Alan Coggins Limited

Knyveton Hall Rest Home

Inspection report

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10 October 2017
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16 November 2017
20 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 10 October and 9, 16 and 20 November 2017. The first day and second days were unannounced.

This inspection was brought forward from the planned date because we received information of concern from whistle-blowers and safeguarding alerts from the local safeguarding authority. At our last inspection in September 2016 we found the service was running well and rated it as good.

Knyveton Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to accommodate a maximum of 39 people who require support with personal care. There were 33 people living in the home at the time of our inspection.

Accommodation is provided in individual bedrooms on the ground, first and second floors. Some rooms have ensuite facilities. There is a large lounge and a dining room on the ground floor.

The service was led by a registered manager. 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.
The registered manager was supported by a deputy manager. Responsibility for many aspects of the day to day management and running of the home had been delegated to them by the registered manager.

All of the people we spoke with, and visitors, told us they felt safe and well cared for. We received only positive comments about Knyveton Hall throughout our inspection. However, at this inspection we breaches of seven of the regulations.

People told us that their care and support needs were met and that staff were kind, caring and respectful. Staff spoke knowledgeably about how people liked their care and support to be given. However, care plans and risk assessments did not cover all aspects of a person's health and care needs and were poorly organised, which meant it was difficult to establish which care plans were current.

There were a number of hazards around the home including loose carpets, unsafe storage of chemicals and inadequate maintenance of the fire prevention systems, which meant that action to identify and mitigate risks, had not been taken. The provider has since confirmed that action has been taken to address all of these areas.

People were not protected against the risks associated with the unsafe management and use of medicines. Care plans and medicine records lacked detailed information and guidance for staff and errors were not

identified through the audit process that was in place. People's rights were not always protected because staff had not acted in accordance with the Mental Capacity Act 2005.

Staff were not receiving regular and effective supervision, training and support. Most of the people we spoke with told us they had confidence in the staff and felt that they had the knowledge and skills to meet their needs. However, not all areas of essential training for staff had been provided and refresher training was overdue in the areas of training that staff had completed. In addition, where people in the home were living with specific health conditions, training to ensure that these were understood and staff knew how to meet these needs had not been provided.

Staff ensured people's privacy and dignity was protected. People received personalised care from staff who were responsive to their needs and knew them well. Staff created a relaxed, friendly atmosphere in the home. People had access to a range of activities that they were encouraged to take part in.

Information about making a complaint was displayed in the home and was also included in the information that was given to people when they moved into the home. Complaints had not always been fully investigated and records regarding this had not been kept.

Quality monitoring systems were not effective. The audits and management processes had not identified any of the issues found during this inspection. The registered manager responded to the concerns raised at this inspection but had not been aware of these shortfalls prior to our inspection.

Some records contained errors and omissions and some were illegible. This meant that staff may not always have important information available to them.

The occurrence of some incidents and events must be reported to CQC. We found that a number of incidents and events had occurred in the home but had not been reported as required. . This meant that the CQC were had not been made aware of important information about the service and the actions the service had taken with regard to the incidents and events.

During the inspection, the registered manager took action to mitigate the risks identified and has since confirmed, in writing, that further work has been completed. The provider has confirmed that they have engaged a consultant to ensure that all areas of non-compliance are addressed and improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected against the risks associated with the unsafe management and use of medicines.

Risks were not always properly assessed and this meant that no action was taken to reduce or manage any identified hazards.

The premises had not always been properly maintained and equipment suitable to meet people's needs had not always been provided.

Staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Is the service effective?

Requires Improvement

The home was not fully effective.

Staff had not received the training, supervision and support they required to deliver care according to people's needs.

The home required improvement to ensure staff adhered to the principles of the Mental Capacity Act 2005.

People told us that meals were good and the menu showed there were alternative options if someone did not want what was on the menu.

People had been supported to see their GP or nurse when required.

Is the service caring?

Good

The service was caring.

People had good relationships with staff and there was a happy, relaxed atmosphere.

Staff respected people's choices and supported them to

maintain their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had their needs assessed before they moved to the home. Some care plans were detailed and person centred.

People were at risk of their needs remaining unmet because assessments were not robust and care plans lacked information and detail. This meant that staff may not have the required information to fully support people.

The service had a complaints policy but had not established an effective system for identifying, receiving, recording, handling and responding to complaints.

Is the service well-led?

Requires Improvement

The service not been consistently well-led.

