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The Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of The Grange on 27 September 2016. The Grange is a residential care home for adults with dementia and /or complex mental health illnesses. It has 22 single rooms and 2 twin bedded rooms on two floors. There is a lift to access the second floor. There are a number of communal areas as well as a garden area to the rear. The Grange is located near Chorley town centre. It has a car park and the front entrance has a ramp.

The service was last inspected on 12 November 2013 and was found to be meeting the regulations applicable at that time.

During this inspection we found the service to be in breach of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014 in relation to, seeking consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staffing, failure to manage risk of malnutrition effectively, failure to send notices of change and other incidents. You can see what action we told the registered provider to take at the back of the full version of the report.

The registered manager was not present throughout our inspection however, one of the members of the partnership operating the home was present. 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 and associated regulations about how the service is run.

At the time of this inspection 23 people were using the service. We spoke with five of these people and three of their relatives. We asked people for their views about the services and facilities provided. We received some positive comments from those we spoke with. People who lived at the service and their relatives told us that they felt safe.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found that staff had received training in safeguarding adults. They showed awareness of signs of abuse and what actions to take. However, we found the home had not reported to the local safeguarding team and Care Quality Commission (CQC) when people had suffered serious and unexplained injuries. We asked the provider to report all incidents to the local authority immediately after the inspection. There was no record of safeguarding incidents and how they had been analysed for trends and patterns.

The provider had recorded accidents and incidents and documented the support people were getting after experiencing falls. However, staff had not sought advice from health professionals in all instances especially, incidents involving unwitnessed falls and head injuries. Risk assessment had been undertaken during assessments and plans to reduce risks had been drawn and reviewed in line with the organisation's policy. However, we found one person's file did not have a review after two significant incidents which resulted in serious injuries.

We found people's medicines had not been managed in a robust manner. This included the storage and administration practice that we observed. People did not have care plans for 'as and when' medicines (PRN). Staff had received medicines training; however, they had not been competence tested to ensure they were administering the medicines as recommended. We found one person was being given medicines that they had not been prescribed and belonged to another person. We informed the home this was unsafe practice that was not acceptable and to report this as a safeguarding incident. In addition to this we observed unsafe medicine administration practices from the manager during the inspection.

Building fire risk assessments were in place; however, people did not have personal emergency evacuation plans (PEEPS) to enable safe evacuation in case of emergency and care staff had not received fire safety training.

Infection control measures were in place and standards of hygiene had been maintained. However, the service had not provided the appropriate bins for disposal of clinical waste which caused a risk of cross contamination.

We found concerns regarding safe recruitment of care staff. Three of the seven care staff files we looked at showed care staff had been employed without suitable references. One member of care staff had employment gaps on their application form, these had not been explained and the provider had no system or processes for checking whether care staff had convictions once they had been employed by the service. This was against the organisation's own policy.

On the day of inspection the service had adequate care staff to ensure that people's needs were sufficiently met. People who lived at the home, relatives and care staff expressed they were happy with the level of staff and did not have to wait long periods of time for help.

We found people's care plans had not been written in line with the Mental Capacity Act, 2005 (MCA). People's consent to receiving care was not recorded in their care files. Staff had not received mental capacity training. This was evident when speaking with staff. Knowledge of mental capacity among staff needed some improvement and the registered provider had limited awareness of the principles of the Mental Capacity Act and how to apply them in practice. Appropriate applications for Deprivation of Liberty Safeguards had not been made for 18 people who were deprived of their liberties.

There was a significant shortfall in mandatory staff training. Staff competences were not checked regularly in various areas of practice including moving and handling and medicines administration.

People using the service had access to healthcare professionals as required to meet their needs. We found that people's health care needs were assessed on admission to the service to ensure the home was able to meet their assessed needs. However, one person had no care plan to show what their needs were and how the home was meeting those needs.

Care plans did not demonstrated people's involvement. People and their relatives told us they were consulted about their care however; they were not involved in regular reviews of their care.

The service could not demonstrate how they sought people's opinions on the quality of care and service being provided. There were no relatives and residents meetings or regular surveys to seek people's views and opinions about the care they received.

People were offered adequate food and drinks throughout the day ensuring their nutritional needs were

met. Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed. However, risks of weight loss were not managed in a robust manner because weight monitoring was inconsistent.

