Four Seasons (Bamford) Limited

Churchfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

This inspection took place on 17 and 18 February 2015 and was unannounced. There were breaches of legal requirements at our last inspection in 2014 and we had been assured by the provider that improvements were made. During this inspection we found some improvements were maintained, but there were still further improvements for the provider to make.

Churchfield Care Centre offers accommodation for to up to 60 people in two separate units, one of which caters for people who require nursing care and the other concentrating on care for people with needs related to dementia. At the time of this inspection there were 40 people accommodated at the home altogether. 27 people were accommodated in the nursing unit of the home and 13 people were accommodated in the residential unit, known by staff as 'Pine Trees'. There was a manager who had recently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 the medicines were not all well managed and people could not be sure they were receiving them on time and as prescribed by a doctor. Also, there were insufficient qualified nurses employed to cover all shifts safely and there were times when there were not enough care staff to ensure all people were safe.

Staff received regular training and felt supported by other staff and managers.

People had sufficient food and drink and staff gave individual assistance to people to help them with their meals, if needed.

Staff were kind to people and cared about them. We found people's privacy and dignity were respected and all confidential information was held securely.

Staff were developing ways of improving how to meet the needs of people living with dementia and how to make the environment more stimulating and purposeful for people. Various activities were arranged for people, but they were not always in response to people's individual interests and preferences.

The quality of the service was not sufficiently monitored in order to ensure people's care and treatment was always safe, but the registered manager led the staff team with support of senior staff and encouraged a positive culture of honesty and valuing people.

There were some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the management of medicines. There were further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, the need for consent and good governance. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

People did not receive their medicines safely as prescribed.

There were insufficient qualified nurses employed to cover all shifts and people's safety was at risk from a nurse working when over tired. Also, there were not always enough care staff to meet people's needs safely.

All new staff were thoroughly checked to make sure they could safely work with people at the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had not all consented to the care they received and their rights were not always protected by the use of the Mental Capacity Act 2005.

The staff were trained to provide the support individuals required.

People received sufficient to eat and drink and they were supported by external health professionals as needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Individual staff were caring and showed compassion in the way they spoke with people, but there were not always enough staff to respond to people's needs.

Information was only available on request about advocates to speak on behalf of people, but most people had relatives to represent their views if needed.

People's privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning was not always responsive to people's changing needs and the activities available were not always designed to meet people's individual interests and preferences.

There was a system to receive and respond to complaints or concerns, but information about this system was not clear for all people.

People who lived in the home and their relatives had been asked for their opinions of the quality of the service, but information was not available about how their comments were acted on.

Summary of findings

Is the service well-led?

The service was not consistently well led.

The quality of the service was not sufficiently monitored in order to ensure people's care and treatment was always safe.

There was a registered manager, who led the staff team with support of senior staff. A positive culture of honesty and valuing people was encouraged at all times.

Requires Improvement

Churchfield Care Centre

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.

This inspection took place on 17 and 18 February 2015 and was unannounced. The inspection team consisted of one inspector and a Specialist Advisor in nursing.

Before we visited we reviewed the information we held about the home including notifications. Notifications are about events that the provider is required to inform us of by law.

During our visit we observed the care in both units. We spoke with eight people living at the home, four visiting relatives, two nurses, four care staff, an activities worker and the registered manager.

We looked at the care plans for four people, the staff training and induction records for staff, five people's medicine records and the quality assurance audits that the registered manager completed

We observed care and support in shared areas and we also used the Short Observational Framework for Inspection (SOFI) in one area. SOFI is a specific way of observing care to help us understand the experience of people who cannot fully express their views by talking with us.

We also consulted commissioners of the service who shared their views about the care provided in the home.

Inadequate

Is the service safe?

Our findings

During our previous inspection on 18 August 2014 we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as people were not protected against the risks associated with medicines. This was because medicines were not always kept safe, they were not given to people living in the nursing unit in a timely manner and, overall, we were not assured that people were given their medicines as prescribed.