The registered manager responded to the concerns raised at this inspection but had not taken action to proactively assess and monitor these shortfalls prior to our inspection.

Quality monitoring systems were not effective and record keeping required improvement.

Knyveton Hall Rest 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 comprehensive inspection took place on 10 October and 9, 16 and 20 November 2017. The first day and second days were unannounced. Two inspectors carried out the inspection on 10 October, 16 and 19 November 2017. One inspector undertook the inspection on 9 November 2017.

This inspection was brought forward from the planned date because we received information of concern from whistle-blowers and safeguarding alerts from the local safeguarding authority. The information shared with CQC indicated potential concerns about the management of medicines, record keeping and storage of records, staff training and supervision and the moving and assisting of people living in the home.

During the inspection, the provider took immediate action to mitigate risks and has since confirmed, in writing, that further work has been completed.

The provider is in breach of seven regulations and requirement notices have been served.

Before the inspection we reviewed the information we held about the service; this included any events or incidents they are required to notify us about. We also contacted the local authority safeguarding and commissioning teams to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion as the inspection was brought forward in response to the concerns received. The PIR 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.

We spoke with and met 10 people who were living in the home. Because some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We also spoke with seven staff, as well as the registered manager. We looked at six people's care records in depth and sampled a further 10 people's care and medicine records. We saw records about how the service was managed. This included 11 staff recruitment, supervision and training records, staff rotas, audits and quality assurance records as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they were comfortable in the home and felt safe living there. However, we found that appropriate steps had not always been taken to keep people safe.

There were systems in place for the management and administration of medicines but these had not always been followed. We looked at the medicines administration records (MAR) and found that the quantities received into the home were not always clearly recorded and added to existing stock records. This meant it was not always possible to audit how much of each medicine should be available and confirm that stock records matched the actual amounts held in the home. MAR had also not always signed by staff to confirm that the items had been administered or a code letter used to explain what had happened in the event that a medicine had not been administered.

Medicines administration records (MAR) did not always contain information about people's allergies or a positive statement that no allergies were known. It is good practice to have a current photograph of each person with their MAR to enable ease of identification for staff when giving medicines. There were photographs for some, but not all, of the people living in the home.

The service used two types of MAR: one for general items that were kept in locked medicines trollies and one for topical items, such as prescribed creams, that were kept in people's bedrooms. The medicines in people's rooms were not kept securely. MAR and prescription labels lacked specific information about what the medicine was for, how often it should be used and where it should be applied. In addition, none of the tubes or bottles of prescribed creams and medicines had opening dates recorded on them to indicate how long they had been in use and to monitor when they needed to be replaced.

Handwritten additions to the MAR did not always include the full name of the prescribed item, the dose and full information that would have been on the prescription label and should therefore have been transcribed onto the MAR. Entries had not always been signed and there was often no second signature to confirm that the entry had been checked and was correct. This meant that a system to check for possible errors was not in place.

Some people were prescribed medicines to be taken as and when they needed them (PRN) or in variable quantities. Not everyone who had items prescribed this way had care plans to guide staff about when to administer the medicines, how much should be administered or the maximum quantity that should be given over a 24 hour period. MAR charts also did not always record the quantity that had been administered. This meant there was a risk that people could take too much of the medicine.

Systems to ensure unused and no longer required medicines were returned to a pharmacy were not satisfactory. We found three large carrier bags of medicines, including specialist drugs, in a room used for storage of tools and DIY equipment. We also found food supplement drinks, which were prescribed for named people, stored in a large box in a food storage cupboard. Most of the items no longer had prescription labels attached. Those labels that were attached showed the items had been prescribed for

people who were no longer living in the home. Staff confirmed that they took the items from the box as and when they felt someone in the home may not be eating well to try to boost their calorific intake. Over 70% of the supplements had passed their use by date.

One person had recently returned from a stay in hospital. Their discharge records showed that changes had been made to their medicines. The discharge records had not been checked and compared with the person's pre-admission medicines records in the home. This meant that staff were not aware that the person's medicines had changed and they had continued to administer medicines as they had prior to the person's admission to hospital.

Most medicines were supplied to the home in multi-compartment compliance aids. Some weeks prior to the inspection the medicines for one person for one evening and one morning had gone missing. Senior staff, who were responsible for medicines, told us that this had been investigated at the time of the incident but no one had been able to establish what had happened. No records of an investigation were available. In addition, the staff concerned had not requested replacements for the missing items, which meant that medicines were taken from other days and new packs were started earlier than necessary.

