Rockley Dene Homes Limited

Carlton Court Care Home

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

The inspection took place on 7 December 2016 and was unannounced. We last inspected this home on 21 April 2015 where no concerns were identified and it was given an overall rating of good.

Carlton Court care home is registered to provide accommodation for up to 80 people who require nursing or personal care and treatment of disease, disorder or injury. The people living in the home are predominantly older people, some with needs around dementia or nursing care. At the time of inspection there were 60 people living there.

Carlton Court care home requires a registered manager to be in post as part of its registration requirements from the Care Quality Commission. There was no registered manager in post at the time of the inspection and there had not been since 30 March 2016. On the day of the inspection there was an interim manager who had been in post for three weeks and a deputy manager who had been in post for one week. 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.

Relatives and people told us staff were caring but at times there were not enough staff.

People's privacy and dignity was not always maintained and there were not always enough staff to provide person centred care to people.

The staff we spoke with understood what abuse was and how to report it if they had any concerns.

Staff recruitment procedures were in place and the provider had a policy in place to ensure they were employing appropriate people. However, this had not always been followed and some staff did not have the necessary criminal records checks on their files.

We found gaps in care records relating to people's health needs which put them at risk.

We found several issues with the recording and administration of medicines which put people at risk of harm because medicines were not safely managed.

There was a complaints procedure in place and available to people and visitors. This had not been followed and relatives were unhappy that their long standing concerns about care were still not fully acknowledged or resolved.

We found overall that people were at risk of receiving unsafe, ineffective care. We found breaches of five of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement

action against the registered provider and will report further on this when it is completed.

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.

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.

Medicines were not always managed safely.

There were not enough staff to ensure everybody had their needs met.

Staff recruitment processes did not ensure that all staff were assessed as safe to work with vulnerable people.

There were gaps in documents that recorded important information about people's health.

Is the service effective?

Inadequate

The service was not effective.

There were gaps in supervision and records showing that staff were not supported according to the company policy.

Staff lacked awareness of the Mental Capacity Act 2005 and how to support people who lacked capacity. Deprivation of Liberty Safeguards applications were not in place for those people that required them.

People told us they enjoyed the food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw some caring, kind interactions from permanent staff.

People were supported to access advocacy services.

Information was not readily available to people or relatives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints often went without an adequate response and relatives felt they were not listened to.

Care planning documents were reviewed regularly.

People's care records were not always person centred.

People spent long periods of time in their rooms with little stimulation.

Is the service well-led?

Inadequate

The service was not consistently well led.

Auditing systems were not fully in place to monitor the quality of care and there were gaps in records regarding peoples health and care needs.

There was no registered manager in post and there had not been for some time.

Significant incidents were not notified to the care quality commission in line with statutory requirements.

The provider had put additional resources in place within the home to help make the necessary improvements.

Carlton Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 December 2016 and was unannounced.

The inspection team was made up of three inspectors, a pharmacist inspector, a nurse specialist adviser in dementia care and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case services for older people and people with dementia.

Before the inspection we looked at information we already held about the service. We reviewed previous inspection reports for this service. We also reviewed notifications made to the Care Quality Commission, reports from the local authority, correspondence with the local safeguarding team and feedback we had received from relatives.

During the inspection we spoke with seven staff members on shift, the commercial director, and the new deputy and interim managers. We spoke with 18 people living in the home, 11 relatives of people, and four professionals who have contact with people at the home.

We looked at 15 care files, seven staff files, staff duty rotas, a range of audits, the complaints tracker, staff meeting minutes and training records. We also looked at incidents and accidents records, the safeguarding log, daily nursing and medicines records and policies and procedures. We observed interactions between staff, people, relatives and the management team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People that we spoke with said they felt safe. One relative told us that they had seen a change in the home in the last few weeks and now felt their family member was safer. Another relative told us "it's not 100 percent perfect, but [relative's name] is safer."

There were not enough staff to meet the needs of everyone. We asked people about staffing levels and if there were enough staff to meet their needs. One person told us "staff shortages impacts on my care; one day I was in bed until 3.30pm", another person told us they were regularly getting out of bed two hours later than they would like and have been told by care staff this is due to staffing levels. People told us they liked the staff but thought there was not enough of them and this meant some of their needs weren't being met. One person said "although there is a staff shortage, the present carers are wonderful and look after me well."