People were supported with meaningful daytime activities however this was not consistent practice. There was no activities co-ordinator and the activity plans were not consistently followed, and staff had not consistently recorded activity records to show what people were doing or had done. On the day of inspection staff were observed to engage people in some activities of their choice. People who were able to access the community independently had been supported to actively have social involvement in the community.

Management systems in the home were not robust. The registered manager was not actively involved in the day to day running of the home. They had not done so for up to 6 months and the provider had not sought a replacement registered manager or informed CQC of the current management arrangements. Staff had not received regular and adequate training to support them in their role. Care staff had not received supervision and recruitment practices had exposed people to risk.

The quality assurance systems were in place however, they were not robust enough as some areas of people's care had not been audited regularly to identify areas that needed improvement. We found audits had been undertaken for the premises and health and safety however; areas such as infection control, medicines, care plans, staff recruitment files and kitchen had not been audited regularly.

There was no business contingency plan to demonstrate how the provider had planned for unplanned eventualities which may have an impact on the delivery of regulated activities.

The provider was not meeting the Care Quality Commission registration requirements. They did not send notifications to CQC for notifiable incidents, such as serious injuries, and other notifiable incidents including the absence of the registered manager.

We found six instances where the service had not worked in line with its own organisational policies. This included recruitment of staff, staff supervision, care planning, mental capacity, infection control, medicines administration and undertaking criminal record checks on care staff.

People felt they received a good service and spoke highly of their staff. People told us they hardly saw the registered manager. They told us the staff were kind, caring and respectful. Many people appreciated having their privacy and independence. People told us the provider visits the home regularly and was pleasant and approachable.

We found the service had a policy on how people could raise complaints about care and treatment however, there was no evidence to demonstrate how complains had been received and dealt with in line with regulations. Complaints had been dealt with face to face.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Risks to the health, safety and well-being of people who used the service were not always properly assessed and significant incidents had not been reported to relevant safeguarding authorities to allow independent investigations.

We observed unsafe care practices during the inspection. People's medicines had not been safely managed. One person had been given medicines not prescribed to them.

There were no personal emergency evacuation plans (PEEPS) for evacuating people in emergencies. Staff had not received fire safety awareness training. There was no contingency plan or building risk assessment.

Is the service effective?

Inadequate

This service was not effective.

The rights of people who did not have capacity to consent to their care were not consistently protected because the provider did not always follow the MCA and associated guidance in practice.

Arrangements for staff training, and supervision were not consistent and were not adequate to ensure all staff had the necessary skills and knowledge to carry out their roles safely.

The service did not consistently follow safe recruitment practices.

People received appropriate support to access health care when they needed it. However, people's weight monitoring was not robust.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's personal information was sufficiently managed in a way

that protected their privacy and dignity.

People spoke highly of care staff and felt they were treated in a kind and caring manner.

Staff treating people with respect and calling them by their preferred names.

There was no end of life care plans in people's records and staff had not undertaken end of life training.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's independence was promoted and people who could go out were supported to do so.

Pre admission assessments were carried out before people were admitted to the service. Important information about people's needs was included in their care plans. However, one person did not have a care plan.

The provider had not gained the views of people who used the service and their representatives. Residents meetings took place regularly.

Complaints had been dealt with however, records had not been kept.

Is the service well-led?

Inadequate

The service was not well led.

We found a number of breaches relating to people's safety, governance, staffing and consent. The organisation was not following its own procedures.

The registered manager was not actively involved in the day to day management of the home and had been absent for a long time.

The provider did not meet CQC registrations requirements as they did not send statutory notifications for notifiable incidents and changes to management arrangements.

Processes to assess safety and quality assurance were not effective to cover all areas of care practice. Medicines records, care plans, kitchen and staff records had not been audited

regularly. There was a lack of oversight from the manager of accidents and incidents.

The Grange

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 27 September 2016, and was unannounced.
The inspection team consisted of two adult social care inspectors, including the lead inspector for the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we gained feedback from health and social care professionals who visited the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the registered provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law.

We spent time talking with people who lived at the home. We reviewed records and management systems and also undertook observations of care delivery. We spoke with three relatives, five people who lived at the home, the registered provider, a manager, two professionals who had visited the service and six care staff. We looked at four people's care records, staff duty rosters, seven recruitment files, the accident and incident reports book, medicine's records, service policies and procedures, records and service maintenance records.

Inadequate

Is the service safe?

