Scarborough Hall Limited

Scarborough Hall and Lodge Care Home

Inspection report

Mount View Avenue
off Seamer Road
Scarborough
North Yorkshire
YO12 4EQ

Tel: 01723381594
Website: www.brighterkind.com/scarboroughhall

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 October 2017 and 7 November 2017. It was unannounced on the first day and announced on the second day. At our last inspection in June 2016 the service met all legal requirements and was rated as 'Good'.

Scarborough Hall and Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service accommodates a maximum of 85 older people, people living with dementia and people living with a physical disability. The service does not provide nursing care. The service operates from one purpose-built building with three floors. At the time of our inspection there were 80 people who used the service.

The provider is required to have a registered manager. There was a registered manager in post and this individual registered with CQC in November 2011. A registered manager is a person who has registered with CQC 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.

We found breaches of Regulations 12, 17 and 18 during this inspection in relation to safe care and treatment, good governance and staffing. You can see what action we told the provider to take at the back of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The assessment, monitoring and mitigation of risk towards people who used the service with regard to medicine management, falls and infection prevention and control was not robust. This meant people were at risk of harm.

Staff training was not up to date and did not equip the staff with the skills and knowledge they needed to meet people's needs. Supervisions took place, but the lack of effective leadership and role models meant staff did not receive adequate support and guidance to promote best practice.

The management within the service did not effectively complete the quality assurance systems which were in place. Audits completed by the registered manager showed there were a number of recognised concerns with regard to documentation and people's health and well-being. However, the registered manager had not taken action to address these, which left people at risk of harm.

The reporting of safeguarding issues was not always robust and left people at risk of harm.

Care files were not completed in a consistent manner. Care plans were not up to date and documentation was not fully completed. This meant staff did not have appropriate records to show how they were meeting people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The completion of food and fluid charts was inconsistent and the risks to people around hydration and nutrition were not always fully identified and reviewed by the care staff.

The majority of people felt their privacy and dignity was respected and maintained by the care staff and care practices within the service. However, for one person their care fell short of expected standards and their dignity was compromised. We have made a recommendation in the report about staff training with regard to people's dignity.

People told us they felt safe and were well cared for and recruitment of staff was carried out safely. Staff were knowledgeable about people's individual care needs and there was a range of social activities available, which people enjoyed.

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.

The monitoring, review and management of risk for people who used the service was not robust.

Medicines were not always managed safely and infection prevention and control practices were ineffective.

The processes in place to help make sure people were protected from the risk of abuse were not always followed.

The recruitment of staff was completed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training and development was not always up to date.

Staff knowledge of risk management around hydration and nutrition was patchy and documentation of this inconsistently completed.

People reported that care was effective and they received appropriate healthcare support.

Is the service caring?

Good

The service was consistently caring.

One person's privacy and dignity was compromised by a lack of staff support, but the majority of people received the care and support they needed.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Documents within the care files and risk assessments had not always been reviewed and monitored appropriately. This meant there was not an up to date record of people's needs, which could put them at risk of not receiving responsive care and support.

People were able to make choices and decisions about aspects of their lives and enjoyed a variety of social activities.

There was a complaints process in place, which people understood and used as needed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Governance systems and processes were not operated effectively by the registered manager or provider.

Scarborough Hall and Lodge 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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This is being investigated by the safeguarding team from the local authority.

The information shared with CQC about the incident indicated potential concerns about the management of risk of falls from beds and unsafe equipment. This inspection examined those risks.

This inspection took place on 6 October 2017 and 7 November 2017. It was unannounced on day one and announced on day two. The inspection team consisted of three inspectors on day one and three inspectors and three experts-by-experience on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The three experts-by-experience had knowledge of older people and people living with dementia.

Prior to our inspection, we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We had not requested the provider to submit a provider information return (PIR). The PIR 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.

