Excelsior Health Care Limited

Stanton Hall Care Home

Inspection report

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Tel: 01159325387

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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

This unannounced inspection took place on 9 April 2018. At the last inspection we placed the home in special measures and the overall rating was 'Inadequate'. There were also regulatory breaches in safe care and treatment, staffing and good governance. At this inspection these breaches had not been met and we identified further breaches in other Regulations. Following the last inspection in September 2017, the provider was asked to complete an action plan in November 2017, to show what they would do and by when to improve the key questions of safe and well led to at least good. The provider had not met all the actions on this plan at the time of this inspection and the overall rating for this service is Inadequate which means it remains in special measures. We do this when services have been rated 'Inadequate' and we cannot see sustained improvements.

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

Stanton Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care is provided in one building across two floors. There are communal living areas and dining areas on the ground floor. The home provides accommodation and nursing care for up to 45 people who are living with dementia. There were 15 people living at the service when we visited.

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. The provider had recruited a manager who had been working at the service since October 2017, they told us they were going to apply to register with us.

At the time of this report they had commenced this process.

We found that risk was not managed sufficiently to ensure that people were kept safe. Due to the reduced staffing levels, plans were not always followed to ensure that people received safe care. Risk assessments were not followed and medicines were not always managed safely. The home completed cleaning schedules to prevent and control infections; however the fabric of the building required substantial maintenance and repairs and this had an impact on some areas of the home.

There were continued concerns about the leadership of the home and the support provided to reflect the care people required. These concerns had been identified and related to lack of maintenance of the building, audits and the staffing levels linked to the level of support people needed. The manager had not completed notifications to enable us to monitor and review the provider's response to such incidents.

The records in place were not always clear or up to date, to guide staff on the support people required. People did not always receive stimulation which could reduce the risks associated with their individual safety.

At the last three inspections we identified there were not enough care staff, this continues to be a concern and this had an impact on people's wellbeing. At times this had an impact on the care provided by staff. Safe recruitment procedures were not always followed to ensure that staff were safe to work with people.

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 support this practice. Staff provided a kind and caring approach to people and when possible spent time with them offering support and affection.

People's health care and the support they received to prevent sore skin had improved. Referrals were made to a range of health care professionals and support was followed. People enjoyed the meals and their dietary needs were being met.

Staff training had improved and these skills were being used to develop the care provided. There had been no complaints to the manager or provider since our last inspection.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Registration Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe
There was not always enough staff to support people's needs.
When staff were recruited, the appropriate checks had not been completed to ensure they were safe to work with people.
Medicines were not always managed safety to ensure people received them as prescribed.
Risk assessments had not been followed to maintain people's safety.
Measures were taken to protect people from infection.
Care for people's skin had improved and lessons learnt in these areas.
Staff knew how to raise any concerns in relation to safeguarding people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective
The environment did not always support people to be safe and met people's needs in orientating them in the home.
Staff had received training at induction and ongoing for their role.
Staff understood the support people required when making a decision and when required assessments had been completed.
People were offered a choice of nutritious food and their dietary needs had been met
People had access to health professionals when they needed them.
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Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated with kindness and compassion when people received some areas of care.
People were encouraged to maintain relationships.
People's dignity was not always considered in all areas of care they received.
Visitors were welcomed and people's religious beliefs had been supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People were involved in their care planning; however details were not consistent to provide clear information about preferences and how to meet people's needs.
There were some opportunities for people to be engaged in activities of interest, however there was not enough to provide stimulation and this enhanced the risk of falls or behaviours that put people at risk of harm.
People and relatives felt able to raise any concerns and complaints if necessary.

Is the service well-led?

Inadequate

The service was not well led.
There was no registered manager at the home and there continues to be concerns in relation to the leadership of the home.
The provider had not always competed audits and those completed did not identify how or if improvements had been made.
The provider had not always informed us about significant events as required.
The home environment had not been maintained.
The provider's rating had been displayed in the home and on the website.
Staff felt well supported by the manager.

Stanton Hall 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 9 April 2018. It was conducted by two inspectors and a pharmacy inspector. A pharmacy inspector focused on the medicine administration and recording. This was an area of concern we had identified at inspections in 2014, 2016 and 2017.