One of the concerns raised with us before our inspection was that a person had been given too much blood thinning medicine for a period of one week. The registered manager and staff confirmed that this had happened some time previously. They told us that the deputy manager had been responsible for this error and had not reported it. There were no records of the actions taken when this was discovered or any investigation that should have taken place.

One person was prescribed a medicine that required very close monitoring of their health including regular blood tests. The results of the tests were sent to the home with instructions regarding the amount of the medicine they should take until the next blood test results were available. Staff confirmed that the most recent blood test record and medicine instructions should be kept with the MAR to ensure staff were administering the correct dose. This had not been done. The person's current prescription for the medicine was to take 2.5mg once a day. Stocks of the medicine held by the home were 3mg tablets and 1mg tablets. Records of quantities received and current stocks were incomplete. This meant we could not establish how many tablets of each strength should be in the home. Staff told us that they had a pill cutter to split the tablets but were not able to find it when we requested it. The MAR recorded that 2.5mg was given to the person but there was no record of how this was done.

Staff had been trained in the administration of medicines. Records showed that not all of the staff had had their competency to administer medicines safely checked within the last 12 months.

This all meant that people may not have received some of their medicines as prescribed.

Staff had the knowledge and confidence to identify safeguarding concerns and knew how to report these. However, information about the outcomes of and learning from safeguarding investigations had not been shared with staff. This meant staff may not have been fully aware of the actions needed to minimise the risks and improve the care and support to people.

During a tour of the building we found a number of issues and concerns. Some carpets in the corridors were loose or worn, which created possible trip hazards. There were cracked and damaged tiles around the bath and window sill in a first floor bathroom. These presented both a health and safety and an infection control hazard.

Also during the tour of the building we found that fire precautions were not being adequately maintained. A number of doors were labelled "fire door keep locked shut" but were not locked shut. Some fire doors were not fully closing to latch or had missing intumescent strips or smoke seals. Combustible items were stored on some escape routes. The provider has since confirmed that they have taken action to address these concerns and the Dorset and Wiltshire Fire Service has told them that the service is satisfactory.

As part of the fire risk assessment for the service, there should be up to date personal evacuation plans for each person living in the home. The information for Knyveton Hall was kept in a red folder in the main office. Staff confirmed that they were aware that it must be collected when a fire alarm sounded. The information in the folder was incorrect. Some people on the list were either no longer living at the home or their needs had changed significantly, which affected how they would be evacuated from the home. Additionally, other people were now living in the home and there was no information about them in the event of an emergency.

Training records showed that none of the staff had completed Control of Substances Hazardous to Health (COSHH) training. Cleaning chemicals were not being stored and handled in a correct manner. Cleaning chemicals were left unattended in a corridor for a period of more than ten minutes, the main cleaning cupboard on the ground floor was bolted shut but not locked and chemicals in the laundry were not stored securely.

The registered manager had a system in place for risk assessing and checking each room before someone moved into it and on an ad hoc basis when rooms were occupied and had delegated these checks to the deputy manager. There were four stair cases in the home. Two of these were particularly narrow and steep and some had worn carpets. One of the stair cases had a notice by it on the ground floor stating that it was for staff only. There were no risk assessments for the general use of the stairs or for specific service users who may have been at risk if they were to use them.

Risks to people were identified and assessed. Where staff had identified possible risks to people such as a risk of falling, skin integrity issues or weight loss an assessment had been completed and a risk management plan for each risk area was in place. However we found that some risk assessments for the use of bed rails had not been fully completed.

Some people had been assessed as being at risk of developing pressure ulcers. There was no information about the specific equipment provided to reduce the risk or the settings required for the equipment. Staff recorded in daily records that air mattresses were checked. They told us that they were reporting that the mattresses were working. There was no information to advise staff what settings should be used for each mattress and therefore this was not checked. The setting for a mattress that we checked was incorrect.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed, action had not been taken to mitigate any such risks and people were not protected against the risks associated with the unsafe management and use of medicines.

Equipment was serviced at the required intervals, thereby ensuring it was safe to use. There were comprehensive maintenance and servicing records for all of the equipment and fire prevention systems as well as the heating, hot water, electricity and gas supplies.

People living at the home, relatives and staff, all told us that they believed staffing levels were sufficient to meet people's needs. People said their call bell was answered in good time and their care and treatment

needs were met. Relatives also confirmed that they had observed that call bells were answered promptly and people were checked regularly where they were unable to use the call bell.

