical disability. At the time of our inspection there were 45 People living at the home. The home is divided into two units; the residential unit and the nursing unit.

The home did not have a registered manager as the person in post had recently left the service. Interim management arrangements were in place. 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.

People were not always protected by a staff team who understood how to manage risks to them effectively. People were sometimes moved in way that increased the risk of injury to them. The provider's systems for safeguarding people were not operated effectively and as such concerns were not escalated to prevent the risk of harm to people who used the service. Improvements were needed to ensure people had sufficient staff available to them to ensure they had support without delays. People's medicines were stored securely and administered safely by trained staff.

We identified shortfalls in the care provided to people using the service. This was linked to the inconsistent management of the home due to several changes in recent months. The systems to monitor and check the standards of people's care and their safety had not been entirely effective. A new home manager had been recruited and the senior management team have developed an improvement plan to address the shortfalls and improve the experience of people living at Castle Meadows. However these changes and improvements will take time to embed before people can be certain they will consistently benefit from safe, strong leadership and governance.

Staff were supported in their roles however improvement was required to ensure staff applied their training to safely care for people. Staff sought consent from people and had some knowledge of the Mental Capacity Act (MCA) (2005) and how to support people with making choices. Where deprivations to people's liberty had been identified the relevant applications had been made. People were supported to eat and drink sufficient amounts although the arrangements for mealtimes needed improving to ensure people had support provided in an appropriate manner.

People and their relatives were happy with the care provided and told us that staff were kind and caring. During our observations we saw people were treated with dignity and respect but this was not consistent across the service. Personalised care was not arranged in a way that ensured people's needs and

preferences were addressed. People were supported to take part in activities they enjoyed.

Any complaints received by the service had been dealt with in line with the provider's complaint's policy and procedure. People were supported to provide feedback about the service provided.

You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not consistently safe.

People did not always receive safe care because staff did not recognise when people may be suffering harm. Staff did not use the provider's processes for reporting such concerns. Risks to people were not always well managed and people were sometimes moved in way that increased the risk of injury to them.

People were not always supported by sufficient numbers of staff.

People's medicines were stored securely and administered safely by trained staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People could be at risk of injury because staff did not use their training when using lifting techniques.

People did not always receive support in an appropriate manner when eating their meals.

People's consent was sought and capacity taken into account. People received support from a range of professionals to maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People described staff as caring but some people had little contact time with staff.

People's dignity was not consistently addressed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not all experience a person centred approach to their care needs.

There were opportunities for people to enjoy activities.

Systems were in place to identify and investigate concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The management arrangements had not been consistent and the overview of the service was ineffective.

Systems to monitor and improve the safety and quality of the service had not ensured people's needs were consistently well met or that governance arrangements were effective.

Castle Meadows 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 checked 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.'

This unannounced inspection took place on the 18 April 2017. The inspection team consisted of two inspectors.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications and reviewed the information from notifications to help us determine the areas we wanted to focus our inspection on.

We spoke with 14 people and met a further six people who were unable to physically speak with us due to their health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the acting manager, two nurses, a unit manager seven care staff, the cook, four relatives and the regional manager. We looked at six people's care records including monitoring records and wound plans. We viewed daily records, the diary and communication books. We looked at medication administration records, three staff files, incident and accident reports, menus and quality assurance records to see how the provider monitored the quality of the service. After the inspection we were sent copies of records about quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

People were not always being protected from risks to their health or safety. We met one person who was cared for in bed and their distressed behaviour led us to see an open weeping wound. We spoke with two care staff who were attending to the person but they were unable to tell us about this wound. We spoke with the nurse on duty who confirmed they were unaware of the wound. Our check on records showed there was no reference to this wound in the person's daily records and no care plan was in place for the management of the wound. The nurse told us, "If someone has a wound or a dressing we put it in the diary so we know when it needs changing". We checked and found there was no diary entry. We found a record of a skin tear that the person had sustained the month previously but there was no further evaluation or monitoring to show staff were checking the healing process. This demonstrated that this person had not received the interventions they needed because staff had not followed the provider's processes for concerns of this nature to be reported to a nurse. Further, the person's care plans had not been maintained or kept under review in order for the wound to be managed.