Notes from a recent relatives' meeting highlighted staff shortages at the weekends and too many agency staff. The explanation given was this was due to staff calling in sick. The provider addressed this in the meeting by stating those staff that were unreliable would be replaced and new staff recruited. On the day of our visit we saw that new staff were being recruited and the interim manager discussed having an active plan to recruit quality staff.
The daily staff meeting minutes for 6 December 2016 showed people with continence needs were left throughout the night, soaked through. The interim manager told us they had addressed this after finding out staff failed to turn up for shifts. One person we spoke with said there was only one staff member at night on their floor and it was often an agency staff member who had not worked in the home before and did not know people or their needs. The night staff meeting minutes showed the staff group included five agency care staff and five permanent care staff. This meeting discussed staffing levels, which showed that staff complained the workload was too much for three care staff.
People on one to one support had a staff member with them on the day of our visit. We spoke with a team leader who said they needed more staff and had been told by the interim manager they would be recruiting staff. One staff member we spoke with gave an example of when one person on one to one support was left alone by an agency staff member and the person sustained a head injury. The interim manager explained what happened after this incident and showed an insight into how the home had learned from this so that it would not happen again.

We asked the interim manager about a dependency tool and audit. We were told it was going to be completed the week of the inspection but there was nothing robust that could be provided to show how staffing ratios were decided on the day of the inspection. When we asked if there were enough staff to meet everyone's care needs the interim manager said "I think we are well staffed" and "for the last few weeks we have had supernumerary staff." The nursing staff that we spoke with told us that they felt there were adequate staff to provide safe care. However we found there were insufficient numbers of staff to give people the care they needed.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and appropriately including controlled drugs. Nurses and senior carers had received training in medicines management. The supplying pharmacy produced medication administration records (MAR) and we saw that new information was added and checked by two staff members. The MAR folder also contained front sheets for each person with photographs for identification and details about their allergies and preferences for taking medicines. Agency staff we spoke with told us that this information was useful to them as they did not know people well. Some people were prescribed medicines that had to be given in accordance with blood tests. We saw that this was done and appropriate action taken when results were abnormal. One person had been highlighted to the doctor for review as their health had changed.

We saw that medicines had been signed for on the MAR as administered and codes used to show non administration, however some of these codes were used incorrectly. One person was refusing their inhaler but it was recorded as 'not needed' rather than refused. Some people were prescribed medicines to be taken when required and we saw protocols to support their use. However, MAR were not appropriately completed for medicines that were prescribed as and when needed. MAR for prescribed creams had gaps in them and were not appropriately completed. We also saw one nurse signing the MAR during the late morning for medicines they had administered earlier in the day. This showed us that safe practice in medicines recording was not always taking place.

Nurses checked controlled drugs (CDs) daily and the medicines we checked were accurate, however there were entries in the CD book for medicines that were no longer in the cupboard. We were told these had been returned to the pharmacy but records had not been made so the service did not have evidence of this.

People who had difficulty swallowing were prescribed a thickening powder for their drinks and instructions as to how thick to make it. In most cases we could find out how thick they needed their fluids from care plans and prescriptions, but staff members who made up the liquids could not show us what instructions they used to make sure they made to the correct consistency; there were no instructions in the kitchens where these drinks were made. The MAR for these people were signed four times a day for these thickeners by the nurses, but this did not reflect their use. During the inspection we intervened and made the care staff aware of this and fed back to the medicines consultant.

Some people had their medicines disguised in food or drink in their best interests. The information relating to these people was not clear. We were satisfied that a mental capacity assessment had been done and a best interest's decision made for them. However there was no evidence of a review of medicines or information from the pharmacist to ensure the medicines were taken safely. There were no protocols for staff to follow to support safe administration. Decisions were not reviewed or updated when medicines changed.

When we spoke with people we had mixed responses to how their medicines were managed. One person said "I lose track of what meds I take and I'm not kept up to date on what I'm taking. Staff seem reluctant to tell me what my meds are for, and I would like to be reminded what I am taking and why." Another person told us their medicines are left on the table for them to take but they were happy with how they were supported in this regard.