There were satisfactory systems in place to ensure that people were supported by staff with the appropriate experience and character. Recruitment records showed that the service had obtained proof of identity including a recent photograph, a satisfactory check from the Disclosure and Barring Service (previously known as a Criminal Records Bureau check) and evidence of suitable conduct in previous employment or of good character.

Requires Improvement

Is the service effective?

Our findings

People told us they had confidence in the staff and believed they had the knowledge and skills to meet their needs. A relative said they found all of the staff approachable, caring and understanding. A person, when asked about the staff in the home, told us, "Ah, beautiful! They take care of you."

Skills for Care is a national organisation that sets the standards people working in adult social care need to meet before they can safely work unsupervised. This is called the Care Certificate. The registered manager confirmed that induction training was in accordance with the Care Certificate. One staff member had joined the team since our last inspection. They told us their induction had been thorough and made sure they understood their role, responsibilities and the help people needed before they started to support them. They said they could gain informal advice or guidance whenever they needed to from the other staff that they worked with and confirmed that they had been supported to complete the Care Certificate.

The staff team at Knyveton Hall was stable and many of the staff had worked in the home for a number of years. Previously, staff have been provided with the training required to ensure they were competent to carry out their roles. The registered manager stated that they had delegated responsibility to the deputy manager for ensuring that all staff completed all essential training and refresher training. They stated that they had recently discovered that refresher training for staff had not been arranged and this meant that staff training was overdue. The registered manager confirmed that they had already addressed this and had booked training in fire prevention, moving and handling, infection prevention and control, the Mental Capacity Act and safeguarding adults for the following month.

Training in other essential areas including health and safety, COSHH, emergency aid, basic life support and food hygiene had not been provided to staff with the exception of those newer staff members who had completed this as part of the care certificate. The registered manager agreed to ensure that all staff were brought up to date with all areas of essential training.

Some people in the home were living with conditions such as dementia, Parkinson's disease and diabetes. No specific training had been given to staff in any of these areas. This meant that staff might not always be able to deliver care and support to people safely and appropriately.

Supervision of staff is important to enable them to discuss their work, resolve any concerns and plan for any future training they need or are interested in undertaking. The registered manager had delegated the supervision of staff to the deputy manager. Staff told us that they had not received regular supervision and raised concerns about the quality and manner in which previous supervisions had been completed. Prior to this inspection, the registered manager had not been made aware of this by the staff and agreed to take immediate action when this was highlighted to them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with regular training and supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us they made their own choices and that staff listened to and acted upon their decisions. Consent from people who had capacity to make decisions, was sought by the service by asking people to sign agreement to things such as the use of photography and equipment such as bed rails.

Some people's rights were not always protected because the staff did not always act in accordance with MCA. Where people lacked mental capacity, we found that that there was not always a sufficient understanding of the processes to assess capacity, make decisions in people's best interests where necessary and to accept that people have the right to make unwise decisions. Mental capacity assessments and best interest's decisions were not clear about the specific decision that was being made, how people had been supported to try to understand the decision or whether there had been any consideration of less restrictive options. Only a small number of staff had completed training in the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can 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). The registered manager understood when DoLS applications would be required and had a system in place to ensure they were aware when DoLS authorisations expired and any conditions had been adhered to.

Some people were not able to leave the home because doors were locked and accessed through a special code. Where people lacked capacity to consent to this, DoLS applications had been made but there were no mental capacity assessments or best interest's decisions to support these applications.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

One of the people we spoke with told us, "The food's good". They added that there was always a choice of omelette or sandwiches if they did not like the meal that was on the menu.

During our observation of one lunch time in the dining room, people were seated at tables for one or two people. These were covered with cloths and wipe clean floral coverings. Tables were laid with cutlery and most had cruet sets. There was no music playing and little conversation. Staff wore plastic aprons.

The meal was served on white catering crockery with a red border.

There was no pictorial information or menu available for people to show them what their meal choices were. Research has shown people living with dementia find pictorial menus easier to understand. People living with dementia and or sight loss would have benefitted from eating and drinking from brightly contrasting coloured crockery. This is because research has shown that food and drinks are easier to see and people subsequently eat and drink more.

We recommend the provider adheres to current guidelines regarding appropriate pictorial signage and crockery for people living with dementia.

Risk assessments to identify if people were at risk of malnutrition had been completed. Some people had been identified as being at risk and care plans instructed staff to ensure regular snacks and drinks in between meals were offered. Some people had been prescribed food supplements following consultations with dieticians. However, neither the registered manager nor any of the staff could identify who had been prescribed these and whether they were receiving them as the dietician had instructed. This was an area for improvement.