We found other risks to people were also not being managed safely. For example we saw two people who had decreased mobility being supported in an unsafe manner by staff. On both occasions staff supported the person using underarm techniques, which can cause injuries to people. The risk assessments for both people did not clearly specify the number of staff needed to support them, or detail of whether they required additional aids to support them to stand. Both staff involved in the manoeuvre had received training in manual handling, however they were not applying this training correctly which could put people at risk of injury.

Staff we spoke with were able to tell us about risks to people's safety and welfare. These included the risk of falls. Staff were aware of the measures in place to prevent people from falling and we checked and saw equipment was in place. For example, the commode had been moved closer to one person's bed to reduce the distance they needed to walk and a sensor alarm and falls mat were in place. Records showed that risks to people had been assessed and contained guidance to staff as to what staff should do to keep people safe and well. However the frequency of falls for other people in the home had increased and we saw most of these occurred during the night. Although accidents and injuries had been recorded there was no analysis of the falls to determine if there was a pattern. The acting manager told us that there was no system in place to identify trends or prevent further accidents.

Failing to ensure that people's welfare and safety needs are met is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

During the inspection the registered manager took action in relation to the omissions of care for one person. The person's wound was dressed and this was reported to the local authority safeguarding team who are the lead agency when people suffer harm or abuse. The manager advised that a nurse meeting had been arranged and a wound management diary that highlighted the dates when the wounds were required to be redressed had been implemented. This action had been taken to ensure that the person received the wound care needed

People told us that they felt safe living at the home. One person said, "I feel quite safe; staff are good to us here". Another person said, "Staff treat us all well there's no abuse here". Although staff told us that they understood the different types of abuse people could be at risk off and we confirmed they had training in this area, we found shortfalls in their practice. One staff member told us, "We all have training in abuse and the procedures are there in the office; if I had any concerns I'd report to the nurse or manager". However they had not followed these procedures, or recognised that the lack of wound care for the person was an omission of care which is a form of abuse. Staff had not reported the wound to the nurse, the nurses had not monitored the skin tear and the person had not received the wound care they required. The provider's systems for safeguarding people were not operated effectively and as such concerns were not recognised and escalated to prevent the risk of harm to people who used the service.

Failing to ensure that people are safeguarded from suffering abuse or improper treatment while receiving care and treatment is a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

People told us that staff were available to support them when needed. One person said, "There's always staff around in the lounge (residential) and they are pretty quick to help". Another person (nursing unit) told us, "If I press my buzzer they come and check me, I've no complaints". A relative said, "Staff are always available in the lounge through the day". Another relative said, "Sometimes there is one (staff member) giving out medicines and they have to stop to help other staff". We observed this on the day because there was an error in the rota for the nurses which meant no nurse turned up for the morning shift. This meant the nurse on nights stayed over to do the medicines. Staff told us that they thought there was enough staff to meet people's needs, although they had experienced working double shifts to cover gaps. One staff member said, "The planned levels are no problem, it's when staff ring in last minute that it is difficult to manage, also a number of staff have left and we have to wait while they [The provider] recruit more". We saw that the staffing levels meant that some people had to wait for support. This was evident in the middle floor nursing unit, where we saw three people experienced several occasions where there was no staff in the lounge for long periods of time whilst the two staff assisted other people who were cared for in bed. We saw a person called out for the toilet on several occasions but there was no staff in the room. The person said, "I can't wait" and was showing signs of distress. We saw that fifteen minutes passed before there was staff available to assist the person. Staff told us that the dependency level of people on the middle nursing floor was compromising how they could meet people's needs. The acting manager was not in a position to explain the dependency tool being used to calculate staffing levels.

The provider had carried out recruitment checks on new staff including nurses. We saw from staff files that they had sought references and completed applications with work history prior to new staff starting work. These checks included obtaining Disclosure and Barring Service Checks (DBS) which provides information about any criminal records. Checks on nurses included confirmation that the remained registered with the Nursing and Midwifery Council (NMC). Staff we spoke with confirmed these checks had taken place.

