Walkden Manor Care Home Ltd

Walkden Manor

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection took place on 30 June and 9 July 2015.

Walkden Manor is located in Salford, Greater Manchester and is owned by Walkden Manor Care Homes Ltd. The home is registered with the Care Quality Commission (CQC) to provide care for up to 29 people. The home provides care to those with residential care needs, many of whom live with dementia. People's bedrooms are located on both the ground and first floors of the building. In addition, there are two lounges and a dining room, with doors opening onto a patio area at the rear of the building. Car parking is available at the home, as well as in side streets close by.

We last visited the home in November 2014 where the service was rated as 'Inadequate' overall. Since that inspection, the provider sent us action plans in relation to each breach of regulation, telling us about what improvements they planned to make. We also met with

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the provider on 5 June 2015, where were told that things were progressing well at the home. This inspection focussed on what improvements had been made since our last visit.

During this inspection, we identified five breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to Person Centred Care, Dignity and Respect, Safe Care and Treatment, Good Governance and Staffing. We raised these concerns with the home owners and manager who following the inspection, sent us an action plan detailing how these concerns would be addressed, along with any necessary timescales they would be completed in.

At our previous inspection we had concerns with how medication was handled and issued a warning notice in relation to this regulation. At this visit, we still identified problems which meant people did not always receive their medication safely. This is a breach of regulation 12 (2) (g) with regards to the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we had concerns over the safety of the environment which placed people at risk. We observed a lock on the door to the basement to be broken, which meant that people could easily access the staircase unaccompanied and fall. When we returned to the home on the second day of our inspection, a key pad lock had been added to the door to ensure it was secure

We also saw that window in the lounge was also left wide open, with a gap big enough for somebody to climb through, leading to a busy main road. The window was open when we arrived at the home at 5.40am and anybody from outside could also have gained unauthorised access. These concerns demonstrated a breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

During the inspection, we observed one gentleman who smoked, had managed to gain access to a lighter and as a result, set a handkerchief on fire. This person also had cigarette burns in their coat which placed them at further risk of starting a fire within the home. We found there was no risk assessment in place for the use of a lighter within this persons care plan. On the second day of the inspection, the new home manager had implemented a risk assessment for this person so that staff were aware of the risks this presented and what they needed to monitor.

We saw that moving and handling transfers were not always completed safely. On the first day of our inspection, we observed three transfers which were not completed in a safe manner. This still proved a problem when we visited the home during the second day. In this instance, a new care plan had been implemented for one person who required assistance from two members of staff with all transfers. However, this had not been fully communicated to all staff on shift as we observed one member of staff assisting a person to stand on two occasions. These incidents demonstrated a breach of regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We also had concerns in relation to infection control and the general cleanliness of the building at our previous inspection. At this visit, we still observed areas of poor practice around the home. These related to a large stain on the floor outside the downstairs bath room, paper towel dispensers being empty, two foot operated pedal bins being broken and hand hygiene guidance not always being located near the sink for people to refer to in the upstairs bathroom. We also observed a mattress with faeces on it at approximately 10am. These issues demonstrated a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We also had concerns over night time staffing levels and the fact that there were no staff trained to administer medication through the night. We saw improvements in this area during the inspection, with the staff present being appropriately trained to administer medicines such as pain relief as required on both days of the inspection. Prior to our inspection, we received whistleblowing information, stating that night staff were working at the home without receiving appropriate training first. We looked at old staff rotas and saw that one member of staff in particular had worked 19 night shifts at the home without receiving any training. We asked the home owner and manager to show us evidence of any training records for this person, however they were unable to provide these to us. This is a breach of regulation 18 (1) of the

Summary of findings

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing. This was because we were unable to see that suitably skilled, qualified and competent staff were working at the home on a consistent basis.

We checked to see what improvements had been made to make the home environment more 'Dementia friendly'. We saw that signage had been introduced around the home directing people to areas such as bedrooms, toilets and the dining room. Although this had been introduced, wall colourings were still very bland in appearance and things such as people's bedrooms doors did not clearly stand out, making them easier to locate. There was also a lack of consistency as to who had their name or picture on their bedroom door which meant they may be unable to correctly locate it.

We checked to see what training staff had available to them and if they felt suitably supported to undertake their role. We looked at the training matrix which identified any training undertaken by staff. This showed that staff had received training in areas such as moving and handling, health and safety, infection control and medication. Despite this, the matrix demonstrated that only five members of staff had done Safeguarding Adults training, six had done Dementia training, two had done MCA/DoLS training and that nobody had received any training relating to Challenging Behaviour. This was out of 16 members of staff listed on the matrix. Following our inspection, we asked the home owner to provide us with evidence that staff were appropriately training in these areas, however this was not sent to us. We were told a refresher course in relation to Moving and Handling had been scheduled for Friday 3rd of July.

We observed the lunch time period at the home on the first day of the inspection. The lunch time period lacked oversight and there was nobody ensuring that people's nutritional needs were being met. For instance at our last inspection, we raised concerns that staff were assisting more than one person at the same time and we saw that this still took place during this inspection. This was not a personalised or dignified way for people to received assistance whilst eating their meal. This improved on the second day of our inspection, with more staff presence in the dining room, where people received individualised support.

There was a lack of stimulation for people during the day with people being left unaccompanied in the lounge areas for long periods. We saw a skittles activity taking place in the afternoon but people told us this did not meet their personal preferences. One person said; "The only activities are skittles, which I'm well past. We need entertainers to come in to entertain us in the lounge as it can get very boring". Whilst looking at people's care plans we saw that 'bucket lists' had been created for people containing activities they wanted to undertake. However, there was no evidence these had been explored by staff at the home. Some contained basic activities such as getting out of the home more often, gardening and playing the guitar. These were missed opportunities to provide activities that were personal to people. This is a breach of regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred.