Some people were able to move independently around the home. They mobilised safely around the home during our inspection and spent time chatting to staff and people in all areas of the home. People that needed support and assistance were supported by staff who were kind and patient. For people with restricted mobility there were two lifts that provided access to all floors in the home. Bathrooms and toilets had grab rails in place to assist people in maintaining their independence.

Signs were placed throughout the premises; however the majority of these were in text format only. Bedroom doors had numbers on them but not all doors had people's names on them and none had individual items, photographs or 'memory joggers' that would be meaningful for people to help them recognise their bedroom. Some of the people in the home were living with dementia. Current guidance for people living with dementia states that pictorial signs and memory boxes are easier for people to understand and enable them to orientate themselves independently around the home. We recommend the service adheres to current guidelines regarding appropriate signage for people living with dementia.

Most bedrooms were personalised with people's own furniture, pictures, ornaments and photographs. The registered manager told us the home had an ongoing schedule of refurbishment and redecoration and bedrooms were attended to when they became vacant. They said this was a gradual process and showed us some bedrooms that had been refurnished and redecorated.

Good

Is the service caring?

Our findings

People described staff as caring and approachable and confirmed that they received help and support when they rang their call bell or asked someone. Relatives told us that they were happy with staffing levels in the home and they always received a warm welcome.

Throughout our inspection we observed people were treated with dignity and respect by staff. There was a relaxed, friendly atmosphere in the home. People were offered choices about what they would like to do and where they would like to sit. Staff knocked on people's bedroom doors before entering their rooms and called people by their preferred name. Personal care was carried out in people's bedrooms to ensure their privacy was maintained. People's care records were kept securely in a lockable room and no personal information was on display.

Staff spoke knowledgeably about the people they cared for; they explained what people's needs were and how people liked to have their care provided. They also knew what their likes and dislikes were and in many cases, knew the person well enough to be able to chat with them about family, friends and past experiences.

There were positive interactions between staff and the people they were supporting. Staff had a good rapport with people. However, we also observed that some staff were task oriented and did not always interact with the people they were supporting. This was particularly evident during meal times. Drinks of squash were provided in blue plastic beakers; we did not see anyone being offered an alternative to squash. Staff also offered people a hot drink later during the meal. Mostly staff just asked people if they wanted coffee, but a few people had a choice of tea or coffee. There were some positive interactions, with smiles and eye contact, between staff and people who could communicate easily. The staff did not have an unkind demeanour, but were busy with serving and clearing away lunch; most of their interactions with people were task focused. Two people sitting on a table together had a conversation about the meal: "I wonder what the meal is today" said one person and the other replied, "I don't know." There was no obvious menu board or other notice informing people what the meal was. Staff put food down in front of people, sometimes saying "Enjoy" but giving no explanation of what the meal was. One person asked a member of staff what the meal was. They responded, "Look. Have a taste, you tell me." This is an area for improvement.

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People's views and preferences for care had been sought and were respected. People's life histories, their important relationships, hobbies and previous life experiences were documented in their care plans. The records included detail about how people preferred to spend their day, their night time needs and what social activities and hobbies they enjoyed. This information was useful for staff to get to know the person well and provide activities they enjoyed.

Relatives told us they felt communication in the home was effective and told us staff were good at keeping them up to date with how people were and whether they needed anything such as items of shopping.

Requires Improvement

Is the service responsive?

Our findings

People received personalised care and support based on their individual preferences, likes and dislikes.

The registered manager stated that they had delegated responsibility for care planning to the deputy manager. Care plan reviews and updates were also completed by some staff. People and their relatives had been included and involved in the process wherever possible.

Care plans were not always a complete reflection of people's needs and the care and support that was provided for them: People's care needs were not always fully assessed and planned for. People with conditions such as diabetes, dementia and Parkinson's disease did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur. This was also the case when people had a short term condition such as an infection or a wound. Staff we spoke with had an understanding of these needs and were able to tell us how they provided support but this may not have been known by all staff. There was, therefore, a risk that people may not always receive the support they required.

Staff completed daily records for each person. These provided other staff with information about how the person had been during the day and was also a method of identifying any changes in people's needs. On occasion the records identified an issue or concern that needed to be followed up. Records were not kept about the actions that were taken or how the issue or concern was resolved.