During this inspection, two people in the nursing unit told us the staff gave them their medicines and they took them with food or drinks. One person told us they got their medicines in the end but had to wait a long time. We saw the arrangements for medicines in the residential unit known as 'Pine Trees' and we saw the medicines were all stored securely. The senior care workers were responsible for administering medicines and we saw clear records. All medicines in that unit were administered on time. However, there were inconsistencies in the management of medicines between the two units and our concerns were about the administration of medicines in the nursing unit.

On 17 February 2015, there was one nurse in the home, who had been on duty since 7.30pm the previous evening and there was no other nurse available to take over the nursing responsibilities. This meant that this nurse was responsible for all medicines in the nursing unit during the morning after having no rest. The nurse told us, "I am having difficulty concentrating on these medicines."

We observed that the nurse was administering medicine until 11.15am and this meant that people were receiving essential medicines two to three hours later than the time prescribed. For example, some people needed insulin to prevent unsafe levels of sugar in their blood which could seriously threaten their wellbeing. Testing should have been carried out prior to breakfast to ensure stable blood sugar levels were measured and insulin should have been given immediately prior to eating. We observed the nurse testing the blood sugar levels of one person at 11am and giving insulin after that. The nurse did not write down the time and result of this blood sugar level test in order to monitor these levels. We reported our concerns to the manager, but on the following day, 18 February 2015, another nurse was unaware that anyone at all was in need of insulin and was systematically going through the medicine administration sheets without any prioritisation of medicines that were needed earlier. On 18 February 2015, the administration of morning medicines continued until 12.15pm and we noted that the insulin for one person was given at 11.45am, which meant the person received their early morning insulin three hours late.

The nurse on duty on 18 February 2015 had not worked at the home previously and had difficulty identifying people, which caused delay to people receiving their medicines at the appropriate time. We saw that care staff assisted part of the time, but there was not a designated care staff member allocated to support the nurse throughout the task.

We found there were handwritten prescription entries in the medicine administration records (MARs) that were not signed to confirm the entry had been accurately copied from the prescription. This is unsafe practice and presented a risk that the medicine being given may not be in line with what a doctor had prescribed. For example, on 18 February 2015, we saw handwritten entries that differed from the information in the care plan file. A specific fixed amount of insulin was written to be given on the MAR sheet, but in the care plan there was information from the GP directing nurses to test for blood sugar levels before meals and give the relevant amount of insulin dependent on the level of glucose in the blood. Two differing amounts were prescribed. The nurse was unaware of these instructions and told us it was nursing practice to follow the instruction on the MAR sheet. This practice posed a serious risk to the person, who had been admitted due to requiring assistance to manage fluctuating blood levels.

We saw other poor practise. For example, one medicines register had already been signed earlier in the morning of 17 February 2015 to say that the stock levels had been checked, but there was no second signature to witness this was done. The nurse told us the stock levels had not in fact been checked, but they had signed the register in readiness. This check was finally carried out after 11am when another nurse arrived to take over responsibility that day. Signing in advance was misleading and falsely stating the check had been completed. The registered manager was not aware of the practice of these nurses and had no information about their levels of competence.

Improvements had not been made and people were still not protected against the risks associated with medicines. The provider was still in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service safe?

Regulations 2010, which corresponds to Regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action to ensure the provider and manager comply with the regulations.

There were not enough staff available to meet everyone's needs safely. In the nursing unit, two people told us they had to wait a long time for help from staff, but a third person said they could always ask for help from staff and it was given. When we observed a group of five people for 30 minutes we saw that just two had any conversations with staff. Two others were briefly acknowledged on one occasion when they spoke to staff and the fifth was totally ignored even when calling out for attention to their needs. We saw that the care staff were busy with other tasks.

Also, in the nursing unit, we had seen that there was no nurse to take over from the nurse who had completed a night shift and we saw that care staff were running around busily trying to cover all care tasks so they could take their breaks. When one of the care staff left due to sickness during the shift, there was no replacement. This meant some people's needs were ignored or met later.

On 17 February, there were just two care staff in the residential unit which meant no one was supporting other people when one person required two care staff. On 18 February there were three staff in that unit and there was always one of the care staff attending to people's needs in the main lounge.