We observed several instances where people who lived at the home were not treated with dignity and respect. For example we saw that one person who lived at the home was seated in a chair which had faeces on it. We alerted staff to this and this person was then moved to another chair, however they were not offered a change of clothing. Another person who lived at the home said that they wet themselves because staff had not assisted them to the toilet in a timely manner. These concerns meant there had been a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Dignity and Respect.

We saw several examples where people's personal preferences were not adhered to and we saw no evidence that people were involved in the creation and ongoing review of their care plans. Where people's care plans specifically stated they would like to do certain things, these were not always provided for them by staff. For instance, about whom they sat with at lunch or the types of clothing they wore. This is a breach of regulation 9 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred Care.

At the time of our inspection, there was no registered manager in post, who was appropriately registered with the Care Quality Commission. A new manager had commenced in post on the day prior to our inspection. A registered manager is a person who has registered with

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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.

There was a lack of leadership on the day of our inspection, with nobody overseeing what was going on within the home. For instance, there was nobody overseeing the lunchtime period where we identified concerns at our last inspection and nobody overseeing that staff were deployed in the correct areas within the home, which we had observed to be unsupervised. The new manager had only commenced employment at the home the day before we visited and was still getting used to how the home needed to be run. The home owners were present, but again, were not overseeing that things were running smoothly at the home throughout the day and were office based.

At our previous inspection we had concerns in relation to records not being maintained at the home such as charts to people being re-positioned and monitoring food and fluid intake. During this inspection we saw that other records were still not being maintained such as checks on people during the night and continence sheets. We saw these had not been completed since 25 June 2015. We raised this concern where we were told they had been transferred to the back of people's doors but when we checked, they were still not being completed consistently by staff. This is a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

We found that records held at the home were not held securely, with confidential information easily accessible to anybody in the building. For example, on the third floor or the home records waiting to be archived were left in boxes on the floor and could be accessed by anybody. On the second day of the inspection, this area was much tidier with the records being stored beyond a locked door. We also found that the drawer containing staff personnel files was not locked and neither was the office door. Additionally, people's care plans were either in a drawer that was not locked or left on the side in the office for anybody to read. This is a breach of regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

There were a range of audits in place which had been completed by the previous manager and also the home owners. They covered care plans, meal time experience, cleanliness, medication, water temperatures, monthly fire equipment checks, weekly H&S and maintenance checks including door guard closure, monthly audits of fire alarm, automatic door closure and exit route checks. A head office audit had also been completed on 2 June 2015 and looked at areas including staff files, training and cleanliness. Despite these audits, they did not identify some of our findings during the inspection for instance that people did not have moving and handling assessments in place, or our environmental concerns. This is a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

Following an examination of safeguarding records maintained by the service, we found that the service had failed to notify the Care Quality Commission of abuse or allegation of abuse in relation to people who used the service. This is an offence under Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014, with regards to notification of other incidents.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if

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they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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. We found that medication was not handled safely which placed people at risk.

Infection Control issues were still present within the home and we saw that consistent numbers of suitably trained staff were not always present during the night.

The environment was not safe for people on the day of our inspection. This included broken locks on the basement door leading down steep steps and the kitchen door. The lounge window was also left wide open, with a gap large enough for somebody to fit through. These issues were rectified on the second day of our inspection.

We also observed unsafe moving and handling techniques being used by staff when supporting people living at the home. This continued on the second day of our inspection. Another person set fire to a handkerchief in the building. In relation to this, appropriate risk assessments were not in place, but were introduced by the second day of our visit.

Is the service effective?

Requires improvement

Not all aspects of the service were effective. Although efforts had been made since out last inspection, further improvements were required to the environment for people living with dementia.

The training matrix we were shown, which we were told was up to date, showed that not all training was up to date. This included topics such as MCA/ DoLS, Safeguarding, Dementia and Challenging Behaviour.

Staff supervision was consistent, with records maintained to show that a regular pattern of supervisions had been maintained in recent months.

Is the service caring?

Inadequate

Not all aspects of the service were caring. We observed several instances where people were not treated with dignity and respect.

We observed there to be a lack of communication between staff and people living at the home. One person was left for 20 minutes facing a wall without being told by the member of staff where they were going.

We observed several instances where staff stood over people to talk to them rather than kneeling down at eye level where they would be able to see and hear them easier.

Is the service responsive?

Inadequate

Not all aspects of the service were responsive. We saw several occasions where person centred care was not provided in line with people's requirements.

Summary of findings

Activities on the day of the inspection were limited, with only a skittles game taking place in the afternoon, which some people told us was not what they wanted.

A visiting professional told us that their guidance and advice was not always followed by staff in relation to people's nutritional needs.

Is the service well-led?

Inadequate

Not all aspects of the service were well-led. There was not currently a registered manager with the Care Quality Commission. A new manager had only just started working at the home the day before our inspection.

We found that appropriate notifications were not sent to the Care Quality Commission as required. This included notifications of several Safeguarding incidents that had occurred at the home.

Leadership at the home was lacking on the day of our inspection. There was nobody overseeing tasks that were being carried out or ensuring that staff were deployed in correct areas of the home.

Audits at the home were not always robust in identifying similar concerns that we had identified. The provider acknowledged in recent months, that the home had not been monitored closely enough by head office.

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We carried out this unannounced inspection on 30 June and 09 July 2015. On the first day of the inspection, the inspection team consisted of three adult social care inspectors, a dementia care specialist advisor and a pharmacist inspector. The pharmacist inspector was following up on previous non-compliance in relation to management of medication. During the second day of our visit, two adult social care inspectors carried out the inspection.

At the time of the inspection there were 22 people living at the home. During the day we spoke with the registered manager, both home owners, six people who lived at the home, four relatives, five members of staff and three visiting professionals. We looked around the building and viewed records relating to the running of the home and the care of people who lived there. This included care plans, staff personnel files and policies and procedures.