At this inspection we spoke with the regional manager, registered manager and deputy manager. We also spoke with six members of staff and two visiting health care professionals. We talked with 25 people who

used the service and nine visitors over the two days of inspection. 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 looked at seven people's care records, including their initial assessments, care plans and risk assessments. We looked at medication administration records (MARs) where staff were responsible for administering medicines. We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Requires Improvement

Is the service safe?

Our findings

On Sitwell suite on the top floor, there were 20 people with moderate to severe dementia needs in residence and three staff on duty. We observed one person walking around in an inappropriate state of undress, with no visible staff around to assist them. This person was walking in and out of another person's bedroom and the occupant was distressed by this. After 10 minutes we had to seek out the staff to assist this person. We found the staff stood together talking and explained the situation. They said, "Oh that will be X" as though it was a regular occurrence. When we discussed this with the registered manager we established that reduction of risk to this person depended on staff observation which was not taking place. This poor risk management left the person at risk of harm.

We saw a person in the small lounge on Laughton Suite eating crisps which had been left for people to snack on. They appeared to be struggling to swallow and required support from the inspector. We observed people eating whole oranges including the skin and grape stalks when they were unsupervised in the communal areas, where snacks had been left out for people. We supported one person to the dining room where the staff were found together. We expressed our concerns about people choking on the snacks and was told, "There is no-one who can access the snacks who has a swallowing problem." This response showed there was a lack of understanding about the risk to people as anyone could choke on an item such as a grape stalk. These concerns were discussed with the registered manager during our inspection.

The recording and administration of medicines was not always safe. Morning medicines were printed on the medicine administration records (MARs) as given at 08:00. However, we saw a senior care worker was still giving out morning medicines at 10:45am. This meant there was no clear gap of at least four hours between morning and midday medicines. We asked the registered manager about this and they said the member of staff would give the midday medicines later on to stagger the administration times. However, as the specific time of administration was not always recorded on the MAR, that would be difficult to do. This meant we could not be sure that people's medicines were being administered in line with the prescribing instructions.

We looked at a selection of MARs and found recording errors on them. For example, time limited medicines, which should be given early morning before breakfast, were not recorded as such on the MARs. Staff were administering these medicines along with the rest of the morning medicines, which meant they would not be as effective as they would be if given at the correct time.

The protocol sheets for bowel medicines given 'as and when required' were not sufficiently detailed to guide staff. For example, one entry stated 'Laxido taken one twice a day' but there was no bowel chart in use to monitor the person's well-being to see if the medicine was required. Protocol sheets were rewritten by the provider before day two of our inspection. Copies of these were sent to us. We were also notified by the registered manager that topical medicine sheets were now retained and archived and they monitored that staff completed the sheets appropriately.

Topical medication charts were used to record the administration and application of external medicines such as creams and lotions. However, we found the use of these was not consistent throughout the service.

This meant we could not be sure that people received their topical medicines as prescribed by their GP.

Infection prevention and control practices were not effective. On both days of inspection we noted strong odours of urine in different areas of the service. One room in particular had an odour that was worse than other rooms. Staff told us the room was difficult to clean due to the occupant receiving end of life care. This was discussed with the registered manager who said they would address it immediately.

Some areas of the environment required attention. For example, a window ledge in the hall on Laughton Suite had exposed wood and fibres following flood damage. There was also exposed wood in the kitchen area on the work surface. We noted that Bronte Suite (ground floor) and Sitwell Suite (second floor) had porous work surfaces in the satellite kitchens with laminated strips missing from the work tops and also gaps where the worktop met the wall. These issues meant that effective cleaning could not take place.

We found uncovered and undated food in the satellite kitchen fridge and skimmed milk that was out of date. The senior care staff threw the out of date food stuffs away when requested by us.