All staff we spoke with said there were not always enough care staff on duty. The manager said the staff had to manage and that kitchen, domestic and activities staff were there to help out when needed. Most had received training in providing care, however, this was in addition to their main tasks and did not always have priority.

The manager explained that the number of staff was determined by a dependency calculator called the Care Home Equation for Safe Staffing (CHESS). This involved assessing dependency in each area of care need for each person as High, Medium or Low, then assigning numerical values and providing a numerical average. This meant the average need was met by a certain number of hours. It did not account for fluctuating dependencies. In addition there were two or three care staff in the residential unit, depending on staff contracts rather than the calculation based on needs. Likewise, there were either four or five care staff on shift in the nursing unit. At times we observed there were no staff in the lounges with people with high needs and this showed people were not consistently cared for in a safe way.

The manager explained that nurses were difficult to find to cover shifts, so they were using bank and agency nurses, who did not know the people.

We found that the way the provider assessed the staffing levels and deployed staff did not provide sufficient staff to meet people's needs at all times and this was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe recruitment and selection processes in place. The staff we spoke with told us they had supplied references and undergone checks relating to criminal records before they started work at the service. From our discussions with staff we were assured that they knew about abuse and how to keep people safe. They had received training and had information about who to contact if they were concerned that someone was being abused. There were records to show that all staff had completed this training. Staff gave us examples of how they used their training and this showed us that they understood what action they needed to take in reporting any concerns.

We saw examples of risk assessments in people's care plan. These covered potential risks including those involved in assisting people to move, the use of bed rails and the risk of developing pressure ulcers. Staff were aware of potential risks and we saw that they ensured people had pressure mattresses and cushions where needed. We observed staff following safe procedures when using a mobile hoist to transfer people between chairs. Fire drills were carried out every week and one occurred during our visit. Staff were aware of their roles in the event of a fire. We also saw evidence of care staff assisting people who were cared for in their beds to change position regularly in order to avoid pressure ulcers. Some people had previously developed ulcers and we saw that these were being appropriately treated. This showed that staff were taking action to reduce risks to people's health and wellbeing.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection on 18 August 2014 we found the provider had breached Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which referred to consent to treatment. We identified concerns that the principles of the Mental Capacity Act 2005 were not being appropriately applied when decisions were made for people who could not give their own consent. During this inspection we found some improvements had been made, but we had further concerns about people's rights and consent to the way their care was given.

There were mental capacity assessments that were specific to some particular decisions. For example, decisions about use of bed rails and end of life care. The previous manager had completed applications for some Deprivation of Liberty Safeguards (DoLS) with respect to bed rails that were being used, but these applications were not fully completed and none of the staff could find any response letter from the local authority. DoLS aim to ensure that when people's liberty is restricted this is done in the least restrictive way and in their best interest. We observed that one person was restrained in a chair that was tipped back and also secured with a lap belt. This person had needs relating to dementia and was trying to move forward, but was unable to, due to the position of the seat and the belt. There was no clear assessment of the need for this form of restraint, though staff we spoke with felt that it was in the person's best interests in order to keep them safe.

We discussed this with the manager, who then gave urgent temporary authorisation for the deprivation of liberty and completed a full application for authorisation by the local authority. We saw that this had been completed by 18 February 2015, but we also spoke with another person who was asking to go outside and was prevented by staff and also by the locked door. The staff felt the person would not be safe outside alone, but there was no assessment of the person's mental capacity to make this decision. The manager agreed to complete the assessments and apply for DoLs for this person. The manager also started to consider other people and what assessments and DoLS may be needed for a range of care and treatment, including arrangements for giving medicines covertly. Until the manager gave full consideration and completed assessments, there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person who used the service told us, "They [staff] are very good. They know how to do things." A relative we spoke with told us, "There are some new staff and they seem to be trained." We observed care staff assisting people and they showed skills in moving people. We also observed the way care staff communicated with people in the Pine Trees unit when encouraging them to accept support and this resulted in a calm environment.