We spoke with people in communal areas and their personal rooms. Throughout the day we observed how staff cared for and supported people living at the home. We also observed lunch being served in both dining rooms of the home.

Before the inspection we liaised with external providers including the safeguarding and infection control teams at Salford local authority. We also looked at any relevant safeguarding/whistleblowing incidents which had occurred at the home.

Inadequate

Is the service safe?

Our findings

At our inspection in November 2014 we found some serious shortfalls in how medicines were managed. At this inspection we assessed if improvements had been made. We checked the medicines administration records and medicines stocks for 12 out of the 22 people that were living in the home. We observed medicines being administered to people and talked to one care worker and two senior managers in relation to medication.

Since our last visit we saw some improvements had been made to the issues that we had identified. Medicines stocks were generally well organised and we saw sufficient quantities were kept in the home to help make sure people received a continuous supply of their medicines. Records were completed clearly and accurately allowing medicines to be fully accounted for. When medicines were not administered, for example if they were refused, an accurate record was made. We found care workers had been trained in medicines handling to cover the night time to make sure medicines could be safely administered at all times.

However, we found some issues that need to be improved to make sure the risks associated with medicines are minimised to protect people from harm. Controlled drugs (medicines that can be misused) were not stored in a legally compliant cupboard so there was a risk they might be misused. Additionally, we found the medicines fridge, although now monitored daily and within the required temperature, was defrosting which had made the medicines packaging within the fridge extremely wet creating a risk of contamination and spoiling.

Medicines allergies were not always clearly presented on the medicines records as recommended by current national guidance. The medicines policy had recently been reviewed but this had not included updating the policy to reflect current national guidance on managing medicines in care homes. Although we found medicines were usually administered and recorded correctly we found two medicines were wrongly given 'after food' instead of the prescribed 'before food' because staff had not followed the instructions properly. This meant there was a risk these medicines might not work correctly or people might suffer unnecessary side effects.

Medicines audits had been completed regularly to help make sure issues were promptly identified and put right to protect people from harm. We found some evidence of these audits identifying and making improvements to the medicines handling systems but given the concerns we found during this visit it was evident these audit processes had not always been fully effective. These issues meant there had been a breach of Regulation 12 (2) (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we had serious concerns over the safety of the environment which placed people at risk. Based on these concerns, the provider sent us an action plan that week detailing how these issues had been addressed. This demonstrated a commitment to ensuring standards were improved at home in a timely manner due to people being placed at risk.

We observed a lock on the door to the basement to be broken which meant that people could easily access the staircase unaccompanied and fall. When we returned to the home on the second day of our inspection, a key pad lock had been added to the door to ensure it was secure. Through looking at accident and incident records we did not see any evidence of people either leaving or gaining unauthorised entry to the building. Additionally, nobody has sustained a fall on or around the basement staircase.

We also observed that a window in the lounge was left wide open, with a gap big enough for somebody to climb through, leading to a busy main road. The window was open when we arrived at the home at 5.40am and anybody from outside could also have gained unauthorised access. On further inspection, the window was not fitted with an appropriate window restrictor. The provider again responded quickly in relation to this concern and told us they had installed a lock to the window so that it could not be opened, with a gap large enough for a person to fit through. We confirmed this work had been undertaken during our second visit to the home on 09 of July.

There were two main stair cases at the home which could be accessed by people who lived there. Whilst it would be good practice that people could use the stairs independently if they wanted to, we were not shown any evidence that the potential risk of people tripping or falling had been considered. Again, one of these stair cases was located in an area of the building which was unsupervised

on numerous occasions. This meant that if people did fall up or down the stairs, staff would be unable to respond in a timely manner. There was however, no evidence that anybody had sustained any injuries as a result of this.

Whilst undertaking a tour of the building we observed five fire doors that were wedged open with either small door stops or fire extinguishers. At various points during the day we observed some staff moving these obstructions, only for them to be propped open again by different members of staff. On closer inspection, one of the door guards did not actually work effectively because of a tear in the flooring. A 'door guard audit' had been completed on 29 June 2015 stating that there were no issues with any of them. These issues meant that in the event of a fire the doors would not close properly. On the second day of the inspection we were shown evidence that replacement door guards had been put on order and were expected to be delivered to the home imminently.

We observed the lock on the kitchen door to be broken and saw someone who lived at the home walking out of the kitchen. This meant they could have been exposed to appliances. These risks were largely concentrated in areas of the home where people were left unsupervised for long periods and meant that if people did fall or leave the building through the window, staff would potentially be unaware. These concerns demonstrated a breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

During the morning of our inspection, we spoke with a gentleman who was sat in their bedroom. They told us they smoked and were independent in managing their cigarettes and lighter. We saw this person holding a lighter as we spoke with them. Following this conversation, we spoke with the acting manager and could smell something burning. The acting manager said; "I think it's just toast in the kitchen". On further inspection, this was not the case. The smell of burning was coming as a result of the same gentlemen holding a handkerchief over the top of his lighter and the activation switch on the lighter was pressed down, resulting in this setting fire to the handkerchief.

The Maintenance Operative was also present and said: "Staff always help him to go out. He doesn't have his own lighter. I don't know where he's got that from". The new Manager asked the senior care assistant to attend to the person and put a risk assessment in place. Further investigation of the care plan confirmed there had been no previous risk assessment completed in relation to this person being able to manage his smoking habit independently. There was no assessment in relation to his ability to use a lighter or understand the risks of smoking and using a lighter. This placed the person at high risk of injury being caused by his inability to understand how to use a device such as a lighter. The risk of fire occurring at the service would also be increased significantly due to the lack of risk assessment and identification of appropriate actions to ensure people's safety. During our visit to the home on 09 July, we saw that an appropriate assessment had been implemented, which stressed the importance of not allowing this person to use a lighter unsupervised.

