Ultima Care Centres (No 1) Limited

Berwick Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 September 2017. The visit on the 12 September was unannounced. This meant that the provider and staff did not know we would be visiting. We carried out a further announced visit to the home on 13 September 2017 to complete the inspection.

Ultima Care Centres (No 1) Limited had taken over the home in September 2016. This was our first inspection of the service under the new provider.

Berwick Care Home is a 50-bed home providing residential, nursing and dementia care. There were 41 people living at the home at the time of the inspection.

There was a manager in post who had applied to register with the Care Quality Commission as a registered manager. She had commenced work at the home in May 2017. 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 and associated Regulations about how the service is run.

The manager was not a nurse and there was no clinical lead in post since the previous clinical lead had left. This meant there was no permanent professionally qualified member of staff to oversee the nursing care of people.

Following our inspection, the nominated individual informed us that the manager had resigned and they were in the process of identifying a suitable replacement. He told us that a clinical lead had been appointed and was due to commence employment on 9 October 2017.

The majority of nursing care provided was delivered by agency nurses. Records of their clinical skills and competencies were not available. There was a lack of evidence to demonstrate that staff were provided with up to date and accurate information which enabled them to meet people's needs consistently, safely and effectively.

Most people, relatives and staff told us that more staff were required. The provider did not use a staffing tool linked to people's dependencies to assess staffing levels. We found that there were insufficient suitably qualified, competent, skilled and experienced staff to meet people's needs.

Safe recruitment procedures were followed. People told us that they received their medicines as prescribed. This was confirmed by the medicines administration records we viewed.

The training matrix contained gaps against certain training courses. It was unclear which training staff needed to complete. There was currently no system in place for clinical supervision.

Diet and fluid charts contained omissions and it was not always clear whether some people were receiving a suitable diet which met their needs.

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 manager had submitted Deprivation of Liberty Safeguards [DoLS] applications in line with legal requirements. There was a delay in the authorisation of applications for people who had previously resided in Scotland. This was due to external factors and was not due to any oversight by the provider.
Evidence of consent was not always included in people's care files.

We observed positive interactions between staff and people. Staff displayed warmth when interacting with people. They were very tactile in a well-controlled and non-threatening manner.

An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained.

Following the inspection, we wrote to the provider to request a detailed improvement plan which stated what action they had taken or planned to take to address the concerns and shortfalls identified during the inspection.

We referred all of our concerns about the service to Northumberland and Scottish Borders local authorities and Northumberland Clinical Commissioning Group. Following our inspection, the local authority had placed the home into 'organisational safeguarding.' This meant that the local authority was monitoring the whole home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found five breaches of the Health and Social Care Act 2008. These related to safe care and treatment, safeguarding people from abuse and improper treatment, meeting nutritional and hydration needs, staffing and good governance.

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 safe.

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

One safeguarding concern had not been reported to the local authority in a timely manner.

Risk assessments had not always been completed for all identified risks.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Documented competency checks for agency staff were not available and their skills were not known.

The training matrix contained gaps against certain training courses. It was unclear which training staff needed to complete. There was currently no system in place for clinical supervision.

Evidence of consent was not always included in people's care files.

Diet and fluid charts contained omissions and it was not always clear whether some people were receiving a suitable diet which met their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to the concerns identified during the inspection, we found that the provider had not always ensured that people received a high quality, compassionate service.

Staff were attentive and kind to people during the inspection.

Most people and relatives told us they were involved in their care. We found that one relative had been unaware of the risks relating to their family member.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always reflect their needs. There were gaps and omissions in records relating to people's dietary and fluid intake, positional changes and activities. Staff explained that this was a records issue and not an omission in care.

There was a lack of meaningful activities. Staff told us that this was due to staffing levels.

A complaints procedure was in place. Detailed records of actions taken to resolve complaints were maintained.

Is the service well-led?

Inadequate

The service was not well led.

At the time of the inspection there was a manager in post. They resigned following the inspection. There was currently no clinical lead in post to oversee people's nursing care.