The staff we spoke with told us they felt supported in their role with some 'E learning' on a computer and some face to face training. The registered manager told us the staff induction training was carried out to standards designed for people working in adult social care and that staff had 12 weeks to complete this. It could be extended if needed. There was a plan for all staff to have individual supervision meetings with a senior or manager and three staff told us this had been taking place.

People received enough to eat and drink and in the Pine Trees unit, we saw the cook encouraging staff to offer the options with two plates, so that people could see what they were choosing. The cook told us one person required a low sugar diet and another was vegetarian. The cook was well aware of the need to provide the appropriate soft textures for various people to meet their swallowing needs effectively. There was no current information in the kitchen of people's needs and preferences, but the cook said a new chart would be available soon so that other staff would have the information they needed in the cook's absence. People's weights were monitored. One person's weight was found to be very low and they required fortified foods The cook explained how they used full fat milk and cream. We saw records of food given that showed a good diet and fluids were recorded.

In the nursing unit, there was a list of people who needed special diets and extra food fortification. People there told us they were satisfied with the meals. One person said, "There's always a choice and it's mostly cooked how I like it." There was a menu on the noticeboard in the dining area and staff told us there was always a choice of at least two options at every meal. In both units, most people were eating unaided, but where they needed help, care staff

Requires Improvement

Is the service effective?

assisted sensitively, by sitting at the same level. We also saw that people had a choice of drinks that were available throughout the day. This showed that people had choice of what to eat and drink.

In addition to the qualified nurse on the premises, some people had visits from community nurses during our inspection for on-going treatment. Only those who had fulltime nursing needs had care from the nurse on the premises. We saw evidence that some people moved from the Pine Trees unit to the nursing unit if their needs changed. There were records of visits from doctors and other health professionals and a relative told us they had made separate arrangements for a physiotherapist to visit.

Requires Improvement

Is the service caring?

Our findings

In the Pine Trees unit, we observed the care staff speaking with people in a very caring manner. We saw that the care staff were very observant and aware of where people were at all times. They noticed when anyone was becoming distressed or agitated and they offered reassurance or gently diverted their attention. We observed that one of the staff was aware when light from the window was bright in people's eyes and quickly responded by drawing the curtains sufficiently, but still allowing enough light in the room. A person told us they were happy living there and staff were really nice and helped them. Another person said, "Yes I'm fine", when we asked whether staff were kind to them.

We saw staff that were caring towards people, but the service, as a whole, was not consistently caring as medicines were not given at the right time and there were not always enough staff to meet people's needs. For example, we observed that, at times, there were no staff in the lounges to give attention to people with high needs.

In the nursing unit, one person told us the staff were, "Very helpful and caring" and another person agreed and said, "They always do their best, but they are very busy." A relative told us that staff were always willing to help and seemed very caring. One relative said, "There have been so many staff changes, the residents don't get to know staff before they've gone, but they all seem to care about people – if only they had more time." We also spoke with a visiting district nurse who agreed that the staff were caring and pleasant towards the people they were helping.

Care staff told us they always offered choices to people and waited for their response before proceeding and we also observed this in practice. However we saw, on one occasion, that a person was moved to the dining table without any attempt to communicate by the care staff involved. We discussed this with the manager who told us they would raise this with all staff and ensure the care plan specified how staff should communicate with this person. Otherwise, we saw that staff understood the different ways people communicated their choices about where they sat or what drink they wanted. This was particularly clear in the Pine Trees unit where staff showed understanding of fully respecting people's individual choices despite their fluctuating memories and moods.

One person told us they did not know what their plan of care was, as no one had talked with them about it. A relative of another person told us they often discussed their family member's care with staff and had seen the care plan. There was no information around the home about advocacy services, but the manager told us that this information was available if anyone said they wanted an objective person to speak on their behalf. She told us that no one was using this service at present, as relatives were advocating for people when needed. The manager was aware that an independent advocate may be appointed when the local authority assessed any restrictions on people under the Mental Health Act.