We observed several instances of unsafe moving and handling transfers being used, which placed people at risk. In the dining room at lunchtime, we observed one person who was sat at the table in a dining chair ask on two occasions; "Can you lift me up please?". On the first occasion, a senior member of staff responded and placed both of their arms under the person shoulders and proceeded to physically lift them up. On the second occasion, the new manager responded in a similar fashion which is referred to as 'drag lifting' and is not safe. We also observed a third person being assisted in the lounge to transfer from wheelchair to armchair. The brakes were not in place therefore each time the person moved, the wheelchair moved further away from them. The staff members assisting, did not make any attempt to put on the brakes, instead they chose to place their feet behind the front wheel in an attempt to prevent the wheelchair from moving. When checking the care plans for these people there was no evidence of an appropriate moving and handling assessment having been completed. We raised this concern with the manager and were told that they had arranged for full assessments of people who required assistance to be carried out. They said they were awaiting contact from the service they had made the referrals to.

We also observed similar unsafe moving and handling techniques being used on the second day of our inspection. We observed one lady in the lounge who required two members of staff to support with transfers. The manager told us a new care plan had only been implemented the previous day. However, when we raised this with the manager, this change had not been fully communicated to staff and we observed one member of staff completing this transfer on their own, on two separate

occasions, which placed this person at risk of falling and sustaining an injury. Both the lady who lived at the home and member of staff were getting frustrated with each other due to the transfer proving difficult for one member of staff to complete on their own.

Due to our concerns, we referred these incidents to the local safeguarding authority following our inspection in relation to the fire and poor moving and handling techniques. These incidents demonstrated a breach of regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We identified continued concerns at this inspection in relation to infection control and the general cleanliness of the building. During this inspection, we observed areas of poor practice around the home. These related to a large stain on the floor outside the downstairs bathroom, paper towel dispensers being empty, two foot operated pedal bins being broken and hand hygiene guidance not always being located near the sink for people to refer to in the upstairs bathroom.

We also observed a mattress with faeces on it at approximately 10am. On further inspection at 4pm, the mattress had not been cleaned and a fresh sheet had been placed over the top. A daily cleaning check list on the back of the door in the downstairs toilet had also not been completed since the 19June 2015. These documents did not appear did not appear to be consistent in each toilet within the home, with none present in other toilet areas. This is a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We asked staff for their views of the current staffing levels at the home. Comments included: “Usually a member of the day shift leaves at 2pm and isn’t replaced. Sometimes it can be chaos if that happens.”; “Staffing levels are up and down and a few have left. There were four this morning and three this afternoon, which is enough.” ; “No concerns, the staffing levels are improving, which means things are getting better.” ;and “No concerns about staffing. Staffing has been short at times, but we had a meeting with management who are addressing it and recruiting more staff.”

We looked at the staffing rotas held at the home. Staff who worked during the day of our first inspection consisted of two senior carers and two care assistants. In addition to this there was the cook and a domestic member of staff. This was to provide care to 22 people who lived at the home. During the inspection we had concerns with how staff were deployed and that lounge areas were left unsupervised for long periods. For example, we observed one person having to wait approximately 20 minutes before being assisted to the toilet with no urgency being shown by staff. This person clearly looked distressed at having to wait for so long.

We saw that the two main lounge areas were left unattended at regular intervals during the day. For instance, between 5.45am and 6.25am we saw no staff in the lounge where three people were sat unsupervised. During this period, both members of staff had gone upstairs together. Additionally, at 9.15am, 13 people were seated in the lounge area, with no care staff present for 25 minutes. When we questioned where staff were we were told that the senior was administering medication in another part of the home and the remaining care staff were assisting with changing bedding in people’s bedrooms. This meant that if somebody had sustained a fall during this period, they would be unable to respond in a timely manner. Additionally, in this period we observed several verbal altercations between people living at the home and if they had escalated, staff would again have been unaware due to the door being closed, after having previously being wedged open with a fire extinguisher. The home owners told us that people who were located in the smaller lounge of the home were ‘independent people’ with no mobility issues. However, we observed that one lady spent the majority of her time in this room and needed to be hoisted by two members of staff during transfers.

During our visit on 09 July, we observed the breakfast meal at the home to see how this was staffed. We observed one person who had been identified in their care plan as being high risk of choking and needed to be supervised at meal times to minimise this risk. Another person’s care plan stated they needed staff supervision and to be watched eating their food so that their nutritional intake did not decline. We saw that at regular intervals, the dining room was left unattended by staff, so staff were therefore unable to monitor these two people to ensure they consumed their food safely.

At our last inspection in November 2014, we had concerns over night time staffing levels and the fact that there were

Inadequate

Is the service safe?

no staff trained to administer medication through the night. We saw improvements in this area during the inspection, with the staff present being appropriately trained to administer medicines such as pain relief as required on both days of our inspection. Prior to our inspection, we received whistleblowing information that night staff were working at the home without receiving appropriate training first. We looked at old staff rotas and saw that one member of staff in particular had worked 19 night shifts at the home without receiving any training such as safeguarding or moving and handling. During this period there were three people who required assistance with re-positioning during the night. This member of staff was not listed on the homes training matrix so we could not see what training they had done. We asked the home owner and manager to show us evidence of any training records; however they were unable to provide these to us. These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing. This was because we were unable to see that suitably skilled, qualified and competent staff were deployed at the home on a consistent basis.

As part of our inspection, we spoke with staff about their understanding of safeguarding vulnerable adults. One member of staff said; “I wouldn’t think twice about safeguarding issues and reporting concerns to protect these people. I have no concerns about safety of people during the night. We do have 2 or 3 who wander, but majority always sleep well”. Another member of staff said; “I have raised concerns in the past and they were addressed. I would look for different changes in people’s behaviour I think as well”.