An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained

Staff told us that morale was low which they informed us was due to staffing levels.

Berwick Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and carried out by one inspector, a specialist advisor in nursing and an expert by experience.

Prior to our inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern.

The manager completed a provider information return (PIR) prior to the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

We spoke with six people who lived at the home. We also spoke with eight relatives and one visitor. We spoke with the nominated individual, the regional manager, manager, two senior care workers, five care workers, the activities coordinator, two chefs and the maintenance person.

We also conferred with the local authority safeguarding and contracts and commissioning teams, a member of staff from Northumberland Clinical Commissioning Group, a reviewing officer from the Scottish Borders, a continuing health care assessor, a pharmacy assistant from the local pharmacy and a team manager from the local NHS Trust's care management team.

Inadequate

Is the service safe?

Our findings

Prior to our inspection, we received information of concern regarding staffing levels at the service.

On the first day of our inspection, there was one permanent nurse employed. 24 hour nursing care was provided by agency nurses with the exception of one day shift a week. There were two senior care workers employed. The manager told us that she tried to ensure there was one senior care worker on duty each day to support the nurse with administering medicines and to oversee the care of people who required personal care.

Staff told us, and records confirmed that more senior care workers were required because there were insufficient senior care staff to cover annual leave. The manager explained that the activities coordinator was going to be redeployed to care. She said the activities coordinator had completed sufficient training to be able to step in as a relief senior care worker. This however, meant there would be no activities coordinator.

The nurse on duty had to administer medicines, carry out wound care and oversee people's nursing care. When there was no senior care worker on duty, the nurse had to oversee the care of all 41 people. The regular agency nurse on duty told us that this was very difficult. On the second day of the inspection, the agency nurse supported a new nurse who had commenced employment at the home. Following the inspection, the regional manager told us that the new nurse had left.

We received mixed feedback from people about whether there were enough staff. Comments from people included, "There's lots of people about and if I never saw anybody I wouldn't feel so safe" and "Well for me, yes [enough staff]." However, one person said, "There's not enough staff." Most relatives told us that more staff were required. Comments included, "They don't have enough staff, "Aye, she's safe. I feel her needs could be met a wee bit more but there aren't enough staff" and "I feel there's not enough staff to cover the floors."

We spoke with the regional manager and manager about staffing levels at the home. They told us the provider did not use a staffing tool linked to dependency levels to assess staffing levels at the home. The regional manager told us that staffing levels were based on feedback from people, relatives and staff. This omission meant it was not clear how staffing levels were assessed because most people, relatives and staff told us that more staff were required.

We identified omissions and shortfalls in the maintenance of records. Staff told us there was insufficient time to complete records, provide care and have meaningful interactions with people.

We observed that staff were busy throughout both days of our inspection. We had to alert staff that one person required personal care and had to intervene when another person got up out of their chair twice and was at risk of falling.

This deployment and staff skill mix placed people at risk of harm because there were insufficient suitably qualified, competent, skilled and experienced staff on duty to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Staffing.

Following our inspection, the nominated individual told us that two staff were undertaking extra training to enable them to become senior care workers. A clinical lead had been appointed and was due to start on 9 October 2017. A bank nurse had also been appointed and recruitment checks were being carried out before they started work at the home.

Most people told us they felt safe living at the home. One person raised a safeguarding concern which we passed to the manager and referred to the local authority's safeguarding team. Most relatives considered that their relations were safe at the home. However, some commented about staffing levels. One relative said, "Yes and no [to the question whether there were enough staff]. I feel some of the carers are fine but others I feel just leave my [relative]."

One of the agency nurses told us he had reported unexplained bruising to the manager on the 12 September 2017. They explained that the bruising to the individual was old and the cause was unclear. They said, "I've reported it so she can be safeguarded." We noted that the manager had not made a safeguarding alert on 12 September 2017. We contacted the person's reviewing officer and alerted the safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Safeguarding people from the risk of abuse and improper treatment.