Our findings

People living at the home told us they felt safe and did not have concerns about the way they were cared for. One person told us, "Staff here are very gracious, I find them really good." Another person told us, "I feel safe, it's nice here." Comments from relatives included, "The staff are brilliant" and "Oh yes, I'm confident [my relative] is safer living here than where they were before."

Staff did not know how to effectively keep people safe and how to recognise safeguarding concerns. They had received training in safeguarding adults. Policies and procedures for people to raise concerns about their own care and treatment were in place. However, these had not been followed robustly. For example, we found incidents that required to be reported to the local safeguarding team for investigations which the registered provider had not acted on in line with local and national safeguarding procedures.

One person had suffered serious unexplained injuries; which we found to have not been reported to the local safeguarding authority and the Care Quality Commission. We asked the registered provider to report this to the local authority and they did this immediately. This lack of reporting meant people could not be assured the registered provider and the staff would raise safeguarding concerns to allow independent investigations by relevant authorities.

We looked at how accidents, falls and near misses were managed. We found processes for the reporting and recording of accidents /incidents had been implemented and staff had recorded the support they had provided people after the incidents. We saw that support had been sought from emergency services and health professionals after incidents however, this was not consistent as we found two instances where staff did not seek guidance from medical professionals after people suffered unwitnessed head injuries.

We found no evidence of accident and incident analysis. The home had recorded falls, accidents and incidents and looked at the causes and actions to reduce the risks. However, they had not analysed the records to identify any patterns or trends that may be occurring. This meant the service did not have systems in place to learn from incidents and accidents and find ways to minimise them.

Risk assessments had been undertaken in keys areas of people's care such as nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. However; this was not consistent throughout the care files that we looked at. For example we found one person has suffered significant injuries that were unexplained. Although care staff had ensured this person received medical attention, they did not review and update their care plan or risk assessments to demonstrate the change in risks and the measures that were required to minimise the risks to this person's personal safety.

In another example we found one person living at the home who did not have a care plan. This person had complex needs. Regulation and guidance require that a clear care and/or treatment plan which includes agreed goals must be developed and made available to all staff and others involved in providing care. We spoke to a manager at the service who informed us they had archived this person's file a week before the inspection as they thought they were leaving the service to return to their own home. We asked for the

archived file and the provider was unable to find it. We could not be assured that this person had a care file. This meant that the provider had not ensured that people's needs had been clearly identified and guidance provided to care staff on how to meet those needs.

There was a lack of robust risk management, reporting incidents of concern under safeguarding procedures and the lack of a care plan. This was a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at how people's medicines were managed and found medicines records had been completed accurately to show what medicines people had been given. However, we observed unsafe medicine administration practices undertaken by a member of staff. We observed them signing medicine administration records before they offered people medicines and before people actually accepted their medicines. Good practice requires that people should be asked first and records should be signed only after people had been observed to take their medicines.

We found one person was being given medicines that were not prescribed to them. People can only be given medication that has been prescribed by their doctor or a qualified health professional. This meant medicine management practices were not robust and the practices had a potential of exposing people to risk of not receiving their medicines as prescribed.

We found staff were trained to administer medicines however, they had not been regularly observed or had their competency tested to ensure they were following the correct procedures. Regulations require that care staff who administer people's medicines must be suitably trained and competent and this should be kept under review.

People who had been prescribed 'as and when required' medicines (PRN) did not have plans in place to guide staff about the correct administration. Care plans are meant to provide care staff with adequate guidance on, what the medicines are for, what signs to look for, and when to offer the medication. We found regular internal medicine audits had not been undertaken. However, an annual audit had been undertaken by a local pharmacy. This has picked a few issues that had been addressed at the time of the inspection.

There were failings in medicines management and administration systems at the home. This was a breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff at the home had been employed for a long time and that staff turnover was low. This meant that staff had a good understanding of the people they supported. At the time of the inspection, we found the service had sufficient numbers of care staff to meet people's needs.

We looked at whether the home followed safe recruitment practices. We found the service had not consistently followed safe recruitment practices. Staff recruitment records we saw showed three care staff members had been employed without satisfactory employment references. The organisation's recruitment policies states that a minimum of two written references are obtained before appointment is confirmed. This meant that the organisation had failed to follow its own recruitment policies.