People told us they received their medicines as prescribed. One person told us they regularly had their cream for their itchy skin and said, "That does help I suppose". Another person said they had their prescribed medicines for a medical condition regularly. A person told us they had regular pain relief when they needed this and said, "Staff always ask if I want any", and we observed this happen. We observed the medication routine in both units and saw staff and nurses checked doses and people's names before administering medication. Medicines were stored securely and a check on people's Medicine Administration Records (MAR) confirmed people had received their medicines as prescribed. The nurse confirmed that regular audits were undertaken to ensure safe practice. Staff had received training to administer medicines safely and were able to describe where people needed medicines to be given in a specific way or 'when

required', and written protocols were in place to guide staff in this. Where people had been prescribed controlled drugs, these were stored within a locked controlled drug cupboard. Records showed regular checks were made on the temperatures of storage areas to ensure they remained within safe ranges.

Requires Improvement

Is the service effective?

Our findings

Staff told us they had regular access to training and refresher courses as well as additional training specific to people's needs. This included for example training in dementia and manual handling. Nurses told us training in specific nursing tasks had also been undertaken. Staff said that supervisions and staff meetings had not been as regular due to recent management changes. Nurses told us that nurse meetings did take place although the previous two meetings had been cancelled which meant the opportunity to discuss clinical practices had been limited. The impact of this was evidenced via the concerns we identified in relation to the lack of wound care plans and management of wounds. We saw that two staff had not applied their manual handling training safely when assisting people to mobilise. We also found that although staff had received safeguarding training they had not followed processes by reporting the person's wound. This also identified that competencies in these areas were not being checked regularly to ensure people's needs were met effectively.

Registered nurses are required to undertake continuous professional development to meet the requirements of the Nursing and Midwifery Council (NMC) and to ensure that they maintain current, best practice knowledge. Nurses we spoke with confirmed that training to help them meet this requirement as well as support with their revalidation was provided and this was confirmed on their records.

People and their relatives provided positive feedback about the ability of the staff to support people effectively. Comments from some people who lived at the home included; "The staff are wonderful to me; I can't fault them", and "They have really got to know me and help me a lot". Relatives commented, "The care is good; the staff know what they are doing". Another relative said, "I'm really happy with the home, you can't knock the staff".

Staff told us they felt they had the skills needed to perform their roles confidently and confirmed they had completed an induction when they started work at the service. This had included a period of shadowing more experienced staff and familiarising themselves with the provider's policies and procedures. One staff told us, "Yes I felt quite prepared and understood my role". The acting manager who had only been in post a couple of days was not sure whether the care certificate, which is a nationally recognised induction programme, was used for new staff inductions. From the staff records we viewed we saw staff had a five day intensive induction and had National Vocational Qualifications, (NVQ), which would equip them with the standards and skills required.

The majority of people told us they enjoyed the meals served and that they had a choice. We saw at breakfast that people were asked what they wished to eat and that this was served individually to them. One person said, "I'm having tomatoes on toast that's my favourite". Some people, relatives and staff described the meals as repetitive and a view of the menus confirmed this. The cook confirmed that they were looking to change the menus and improve choices on offer. They had also decided to trial the main meal at teatime as a result of people's feedback. We saw that staff supported some people with their meals where they were unable to manage this for themselves. However in the nursing unit17 of the 18 people ate seated in their arm chair. There was limited space for staff to assist people which resulted in them at times standing over

people or kneeling at their chair. Staff said everyone chose to sit in their arm chairs but there was no record of this. One person told us, "I can walk to the table; I don't really mind where I eat". Another person said, "Mostly we just sit here, I don't know why". This meant that people did not have the opportunity to experience mealtimes as a social event. Mobilising to tables would also encourage and promote people's mobility and pressure relief for fragile skin.

The cook said they were aware of people's specific dietary needs although we saw people's likes and dislikes had not been recorded. Allergies and dietary information, for example guidance from the Speech and Language Therapist (SALT) regarding the consistency of people's meals was available in care plans to reduce the risk of choking. We saw staff supported people well when assisting them to eat in terms of encouragement, the pace of assisting them and prompting. A variety of drinks were offered to people throughout the day and we saw that fluid intake was recorded to ensure people drank enough.

People had access a range of healthcare services when they needed which included the GP, SALT, dietician, dentist and podiatrist. We heard from one person and their relatives that physiotherapy had been arranged and staff helped them with their exercises. Relatives told us that staff kept them informed of any healthcare changes.