The equipment used in the service was not always fit for purpose. We saw that floor safety mats (also known as crash mats) were used in four bedrooms where people were deemed by staff to be a risk of falling out of bed. However, none of the mats were fitted with a sensor so staff would not be alerted if a person fell. On day one of our inspection we found one of the crash mats in use was badly torn, which could have caused a fall if a person had caught their foot in the rip. Another crash mat in use had tears in it. The first mat was replaced immediately with a new one but the second was still in place when we visited again on day two of our inspection. Although this was also replaced this meant these safety risks were not identified or promptly rectified and people remained at risk of harm.

We asked the registered manager whether the crash mat in one bedroom had possibly caused a person to fall after it was put in place. The registered manager accepted that it was a trip risk, but went on to say nobody knew if this was the cause of the fall. We identified that the senior care staff who had put the crash mat in place did not have enhanced moving and handling facilitator or falls training. This meant they did not have the necessary knowledge to know which piece of equipment would be appropriate and safe based on needs and risk. This meant the person was at risk of harm.

One person had fallen and sustained a head injury. No documented head injury monitoring observations had been carried out when they returned to the service from hospital. We found that the person's falls diary had not been updated to outline the fall and their care plan and risk assessment had not been reviewed. We looked at other care files and found evidence that care plan and risk assessments for another person who had fallen had not been updated following an incident. This meant the monitoring of people following accidents and incidents was not effective.

We identified that bed safety rails were not being used and that no-one in the service had a risk assessment completed for their use. We were told that this approach was because the service 'was not a nursing home'. The regional manager advised that following a risk assessment it would be possible to have bed rails in place if appropriate.

The above evidence has shown that the oversight and reduction of risk for people was not effective, even when they were identified by the service as at risk or harm through falling or injury. Medicine management and infection prevention and control practices were not robust and did not promote people's health and wellbeing.

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

On day two of inspection the registered manager had replaced the crisps with a softer variety to reduce the risk of choking and fruit snacks for people living with dementia were prepared by staff so they were ready for eating. We also noted food in the satellite kitchen fridges was covered and in date.

The Care Quality Commission (CQC) had received safeguarding notifications from the service over the last year. However, during our inspection we found evidence that there had been a lack of instigating reporting of incidents on two occasions. These were when one person returned from hospital with extensive bruising from an unknown cause and when a person had entered another's bedroom and their behaviour had caused the second person distress. These incidents were discussed with the registered manager. We found that the first incident was currently being looked at by the local authority safeguarding team as a part of a wider investigation into a person's death. The second incident was caused by a person whose challenging behaviour had now settled and was no longer a risk to other people.

Each of the three floors of the service had their own group of staff on duty. We found there was a lack of staff observation of what was happening in and around the communal areas. One person had their dignity compromised and another person had difficulty swallowing food. Both people had assistance from the inspection team.

Health and safety checks on the fire, electric, gas and water systems were carried out by external contractors.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

Requires Improvement

Is the service effective?

Our findings

We found that staff knowledge and skills did not extend to the appropriate use of risk assessment tools such as the Malnutrition Universal Screening Tool (MUST). One person, whose care we looked at, had lost 8 kilogrammes of weight in the three months up to September 2017. We looked at the 'professional visitors' and 'discussions with significant others' records and found no evidence to indicate GP or dietician involvement in this person's weight loss. We spoke with the deputy manager about this as the MUST tool had been incorrectly completed over numerous months. They explained they would review all the MUST assessments on the middle floor. Later in the day they said they had implemented food diaries for three people based on the scores from the MUST assessments.

We checked a second person's weight and found that, had the MUST tool been completed correctly, this would have shown this person had lost more than 10% of their body weight over the last year indicating a high risk of malnutrition. Their 'Assessed Needs Care Plan' for nutrition was not updated with weight loss concerns. This was fed back to the registered manager who said they would review people's weights immediately.

This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulations 2014.

When we returned on day two we found people's weights were being monitored more appropriately and professional advice was sought where needed.