Risk assessments had not been completed for all known risks. We identified a concern relating to one person's moving and handling. The reviewing officer also raised concerns about the risk of choking for this individual. Staff were aware of these risks, however action to address these risks had not been taken in a timely action.

We spent time sitting in the lounge and saw that one person had a sensor mat beside them on the floor. This was to alert staff if they stood up and were at risk of falling. We observed that the individual moved the mat away with his foot and attempted to stand up twice. We intervened twice because there were no staff in the lounge.

We spoke with the manager about the use of sensor equipment. She told us they used to have a chair sensor alarm; however, another person had broken it. She told us a new chair sensor was on order. We checked the person's care plan and although a mental capacity assessment had been carried out about the sensor mat and restriction on the person's movements, the care plan did not contain information regarding the use or type of sensor equipment required.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safe care and treatment.

Following our inspection, the nominated individual told us that these risks had been addressed.

We checked the condition and suitability of the premises and equipment. Checks and tests had been carried out on electrical, water and equipment safety. We noted however, there was no evidence that the gas appliances had been checked. The nominated individual sent us copies of the gas safety checks which had

been carried out on 15 September 2017, following the inspection.

We read the minutes from a staff meeting on 16 August 2017. These stated that the upstairs sluice was out of order. Staff were currently using the ground floor sluice. Following our inspection, the nominated individual wrote to us and stated, "This is being dealt with as a matter of high priority." We did not identify any other shortfalls in relation to infection control. Staff told us they had access to suitable personal protective equipment such as gloves and aprons.

We checked the management of medicines. People did not raise any concerns about medicines management. They told us they received their medicines as prescribed. One person said, "I have something in the morning and I always have it at the same time."

We examined medicines administration records and saw that these had been completed accurately. We spoke with a pharmacy assistant from the local pharmacy who supplied their medicines. They said there had been occasional delays in staff sending in the monthly prescriptions. They also stated that staff were not completing and submitting update forms which informed the pharmacy of any new people living at the home or changes in medicines. These were required to ensure medicines administration records were accurate and contained details of the person's allergies. The manager explained that this had been due to the current issues with staffing.

We examined staff recruitment. Checks were carried out to ensure that applicants were suitable to work with vulnerable people. This included obtaining two written references including one reference from the applicant's previous employer and a Disclosure and Barring Service check [DBS] to help ensure that staff were suitable to work with vulnerable people. We were satisfied that procedures followed to recruit staff were thorough.

Requires Improvement

Is the service effective?

Our findings

In August 2017, the manager informed us there had been a two-week delay in taking one person's blood. There had been no permanent or agency staff trained in this clinical skill known as venepuncture.

The nurse currently employed at the home had completed this training on 23 August 2017. We checked the profiles of agency staff and noted that the clinical skills and competencies of agency staff were not recorded. This omission meant that the clinical skills and competencies of agency staff who provided 24 hour nursing care were not known and thus the provider could not ensure care and treatment could be provided safely, effectively and in a timely manner.

We examined the training matrix and identified gaps against various training courses including choking and dysphagia [swallowing difficulties], fluids and nutrition and falls training. We identified concerns regarding these areas during our inspection. We asked the manager and regional manager which training was deemed mandatory and the timescales for completion. The manager told us that a new training matrix was being introduced. It was not clear however, at the time of the inspection, which training staff had to complete to ensure people's needs were met.

Most staff told us that supervision sessions had recommenced following a lapse when the previous manager left. The manager had not yet carried out any appraisals because of the short time she had worked at the home and her knowledge of staff. She told us that this was being addressed. There was currently no system in place for clinical supervision. The manager did not have a clinical background and there was no clinical lead at the home. Clinical supervision is a formal process of professional support and learning which enables staff to develop their knowledge and competence.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Staffing.

Most people and relatives informed us that staff knew what they were doing. Comments included, "I don't know what training they've had but they seem to know what's wanted" and "They are brilliant." Some relatives remarked upon the high use of agency nurses. One relative said, "There's a lot of agency staff as well and they don't always know my [relative]."