We checked to see how people who lived at the home were protected against abuse. We found people were protected against the risks of abuse because the home had a robust recruitment procedure. We reviewed a sample of six recruitment records, which demonstrated that staff had been safely and effectively recruited. Appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained.

Requires improvement

Is the service effective?

Our findings

We checked to see what improvements had been made to make the home environment more 'dementia friendly'. We saw that signage had been introduced around the home directing people to areas such as bedrooms, toilets and the dining room. Although this had been introduced, wall colourings were still very bland in appearance and bedrooms doors did not clearly stand out. There was also a lack of consistency as to who had their name or picture on the door. Additionally, there was nothing clearly displayed to inform people what day or time of the year it was. We spoke with the manager and home owners about this who told us they would explore the use of a white board near the lounge, where this information could easily be displayed for people to see. We observed that this board was being used during the second day of our inspection.

We recommend that the service looks at relevant guidance about developing appropriate dementia friendly environments.

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. Supervisions and appraisals enable managers to assess the development needs of their staff and to address training and personal needs in a timely manner. Most staff confirmed they had supervision, which we verified by looking at supervision records. Staff told us they felt supported and valued by management. We found no evidence that annual appraisals were undertaken by the service. The new service manager told us they would shortly be introducing a new system of supervision and appraisals to support staff in their personal development.

We checked to see what training staff had available to them and if they felt suitably supported to undertake their role. We looked at the training matrix, which identified any training undertaken by staff. This showed that staff had received training in areas such as moving and handling, health and safety, infection control and medication. Despite this, the matrix demonstrated that only five members of staff had undertaken safeguarding adults training, six had done dementia training, two had done MCA/DoLS training and that nobody had received any training relating to managing behaviour that challenges. This was out of 16 members of staff listed on the matrix. Following our inspection, we asked the home owners to provide us with evidence that staff were appropriately trained in these areas, however this was not sent to us. This is a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We spoke with staff about the support available to them. One member of staff said; "I have had a lot of training. I am currently doing an NVQ3. If I want any training, anything specific, they put me on that". Another member of staff said; "I have completed Health and Safety level 2, Mental Health Awareness and Moving and Handling. I have done medication training, which I failed, but they are coming back to me with more".

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw there were procedures in place to guide staff on when a DoLS application should be made. During the inspection, we were told that two people living at Walkden Manor were subject to a DoLS with appropriate notifications having been sent to the Care Quality Commission. Staff however, demonstrated a minimal understanding around the principles of Mental Capacity Act (MCA) with regards to DoLS and reported that they had not received any training. We looked at training records and found that only two members of staff had received training in this area. One member of staff told us; "I have done no training in Mental Capacity/DoLS. Training for this would be very useful".

One person with a DoLS in place has no representative who was able to advocate for them. When visited by a best interests assessor as part of the DoLS application process, it clearly stated in the assessment that this person must have an IMCA (Independent Mental Capacity Advocate) appointed to ensure all care and treatment is delivered in the best interests of the person as they lack capacity to understand the decisions they may be required to make in this regard. An IMCA is an independent advocate, independent from the family, care home or medical team who has received in depth training in the Mental Capacity Act (2005). They become involved when a person has no significant person to advocate on their behalf or if there is conflict within a family or between the family and care

Requires improvement

Is the service effective?

team over a specific decision or care choices. As this person did not have an IMCA appointed, there was a risk that care and treatment would not be carried out in their best interest.

We looked at how people sought the consent of people living at the home. Within care plans, consent forms were in place showing people who use the service or those important to them have agreed to the use of photographs, the sharing of information and the delivery of care and treatment. There was a lack of consistency with regards to these being signed for each person. Additionally, a previous manager from the home had signed two people's consent forms on their behalf as if they were a representative.

Through observations, we did see however that consent was sought from staff before tasks were completed. For instance, we observed the senior carer on shift asking people if they wanted to take their medication. On another occasion, we saw a member of care staff asking if was ok to open a window because of the hot weather and checked with them first.

We saw that people had access to GPs, Dentists, Opticians and other external health professionals such as a Dietician and Speech and Language Therapy (SALT). We saw that referrals on the whole were made in a timely manner and saw evidence of correspondence between the external teams and the home, detailing the treatment of people. One visiting professional said to us; "No apparent concerns. I have only been coming for a few days. The staff have supported me with a resident who struggles to communicate. The resident can only communicate via a thumbs up or down. I have found them to be very good".

We observed the lunch time period at the home. The menu was displayed on the wall with a choice of chicken curry and rice, fish and mash potatoes with vegetables and an ice cream dessert. Drinks of tea and coffee were served, along with a selection of juices. There were five members of staff present to assist with lunch, including the chef who was serving food from a trolley in order to give to staff. We saw that food portions were of a large quantity and in the main people appeared to eat well. People had care plans in place relating to nutrition and hydration which provided guidance for staff to refer to when they needed.

Inadequate

Is the service caring?

Our findings

During the inspection we asked both people who lived at the home and relatives for their opinion of the care provided at the home. One person told us; **"**I'm quite happy here, but I'm bored. There aren't a lot of people I can chat with unfortunately. There is plenty to eat and drink. I do feel safe and the girls are brilliant. They are all good". Another person added; "I love it here". A visiting relative also said to us; "I'm very happy for my Mum to come here. I have no concerns and think my Mum is safe living here".

One of the relatives we spoke with however, expressed their disapproval at the care provided at the home. This person told us; "It is very poor here. I am here often and have seen it with my own eyes. I don't think moving mum would be a good idea though because it might upset her. My mum was involved in a safeguarding incident and the home didn't even tell me about it and I had to find out from social services. I often witness poor moving and handling techniques being used. Unfortunately, I don't feel mum is safe living here. She is not treated with dignity and respect. I came in one day a few weeks ago and she was filthy. The staff did not seem bothered though. Three staff were on and they all went smoking in the back at the same time".