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. Staff explained that they did involve people in daily decisions about their care and gave examples about involving people in choosing their clothes, what they ate and drank and what they did. A relative we spoke with confirmed this and told us, "I hear staff ask people first". A person living at the home said, "Oh yes, they always ask; they'd never do anything without asking". Staff were able to identify where a person's capacity had changed in some aspects of their care whilst in other areas they maintained the ability to make decisions for themselves. We saw this was recorded in people's care plans.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. One DoLS application had been approved at the time of our inspection. We saw a further nine applications had been made so that people could continue to receive the support they required. Staff told us they had received training in this area and understood they could not unlawfully restrict people.

Requires Improvement

Is the service caring?

Our findings

We identified that the dignity of some people on the middle floor nursing unit who were unable to tell us about their care experiences, was not consistently addressed. For example we saw a person with spillages down their clothing, their protective apron on the floor, dishes and cups still on the table in front of them at noon as these had not been moved after breakfast.

On this unit we saw that there was very little interaction with some people from staff. The interactions we observed were mainly task orientated, for example providing meals and drinks. People sat for long periods with the T.V. on, the only form of stimulation which they were not responding to. When staff did interact they were friendly and caring, however the amount of contact and care people had during the morning routine was minimal. We saw staff were consistently busy with other people, which left some people quite isolated during this time.

In other areas of the home we saw that staff ensured that they protected people's privacy when they assisted them with personal care. They spoke with the person discretely and assisted them to the toilet or bedroom. A person living at the home told us, "They [staff] always cover me up and make sure doors are shut if I'm having a wash or on the toilet". Staff described how they tried to provide people with care from same gender staff. One person who lived there commented, "A male carer came to assist me and I said I don't think so, and there was no problem they went away and fetched a female".

People told us that the staff were very caring. One person said, "Good as gold they are; ever so good to me here". Another person described how staff cared for them; "Six weeks here, never been in care but the staff are marvellous; can't do enough". A relative told us, "Girls are very good, very friendly, mom is happy here".

We observed that staff had a caring approach; they frequently smiled at people when they spoke with them. We heard staff exchange friendly banter with people who smiled and chatted back to them. We saw staff checked that people were sitting comfortably and noticed when people were distressed. We saw they offered reassurance to a person who told us that they got anxious when they were waiting for their husband but that staff were; "Good at calming me down". A relative spoke about how staff were caring towards their family member who due to their dementia got anxious. The relative said, "Staff do reassure her if she gets fretful, they are very calm. Watching them with other residents is very reassuring; I can't say I have seen a situation which staff has not handled well".

It was clear from our observations that staff knew people well and used this knowledge and their relationships with people to engage with them. People told us that staff listened to them and they felt they mattered because staff took an interest in them. We saw this when staff engaged with people about topics they were interested in. For example discussing popular TV programmes, events in the news, their interests such as gardening and family members they missed.

People confirmed they were involved in making decisions about their care and treatment. They told us that staff knew how they liked their support to be provided; such as their routines and how they liked things

done. One person told us, "I get up quite early and staff help me, I like to come down for breakfast early". Another person told us, "I tell the staff what I want and they are very good; help me to do things when I want to like going to bed, when I get up and what I want to eat". We saw that people's care plans contained information about how they liked their support to be provided and reflected that people had been involved in this process. One person told us, "They [staff] do ask me questions and keep me involved". Relatives we spoke with confirmed they were involved in their relative's care and this was reflected in people's care records. One relative told us, " I do discuss mom's care needs and staff keep me up to date if there are any changes in her health; I am Involved".

Staff told us that they encouraged people to maintain their independence. One person told us how staff promoted this; "I can walk so far but not long, if longer staff will use a chair". Another person told us, "I do certain things for myself; the staff will always check I can manage but don't take over". Our observations showed that staff did look for opportunities for people to do things independently; for example we saw a member of staff assisting a person with their meal, a senior staff member stepped in and told the staff member, "Let (name) help self where able just observe and offer assistance when needed". We also saw a staff member support a person to walk independently with a Zimmer frame before they tired and transferred to a wheelchair.

People told us they had opportunities to attend religious services within the home so that they could express their faith. The cook confirmed that people's religious or cultural diets could be catered for. People told us that they were supported to maintain the relationships that were important to them. One person said, "There are no restrictions my family come when they want to". A relative told us, "I visit regularly and am always made welcome; the staff are friendly and offer me a drink". A person told us, "I was very worried about moving into care but to be honest I can see my family the same and I have lovely carers in the meantime".