Following our inspection, the nominated individual told us that a clinical lead had been appointed who had previously worked at the home. They were due to start on 9 October 2017.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is 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 the manager had submitted DoLS applications in line with legal requirements. There was a delay in the authorisation of applications for people who had previously resided in Scotland. This was due to external factors and was not due to any oversight by the provider.

Most staff had completed training in MCA and DoLS. We noted however, that none of the agency staff profiles we viewed stated that staff had completed training in this area.

We read one person's care plan and noted that staff had assessed them as having capacity to make decisions about their care and treatment. A sensor alarm mat was in place because staff had assessed them as being at high risk of falls. However, staff had recorded that the person did not want any sensor alarm equipment in place. There was no documented evidence that consent had been obtained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

Following our inspection, the nominated individual wrote to us and stated that the sensor alarm had been removed and staff were being vigilant with regards to the risk of falls. He stated that a multi-disciplinary meeting involving health and social care professionals and staff at the home was due to be held.

People and relatives informed us that they were happy with meals at the service. Comments included, "Excellent. They have the biggest choice anyone could ask for," "I like all the food; I don't have any dislikes" and "Good, I enjoy them." Several relatives told us they thought that people should be provided with more fluids. Comments included, "The food looks okay, but they could be going round a bit more often with a tea trolley; and have a bit more choice of what they have to drink – like tea, coffee, milk and juice" and "The meals seem to be alright. There's some of them that'll make a coffee or something but I think they need more drinks and they should make sure they're drinking it."

We checked people's diet and fluid charts and noted that these contained omissions. We read that two people had received 200mls on one particular day. In addition, we found that people's dietary requirements were not always clear. Staff told us that two people required a pureed diet. We examined these people's care plans and noted that this information was not included. . A pureed diet is not the most appealing of diets. In addition, pureed meals can have a lower calorific value.
This was a breach of Regulation 14 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Meeting nutritional and hydration needs.

Following our inspection, the nominated individual told us these omissions had been addressed and action taken. He told us that further training in nutrition was being sourced.

We spent time observing the lunch time periods on both days of our inspection. We saw that staff supported people with their meals and offered discrete assistance when required.

People and relatives told us that staff contacted relevant healthcare professionals when required to meet people's health care needs. One person told us, "I've never needed anyone. I would like to see a chiropodist but they know about that" and "They take me to the dentists; I go to a podiatrist as well." We received information of concern that there had been a delay in sending one person for an X-ray following a fall. We

spoke with the manager who told us that the GP had been happy for the individual to attend hospital the following day due to the time of day and transport arrangements. The person attended the X-ray department the following day and no injuries were identified.

We read one person's preadmission assessment. This stated that the person had lost weight and staff should consider a referral to the dietitian. There was no evidence that the individual had been referred and their malnutrition risk assessment had been incorrectly completed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safe care and treatment.

Following the inspection, the nominated individual wrote to us and said that the malnutrition risk assessment had been updated and a referral to the dietitian had been made.

We checked how the design and decoration of the service met people's needs. The manager told us they were in the process of consulting people, relatives and health and social care professionals about their plans to divide the home into two units. Those who had a dementia related condition would be offered accommodation on the ground floor and those with nursing and personal care needs would be accommodated on the first floor. The manager considered that the "unitisation" of the home would help reduce staff workload. She explained that staff were currently providing care and support to people who displayed behaviours which challenged alongside those who were receiving end of life care. Most relatives and staff with whom we spoke considered that this would be a positive move. One relative told us, "There's three types of people up here; Alzheimer's, nursing and general and I think they shouldn't be altogether."

Requires Improvement

Is the service caring?

Our findings

Due to the concerns identified during the inspection, we found that the provider had not always ensured that people received a high quality, compassionate service. We have taken this issue into account when rating this key question.

People and relatives told us that most staff were caring. Comments included, "They're angels" and, "They're lovely." Some commented that certain staff were more caring than others. Comments included, "Some of them are good but some of the others just take a look and then walk out," "Some of them's caring, but some, I don't think they are," "There's ones I can rely on will go that extra mile for you, so I feel they care a little bit more" and "Some of them; some are more helpful than others."