The service had recently employed a consultant to audit and improve their medicines management. The findings of the pharmacist inspector and the medicines consultant were similar in the gaps they found. The consultant was working with the home to improve medicines management but the errors that we found showed us that on the day of inspection medicines were not being managed safely.

We spoke with staff and they showed an understanding of risk and how to support people to reduce risks. We looked at risk assessments for people and saw assessments in place for risks such as falls, choking and moving and handling. We saw that each month risk assessments were signed to note any change, although, there were inconsistencies in some risk assessments, making them confusing. On some forms questions were left blank such as a question about whether staff had been trained on using bed rails on a bed rails risk assessment. On other risk assessment forms multiple choices to risk questions were selected making it unclear what action needed to be taken to manage the risk. For example on one form we looked at, both yes and no options were selected for whether the person needed additional control measures in place for their comfort and safety. We found that plans around managing risks were not always clear or co-ordinated.

We found that people's records, particularly their daily records were not maintained to ensure they were accurate, complete and contemporaneous. It is important that an accurate record of the care and treatment provided to a person is kept to minimise risks for people in their care and treatment. Some care records were completed in different ways, which meant it was difficult to find information. For example, one person's records related to blood sugar levels were entered onto two different forms with gaps. We were told the 'Daily Record Note' was for completion every six weeks or at a significant event. There was lack of clarity regarding the use of documents. This was of concern as agency and permanent staff were recording information in different places, making it hard to find.

We found there were gaps in care records that were important in monitoring people's health. For example the fluid chart for one person was not completed on 6 December 2016 and had not been consistently completed. This person was on a percutaneous endoscopic gastrostomy (PEG- where a tube is inserted into the stomach to help feed someone) feed so at risk of not getting enough nutrition if staff were unsure how much had been given that day. The night before there had been an entry 'D' which meant that they had been offered and given a drink, but the care plan and risk assessment showed this person to be Nil by Mouth due to choking risks and all fluid to be received through the PEG. We spoke with the agency care worker who was with the person with the PEG feed as a one to one and they were not aware that the person they were caring for had a stoma (a stoma is an opening on the surface of the abdomen which has been surgically created to divert the flow of faeces or urine). This could put the person at risk of not receiving effective treatment if staff caring for them were not aware of their needs and how to meet them. It also showed that there had not been a comprehensive induction for the agency staff member that included the needs of the person they were caring for.

The fluid chart we looked at for another person was not filled out fully for 5 December 2016, this person's care plan noted that they need to have at least two litres of fluid a day to prevent a Urinary Tract Infection (UTI) or dehydration. They were being put at risk of dehydration and developing a UTI if they were not receiving enough fluid throughout the day.
One person with a grade three pressure sore on admission to the service had the sore noted on the initial needs assessment but the body map in the assessment was left blank. Their care record stated they needed their dressing changed every three days. The records in the wound care booklet were filled out for 12, 15, 27 and 29 November 2016 with large gaps in the middle of November and no recent entries despite a review being noted in the booklet as due for 2 December 2016. This same person told us they were in pain but the booklet said mild pain and only paracetamol needed. On the pain care plan it stated "says he has no pain". This person was not getting appropriate pain relief for their pressure sore and the sore was at risk of getting worse and an infection developing if dressings were not being changed.

One person's daily notes had no entries at 2.45pm of what this person had eaten or drunk that day. This person was immobile, and unable to communicate in any way either verbally or non verbally. Care staff did not know from the daily notes what the person had eaten or had to drink and therefore not be able to assess

how much more they needed or manage risks around dehydration and malnutrition. Staff told us records were not completed due to a combination of agency staff who were unclear regarding expectations of them and also they reported staff had been told to complete entries near the end of the shift. They told us there had been staff shortages and increased use of agency staff, so recording had at times been overlooked. We spoke with the interim manager regarding this. He said that staff should be completing the records contemporaneously and would ensure this message was conveyed to staff.
The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Staff personnel files showed that most staff were subject to the necessary checks before starting work and had recruitment documents in place. However, we found two of the files reviewed did not have a complete Disclosure Barring Service check and one staff member had one from a previous employer. This meant that staff had not gone through a recent criminal records check before starting working with people. During the inspection we intervened by feeding this back to the management team.