At our previous inspection we had concerns in relation to people's choices and preferences not being adhered to, mainly in relation to what time they chose to rise in the morning. It became apparent to us that there was a culture within the home where is was expected that the night staff would get so many people up early in the morning before the day staff started at 8am. This culture was confirmed to us by both staff and a previous manager. We saw improvements in this area during the first day of our inspection and we experienced a much calmer atmosphere within the home between the hours of 5.40am and 8am, with only several people being awake who were able to walk to the lounge independently and have breakfast. The provider told us that in order to evidence that this was people's choice; they had introduced 'personal preference sheets into people's care plans detailing their preferred choice of rising and retiring to bed. However, there was a lack of consistency as to who had these in their care plans. The ones that we were able to see, did state peoples preferred times, however some did not. The new manager told us they were looking to re-write these in the coming weeks to reflect people's personal preferences clearly.

We observed several instances where people who lived at the home were not treated with dignity and respect. For example we saw that one person who lived at the home was seated in a pressure mattress, which had faeces on it. We alerted staff and this person was then moved into a normal arm chair, however they were not offered a change of clothing. Based on this observation, there did not seem to be a system in place as to which people sat on pressure cushions and who didn't. We raised this concern during our feedback where the home owners told us this issue would be raised with all members of staff and that a full audit of the cleanliness and effectiveness of the pressure cushions would be undertaken.

Another person who lived at the home had wet themselves because staff had not assisted them to the toilet in a timely manner. We had also observed this person earlier in the day asking to be taken to the toilet for 20 minutes, with no apparent urgency from staff to assist this person. We raised this concern with the staff on duty who said that they were aware this person needed toileting, but had started doing another task and had therefore forgotten to return and provide assistance. This meant this person had to suffer the indignity of wetting themselves in a room being used by other people.

On both the first and second days of our inspection, we observed the same member of staff knocking on a bedroom door, but not waiting for a reply to see if it was ok to enter. On both occasions we could see that the person was lying on their bed, not fully clothed. We also observed several people who, although they had taken themselves to the toilet independently, left the door wide open in doing so. On two occasions, we saw staff walking past and not offer to close the door to respect the privacy and dignity of these people. Additionally, in the dining room of the home, there was a list of people who were diabetic or needed their food fortifying by staff. The chef told us they already had this information in the kitchen, therefore there was no need to display it on the wall for anybody to see, which was not respectful of people. These concerns demonstrated a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Dignity and Respect.

During the inspection, we also observed positive interactions between staff and people who lived at the home. We saw staff addressed people by their chosen name and spoke with them in a friendly and kind manner.

Inadequate

Is the service caring?

In the morning staff appeared very rushed and did not have time to spend with the people who use the service, however this did improve through the afternoon. One person commented; “I like everybody here they are all lovely”. Additionally, we observed staff giving people choice of where they wanted to sit and what they wanted to eat.

On both days of our inspection, people generally looked clean and were well presented. Where we did observe that people had spilt food on their clothing, staff responded quickly and assisted them to put on fresh clothes. One person living at the home wore dirty clothing and on occasions there tracksuit pant were loose and low around their waist. This person’s care plan stated that this was how they wanted to be presented, however their mental capacity assessment in relation to this decision was four years old. With this in mind, we asked the manager to urgently re-assess this person’s mental capacity where it was found that they were able to make decisions for themselves and that it was their choice.

We saw several examples of how people’s independence was promoted. For example, on the first day of the inspection we observed one person living at the home received support from staff to eat their food, however on the second day, a member of staff was encouraging them to try and eat themselves before providing support and this seemed to work well. We saw another person being prompted to walk down a corridor whilst being monitored by a member of staff. This allowed these people to retain some independence.

We saw evidence within care plans relating to how people would like to be cared for as the end of their life approached. We saw that these had been completed in conjunction with the GP and with families where necessary.

Inadequate

Is the service responsive?

Our findings

Each care file we looked at contained an initial assessment of people's care and support needs. This enabled staff to gain an understanding of people's care needs and how they could best meet peoples' requirements. Each person living at the home had a care plan that was personal to them. This provided staff with guidance around how to meet people's care needs and the kinds of task they needed to perform when providing care. These covered areas such as mobility, personal care, pressure sores, falls, and communication.

We found several instances where people's care plans were not updated in line with changes in people's circumstances. In two instances, two different people had fallen four times each whilst living at the home and had been referred to the falls service as a result. However, the care plan stated 'NC' (no change) and had not been updated to reflect these circumstances around the times the falls had occurred. This meant that staff did not have access to current information about each person who lived at the home. Another person had sustained a fall from bed in December 2014, but again the care plan had not been updated as to what was being done to prevent this from happening again. We raised these concerns with the manager who told us that over the coming weeks, care plans were to be re-written to ensure they were updated when people's care needs changed.

On the day of the inspection, we spoke with a visiting professional. They told us staff were quick to make referrals to the service when required, however there was currently a long waiting list. In order to ensure people were not becoming more malnourished, the service assessed the risk to each person and sent the home an interim care plan. These care plans consisted of a set of specific instructions the home needed to follow in order to maintain the weight and nutritional status of each person. The dietician told us that the care plans put in place were not being followed consistently by staff.

The visiting professional told us how on one of their first visits to the home, they had asked to review food and fluid diaries for people who were under their care. However these were not being completed by staff. On the day of inspection, we saw one person was being visited for the first time by the professional. The service had not been diarising this person's food and fluid intake, which confirmed what we had been told by the visiting professional. Despite this, we did not see any evidence this person had been losing weight in an unsafe manner.