We observed positive interactions between staff and people. Staff displayed warmth when interacting with people. They were very tactile in a well-controlled and non-threatening manner. One staff member sat beside a person and the individual gently stroked their arm. We heard another staff member say to another individual, "It's good to see you today" and they held the person's hand. A third person said to a staff member, "I'm enjoying being with you – you're a good-un [good one]."

Staff told us how they always held people's needs in the forefront of everything they did. They told us they would like to be able to spend more time with people to meet their emotional needs. However, due to staffing levels this was not always possible.

People and relatives told us that staff promoted people's privacy and dignity. Comments included, "They will say, 'Do you mind if I dry you here?' and things like that. They're very thoughtful," "Aye, they shut the curtains and door and that when she's needing changing" and "He's quite a private person; they bring him in his room to change him if need be."

We observed that staff knocked on people's doors before they entered and spoke with people respectfully. One person indicated that they needed to use the toilet and staff discreetly supported them to the toilet.

Most people and relatives said that they were involved in people's care. We found that one relative had been unaware of the risks relating to their family member.

Following the inspection, we contacted the nominated individual about this omission. He stated, "We will ensure that service users' closest relatives are aware of any risks identified and with the contents of their relative's care plans, following consent from the service user where possible. It is our policy to get service users or their representatives to sign the care plan documents to state that they have been consulted and are in agreement with the care plans."

Requires Improvement

Is the service responsive?

Our findings

People's care records did not always reflect their needs. We noted that one person's care plan had not been fully updated since their health had deteriorated. We identified gaps and omissions in records relating to people's dietary and fluid intake, positional changes and activities. This meant there was a risk that people may receive care and treatment that did not meet their needs because their care records were not always accurate or well maintained.

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

Following our inspection, the nominated individual wrote to us and said that new recording sheets had been implemented. He stated, "Any omissions will be addressed on the day, prior to the end of the shift."

Some people and most relatives told us that more activities would be appreciated. Comments from people included, "I tend to do my own things. There's a lot of activities if you wish," and "I prefer to look out of the window and watch nature, the clouds, blue skies, birds and there's rabbits sometimes." However, comments from relatives included, "Even when they took on a new activities co-ordinator, my [relative] just has the TV on all the time," "There's never enough activities for the people here" and "No, there's nothing for him to do." We read the regional manager's report which was carried out on 22 August 2017. This stated, "Still a lack of meaningful activities."

There was an activities coordinator employed. She told us, "I do sensory stuff like bean bags/fiddle cushion and sound bingo. I just go with the flow. I try and find out their interests; it's trial and error trying things. I do anything they want such as paint their nails, hand massage, life stories, read to them and dominoes." The home had their own mini bus which was used to take people out into the local community. People had recently visited a local stately home with tearooms.

Staff explained that sometimes the activities coordinator was diverted from activities to support with care duties because of staffing levels. The manager told us that the activities coordinator was going to be permanently redeployed to care duties the week after our inspection. This meant that there would be no activities coordinator employed.

Following our inspection, the nominated individual wrote to us and stated, "We are currently advertising for an activities coordinator, interviews are arranged for 21st September. Staff continue to be encouraged to provide activities in the interim. New paperwork is to be introduced for each resident to ensure person centred activities and to include a review of the activities offered, taken up and declined, to promote an increased and improved experience for the residents."

Most people and relatives told us that staff were responsive to their needs. One relative said, "When my relative had a fall last week, the home rang for an ambulance and rang me at home to let me know of what had happened." Another relative however commented, "I feel something has to happen before they say

anything; I feel they're not quick off the mark in reporting things."

People told us that they could choose how to spend their day and what time they wanted to get up and go to bed. Comments included, "They generally come and ask if I would like a one [bath]. I've never had to ask for a bath," "Oh yes, of course [they give me a choice]. I get up roughly about 8am and go to bed after the 10 o'clock news" and "I like to get up at 8-8.30am and then breakfasts about 9am. I go to bed about 10pm, not later [their choice]" and "I'm a late bird, so I go to bed at 10.30pm. I'm always up at 7am [their choice]."