We spoke with staff about their understanding of abuse and what to do if they suspected it. They showed an understanding of what abuse might look like and how to report it. We were told by the interim manager that there were several open safeguarding investigations taking place and the home was working with the local authority to safeguard people. The interim manager had an understanding of abuse and was able to describe in detail a recent case and what had been done to safeguard that person. The interim manager told us how staff were being supported to report accidents and incidents to him at earlier stages before they developed into a safeguarding concern. For example he showed incident reports for people with small red marks so the potential of them developing into a pressure sore could be explored.

The premises was clean and well maintained on the day of our visit and we saw staff washing their hands and wearing protective equipment such as gloves to manage infection control.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We looked at care records and saw that there were gaps in records relating to people's mental capacity. One member of nursing staff that we spoke with said "all people with dementia lack capacity." The care records we looked at did not have evidence of best interests meetings having taken place and for one DoLS application we looked at it had the wrong name on the form. Training was provided but staff did not understand what they must do to comply with the MCA.

Do Not Resuscitate (DNR) forms had been completed in some care files noting that the person did not have capacity. These forms did not state why a person could not make a specific decision about their future care and there was nothing in the care files to record why the person the DNR referred to could not be consulted. Whilst people's cognitive ability may not have enabled them to participate in the discussion the records did not always make explicit what decisions people could make and what they could not. We spoke to the interim manager about this and he recognised that this was an area already identified for improvement within the home and that ensuring the DoLS were properly applied for and in place was a priority. After the inspection we requested and were sent an audit of the DoLS applications and the provider identified there were 27 people that needed an application that had not yet been applied for.
The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The staff supervision matrix showed staff supervision did not take place in line with the provider's policy which states staff should receive 'six supervision meetings each year.' We saw that there were brief daily meetings with staff in a group setting but some staff had not received one to one supervisions in 2016 and most staff had received one supervision for this year. When we spoke with the interim manager he acknowledged there were gaps and said "we are trying to catch up with supervision." When we spoke with staff some felt supported whilst others did not.
The staff training matrix showed that staff completed training in areas such as wound management, safeguarding, moving and handling, dementia, health and safety, infection control, equality and diversity and MCA and DoLS. On the day of our visit we observed staff attended training in mental health awareness. We saw there were gaps in training dealing with behaviours that challenge the service. This was a concern because the home had many people living in it who would need the support of staff who had this training for their needs to be understood and met.
The commercial director told us they would be introducing a new induction programme, which would include an induction orientation checklist of activities to be completed by staff. He also told us that they were introducing a clinical competency framework over the next few weeks so the competency of staff to provide quality care could be assessed.

The people that we spoke with said they were happy with the food, one person said they particularly enjoyed the cooked breakfast. People were given a choice of menu which was displayed in communal areas,

there was a pictorial menu as well as written. We saw that people were assisted to eat and drink where required. At lunchtime we saw people were not rushed and were given time to eat. One person told us about their specific dietary requirements and how these were met. We looked in the kitchens of the home and saw that there were charts with each person's allergies, preferences and choking risks outlined for kitchen staff. People told us snacks were available outside of meal times if they were hungry and in communal areas we saw squash and water in jugs with cups available, so that people could help themselves, ask for, or point to a drink if they were thirsty.

Carlton Court is decorated to a high standard but we found the new décor had not taken in to account the needs of people living there. We noted there was inadequate signposting throughout the home for people to orient themselves. Memory boxes outside bedrooms to remind people it was their room were often empty. We saw that wallpaper and furniture were patterned, striped or chevroned and not in line with dementia friendly best practice. We saw contrasting floor colours which may have caused confusion for some people with dementia and put them at higher risk of falls. We fed this back to the interim manager and commercial director who said they would be seeking advice on best practice in this area.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and kind. One person said "staff are wonderful", and another said "staff are good and caring, and if I asked for something, they would oblige- maybe not immediately, but eventually." A relative that we spoke with said they felt welcomed by staff and staff had gone out of their way to facilitate a late night visit when their relative was ill. Another relative that we spoke with said "the carers are very good – they do try to be as personal as possible."