Systems for checking whether staff continued to be safe to work with vulnerable adults were not robust. We found no evidence of how the provider assured themselves that staff continued to be safe to work with people once they had been employed. We found DBS checks for four care staff were last undertaken 10 years ago. The provider's policy stated that 'CQC does not stipulate how often checks should be made, we would recommend an annual review of employees DBS certificates'. However, they did not follow this

policy. Regulations require that providers evidence how they assure themselves that people they employ are not a risk to people using their services and continue to be safe once employed. This meant the provider had not followed safe recruitment procedures consistently to help to protect vulnerable adults.

There was a failure to undertake robust safe staff recruitment practices. This was a breach of Regulation 19 (2) (a)(b)(3) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four out of seven staff files that we checked demonstrated safe recruitment had been followed. They contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment was made. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS).

We looked at how risks around the premises were managed and found the premises had been well maintained, building and fire risk assessments had also been undertaken. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly and fire evacuation drills were also undertaken periodically to ensure staff and people were familiar with what to do in the event of a fire. However, we found staff had not received regular fire safety awareness training or refresher training. We found seven staff had fire awareness training which was out of date. This meant care staff could not effectively support people in the event of a fire at the home. We spoke to the provider regarding this and they arranged training immediately following the inspection.

We looked at how people would be supported in the event of emergencies. We found people did not have personal emergency evacuation plans (PEEPS) in place for staff to follow should there be an emergency. Regulations require that every person should have a PEEP which states their physical capabilities, assistance they require, any difficulties that others may face when assisting them and where they will be evacuated to. This meant that the home had not put sufficient measures in place to establish what assistance each individual required and people could not be assured they could be evacuated in a safe and timely manner during an emergency.

There were failings in fire safety training and a lack of personal emergency evacuation plans. This was a breach of Regulation 12(2) (a) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found management of risks associated with infections were implemented however some improvements were required. We found risk assessments had been put in place for areas of known risks of infection and there was guidance for staff. We also found the service had employed a cleaner who worked part time. The home smelt clean and fresh and furniture and décor looked clean.

We found people's care plans contained important information they needed if they were being transferred to hospital or other services. These are also known as hospital passports. Regulations state that people's details such as their health and social care needs, allergies and medication are recorded and ready for when they need to be shared with other professionals. This meant people were assured they could be effectively supported if they were to be transferred to another service or hospital.

Inadequate

Is the service effective?

Our findings

People's views on meals were positive. One person told us "The meals here are great, and we get a varied choice." Another person told us, "Staff are knowledgeable, they understand my condition and offer timely support." One relative told us, "There is always plenty of staff and the property is kept clean."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was not consistently working in line with the key principles of the MCA. Two people who were unable to access the community without constant supervision were actively asking to leave the care home however; the registered provider had not made DoLS applications to the local authority to ensure the restrictions imposed on these two individuals were the least restrictive and were legal.

We found up to 18 people living at the care home who were at risk of being deprived of their liberties. These people were not free to leave the care home, lacked mental capacity and were under constant supervision by the staff team. We spoke to the registered provider and the manager in relation to this. The registered provider told us he/she did not know the process to follow in relation to making appropriate applications to the Local Authority. We directed them to speak to the Local Authority DoLS Team and we are aware they have now applied for urgent authorisations for the people who were actively asking to leave the home.

There was a failure to request deprivation of liberties authorisations from the local authority for people who lacked mental capacity and who received care that included restrictive practice. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We found no evidence of mental capacity assessments carried out for key decisions such as, residing at the home, receiving personal care and for medicines administration. MCA requires that, where there is a reason to believe that a person's ability to make decisions may be compromised, such as mental illness, living with dementia or a neurological condition which affects the mind, a mental capacity assessment must be carried out. The organisation's policy on mental capacity also stated that, 'Where the home had information to suggest the person might be unable to make some decisions; it carries out an assessment of that person's mental capacity'. We found the organisation had not followed this policy. We asked the provider to ensure this was done as soon as possible.

We looked at seven training records and found in all the seven records care staff had not completed training

to help them understand the principles of the Mental Capacity Act, 2005. Some staff however, showed awareness of mental capacity and Deprivation of Liberties legislation and requirements and informed they had received training in their previous roles. However, the registered provider lacked knowledge of MCA principles to support and guide their care staff.

The registered provider had not taken necessary steps to ensure that peoples' rights had been protected. This was a breach of Regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We noted that there was a significant shortfall in the amount of training we would expect the provider to offer staff to enable them to competently and safely care and support people who used the service. For example, not all staff had completed training in moving and handling. 10 out of 25 care staff had not received training in health and safety, food and hygiene and infection control. Staff had not received training in mental capacity, end of life care and managing nutrition. We also found care staff had not completed fire safety training, dementia awareness or dignity in care. People had been placed at risk as they could not be assured that they could be supported by staff who had skills and knowledge of best practice.