The registered manager gave us a copy of the staff training plan, which showed a range of subjects the provider deemed as 'essential' such as fire training and moving and handling training. We saw from this that a number of staff needed to attend relevant training sessions. For example, fire safety training was at 48% compliance, safeguarding was at 59% and training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was at 65%. We brought this to the attention of the registered manager who said they would book staff onto the relevant courses.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Two days after the inspection the registered manager provided us with information to show that staff had been booked onto training sessions in November and December 2017. They told us that staff would be up to date by 8 December 2017.

New staff received an induction and the registered manager said that new employees were supernumerary for their first few shifts. This was confirmed by the staff who spoke with us.

Staff received regular supervision. Staff told us, "We receive supervision every two months. You can say what you want during these sessions and you are listened to." However, the concerns we had about staff practice indicated a lack of effective leadership and role models to support and guide the staff in relation to

following best practice and delivering good care.

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 so that they can receive care and treatment when this in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people had been assessed for capacity, and where appropriate DoLS authorisations had been sought.

People wishes and needs were respected by the staff and people were asked for consent before staff carried out care tasks. One person told us, "I can go to bed when I want and talk to staff about my daily life and any changes to my daily routine that I want to happen. They listen to me and do as I ask." A visitor was satisfied that their relative was able to make decisions and choices where possible. They told us, "This morning I was here when my relative was being dressed. My relative said they did not want the jumper the staff had got out for them as it was too tight. Straight away another one was found for them."

We received good feedback from people about staff practice and communication skills. Relatives told us that staff kept them up to date with GP visits, changes to medicines and people's general wellbeing. Two people told us, "If I need a Doctor then the staff sort this out straight away" and "The staff will arrange me an appointment with the GP if I want one."

Observation of the lunch time meal showed that people were able to make a choice of food to eat and the empty plates going back to the kitchen indicated it had been enjoyed. Staff offered people appropriate support with eating and drinking and their actions were patient and focused on the individual they were assisting. People said, "The food is very good" and visitors commented that, "The food is nicely presented" and "There is plenty available at every meal."

Good

Is the service caring?

Our findings

We observed that for one person their dignity was compromised by a lack of staff to oversee their behaviours. They did not receive staff support to ensure they were dressed appropriately throughout the day. This person came into a room where we were sat talking to another person and they did not have any clothes on their lower half. We directed them out of the person's room and back towards their bedroom. However, a few minutes later they walked down the corridor in the same state. This meant they were not being supported by staff in a dignified way.

We recommend that the service seek advice and support from a reputable source, about supporting people with behaviours that challenge, in relation to maintaining their dignity and modesty.

Despite this people said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. People and visitors confirmed to us that staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when completing care tasks. One visitor told us, "They always treat my relative with respect and kindness. My relative is always clean and tidy and when my relative could speak there was always a choice. Such a basic thing, but so important." Visitors told us their views of the staff and said, "They are very happy and smiley" and "Nothing seems to be too much trouble for them. I have never had any issues with them." One person said, "Staff are alright. They listen to me and give me the support I need."

People told us that staff treated them on an equal basis and staff gave us examples of how they had provided support to meet the diverse needs of people using the service. For people who wished to have additional support whilst making decisions about their care, information on advocacy was available in the service. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Staff told us they were aware of the provider's confidentiality policy and were able to explain to us what this meant in practice. We found that paperwork and files were stored appropriately in the service, within locked facilities, to keep personal information confidential.

Relatives and visitors told us that they thought the staff managed people's dementia care needs in a thoughtful and enabling way. One visitor told us, "Staff used to help my relative be as independent as possible, but my relative is unable to do a lot of things now. When they stopped using cutlery, staff gave them finger foods to eat."

We observed staff being kind and considerate to people in their care. People told us, "Staff are lovely" and "All the staff are very kind." We spoke with one relative who told us, "I come and visit my partner who has been in the service for six months. I have found the service to be homely and good. My partner has dementia and likes to walk around the service. Since coming into the service they have settled more and I have been able to personalise their room."