We saw some interactions during the day where staff were gentle and friendly. We witnessed a nurse reassuring a person who was upset and using comforting words and put her arm round her shoulders. We also saw people were pleased to see the staff they knew in the hallways and greeted them with smiles. Staff told us they take pride in their work and supporting people and one nurse told us "I enjoy coming to work every day, I love it."

We also saw instances where care staff did not focus on the person they were caring for. For example; we saw two people with one to one agency carers throughout the day where the carer followed them around or walked with them to make sure they did not fall but they did not make eye contact with or make conversation.

We asked the interim manager about equality and diversity in the home and were told how people could request a carer of a specific gender or culture and the home would do its best to meet requests. We were told by the interim manager how the home held activities around religious observances and festivals and how one person had a care worker of the same cultural heritage at night because they felt more comfortable with this arrangement. The home had an equality and diversity policy which covered equal opportunities for staff members and their recruitment, we were not provided with the homes policy on the equality and diversity needs of people living in the home.

We saw that three people who had no known next of kin had an independent advocate to mediate on their behalf and make sure their dignity was being respected. We observed staff knocking on doors before entering people's rooms. In one case where a staff member did not knock on a door they greeted the person loudly and stated the reason they were entering the room on opening the door. Staff were able to tell us about how they respect the privacy and dignity of the people they care for by drawing curtains and closing doors when giving care. One staff member said they "have to respect what they want." Another gave the example of keeping people covered so they did not feel vulnerable when receiving care. During our visit we saw some confidential documents left in communal areas, we gave these to the interim manager so they could be stored securely.

We saw people at lunchtime being encouraged to eat more independently by themselves rather than being fed. The interim manager told us they "now encourage people to feed themselves and they didn't before".

Relatives told us that information about their family member was often hard to come by and sometimes this was because there were no staff around or the staff did not know about the health of the person they were

caring for. One relative we spoke with said there are "no updates, we have to seek out information."

Requires Improvement

Is the service responsive?

Our findings

We looked at the complaints policy outlining how verbal and written complaints should be managed and where they should be recorded and within what timeframe. We found that there had been a continued lack of response to complaints and recording of complaints received and their handling. These were not recorded on the complaints log and no written response had been given to families at subsequent meetings to discuss concerns. People's relatives told us of their concerns and complaints not being responded to effectively despite complaints being raised consistently in person and writing and although there had been improvements in care the home had "not improved in responding to concerns." Relatives we spoke with told us of historical and current unresolved complaints about belongings going missing, nutrition records not being filled out, their relative being cold, lack of response to complaints, and staff response times when a person needed to go to the bathroom. The interim manager said that he had inherited lots of complaints as he was new in post but that there had been only one they were aware of in the two weeks previous to the inspection, and the home were starting to meet with relatives to discuss past complaints.
The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw some people in lounges but the majority of the time people were in their rooms, with many spending all day in their rooms. This showed us many people were routinely cared for in their beds. During lunch we observed 14 people throughout the home over three floors eating lunch in the dining rooms, there were six other people in lounges and most people remained in their rooms.

We checked the daily notes for two people who were routinely in bed. Whilst one care plan noted a person enjoyed listening to music and hand massage, there was very little information recorded in the daily notes regarding any activities people had undertaken with them. It was simply noted they had sat in the chair. This meant that people who had very limited mobility lacked stimulation appropriate to their ability and personality. Throughout the day we saw televisions were often on or radios playing music from a radio station that was not identified as a preference of that person or might not be appropriate. For example, we saw a one to one carer listening to pop music whilst the person they were caring for had their eyes closed and appeared to be asleep. Where a preference was stated, for example, classical music, there was no recording of what had been played that day or week or if the music had been changed or rotated to provide variety.