Staff had not received regular supervision and appraisal in accordance with the organisation's own policy. Four out of seven staff files we looked at showed staff had not received ongoing supervision. The manager had not received appraisal or supervision for 5 years. The organisation' supervision policy states that staff should receive a minimum of six sessions of supervision per year if working full time. We spoke to care staff who informed us that had not received supervision for a long time but used to have this regularly. This meant that the provider had not provided staff with supervision to enable them to carry out the duties they are employed to perform. They had also failed to follow their own policies on staff supervision. Staff however, informed us that they could speak to the provider regarding their work whenever they had concerns.

There were shortfalls in staff training and supervision. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. We found snacks and drinks were readily available throughout the home and people were offered drinks regularly. Nutritional care records we looked at showed people had been assessed to ensure their nutritional needs were met. However, systems and processes to manage risks of unintentional weight loss were not robust. This was because people's weight was not monitored in a consistent manner. In some instances people at risk of weight loss had been not been weighed for two months. This meant staff could not effectively identify trends in people's weight and refer them to specialist professionals.

There was a failure to consistently monitor people's weight, their risk of malnutrition and there were a lack of referrals to relevant professionals. This was a breach of Regulation 14(4)(a)of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We observed people eating during lunch time. People were offered choice and encouraged to eat. The atmosphere during lunch time was relaxed and people enjoyed their meals. The care staff offered people food with respect, in an effective and efficient manner. People were not rushed and staff had time to talk with residents.

We looked at how people were supported to maintain good health, access health care services and receive

on going health care support. There were links with the local primary health services and professionals such as community mental health practitioners came into the service to offer support regularly.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. Comments included, "They are great here, they talk to you," and "The girls are really great", "Carers here don't keep you waiting." Similarly relatives told us, "It's a nice atmosphere; staff are always friendly and always say hello and goodbye", "I can visit whenever I want." Another person told us "Staff understand my condition and know when I need someone to talk to."

Feedback from people who lived at the home, their families and professionals was overwhelmingly positive.

During the inspection, we observed some warm and genuine interactions between people and staff. Conversations showed kindness and compassion. People appeared to be very comfortable in staff presence and staff knew people well. We saw members of staff working, providing consistent care and support to people. We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance promptly. People were referred to by their preferred names.

We spoke to professionals who visited the home and they informed us they felt staff were caring and witnessed warm relationships between carers and people when they visited.

We looked at how the service supported people to express their views and how people were actively involved in decisions about their care, treatment and support. We saw evidence to support that people had not been actively involved in the planning of their care. Care files did not show how people or their relatives had took part in planning their own care. We spoke to relatives who confirmed they had not been formally involved in reviewing their loved ones' care. They however, informed us they had been kept informed of any changes to their loved ones' care needs.

We looked at how people's privacy and dignity was respected and promoted. People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. A staff member we spoke with told us how they would respect people's dignity. For example, they told us they would knock before entering people's bedrooms and ensured people go to bed when they want to.

We looked at people's bedrooms and found they were clean, warm, well presented and people had personalised their bedrooms with their own possessions.

We found no evidence of end of life care plans and staff had not undertaken training in end of life care. This meant that people could not be assured they would receive end of life care in line with their wishes.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to. One person told us, "They support me to go in town, they encourage you" and: "They are never short of staff and staff are always with people."

We looked at how the service provided person centred care. We found assessments had been undertaken before people were admitted to the home to ensure the service was the right place for them. A person centred care plan had then been developed outlining how these needs were to be met.

We found the care plans were organised and clearly written. They also included people's personal preferences, life histories, and aspirations. However, we found one person had no care plan which shows how the provider had assessed their needs and how they would be met. There was not always information about people's ability to make safe decisions about their care and support. The registered provider informed us the person with no care plan was due to return home and they had archived the care file, they gave assurances the care plan would be written for this person.

People's care records were reviewed for effectiveness, however; this was not consistent throughout the files we looked at. We found in the files that we looked at care records had not always been reviewed following significant incidents or changes in people needs.

People were supported with meaningful daytime activities however this was not consistent practice. There was no activities co-ordinator and the activity plans were not consistently followed, and staff had not consistently recorded activity records to show what people were doing or had done. On the day of inspection staff were observed to engage people in some activities of their choice.