Staff who spoke with us knew the people who used the service very well and were familiar with their needs and requirements. One visitor said, "They don't mind how many times I ring them they are always very polite and approachable. I can sleep at night knowing my relative is looked after. Staff suggested I start a memory book so it can help my relative remember things and it is working very well."

We saw that people were clean and tidy with combed hair and clean fingernails. One visitor told us, "It took me a long time to decide on this home. This one is the best and after four years of my relative being here I remain satisfied with it. I cannot fault it. If my relative spills food on their clothes at meal times then they are taken to their room and changed. Staff are unsung heroes."

The service had good links to community specialists in end of life care and people received support in line with their wishes and choices for death and dying. People who were receiving end of life care had 'just in case medicines' in place, and 'Pal Call' plus the hospice at home team were available for staff to ring in an emergency. The specialist nurse told us they found staff were meeting people's end of life needs. They said, "Staff will ask for advice and do follow this. Staff are getting more confident at making appropriate referrals to the end of life team."

Requires Improvement

Is the service responsive?

Our findings

We found that people's care plans did not always clearly describe their needs or record the care being given. Care plans and risk assessments were not updated or reviewed following a fall. For example, the 'falls diary' for one person detailed a fall in October 2017, but their care plan was not updated and the risk assessment was not reviewed until five days later. Their risk of falling was deemed by staff to be high. This put this person at risk of further falls as the information in their care file had not been reviewed to ensure the care being given was sufficient to meet their needs. The day after our inspection the registered manager sent us information to say they had spoken with staff and discussed that after a fall staff should review and update the long terms fall risk assessment to ensure a person remained safe.

Although care file audits had been carried out issues identified were not followed up. For example, one person's care file included a care plan audit tool completed in September 2017. It had identified that the person's care plans did not match their current needs, but staff had not taken any action to update these. This meant the person may not have received appropriate care and support.

We found that the 'Nutritional Needs and Expected Outcomes' document in one person's care file stated that, "[Name of person] can eat and drink independently." However, the monthly care plan reviews made reference, from March 2017, to this person requiring assistance with meals.

One care file we looked at held information that said the person was diabetic and had associated problems with their eyes (diabetic retinopathy). However, there was no care plan for their eye condition such as sight problems and how it affected their daily life. This meant staff may not have given the person the necessary support they needed to manage their condition.

The care plan for one person receiving end of life care was not up to date. This person was being nursed in bed but their assessed needs were last reviewed in July 2017 and said they required two care staff to assist them with mobilising with their walking frame or wheelchair. This meant care staff did not have clear written guidance in respect of this person's needs.

This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Some people knew they had a care file, but no one we spoke with knew what was in it. Relatives said they had been invited to care reviews and had input into developing their relation's care plans where appropriate.

We spent time on Laughton suite looking at interactions between staff and people who used the service. The people we saw were in a positive mood and had positive interactions with staff members. One relative said, "There is a good programme of entertainment and my partner enjoys going to the chalet at the sea front. They have also has been out to a tea dance."

Activities were facilitated by an activities coordinator. People had the choice of joining in the planned activities, although some people preferred not to join in and chose to spend time in their room or in the other communal areas within the home. We spoke with the activities coordinator and they told us, "We have lots of activities, but many people cannot cope with a lot. We try to arrange activities to suit each person. We have music afternoons and produce a monthly newsletter mainly about singers of their generation. We have people come into the home for singing and we take people out to 'Singing for the Brain' sessions in Scarborough. We also do crafts, play dominoes, bingo, bowls and have chair exercises. I have one to one chats with people that stay in their rooms and I read to people. Some people just watch activities."

Outings included going to Sewerby Hall, church services in local churches, the Rotunda Museum and to outside concerts at the Spa in Scarborough. The activity coordinator told us about the chalet on the seafront and that the service had tea parties and picnics in summer and took people into the gardens in summer months. There was a knitting group, animal therapy came into the service and there was an in-house church service every so often.