Information about local advocacy services was available within the home. Staff we spoke with were aware of when advocacy could be used to support people's choices.

Requires Improvement

Is the service responsive?

Our findings

A person told us, "I came to live here recently and they [staff] sat with me and my family and went through everything; what I can do and what I can't". Another person told us, "I think they spoke with me and my family and I'm quite happy they know my routine". Another person's plan detailed how they liked their door closed and the lights turned off. Care plans provided information as to what people liked to do for themselves and where they were able to make their own decisions such as getting up, going to bed and what clothes they wore.

However we saw that people's care was not always delivered in a way that reflected their individual needs. For example three of the people whose care we looked at in detail looked unkempt with greasy hair. The three people were unable to tell us how their needs were met. Staff spoken with stated that the hairdresser usually 'see's to people's hair'. We checked the daily records for each of these people and could find no evidence of when they last had a bath, shower or hair wash. People's preferences were not clear in their care plans and there was no system for ensuring personalised care was provided in line with their care plan. Staff told us that one of these people regularly refused personal care; there was no record of this to show how staff should manage this situation to ensure the person received the care they needed.

Another person had recommendations in place regarding their diet as they had been assessed as at risk of choking. We saw they did not follow the 'soft' diet recommended and told us they did not like this. Staff told us the person had no difficulty eating or swallowing. The care plan was not in keeping with the person's choices and improved condition and there was no record that staff had ensured they responded to this need via seeking a second assessment for the person.

Staff were able to describe the needs of people and told us they had access to people's care plans to provide guidance. We saw where risks had been identified such as falls, that appropriate equipment such as alarm mats and door alarms had been sourced to alert staff about people's movements. A staff member told us, "We know who is at risk and who needs support and if they need other input we would refer to other healthcare professionals for advice".

People told us that they had been involved in reviews of their care. A relative told us, "I've attended reviews and discussed changes". We heard from people that when their needs had changed such as a hospital stay, that they had been visited by staff who updated their assessment. One person told us, "I was in hospital recently but staff came to see before I came home". Several people had chosen to live at the home following an initial respite stay indicating that they enjoyed the standard of care provided to them. One such person told us, "It's a nice home; staff try hard and are helpful to me".

People told us they had attended meetings and relatives confirmed this also. One relative told us, "I have been invited but I had to miss the last two". Another relative said, "We've mentioned the general decoration and repairs and they told us they are looking to improve this; it's the only thing I think lets the home down". People's views had been obtained via the use of surveys but an analysis of these had not been completed.

People told us they took part in a range of planned activities. We saw that a list of events was on display in a pictorial format for people to access. One person told us, "I like the gardening we do a bit of that". Another person said, "We have music, massages sometimes craft, we make some nice things". An activities coordinator was employed although they were not available on the day. People said she regularly asked them for ideas of what they would like to do and was, 'very nice and accommodating'. We heard that a large group coach trip was planned and relatives had also been invited. A relative told us, "The activities co-ordinator does a good job and makes sure people get involved".

People told us that they were confident to share any concerns with staff. One person said, "If I wasn't happy I'd speak to (name of keyworker) and they would sort it out". A relative said, "If I have any grumbles I do have a word and issues are sorted out". There was a system in place for receiving and managing complaints. We saw action had been taken to resolve concerns and a letter of resolution was sent to people to ensure they were happy with the findings.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection of this home under the new provider. There was a manager registered with Care Quality Commission [CQC] but they left in December 2016. A previous acting manager had left the week prior to our inspection. The acting manager present at our inspection told us they had little experience in a management role having only worked as the deputy for a three month period before being promoted to acting manager. They told us they were being supported by a regional manager who visited weekly and who was available if they needed advice. The provider told us this was an interim measure and that a new manager had been recruited and it was their intention to register them with CQC. On the day of our inspection the acting manager was starting her first day in this position. She presented as enthusiastic and was knowledgeable about people's needs. However she was not familiar with all of the processes within the home and delegation of management tasks had not yet been established.