We looked at how people were supported to maintain local connections and take part in social activities. We found people were encouraged to maintain local community links. People who were able to go out independently in the community were encouraged and supported to do so and those who required support were accompanied by staff to access the local community. This ensured that people continued to make a positive contribution to the local community. People's independence was promoted. We observed some people helping set out tables. Three people were able to go out and do their own shopping in the local community.

There was a complaints procedure advising people how to make a complaint; this included the contact details for external organisations including social services and the local government ombudsman and the Care Quality Commission. Information about how to raise concerns, complaints and compliments was displayed in the entrance hall. At the time of the inspection the service had not received a complaint. They informed us that they encouraged people to speak to staff if they have concerns and issues are resolved satisfactorily. People we spoke to informed us they could approach the care staff or the manager if they needed anything. We saw people had made complimentary comments about the service.

We looked at how people were assured they would receive consistent, co-ordinated, person centred care when they used, or moved between different services. We found evidence of information that had been completed to facilitate information sharing when people moved between services. These are sometimes referred to as Hospital Passports.

People were facilitated to maintain contact with their families. People told us they could visit their family and friends whenever they wanted. This ensured that people could visit and spend time with their loved ones and maintain family links.

Inadequate

Is the service well-led?

Our findings

People we spoke with spoke highly of the manager. They told us: "The Manager is wonderful" and, "She's brilliant, absolutely great, she's the best ever."

There was a positive staff culture within the home. This was reported by all the staff members that we spoke with. Comments included, "I like working here", "The staff and service users are like family" and "We have enough staff here and we get time to sit and speak with people."

Staff informed us that the management team were approachable however; they reported they did not see the registered manager that much in the home. One staff member said, "The registered manager is good and caring but not always here." We spoke to the registered provider who informed us, the registered manager had not been actively involved in the day to day running of the home for a period of up to six months due to personal reasons. They however, told us the registered manager had visited the home on occasions. Satisfactory steps had not been taken to recruit a new registered manager within a reasonable timescale. The arrangements to cover the absence did not provide consistent leadership and direction for staff.

The provider had not informed CQC of the registered manager's absence. The intention of this regulation is to ensure that CQC is notified of specific changes in the running of the service, so that CQC can be assured that the provider has taken appropriate action. We found shortfalls and failings within the services which were related to the absence of a registered manager. However, the provider was visiting the service regularly and undertaking repairs and providing some oversight on the service.

The lack of a registered manager meant that the provider had failed to provide effective leadership and governance to ensure the service and care that people received was in line with regulation and guidance.

The provider had failed to notify the CQC of the changes regarding the registered manager. This was a breach of Regulation 15 (1) (a) (b) (d) of the Care Quality Commission (Registration) Regulations 2009.

Governance and leadership within the service was not robust. Staff told us that they felt well supported however; there were no systems and processes in place to ensure people and staff were actively involved in developing the service.

Staff and people we spoke with informed us the provider had not held staff meetings or residents and relatives meetings. They informed us they used to have these meetings however, they could not remember the last time meetings were held. We spoke to the manager and the provider who confirmed meetings had not taken place for a long time.

We found that there was a lack of consistent quality auditing and governance processes. Formal audits had been completed in a number of areas such as health and safety around the premises. However, the audits had not been carried out consistently. Audits had not been carried out when the manager was away on

holiday. We found no evidence of regular medicine management audits. Care files, infection control audits, cleaning audits and staff personnel files, staff supervision and training records had not been audited regularly. We found things that could have been picked by formal audits. The manager had not provided oversight on the audits or develops actions plans on some of concerns found in audits completed.

Staff had not been competence tested in a number of care practices. Competence checks ensure that staff are checked to see if they continue to be able to deliver care within the required standards. We found competence checks on medicine administration however; these had not been signed by staff to show they took part in the exercise. We observed unsafe practices by a staff member around medicine administration; they had been responsible for competence testing other care staff regarding medicines administration. We could not be assured they could lead by example in this area and effectively assess other staff's capabilities.

We found the provider did not have systems in place to enable them to learn from significant incidents such as accidents, or safeguarding concerns. Accidents and incidents were recorded in people's individual files however, there was no evidence of how the service has analysed the accidents and incidents and develop trends and patterns and ways to reduce the accidents. Local safeguarding board protocols for reporting incidents had not been followed on three occasions from the evidence we reviewed.