We saw that people did not always benefit from individual activity plans for meaningful activities to promote their wellbeing. We saw some care files with activities noted, but in most cases there was a generic activities page as part of the care plan with no specific activities, hobbies or preferences recorded that would indicate how people liked to spend their time. We were told the cinema room was open twice a week and a hairdresser and massage therapist visited the home and there were regular trips out. However, during the inspection we observed that people at Carlton Court were provided with little stimulation. This led to some people becoming disengaged with their surroundings. We saw this in the lounge areas and in people's rooms.

Individualised care plans had been developed from a 'Needs and preferences' assessment. Care plans were comprehensive and broad ranging in their scope and included areas such as skin integrity, nutrition, communication, medical conditions and moving and handling requirements.

Inadequate

Is the service well-led?

Our findings

Carlton Court care home requires a registered manager to be in post as part of its registration requirements. There was no registered manager in post at the time of the inspection, and there had not been since 30 March 2016. People that we spoke with and their relatives said the management had seemed inconsistent and the home had difficulty in retaining managers for long periods of time which affected how it was run and care was provided.

The feedback from staff in relation to the leadership of Carlton Court care home was mixed. Some staff felt supported and enjoyed coming to work, whilst others enjoyed being in a caring role, but felt there were not enough staff. The interim manager and commercial director were open about the improvements that needed to be made and positive that care could be improved and acknowledged that our feedback highlighted areas for improvement they had noted themselves. The interim manager had an understanding of how nursing care could be improved and was focussed on staff using best practise by providing day to day support. The provider had sent extra resources in to make improvements in the home and recognised that improvements needed to be made and they were being worked towards. Feedback that we had from people, staff and relatives was that some improvements in care had been seen but there were still many to be made.

The interim manager and registered provider carried out quality assurance checks to monitor and improve standards at the service. Spot checks were carried out on nursing and care records and medicines were being audited. We were told there were plans to do further audits on care records and DoLS applications. However, we found the governance systems in place were not operating sufficiently robustly to always identify and address improvements that were needed, in a timely and effective way. Supervisions were not being done according to the company policy despite the management team being aware of the gaps and the home acknowledged they had not been complying with the MCA and had 27 DoLS applications outstanding.

When we looked at care records we found gaps in nutrition and wellbeing charts where entries had not been made and entries in risk assessments where sections had been missed out. We found that care records were not always complete or up to date and did not include an accurate record of all decisions taken in relation to care and treatment.
The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of partnership working in referrals to health professionals such as occupational therapists, dieticians, and dentists in care records.

We were told of the vision and values of the home and an aim to deliver high quality care by the commercial director. Staff did not always share these views and their lack of supervision showed in the way records were being filled out and staff feeling there were not enough of them to provide quality care. The nurses that we

spoke with said that leadership was visible, however this opinion was not always reflected by care staff. People we spoke with said they were aware there was a new interim manager but for several of them they had not yet met them or been introduced.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the home. The registered provider had not always informed us of significant events that they were required to. For example if a safeguarding concern was raised by a visiting professional or if there was an allegation of abuse. This did not show an understanding of what was required of the provider in terms of making statutory notifications. We looked at notifications made to us and asked the home to provide information around what safeguarding notifications had been made and found there were seven cases where a notification had not been made to us in the last 12 months.

These issues were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not always gain consent of the relevant person in regards to care and treatment. The provider did not make sure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure appropriate action was taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. The provider failed to keep complaints informed about the status of their complaint and its investigation and did not maintain a record of all complaints, actions and outcomes taken in response to complaints. Regulation 16(1) (2)

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission without delay of incidents which occurred whist services are being provided in the carrying on of a regulated activity. Incidents that have not been notified to the commission are regarding abuse or an allegation of abuse and incidents where a person has been harmed.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always provide care and treatment in a safe way for service users. The provider did not adhere to this regulation by failing to do all that is reasonably practicable to mitigate any such risks posed to service users receiving care and treatment and by failing to provide the proper and safe use of medicines. Regulation 12(1) (2) (b) (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effectively systems or processes to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and

	treatment provided. Regulation 17 (1) (2) (c).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent and skilled staff to meet the need of the service. Persons employed by the service were not in receipt of appropriate support, supervision and appraisal. Regulation 18 (1) (2(a))

The enforcement action we took:

Warning notice