To assist in our planning we sought feedback from the safeguarding team and from the community healthcare team prior to the inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to formulate our inspection plan.

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication We spoke with two people, however to enable us to understand how people's needs were being met we observed the care that was provided. We saw the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with two people's relatives about their experience of the care that the people who lived at the home received. After the inspection we spoke with two health care professionals.

We spoke with the manager, one nurse, one senior care staff, and two care staff. The area manager was present for the feedback in relation to the inspection. We reviewed care plans for five people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. For example, we reviewed audits and quality checks for falls, medicines management, fire risk assessments, health and safety checks and infection control. . We looked at three staff recruitment files. After the inspection we asked the manager to email copies of their staffing matrix, the most recent pharmacy inspection and a risk assessment to support areas discussed during the inspection. The manager sent these to us within the required

timeframe.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2017 we found that the provider was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our previous three inspections prior to September 2017 we found that there were not enough staff to support people's needs. This was mainly reflected in the staffing to support the Stanhope unit. Since our last inspection the Stanhope unit had closed. However, there are continued concerns in relation to staff being able to support people needs. We saw at this inspection visit that some people had to wait to receive care. For example, one person waited 20 minutes after their initial request for support. A family member told us they had requested support for their relative, however after 15 minutes asked us to intervene and obtain staff support. The relative said, "This happens often, it's not the first time." Another person did not receive their breakfast and personal care support until 11.30am. We discussed this with a staff member who told us, "They are still in bed and it's not their choice, we are struggling to meet people's needs since the staff changes." The manager told us the provider had reduced the staffing levels by one staff member during the day. A staff member told us, "The four staff were working well and now there has been staffing changes." A health care professional we spoke with said, "It has improved, but they need to have regular staff. The consistency is needed to support the communication."

We saw how the staff reduction also had an impact on the staff supporting people to remain safe. Following a safeguard action plan, the provider told us they would ensure the communal space [known as the lounge] would be supervised. We saw the lounge was not supervised on several occasions. During this time some people sitting in these areas was noted to get up and mobilise unsafely. Risk assessments had identified how these people required staff to be with them when they mobilised. For example, '[Name] to be monitored throughout the day whilst in the communal areas' It also noted, '[Name] continues to lack awareness of their surroundings and how to keep themselves safe.' Guidance notes to staff recorded as, 'When walking, the person needs one staff member to hold on to.' We saw on more than four occasions this person and other people walking without supervision. These people used furniture as a walking aid or stood hesitantly ahead of moving. On two separate occasions we had to ask staff to support these people as they were walking or balancing and were potentially at risk of falling.

Another person's care plan noted they used furniture to mobilise and for staff to encourage the person to use their walking aid. We asked staff about this because the person had not got a walking aid available to them. Staff confirmed the person does not have a walking aid as they're unable to use it safely. This meant that the risk assessments to keep people safe were not effective as there were not always enough staff to implement these guidelines and support people as required.

This evidence represents an ongoing breach in Regulation 18(1) of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the management of medicines, pressure area care and fire safety was managed in a safe way. At this inspection we found that

some improvements had been made with pressure care and fire safety. However, in relation to medicines further improvements were required.

We found that medicines were not always managed safely. For example, we saw when some people required the use of medicinal skin patches the position where the patch was applied to the body was not always correctly recorded. The records showed that patches were not being applied in line with the manufacturer's guidance, which could result in unnecessary side effects.

We looked at five records for topical administration of creams and found that four of them showed that members of staff were not applying the creams as often as instructed. A person's skin condition may not be treated effectively if creams are not applied as the doctor intended.

People that needed to take medicine on an as required basis had protocols in place to provide staff with information about when the medicine was to be given. However, we saw that this information was not specific to the person, which meant people might not always be given their medicine consistently, and at the times they needed them.

We found some gaps on people's Medicine Administration Record (MAR) charts. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. The MAR for one person had been filled out to indicate a medicine had been given but we found the medicine was still in the medicines disposal basket and therefore the person had not received it. If medicines are not given as prescribed, a person's healthcare condition may not be well managed.

Some people with limited mental capacity to make decisions about their own care and treatment and who would otherwise refuse their medicines were being given them by disguising them in food or drink [known as covert administration]. We saw that there was not enough information available to inform staff how to prepare and administer these medicines safely. In addition, the correct people had not always been involved in the decision making process for people to be given their medicines covertly.