We saw there had been significant improvements in the decoration and cleanliness in the home and the manager told us that most of this work had been done over the past six months. This showed that attention was given to providing an environment that respected people's privacy and dignity. The work was on-going and we saw bathrooms that had been redecorated, but not yet completed with furnishings. There were, though, some appropriately completed facilities that were available for use. Bedrooms were kept clean and some were being redecorated. Also, new carpets were being fitted and the home was clean in all areas, which showed respect for people and their visitors.

One person said, "They are good at keeping me covered up when I'm having a wash. I feel respected." Two staff told us about their training that included respecting people's dignity in every way they could. One care staff said, "It's always important to keep things private. When family members ask about their relatives, we always talk to them in private." We saw that all confidential and personal information was held securely in locked offices. Another care staff told us, "We always close doors and windows when we're helping to wash and change people." We heard staff showing respect and using people's preferred names.

Requires Improvement

Is the service responsive?

Our findings

Four people that lived at the home and three relatives told us they were involved in decisions about the care and they had seen care plan files in the past. However, in the nursing unit we found that plans were not all complete or up to date. For example, one relative told us they had discussed their family member's care with staff, but they did not think it was all written down as they had seen the care plan file that was not up to date. Also, there was information in an assessment that one person wanted to be involved in their care and treatment, but how it was to be done was not in the care plan. We discussed this with the manager and part of this care plan was rewritten for our second day of inspection.

In the Pine Trees unit we saw clear information in plans for care staff to follow. We saw there were up to date monthly evaluations of all care needs and clear daily notes were recorded. Staff in the Pine Trees unit told us they had read all the care plan files and kept them up to date. However, in the nursing unit, one relative said, "I don't think they read the information they have about people, as they don't know [family member]'s needs very well at all." We found that the nurse on duty did not have full information about people. Other staff told us they had received some information in handover meetings and they read the daily records. Some staff knew some people's needs very well from working with them for a long period of time. New staff told us they would ask senior staff if they needed to know anything. However, two relatives complained to us about the lack of continuity of care, as the staff changed frequently and information was not passed on sufficiently well for staff to respond to all people's needs.

Although there were some differences between the way the two units responded to individual care needs, in both units we saw that people's personal preferences and likes and dislikes were recorded using "My choice, my preference" booklets. These differed in the amounts of information they contained and more work was needed to complete them and keep them up to date, so that people's choices were all taken into account in their care.

One activities worker was employed. We saw a group throwing and catching activity taking place with the activities worker in the nursing unit and people were encouraged to take part in what was planned for them. It was not clear if people had chosen this activity for themselves. Some chose not to join in and two people told us the music was too loud. The activities worker had chosen the loud music. We saw that some people were sitting near a television that was tuned into a children's programme and two people asked for it to be changed to another channel, but, as the remote apparatus could not be found, a member of the care staff switched the television off.

Care staff told us that the activities worker provided and arranged a variety of activities for people. Some people had joined in knitting and some liked the ball games. The activities worker told us that they carried out an activity in one unit and then repeated it in the other unit. We also saw a 'petting dog' visited each unit during our inspection. The activities worker had records of group activities undertaken during the last year and also wrote in daily notes for people that had joined in. The activities worker told us they had not seen the choices and preferences information in the care plans. They, therefore, did not know everyone's interests. A visitor told us they had seen some activities, but felt they were always chosen by the activities worker and were not centred on the needs and preferences of people living in the home.

The Pine Trees unit was more responsive to the needs of people living with dementia. They were using 'PEARL', which stands for 'Positively Enrich and Enhance Resident's Lives'. This is a programme intended to improve dementia care in care homes. At Churchfield Care Centre it took place in the Pine Trees unit. Staff there were developing ways of improving how they meet the needs of people with dementia and how to make the environment more stimulating for people to look at and purposeful. We saw a clear display showing the time, date and weather. This was not available in the nursing unit, even though there were also people there who were living with dementia. The layout of the Pine Trees building was particularly helpful for people who wanted to walk purposefully around the different areas and the activities worker had been developing a shopping area, by using the walls on one corridor.