There was little or no information about people's wishes for end of life care and support if they should require this whilst at Knyveton Hall. It was not always clear whether Do Not Attempt Resuscitation (DNACPR) orders for people were in place. DNACPR means that people have chosen not to receive cardio-pulmonary resuscitation (CPR) if their heart stops beating. This information was not readily accessible to staff in the event of a medical emergency and there was therefore a risk that treatment that was against their wishes would be provided.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure people received the care, treatment and support they required.

Some people had fluctuating levels of need depending on how their condition was affecting them at the time or other factors, such as how tired they were. Care plans instructed staff to assess on each occasion how the person was and to agree with them how their needs should be met. There was information to guide staff about the actions they should take depending on the person's level of ability at the time.

A number of activities were organised in the home and people were encouraged to take part in these. Activities were mainly group sessions and the registered manager confirmed that they had identified a need to provide more individual things for people, especially those who preferred to stay in their rooms. Relatives told us they were happy with the level of activities offered and told us about the different entertainers that

visited the home. The registered manager told us staff accompanied people out into the community. These visits included walks to the sea or cliff top and shopping trips as well as attendance at medical appointments if necessary

Visitors were also welcome to come to the home at any time and throughout the inspection there were a number of relatives and friends who arrived for visits. Staff greeted them and made them welcome.

There was a system in place for receiving, investigating and resolving complaints. People and relatives told us they knew how to make a complaint and felt any concerns they raised would be listened to and resolved to their satisfaction. There was guidance on a noticeboard in the main entrance of the home, informing people how and who to make a complaint to if required. However, there was no information about whether or when people would have their complaint acknowledged and no information about the timescales for investigation and resolution.

The provider had received two complaints in the previous twelve months. The registered manager confirmed that both of these had been passed to the deputy manager. We found that neither of the complaints had been acknowledged or investigated.

This meant that an effective system for identifying, receiving, recording, handling and responding to complaints had not been established and was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records also showed a number of compliments and thank you's had been received from people and relatives.

Requires Improvement

Is the service well-led?

Our findings

Although people and relatives told us they felt the service was well led, we identified some areas where improvements were needed.

There was a lack of consistency in how the service was managed and led. Many of the actions required to monitor the quality and safety of the service had been delegated by the registered manager to the deputy manager and some senior staff. The registered manager had not checked that this work was completed. None of the shortfalls highlighted at this inspection had previously been identified by the provider. This meant that the provider and registered manager had not taken action to proactively assess and monitor the quality and safety of the service prior to our inspection.

At this inspection we have found breaches of seven regulations. Audits and management processes had not identified any of the issues found during this inspection. Senior staff were responsible for completing weekly audits of systems to manage and administer medicines. The audits were not effective because they had not identified any issues of concern.

In previous years, monitoring of the service through the use of surveys, questionnaires and audits had been carried out and actions taken. This system was still in place but had not been used effectively. The registered manager confirmed that this was due to staffing issues and since becoming aware of the issues and concerns, they had engaged a care industry consultant to support them and ensure that the service took the necessary steps to address all of the shortfalls identified.

A number of records, including care, medicines and staff records, contained entries which were not dated, timed or signed. In addition, some records were illegible. Records also lacked detail and information. For example, records of staff meetings did not always include a record of the staff that attended or their signature to confirm their attendance. This was also the case for some records that were noted to be supervision records but had not included the member of staff. Other records, such as care plans, contained out of date information as well as current information, but it was not always easy to establish which was the current information that should be followed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

With the exception of notifications about people who had passed away whilst living in the home, we had not received notifications about a number of other events and incidents. There were at least two significant injuries, and a number of safeguarding concerns including the missing medicines and possible overdose of medicine and people were living in the home with authorisations to deprive them of their liberty. All of which should have been notified to CQC.

Providers are required to notify us of any allegations of abuse at the home. The local authority had made us aware of allegations of abuse that had been investigated by them. However, we did not receive any notifications about allegations of abuse from the registered provider or registered manager. The registered manager stated that they had delegated this responsibility to the deputy manager and agreed to ensure all future notifiable occurrences were reported to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered manager had not notified us of all incidents.

The provider has since confirmed that they have engaged a consultant to ensure that all areas of non-compliance are addressed and improved.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified us of all incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks. People were not protected against the risks associated with the unsafe management and use of medicines.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system for identifying, receiving, recording, handling and responding to complaints had not been established.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported with appropriate induction, regular training and supervision Staff had not been provided with appropriate training to enable them to recognise abuse and raise concerns.