Customer comments and complaints information was displayed in the reception area. This was difficult to read due to its location behind two chairs. We looked at the complaints folder kept by the registered manager and saw that four complaints had been received in 2017. All had been responded to appropriately.

None of the people who used the service, that we spoke with, had made a complaint about their care, but all said they would speak to one of the care staff or deputy manager should they have a problem. However, two visitors felt things could be better and said, "I have complained in the past and staff did respond for a while, but then things slip back again" and "There are a lot of good things here, but lots of the details are missed. I don't think staff have the time to chat and whilst most staff are good there is a turnover and one or two staff are short with people." These comments were fed back to the registered manager and regional manager during our inspection. They said that they would continue to work with people and relatives to resolve any complaints raised with them.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported in their role by a deputy manager and senior care staff.

Although the provider and registered manager had completed audits of the service they had not identified the range of concerns we found during our inspection. Where issues had been identified action had not been taken to correct these. This meant people who used the service were at risk of harm. For example, we saw the audits for medicines and care plans did not look at trends and patterns to identify repeated errors. The audits also did not identify if, or when, action had been taken to resolve the issues.

There was a systematic approach to determining the number of staff and the range of skills required in order to meet the needs of people using the service and to keep them safe at all times. However, the system was not used effectively. The dependency tool used by the registered manager was not up to date and did not reflect people's current needs. We case tracked five people whose care files showed their care plans and dependency needs had not been updated even though their assessed level of need had increased. When we spoke with the registered manager we found they were not aware of the changes, which had affected the staffing tool (CHESS) and meant more care hours were needed to meet their needs.

Staff training was not up to date. We saw records that showed fire evacuation drills and fire training were out of date. Information in the provider's fire file said fire drills should be done monthly and ideally fire evacuations done twice a year. This lack of drills and training had been picked up by the provider at their monthly visit in September 2017.

The quality of record keeping was inadequate with a lack of risk assessments and up to date care plans to guide staff in delivering effective support and care to people who used the service. Fluid charts we looked at were not well recorded. For example on one chart the target fluid intake was blank. The chart dictated that the person should have been given 25mls of fluid per kilogram of weight so for this person -1400mls of fluid a day. When we looked at the last seven days of records we saw the person had consumed between 100mls and 1000mls a day. We requested that the deputy and senior care staff organise a more realistic target and use this to monitor hydration. We observed the person in their room and saw no overt signs of dehydration or distress, which indicated they were receiving appropriate care but staff were not documenting the care they had delivered.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed us of significant events in a timely way, but we found two occasions where safeguarding concerns had been raised with them by relatives and no action had been taken. This had left people who used the service at risk of harm and demonstrated to us that leadership in the service was ineffective.

During the inspection we found that systems and processes were not established and operated effectively to ensure the service was assessed or monitored for quality and safety in relation to the fundamental

standards. This led to breaches of regulation in relation to staffing, safe care and treatment and good governance. This meant people who used the service were at risk of harm.

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

We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Following the inspection the registered manager provided information to show that fire training and evacuation drills was booked for all staff and would be completed by 4 December 2017.

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 and registered manager failed to ensure care and treatment was provided in a safe way for people who used the service. Risks to people's health and safety and the mitigation of those risks were not sufficient to keep people safe from harm, including those around equipment, medicines and infection control. Regulation 12 (1)(2)(a-c)(e-h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people who used the service and keep them safe at all times. Staff did not receive appropriate support and training to enable them to carry out the duties they were employed to perform. Regulation 18(1) (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A lack of governance and oversight within the service meant effective systems and processes to assess and monitor the compliance of the service were not in place. The provider and registered manager failed to assess, monitor and mitigate risk to the health, safety and welfare of people who used the service and failed to maintain accurate and complete records in respect of each person. Regulation 17(1)(2)(a-c)

The enforcement action we took:

We have issued a warning notice against the provider and registered manager in respect of a breach of Regulation 17: Good Governance.