Once the initial assessment had been completed, a person specific care plan was then formulated. This included information relating to fortifying foods to make them higher in calorific content and increasing the nutritional value, resulting in the person gaining or maintaining their current nutritional status. The visiting professional told us that the chef told her they are fortifying food in the kitchen and then placing it in a separate batch. We were then told; "It's very frustrating. I feel like I am wasting my breath". Despite this we saw no evidence of people sustaining any significant weight loss. In fact, several people had gained weight over a certain period of time.

On the second day of the inspection, we observed four people who been given mashed potatoes which had been fortified by the chef in advance of the meal to make it higher in caloric content. Each of these people left their mashed potatoes which meant they did not consume the important part of their meal which was fortified. One of these people was prompted to eat their mashed potatoes by the manager, however staff removed the plates from the other three people and did not encourage them to eat it. Later in the day, we checked food and fluid charts which showed only 'Sausage and Onion' had been consumed for instance. This meant that not all people were eating, or even being prompted to eat their fortified food, in response to advice from other professionals.

On the first day of our inspection, the lunch time period lacked oversight and there was nobody ensuring that people's nutritional needs were being met. For instance at our last inspection, we raised concerns that staff were feeding more than one person at the same time and we saw that this was still taking place during this inspection. This was not a personalised or dignified way for people to received assistance whilst eating their meal. We raised this with the home owners and new manager who said that they would look to have the lunch time meal across two sittings so that personalised support could be provided to people. During our inspection on 09 July, there were not two sittings at lunch time, although there was greater staff presence in the dining room, where people received personalised support from staff.

Inadequate

Is the service responsive?

There was a lack of stimulation for people during the day with people being left unaccompanied in the lounge areas for long periods. The weather on the first day of our inspection in particular was very hot and at no point were people offered the opportunity to sit outside. We saw a skittles activity taking place in the afternoon but people told us this did not meet their personal preferences. One person said; "The only activities are skittles, which I'm well past. We need entertainers to come in to entertain us in the lounge as it can get very boring". Whilst looking at people's care plans we saw that 'bucket lists' had been created for people containing activities they wanted to undertake. However, there was no evidence these had been explored by staff at the home. Some contained basic activities such as getting out of the home more often, gardening and playing the guitar. This was a missed opportunity to stimulate people with activities that met people's personal preferences. On the second day of the inspection on 09 July, we did not see any activities taking place within the home at all. We were told the most recent activities coordinator had now left the service and that the post was being recruited to.

We found people's personal preferences were not always adhered to. We read one person's care plan, which stated it was important for staff to offer them the choice to wear beige trousers if possible and that they would become upset if this was not provided for them, or if staff did not offer them the choice. We checked the clothing this person had available, which contained various pairs of beige trousers, but saw this person had been dressed in green pants instead. In addition to this, there was no record in this persons care plan about what choice had been offered to them. Another person's care plan stated that they would like to sit on the same table as another person who lived at the home, who we had observed to be close and get on well with each other. However, at lunch we saw they were seated on different tables, with their backs to each other. We also observed this person in the lounge during the morning of our second visit to the home. On two occasions, we heard this person ask staff if they could go back to bed due to being tired, only to be told by staff that they couldn't because they needed to be in lounge where they could be observed. This person eventually fell asleep in their wheel chair and had a blanket taken from them by another resident.

We asked how people's food and drink preferences were sought and if people had been involved in the creation of menus. Although there were two different options available to people at meal times, the manager told us this had not been provided based on feedback from people who lived at the home. We asked why this was and the new manager said they were looking to hold a residents meeting imminently, where people's preferred choices of food could be explored further and provided in line with what people wanted. The menus would then be re-written as a result.

At the time of our inspection, people were not in a position where they could choose if they wanted a bath or shower as part of their personal care preferences and requirements. On the first day of our inspection, we had raised with the home owners whether the rising bath, in the upstairs bathroom was fit for purpose because it was showing as not having been serviced since October 2012. We were told this was not in use. However there were no other bath facilities in the home for people to use if they wanted one. There was also no mention of which method people preferred within their care plans.

We saw no evidence that people who lived at the home were involved in reviews of their care plans or had been asked about things which were going well, or if there was anything they would like to change. One person living at the home told us; "I didn't know I had a care plan". Another person said; "I have never been asked about anything I would like change. I have not been given the opportunity". A relative also commented; "I have never been asked to go through a review with my mum". We raised this issue with the home owners, who acknowledged that care plan reviews needed to be more meaningful and involve the relevant people. These issues meant there had been a breach of regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred Care.

On the second day of the inspection we looked at the care plan for a person who needed to be re-positioned every hour to prevent the risk of pressure sores. However, when we checked records these were only being completed every two hours by staff. This person was also still in bed at 10.40am in the morning and the records indicated they had not been turned since 6.50am which was nearly three hours later.

We looked at the complaints procedure that was in place. The home owners told us that there had been no complaints made against the service other than information received from the Care Quality Commission

Inadequate

Is the service responsive?

(CQC). On the second day of the inspection, it became apparent that several concerns had been raised previously, but were being taken forward as part of a safeguarding investigation.

There was a complaints policy and procedure in place, although there was nothing displayed around the building to inform relatives or people who lived there how to complain if they needed to. Additionally, we were told people had a statement of purpose on the back of the door, however when we checked they were not there. This meant people may be unaware of the process to follow.

We looked at the most recent surveys which had been sent to people living at the home. These had been sent in March 2015 with 10 being returned. We noted that comments made within these were mainly positive about the service being provided.

We were unable to see any meeting minutes from any residents or relatives meetings that had taken place. Following our inspection, we contacted the home owners to see if any evidence of these meetings taking place could be located, however none could be found.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection, there was no registered manager in post, who was appropriately registered with the Care Quality Commission. A new acting manager had commenced in post on the day prior to our inspection. 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.