Medicines that need cold storage were kept in a fridge and daily records showing temperature monitoring was completed. However, records showed that the fridge temperature was out of the recommended range and the staff we spoke with were unable to demonstrate how to take the reading accurately. Staff told us this had not been reported to the manager. It also meant we could not be assured of the integrity of the medicine stored in the fridge during this period.

Some people required thickener to avoid them choking when drinking. At the last inspection we reported that the thickeners were not specific to the individual. We saw at this inspection one person's thickener was not available on the tea trolley. Each thickener provides details of the consistency the person had been assessed for. This meant we could not be sure the correct consistency would be used.

At previous inspections the maintenance of the building has been a concern in ensuring the environment was safe and well maintained. An infection control audit was completed in March 2018 by the Infection Prevention and Control Team, from NHS Erewash CCG. The audit noted that, investment was needed in the general maintenance of the home to enable effective cleaning. The details of the CCG audit confirmed that damage was found to a door to a shower room, along with two other damaged doors to people's rooms. A broken tap in a person's room and the sealant had not been renewed around several sink areas. Where fabric curtains were in place, there was no evidence available to suggest the curtains were included on a cleaning schedule, the guidance notes curtains should be cleaned six monthly. It was also noted the cleaning cupboard required repairs and space for storage of the equipment and chemicals used for

cleaning. The manager was required to complete an action plan to show how they would be addressing these areas.

Since our last inspection we saw the only repairs completed had been to the conservatory, which was due to the roof leaking. In the action plan completed by the provider after the last inspection, it stated, 'The maintenance hours at the site have been increased to help ensure that the home is better maintained, and all statutory checks are being carried out. Maintenance remains on-going, and will be kept under review.' However we saw many areas required repairs and maintenance. This showed the provider had not followed through on their planned approach to support the ongoing maintenance of the home.

We had noted at the last two inspections in October 2016 and September 2017 the mal odour in the lounge. This was partially due to chemicals used and the age of the carpet which had received constant cleaning. We noted that between the two rooms the carpet had been fastened down with tape as it was frayed and unsafe. In the PIR it stated, 'We aim to provide an environment that is appealing.' The manager had completed an audit on the home. In reference to the lounge carpet the audit noted, 'Carpet replaced, prioritised considering danger, malodour and poor condition' however the planned date for this repair to be completed was 31.12.2022.' The manager told us they had passed the audit to the provider as a number of items required financial input. The manager said, "I have been told until my occupancy increases there will be no investment." This showed that the provider had not fully considered the maintenance of the home to create a clean and safe environment to support people's safety and wellbeing.

This evidence represents an ongoing breach in Regulation 12 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed recruitment records at the last inspection and reported on the risk assessments not being followed by the provider. At this inspection we reviewed three recruitment files and found that further information for some staff was required. There was no record of the provider completing a risk assessment to ensure that there were measures in place to protect people from the risk of harm. After the inspection the provider shared with us a risk assessment they had completed, however one measure identified the staff member should complete all mandatory training and competency in medicines. There was no evidence these had been completed. In addition, references were not always received from the previous employer in line with best practice guidance, so that the provider could make a judgement about the character of the new employee. In the provider information return (PIR) the manager told us, 'Recruitment is selective to ensure the appropriate appointment of the right staff.' However we saw the required checks had not always been completed.

This evidence represents a breach in Regulation 19 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

Staff used protective equipment such as gloves and aprons when they provided personal care or served food. The home had a five star rating from the food standards agency, which is the highest award given. The food hygiene rating reflects the standards of food hygiene found by the local authority.

We reported on fire safety within the home at our last visit and asked the provider to make improvements. At this inspection we reviewed this area. People's evacuation plans were current and had been updated when people's needs changed. For example, we saw one plan had changed from a medium to high risk as the persons mobility had reduced. Fire safety checks had also been completed on the home to ensure the alarms and extinguishers were safe to use. One staff member we spoke to was the fire marshal, they were able to explain about the equipment and the fire door exits within the home.