People who lived in the home were not aware who the manager was; one person commented, "I don't know who is in charge", another person told us, "I think there's been a few changes but not sure why". Relatives told us they had a meeting to update them on changes with the management. They expressed concern that there had been, 'several changes recently' and 'it seems a bit unsettled'. Staff we spoke with described low morale as a result of all the changes. One staff said, "I really don't know what's going on; it's really unsettling with all these changes". Another staff member said, "Communication and expectations are so unclear, I don't know, I'm very uncertain with all these management changes". Staff told us it was difficult to maintain any consistency with three different managers in a short time. The regional manager acknowledged that the management changes had caused some lack of consistency and recognised that some aspects of the service provided required improvement.

All of the staff we spoke with told us that they had confidence in the new acting manager. One staff member said, "She is very supportive and will have some good ideas to take us forward". Another staff member said, "I think she will be good for us, but we really need a management structure and some better delegation, it lacks leadership". Additionally nurses told us that the acting manager's clinical experience would help to improve the shortfalls in nursing practices because she understood what was required.

There was a management structure in both the nursing and residential units; this included a manager for the residential unit and a registered nurse in the nursing unit. Staff reported that they felt supported by their immediate manager or nurse. One staff member told us, "Manager is wonderful can approach her." We also heard from staff that they were satisfied with their training and supervision. However we were informed that the two previous nurse meetings had been cancelled. This nurses felt, did not enable them to discuss clinical tasks or have a full overview. None of the staff we spoke with were able to tell us about any competency checks that had been carried out. The incident with the unsafe manual handling techniques indicates that there was no system for ensuring that staff applied their training to their practice.

A range of systems were in place to monitor the quality and safety of the service. However these were not fully effective in monitoring and managing risks to people or capturing people's experiences of care. Our inspection identified further work was required to ensure that everyone experienced a consistently safe,

good quality service. For example we identified the staffing allocation on the middle nursing floor was ineffective. This resulted in people spending long periods quite isolated without interaction. We also found care plans did not specify how people would receive support in the way they would like or need. Records we viewed relating to people's nursing needs had not been maintained to an acceptable standard, for example the lack of wound care plans and monitoring systems. We found that where clinical tasks had been delegated to nurses there was no system in place to monitor whether these were being completed to an acceptable standard, for example ensuring people's wounds were monitored and dressed. As a consequence we saw there was an impact for a person due to omissions in their care.

We identified that there had been an increase in people falling at night. Whilst there was a system for recording falls and providing equipment to keep people safe, there was no formal review/analysis evident to look for patterns or trends. For example, to ascertain whether people were falling at certain times when there were less staff available. We identified the arrangements for people's meals did not take account of their social needs or the opportunity to mobilise. The cramped conditions led to staff supporting people by standing over them or crouching on the floor.

The acting manager understood their responsibility to inform CQC of specific events that had occurred in the home. The regional manager that we spoke with was supporting the acting manager on a regular basis.

There were systems in place to ensure people had the opportunity to provide feedback via meetings and the use of surveys. However the results of surveys had not yet been analysed. Relatives and staff told us that there were meetings where topics were discussed. Their main feedback related to the general décor of the home, we saw the provider was looking to make improvements in this area.

The provider wrote to us following our feedback on the inspection and told us about the immediate actions they had taken. In relation to the unsafe manual handling techniques the provider informed us that they intended to purchase 'belts' for assisting staff to support people to stand. They advised they had taken steps to increase the staffing levels to ensure that the needs of people on the middle nursing floor could be met. They were developing a new dependency tool, and would review the use of the respite occupancy. [Respite is for people who require only a short stay at the home] as this service accommodated very dependant people. They had sourced additional staff training due to commence over the next three months with a view to seeing improvements in all areas of care and support for people in the home. The provider said they were, "Developing a detailed home improvement plan focused on achieving these improvements, with a clear priority given to the care and safety of our residents". They were confident that the new and experienced management team would, "Enable us to drive progress, challenge poor practice where it occurs and ensure that standards at the home continuously improve". They showed a strong commitment to improving and developing the service. However these changes and improvements were not yet fully established or working consistently across all areas of the home or staff group. This meant people could not be certain they would consistently benefit from safe, strong leadership and governance.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care was provided to people in a safe way. We found that risks to people were not always monitored and managed which resulted in omissions in their care. People were sometimes moved in way that increased the risk of injury to them. There was a lack of analysis of falls for patterns or trends.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). The provider had failed to ensure that people are safeguarded from suffering neglect or improper treatment while receiving care and treatment.