There was a lack of leadership on the first day of our inspection, with nobody overseeing what was going on within the home. For instance, there was nobody overseeing the lunchtime period where we identified concerns at our last inspection and nobody overseeing that staff were deployed in the correct areas within the home. The new manager had only commenced employment at the home the day before we visited and was still getting used to how the home needed to be run and did not yet know staff and people who lived at the home well enough at that stage. The home owners were present, but again, were not overseeing that things were running smoothly at the home throughout the day. The action plans, which we received prior to our inspection had been completed by the head office, therefore they knew more about the concerns we had previously identified.

We looked at how accidents and incidents were managed at the home, particularly in relation to falls. Although we saw that accident/incident forms had been completed, there was no record of any prevention measures or remedial action taken by the service to prevent them from happening again. Additionally, the incident which we witnessed on the first day of our inspection where a resident set fire to their handkerchief had not been recorded as an incident. We asked the manager about this who told us it had been overlooked in being recorded.

There were a range of audits in place, which had been completed by the previous manager of the home. They covered care plans, cleanliness, medication, water temperatures, monthly fire equipment checks, weekly health and safety and maintenance checks including door guard closure, monthly audits of fire alarm, automatic door closure and exit route checks. Despite these checks, they did not highlight some of the concerns that we had found during our inspection. For instance lack of moving and handling/risk assessments and environmental concerns.

A head office audit had also been completed on 02 June 2015 and looked at areas including staff files, training and cleanliness. We looked at this audit and although it did identify areas for improvement such as staff training and areas of the home to be decorated, it did not provide a focus on areas where we had found concerns both during this inspection and at our inspection in November 2014. For example our last inspection highlighted concerns about record keeping, the lunch time period, medication and submitting appropriate notifications to the Care Quality Commission (CQC). Due to us finding further concerns in these areas at this inspection, the quality of service was not being monitored effectively and improvements were not being made in a timely manner. This is a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

Prior to our inspection we received whistleblowing information, which stated that there was an expectation within the home not to report safeguarding incidents to agencies such as the Care Quality Commission or the local Safeguarding team, as it 'Drew attention to an already struggling home'. It also stated there was an expectation to 'Turn a blind eye to safeguarding, for fear of repercussions on the home'. In advance of our inspection the local Safeguarding team told us there were seven active safeguarding investigations currently on-going. Following examination of safeguarding records maintained by the service, we found that the service had failed to notify the Care Quality Commission of abuse or allegations of abuse in relation to people who used the service. We are following this up outside the inspection process.

At our previous inspection we had concerns in relation to records not being maintained at the home such as charts for people being re-positioned and monitoring food and fluid intake. During this inspection we saw that other records were still not being maintained such as checks on people during the night and continence sheets. We saw these had not been completed since 25 June 2015. In light of this being a concern at our last inspection, the checking of records did not form part of the auditing process carried out within the home. This meant nobody was overseeing

Inadequate

Is the service well-led?

that they were being completed in a timely manner. We raised this concern with the provider where we were told that staff had been told to stop completing these because they were going to be placed on the back of people's doors instead. However when we checked the doors, they were still not being completed consistently by staff, in five of the sample bedrooms that we checked. This is a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

We found that records held at the home were not held securely with confidential information easily accessible to people in the building. For example, on the third floor or the home records waiting to be archived were left in boxes on the floor and could be accessed by anybody. The owner told us that nobody went up onto this floor so would not see them, but there was nothing stopping people walking into this area to read them. We saw this was rectified during our inspection on 09 July. We also found that the drawer containing staff personnel files was not locked and neither was the office door. This meant that confidential information about staff such any discussions during supervision or details about their personal circumstances could be seen by anybody. Additionally, people's care plans were either in a drawer that was not locked or left on the side in the office for anybody to read, some of which belonged to people who no longer lived at the home. This is a breach of regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

On several occasions, we were told about incidents that had occurred within the home which family members had not been told about. For example, we saw that in one person's care plan that they had fallen four times, however their relative said to us; "That is interesting, because I have only ever been told about two of them". Another relative told us; "My mum was involved in a recent safeguarding incident where a member of staff was suspended. I only found out through social services as the home did not tell me about it".

We spoke with five members of staff during the inspection and asked if they felt well supported by management within the home. One member of staff said; "I wouldn't hesitate to report any concerns, and management are always there to listen to me". Another member of staff added; "I do feel supported and valued. Management always make a point of speaking with us when they come to the home". A further member of staff added; "If we have issues management do listen to us and any concerns we have. I feel supported and valued here".

The home had a range of policies and procedures in place. These had been reviewed this year and included Accident & Incident Report, Safeguarding, Advocacy, Challenging behaviour, Violence & Aggression, Complaint Procedures, Person centred planning, DoLS & MCA, Fire Safety, Food Hygiene, Infection Control, Missing Persons & CQC Notification Policy.

On both days of our inspection we shared our feedback with both home owners (on the first day) and the new manager and one of the home owners on the second day. On both occasions, they listened to our findings and demonstrated a commitment to improving standards within the home, now that the new manager was in post. We spoke with the owners about the importance of ensuring appropriate support was provided for the new manager, in order for them to undertake their role effectively. They acknowledged that governance systems had not been as robust in recent months, but re-assured us that this would be done moving forward.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected with the risks associated with not receiving care that was person centred to their needs

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect

The enforcement action we took:
We issued a Warning Notice with regards to this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate systems were not in place to assess the risks to the health and safety of service users of receiving the care or treatment.

The enforcement action we took:
We issued a Warning Notice with regards to this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Appropriate systems were not in place to monitor the quality of service effectively.

The enforcement action we took:
We issued a Warning Notice with regards to this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient staff working at the home to meet people's needs in a timely way. Staff did not always receive sufficient training to support them in their role effectively.

The enforcement action we took:
We issued a Warning Notice with regards to this regulation.