People were supported to be safe from abuse or harm. Staff had received training in safeguarding and were able to discuss with us the different types of abuse and how they report any concerns. We saw information relating to safeguarding was available and safeguards had been raised by the home when they had concerns. The home discussed these with the local authority lead for safeguarding and worked with them to reduce the risks in the future. We saw how lessons had been learnt from previous safeguards and measures implemented. For example, at the last inspection safeguards had been raised in relation to pressure care. The manager had introduced a system to ensure people received the care they needed to reduce the risk of sore skin. These records were reviewed during and at the end of the day to check that people had received the necessary pressure care they required. Any concerns were raised with the nurse. One staff member said, "The nurses are great, really supportive and respond to any concerns." Another staff member said, "[The manager] has introduced all new paperwork, at first it was challenging, but we are in the swing of it now and it works." We saw a wound plan had been noted to require amendment and a new plan had been put in place. This meant people were protected from the risks associated with sore skin.

Requires Improvement

Is the service effective?

Our findings

People were able to personalise their own space, such as their bedrooms. However, other areas of the home did not reflect adaptation and decoration, we have reported on this in the safe section of this report. The home was supporting people living with dementia, but the environment did not reflect aspects to support them. For example, any signage to support people with their orientation.

The Accessible Information Standards (AIS) is a framework put in place from August 2016. This is a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given. We saw on the notice board in the lounge a written menu for Easter. This celebration had passed and the information remained on the board. Many people using the service were unable to recognise the written word. No alternative formats were available, for example pictures. The manager told us, "We have a menu board, it just needs putting up." One person had a sign on their table to guide them on how to use the call bell. This person was visually impaired and they told us and family confirmed they were unable to read the sign. Other options had not been considered to provide the person with a way to request support when they needed it. This meant we could not be sure people were able to continue with aspects of their independence, like orientation and daily choices.

At our last inspection in September 2017 we found that the provider was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured training was available consistently. At this inspection we found that the required improvements had been made.

The staff in the kitchen told us they had been on a nutrition and hydration course in March 2018. They told us how they had learnt about how to add calories to meals to support people's nutrition in their diets. They planned to share this information with colleagues at the next staff meeting. Other staff told us about training they had received to support people with dementia and end of life care. One staff member said, "The training here is very good." Another staff member told us about their training on behaviours which challenge. They said, "It was good to learn some new techniques and the use of 'leave and return' or to try a different staff member." New staff had received training and support and we saw that staff received probation meetings and supervision for their role. One staff member told us, "It's useful to have that time to discuss your role.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. 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 procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Assessments that had been completed were decision specific and had been used to reflect areas when the person was unable to make the decision themselves. We saw best interest meetings had been instigated with professionals when a decision was required which could have an impact on a person's wellbeing. Staff had received training in MCA and were able to explain to us how it affected the decisions people made. The required DoLS authorisation had been requested when a person was restricted.

People were given choices regarding their preferred meal and their choice of clothing. We saw staff ask people's consent before they provided support. When people refused this was respected. For example, one person was support to the conservatory for their meal. When they got to the door their facial expression showed distress. The staff member asked them if they wished to sit somewhere else and they responded. The person was then sat in a different location they felt comfortable with.

People had a choice of meals and their dietary needs had been considered. The cook told us they had introduced a board which we saw identified all the people and their dietary needs along with their likes and dislikes. They told us they were in the process of developing the summer menu. People and relatives had been given the opportunity to write ideas on a board and the cook planned to incorporate these into the menu. When new people came to the home, or if their needs changed the cook was informed. People were prompted to eat independently if they could or staff supported them in a patient and unhurried manner when required. Staff monitored people's weight regularly and we saw whenever there was a concern, action had been taken to support people's nutritional wellbeing.

People's health care had been considered. We saw referrals had been made to a range of health care professionals when people's needs increased or changed. For example, one person had become more anxious and demonstrated behaviour that was a risk to themselves and others. The staff had recorded the incidents and this enabled the health professionals to make a referral to the mental health team for additional support.

Requires Improvement

Is the service caring?

Our findings

Our last inspection found that whilst the provider was not in breach of regulation in this area there were aspects of care that could be improved upon to make the experience for people more respectful.

We reported on these in our last report. During this inspection we found that the provider had taken note of our comments and had made some improvements. For example, when people had an accident with their drink or meal their clothes were changed with their consent. One person had jam on their skirt; staff noticed this and made arrangements to support the person to change their clothes. One staff member said, "I enjoy working here and I get on with everyone really well."
However, at other times people's dignity was not always considered. For example, some people were left unsupervised or did not have their needs met in a timely manner. We have reported on the detail of these aspects in the safe domain.