The complaints procedure was not clearly displayed, but was available in small print and had been included in the information about the home that people received when they first moved in. One person told us they didn't know who the new manager was, but they would tell one of the staff if they wanted to complain. Another person said they

Requires Improvement

Is the service responsive?

would speak to their son and leave it with him to complain to the right person. A senior care staff member was not sure of what was in the complaints procedure, but would tell the manager if any complaint was received. The current manager had received one complaint since November 2014 and had responded. One visitor told us they had made a complaint, but had not received a response. Another visitor said they felt they could speak to the manager or a nurse on duty at any time about anything. The procedure to make a complaint and when to expect a response was not clear for people and their relatives.

There was a notice on display that stated, "What we asked, what you said, what we did." However there was a blank space under these titles. The manager told us it was for responses to questionnaires that were sent and returned about the service. She also told us there had been resident and relatives meetings every three months, but the last minutes available were from May 2014. There was no information about actions taken in response to any comments received through surveys or meetings.

Requires Improvement

Is the service well-led?

Our findings

A new registered manager had been managing the home for a few months and was based in the nursing unit. There was also a deputy manager based in the same unit. This person was a qualified nurse, but was not on duty during this inspection.

A new regional manager was responsible for monitoring the quality of the care on behalf of the provider, but had not visited the home until the first day of this inspection. No other regional manager had visited for the previous four months. However, the registered manager told us she had carried out checks and audits herself, on a monthly basis, and completed information on computer to forward to the provider's head office.

The registered manager told us she did not always have time to visit the Pine Trees unit each day, but she was in contact with the staff there by telephone. She was recruiting a unit manager to take on some management responsibility for that unit and this person would have responsibility to supervise the staff there.

When we discussed the Mental Capacity Act with the registered manager and the lack of applications for Deprivation of Liberty Safeguards under the act she told us that, since commencing as manager, she had "not had time to sort out DoLS", as there were other priorities that involved improving care. However, we noted that she appropriately commenced this process before we completed the inspection. Also, following our discussion, she updated a care plan for one person to enable them to be involved themselves with their treatment.

Both the regional manager and the registered manager were not aware of poor practice regarding administration of medicines and did not have an up to date system for carrying out competency checks for all staff administering medicines including agency and bank nurses. They were, though, aware of the difficulties in finding suitable nursing staff to cover all shifts, which was putting nursing care at risk. This meant that the quality of the service was not assessed and monitored sufficiently in order to ensure the safety of the services provided and this is in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since commencing in post the manager had held staff meetings in the nursing unit. Care staff told us there was a staff meeting every three to four weeks and they felt they could contribute in the meetings. However, there had not been any meetings for staff who worked only in the Pine Trees unit.

We observed that the manager assisted with direct care when no other care staff member was available. This happened from time to time and gave the manager an opportunity to lead by example.

Staff told us the manager was approachable and they could speak to her about any concerns at any time. The manager said that the staff culture was changing and all staff seemed more positive than when the manager first commenced at the home. She was aware of the need to value individual staff rather than directing them all the time. Staff who had been working at the home the longest also told us they enjoyed coming to work and felt the service at the home was continually improving. There were some new staff and they felt supported by existing staff.

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 did not take formal enforcement action at this stage. 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing This corresponds to: Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. How the regulation was not being met: There were not always enough staff available to meet everyone's needs safely. Regulation 18 (1)

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment This corresponds to: Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. How the regulation was not being met: Full consideration was not given to the rights of people who used the service as the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not being appropriately applied when decisions were made for people who could not give their own consent. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision This corresponds to:

This section is primarily information for the provider

Action we have told the provider to take

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

How the regulation was not being met:

The provider was not aware of the poor practice regarding the administration of medicines and had not found suitable nursing staff to cover all shifts. This is because the quality of the service was not assessed and monitored sufficiently in order to ensure the safety of the services provided.

Regulation 17 (2)(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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who used the service were not protected against the risks associated with unsafe use and management of medicines due to a lack of systems to assess the competency of nurses administering the medicines and a lack of checking that medicines were being stored, managed and administered safely in accordance with the directions of a prescribing medical officer. Regulation 13

The enforcement action we took:
We served warning notices on the registered provider and manager and told them they must take immediate action to become compliant.