Surveys or relatives and residents meetings had not been carried out to seek people's views on the quality of the service. We looked at how staff worked as a team and how effective communication between staff members was maintained. Staff had been kept informed through handovers and speaking to manager directly if they had concerns, however there were no regular staff meetings. We were assured that regular staff meetings will be arranged.

We identified a number of breaches of regulations during this inspection, several of which related to areas of safety such as safeguarding people, staff recruitment, training and supervision. Some of these issues had not been identified by the provider. For example lack of systems and processes to check whether staff continue to be safe to work with people, shortfalls in training and supervision and appraisals, and shortcomings with the quality assurance systems. This demonstrated that the arrangements for assessing quality and safety were not effective. Following the inspection we asked the provider to send us information on how they intended to address the concerns we found. They responded with a plan of how they intend to resolve the concerns.

We raised concerns about the provider and the manager's awareness of safeguarding protocols. Action had not been taken to investigate how one person had obtained significant unexplained injuries on two separate occasions. They also failed to report the injuries to the local authority safeguarding department and CQC.

There was a lack of oversight on incidents and accidents to ensure policies and procedures had been followed robustly and that action had been taken to ensure the safety of people using the service.

We found the registered provider and the manager lacked awareness of mental capacity principles and people's records had no mental capacity assessments where that was necessary and consent was not routinely sought and recorded in people's records. There were people whose care was restrictive and the provider had not sought relevant authorisations from the Local Authority to ensure they did not unlawfully restrict people.

The service did not have a business contingency plan to show how they would deal with unplanned events that affect the delivery of regulated services.

The provider failed to maintain good governance. This was a breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked to see if the provider was meeting Care Quality Commission (CQC) registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had not fulfilled their regulatory responsibilities. They had not submitted statutory notifications to CQC. For example, one person had suffered unexplained injuries and suspected fracture of on their ankle which required hospital treatment. These incidents should have been reported to CQC as well as the local authority. Regulation requires providers should notify CQC of certain incidents. The intention of this regulation is to ensure CQC is notified of specific changes in the running of the service, incidents involving people using the service and allegations of abuse, among other things. This is so CQC can be assured the provider has taken appropriate action. This also helps to ensure CQC is able to undertake its regulatory activities effectively.

The provider had failed to make statutory notifications of notifiable incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Audits in relation to the environment including maintenance and housekeeping were in place. A range of certificates demonstrating that facilities and equipment within the home, such as fire safety equipment and lifting equipment, water testing were regularly checked. Current gas certificates were available to show these facilities had been checked by external contractors. However, the electrical inspections were overdue by 18 months. We spoke to the provider who assured us this will be done as soon as possible. We found the provider had carried out maintenance checks and an annual refurbishment plan was in place and regularly updated when actions had been completed.

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as 'Investors in People' and 'Local commissioning groups, pharmacies, and local doctors. We found the registered provider receptive to feedback. They worked with us in a positive manner and provided all the information we requested. Following the inspection, the provider sent us an action plan showing how they had responded to the concerns that we raised during the inspection, they responded to most of the concerns immediately and had plans on how they plan to meet majority of the concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The provider did not send notifications informing a person other than the registered person carries on or manages the regulated activity; and that (b) a registered person had ceased to carry on or manage the regulated activity; Regulation 15 (1) (a) (b) (d) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying the Care Quality Commission of reportable incidents Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that legal consent for care and treatment was obtained from people who used the service.-Regulation 11 HSCA RA Regulations 2014 Need for consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment The provider failed to ensure that people were protected from abuse and improper treatment restrictions because systems and processes did not ensure service user were not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5) HSCA RA Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People had been exposed to risk because systems or processes were not established and operated effectively to monitor people's weight and risk of malnutrition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People had been exposed to risk because systems or processes were not established and operated effectively to ensure safe recruitment of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to operate robust systems that ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to the health and safety of people who used the service were assessed and planned for. The provider had failed to ensure that staff had the skills to care for people in a safe manner. The provider had failed to ensure medicine management systems were effective to ensure people receive their medication safely. The provider has failed to report safeguarding incidents to relevant bodies.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People had been exposed to risk because systems or processes were not established and operated effectively to ensure compliance. The provider had failed to ensure there were systems in place to monitor the safety and quality of the service. Governance systems were not robust and there was lack of oversight from the registered manager on the regulated activities. Regulation 17 HSCA RA Regulations 2014 Good governance

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.