There was a complaints procedure in place. People and relatives told us that they knew how to make a complaint. One relative said, "I've made a complaint about an issue I wasn't happy about and something is going to be done about it." We saw records of complaints and detailed notes about how complaints and concerns had been addressed.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection, there was a manager in post who had started working at the home in May 2017. She had applied to be a registered manager with CQC.

People, relatives and most staff spoke positively about her. Comments included, "She's very professional and knowledgeable" and "She is a lady of unusual qualities. She's very understanding. She's a very rare breed."

The manager was not a nurse and there was no clinical lead in post since the previous clinical lead had left. This meant there was no permanent professionally qualified member of staff to oversee the nursing care of people.

Following our inspection, the nominated individual informed us that the manager had resigned their post. He sent us details of the managers who would be covering until a permanent manager was in place. He told us that a clinical lead had been appointed and was due to start on 9 October 2017.

We identified shortfalls and omissions in many areas of the service. Some of which had been identified by the provider's own quality assurance system. We read the minutes from a recent staff meeting which stated, "[Name of quality manager] completed a mock CQC inspection recently and it wasn't good. If it had been a proper inspection we would probably have been inspected as poor or possibly had an embargo put on the home." An action plan had been formulated following this audit. We noted that shortfalls with the management of medicines had been highlighted during this inspection. These had been addressed by the time of our inspection. The manager told us she was addressing the other issues highlighted in the action plan.

We found however, that care plans did not always reflect people's needs and care recording charts did not always document the care and support which was provided. These gaps and omissions meant accurate, complete and contemporaneous records were not always maintained to ensure people's health, safety and wellbeing.

Records were stored in two offices based on the ground and first floor. Staff did not always shut the office doors which automatically locked them to ensure the security of records. In addition, supplementary and handover records were not always easy to locate since they were stored loosely in various piles in both offices.

We also identified shortfalls in the maintenance of records relating to the management of staff. Records of the clinical skills and competencies of agency staff were not available. In addition, the training matrix contained gaps. It was not clear which training staff needed to complete to meet the needs of people. The provider did not use a staffing tool linked to dependency levels to assess staffing levels at the home.

Most of the nursing care provided was delivered by agency nurses. There was a lack of evidence to

demonstrate that staff were provided with up to date and accurate information which enabled them to meet people's needs consistently, safely and effectively.

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

Following the inspection, the nominated individual wrote to us and said that a new handover recording system had been introduced; new care recording charts had been implemented and they were piloting a new staffing tool.

Staff told us that morale was low which they informed us was due to staffing levels. In addition, many staff raised concerns about the regional manager's management style which we passed to the nominated individual.

Some people rated the home positively with one describing it as "Outstanding plus." However, most relatives told us that improvements were required, mainly in relation to staffing levels.

Meetings for people, relatives and staff were carried out.to obtain their feedback and involve them in the running of the service. One relative said that they would like the times and days of meetings to be varied to allow them options to attend. We spoke with the manager about this feedback. She told us that an evening meeting had been organised, however, no one attended.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive suitable food and hydration. Regulation 14(1)(2)(a)(4)(a).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people had not always been assessed and action had not always been taken to mitigate any such risks. Regulation 12 (1)(2)(a)(b).

The enforcement action we took:

We imposed conditions upon the provider's registration.

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 People were not fully protected from the risk of abuse because safeguarding procedures were not always followed. Regulation 13 (1)(2)(3)(6)(b).

The enforcement action we took:

We imposed conditions upon the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people and others. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(f).

The enforcement action we took:

We imposed conditions upon the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably

Treatment of disease, disorder or injury	qualified, competent, skilled and experienced staff deployed. Regulation 18 (1)(2)(a).

The enforcement action we took:

We imposed conditions upon the provider's registration.