Further improvements were required to ensure people received care which was responsive to their needs. We saw when some people were supported with equipment staff did not always consider their needs. For example, one person showed distress on seeing the equipment which was required to help them move. We saw staff hesitated with the equipment which caused the person to become distressed. This meant that staff had to take additional time to ensure the transfer was safe and to manage the person's anxiety. Staff had not fully considered their approach in how they could reduce the person's anxiety. As the person lacked capacity to relate to instructions, a behavioural plan had not been considered to support the person to receive a consistent approach when equipment was necessary to support the person.

The manager was in the process of forging relationships with the local community and the church. They told us they planned to enable people who wished to follow their beliefs to be supported, through a new link with the local church. The home was also planning an open day to encourage the community to visit with a theme about the heritage of the home

We saw other interactions where staff showed kindness towards people. For example, staff holding people's hands and showing affection we saw and staff told us this time was limited due to the staffing levels. A staff member told us, "When we had the extra staff member we could do some things with people." They went on to explain some of the things they had done and how that had been positive for people's wellbeing.
Relatives told us they could visit at any time and we saw those who visited were offered refreshments and made welcome.

We saw staff knocked on doors before entering people's own space. When they required personal care, people and staff told us that the curtains were drawn. One staff member said, "You think about how you would treat your own parents."

Requires Improvement

Is the service responsive?

Our findings

Our last inspection found that whilst the provider was not in breach of regulations in this area there were aspects of care that could be improved. This was to make sure people received the response they needed for their care and that stimulation was available. During this inspection we found that some improvements had been made however, further improvements were required.

Care plans had been updated and there had been more liaisons with family members. We saw how family members or those important to people had been invited to attend reviews and where appropriate supporting people who used the service to make decisions. However the care plans were sometimes contradictory. For example, one section identified a person as having their own teeth; however in other sections it was recorded they had false teeth. Another section in relation to medicine identified how the person was supported with their medicine; however we saw this information was contradictory to how they actually received their medicine support.

Audits had been completed on the care plans; however these had not been revisited to confirm the changes had been made. Staff knew about the care plans, but told us they had little time to read them as they were so detailed. One staff member said, "We know the information is available so we can check things, like people's mattress settings or weights." A health care professional told us, "The communication has improved, however there needs to be a clear process for recording the concerns for a person and how this is passed on."

In the PIR the manager told us they were implementing 'Resident of the Day' we asked who was resident for the day at the inspection. The care staff we spoke with were unaware of the scheme and had to ask what that meant. After the staff member had asked, they told us, "It's a focus on the person, what activities they wish to do, their choice of meal, family are contacted and their room is deep cleaned." However we did not see any evidence of any of these activities for the person identified. Their meal was one off the menu and they received no additional stimulation. The PIR stated that care plans would be updated on the 'Resident of the day basis', however we saw no evidence to show this had been implemented.

People did not always have enough encouragement and interaction to engage in activities. There was an activities co-ordinator who was newly appointed to Stanton Hall. People and relatives we spoke with told us that they enjoyed the activities they had provided and that the new person had lots of new ideas. However, there were large periods of the day when people were not stimulated. Some people became restless and got up from their chair. These people required support to walk and potentially this action left them at risk of falling. We saw on one person's plan to manage their behaviours it said, '[Name] requires stimulation to occupy them.' One staff member we spoke with said, "I feel I am not spending time with people." This meant people were placed at risk from lack of stimulation.

There was a complaints policy available. There had been no complaints since our last inspection. People and relatives told us they would have no hesitation in raising any concerns as they felt it would be dealt with under the new manager. We saw that some positive feedback had been recorded on a Care home website.

This was displayed to share with the staff. It said, 'Cannot fault their efforts. Care is excellent. Staff compassionate and they care. The manager is very approachable.'

At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this. The provider had supported staff to receive training in this area and was developing aspects of people's plans to include their wishes and beliefs.

Inadequate

Is the service well-led?

Our findings

We have carried out four comprehensive inspections at this service. On three of these occasions, the service has been rated as 'requires improvement', and one occasion as Inadequate. We have also seen a repeated cycle of breaches and any improvements not always being sustained. We found continued breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in Regulations 12, 18 and 17. The service has not met some of the regulations since October 2016. We have taken this into account when considering our rating in this domain.

At our last inspection in September 2017, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that measures were in place to support the manager and the running of the home. At this inspection we found these areas were unchanged and our concerns about leadership remain.

There was not a registered manager in post. We had identified that there had not been a registered manager for the last four years. Previous managers during this period had not registered with us. The current manager had been in post since October 2017 and the provider told us they would be registering. After a meeting we attended with the LA in January 2018 the manager told us they would be completing their registration. On 9 February 2018 we received the initial stage of registration the disclosure and baring form. At this inspection visit the registration had not been completed. The manager told us they would complete the registration process as a matter of urgency. At the time of this report they had commenced the application process. It is a condition of the home's registration that the provider has a registered manager.

Previous managers had told us about the provider not always listened to their point of view in relation to the care needs and resources to support people. The PIR for this inspection reflects the use of a dependency tool to consider people's needs and the staffing levels. It also notes, 'The manager is in a position to discuss the dependencies and independent characteristics of the residents to put forward a sound rationale as to why the numbers of staff on duty are required'. We saw and the manager confirmed their staffing rational had been overruled and the staffing numbers had been reduced. One staff member said, "It was head offices decision, the manager tried to keep the staffing numbers."

The manager had completed a range of audits on the home during January 2018 and February 2018 we saw these were followed up with an action plan. However these plans were not revisited to sign off the required actions and therefore we could not confirm if the areas requiring action had been completed. For example, the audits had not been completed in March 2018 or the action plans updated. We discussed this with the manager who said, "There are only so many hours in the day." The audit in relation to falls had been reviewed in January 2018 and provided some analysis in relation to the number of falls and any trends. However, we saw that for the following months the falls had been recorded but not analysed. The provider had started to use the fall safety cross however we saw this had not been completed for February and March. A falls safety cross is a monthly calendar in the shape of a cross which is used to record the number of falls. Each number on the cross represents the day and date for that month to enable staff to differentiate safety incidents, using different colours. This provides a visual guide to falls within the home and can

support evaluation.

At the last inspection the provider told us in their action plan they would be introducing weekly medicine audits. We saw these had not always been completed which meant that errors had not always been identified. We noted some near misses or errors and these had not been reported to the manager. This practice is used to address and share learning or meaningful actions to reduce the risk of reoccurrence. All staff handling and administering oral medicine or medicines applied to the skin should receive training and competency checks. However, the manager was unable to provide us with the evidence to demonstrate that all the competency checks had been completed.

At this inspection, we found some improvements in the management and oversight of people's care and we saw improvements in the staff culture. However, continued breaches of the regulations demonstrate that the service is still not consistently well led and does not give us confidence that the provider can deliver and sustain the improvements needed to drive improvement and ensure the health, safety and welfare of people using the service.

This evidence represents an ongoing breach in Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

At previous inspections in October 2016 and September 2017 we had found the provider had not informed us of all the incidents that they are required to under their registration with us. At this inspection we found that although safeguards had been raised with the local authority of the two we looked at we had not been informed of these. The manager was unaware they were required to report these to us. This meant that we had not been able to monitor and review the provider's response to such incidents.

This evidence represents an ongoing breach of Regulation 18 of the Registration Regulations (2009)

All the staff and relatives we spoke with without exception had identified that the new manager had made some positive changes. One relative said, "There have definitely been improvements." This was supported by staff, one staff member said, "[Name] has made a real difference, and they are firm but fair. They get involved and deal with things by working with you." Another staff member said, "The manager is turning things around, better paperwork and following things through."

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. We saw these were conspicuously displayed as required.

The manager was working with the local authority and the health care professionals to develop better systems of communication. One health care professional said, "Communication here has improved, however there are still some areas which require a better understanding of making referrals and appropriate contacts when support is required."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always reported significant events that occurred in the home. We had not received notifications from them for important information affecting people and the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. People had been placed at risk from not receiving their medicines. The provider must ensure the premises used by the service are safe to use and for their intended purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	proper persons employed The provider needs to ensure the correct checks and assurances have been completed when employing staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs.