HC-One Limited

Brindley Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Brindley Court on 23 November 2016 and it was unannounced. It provides accommodation and nursing care for up to 52 people, some of whom are living with dementia. There were 51 people living at the service when we visited. The overall rating for this service is Inadequate which means it will be placed into 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 service had 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.

Risks to people's health and wellbeing were not managed to keep them safe from harm. Some situations which could be harmful to people were not risk assessed and when risk was assessed staff did not always follow the plans put in place to reduce it. Accidents and incidents were not thoroughly reviewed to try to avoid repetition. There were not enough staff available to support people safely as agreed or to respond to their needs in a timely fashion. People did not always receive their medicines as prescribed and the systems in place to manage the risks associated with them were not always followed.

When harm had occurred to people the circumstances around the incidents were not always thoroughly investigated or reported to the local authority to safeguard people from potential abuse. Some people had legally approved restrictions on them to protect them when they didn't have the capacity to make their own decisions. However, some staff were not aware of these safeguards or what the restrictions were and therefore may not support them as defined.

Staff did not always uphold people's dignity or treat them with respect. They were often rushed and task focussed and this resulted in not responding to people's requests or questions. They sometimes spoke about people in front of them and did not always allow them to make choices about their care.

Care was not always provided to meet people's preferences. Staff were not always aware of people's changing needs and records were not always amended to reflect the changes and ensure that the care was correct. Audits and quality monitoring systems were not always regularly completed and did not always record all relevant information so they were not effective in driving improvements.

Mealtimes took a long time because there weren't enough staff to meet everyone's needs promptly. People were not always given a choice of food. People told us that the food was of good quality.

Staff did not always receive the training and support that they needed to complete their roles effectively. Some staff felt that when they raised concerns they were not listened to and no action was taken to resolve them. Surveys were completed by relatives on an annual basis and although some concerns were responded to others were not thoroughly investigated. The registered manager had not notified of all of the events that they need to meet their registration.

People saw healthcare professionals when needed. The provider had a complaints procedure in place and complaints were responded to within the defined timescale.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 protected from risk of harm because risk was not always assessed and actions agreed to reduce it were not always followed. There were not sufficient staff deployed to meet people's needs safely or in a timely manner. People were at risk because they did not always receive their prescribed medicines. Incidents which could mean that people were involved in abuse or poor practice were not always fully investigated or reported. There was a recruitment process in place to ensure staff were suitable to work in a caring environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.
Staff did not always understand the legal restraints that people were protected under. They did not always receive the training and support that they needed to meet people's needs effectively. People were not always given a choice of food at mealtimes. Healthcare needs were met and people saw other professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People's dignity was not always upheld by staff who showed them respect. They were not always given the opportunity to make choices and decisions about their care. Their visitors were welcomed into the home without restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People's care was not always planned to meet their preferences. Records were not always amended to reflect people's changing needs. Activities were provided so that people could pursue interests and hobbies. Complaints were responded to within the provider's procedure.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not always respond to feedback about the quality of the service to ensure that it improved. Audits and quality systems were not always completed or accurate. The registered manager did not notify us of significant events in line with their registration.	

Brindley Court

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 visit took place on the 23 November 2016 and was unannounced. It was carried out by two inspectors.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

The provider had 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. We used this information to help us to come to our judgement.

We used a range of different methods to help us understand people's experiences. We spoke with six people who lived at the home about their care and support and to the relatives of four people to gain their views. Some people were less able to express their views and so we observed the care that they received in communal areas. We spoke with seven care staff, two nurses, the activity co-ordinator, the deputy manager, the registered manager, the learning and development lead facilitator and the assistant operations director. We also spoke with two visiting health professionals. We looked at care records for eleven people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Inadequate

Is the service safe?

Our findings

Risk was not always managed to protect people from the risk of harm. We saw that one person was alone in their room while two maintenance staff were removing the window from that room. We saw that the person was cold and distressed. They were not supported by staff and when we intervened to alert staff to the situation they were not aware that the work was happening. We reviewed records and saw that this person had a risk assessment which stated that they should be monitored every half hour in their room. We saw that the person spent over two hours in their room and were not regularly monitored. They were at risk of harm in this period because they were unsupervised with maintenance staff who were not trained to support them. They were also placed in a cold environment which had caused distress. When we reviewed records we saw that staff had signed these every half hour even though we had seen they were not always checked at that time. This meant that staff were not supporting the person in line with their risk assessment and that these records were not accurate or reliable.
This person had also been assessed as being at a high risk of choking. The assessments stated that they should have their drinks thickened to reduce the risk and that they should be supported by staff when eating and drinking. We saw that they had a drink which was not thickened to the correct consistency beside them when they did not have staff support. We saw that the person drank this independently without support from staff. This meant that they were at risk of choking because they had not been supported in line with their risk assessment.

The provider did not ensure that staff were available to support people in order to reduce the risk of harm to them. We saw one person had pressed their buzzer to ask for assistance and they waited over twenty minutes for staff to offer support. The person told us, "I need help and I have been waiting for a long time". During this time the person transferred themselves from their chair to their bed independently because they said that they would be more comfortable. We looked at records for this person and we saw they were at high risk of falls and had fallen three times in one month when they were unsupported. The action that was put in place to reduce the risk of falls was that the person should be supported by two staff and that they should be encouraged to use their buzzer to ask for assistance. This meant that staff had not responded to the person by following the actions that had been put in place to reduce the risk of falls.

People were not always supported to move in a safe way. We saw that one person was asleep in the dining room and a member of staff woke them to say that they would take them to their room because they were tired. They asked the person to lift their feet which they did not do and the member of staff continued to move them in the wheelchair with their feet dragging on the floor. One other person was supported to move with only one footplate on their wheelchair. We saw the member of staff noticed this however they responded by putting both the person's feet onto the one footplate. On three other occasions we saw people wheeled into communal areas by staff who let go off the wheelchair and left the room before the chair had finished moving. This meant that people were at risk of harm because plans to move them safely were not followed.

When accidents and incidents did occur the provider did not always review risk assessments in line with the incidents to ensure that they were accurate and current. One person had three falls in one month recorded

as accidents but only one of these was recorded in their care plan. Their risk assessment had not been reviewed as a consequence of the falls, and only considered as part of the monthly review which was over one week later. When it was reviewed after the falls their risk rating was amended but the risk had been recorded as reduced. This meant that the systems to monitor and review risk were not always accurately followed to ensure that accidents were monitored and repetition avoided to protect people from harm.

The risks associated with medicines were not always managed to protect people from harm. We saw that one person was given their medicines and that the member of staff who administered them did not stay with the person to ensure that they had been swallowed. The staff member then returned to the room and was looking on the floor with another member of staff. When we asked what they were doing the member of staff said, "The nurse thought that the person had dropped the tablet but they haven't". The nurse said, "Yes, the person has had it". They showed us that they had signed the medication administration record to say that the person had taken all of their tablets. We saw that there was a tablet on the floor. After a few minutes the other staff member found the tablet. It was disposed of and arrangements were made to replace it. This meant that we could not be sure that people had their medicines when needed, that they were not always administered to meet their needs and that records were not always accurate.

This evidence represents a breach in Regulation 12 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

There were not enough staff deployed to meet people's needs and protect them from harm. We saw that one person was sat in a wheelchair in a communal area. They were calling for help and pointing towards the comfortable lounge chair and indicating that was where they wanted to sit. They were distressed and moving towards the chair which was causing their wheelchair to rock and become unsteady. After thirty five minutes we intervened and asked a member of staff to assist them. The member of staff told us that they were unable to support them because they had other tasks to complete first. They waited a further five minutes before a second member of staff assisted them.

We saw and people told us that they had to wait for long periods of time to receive their meals. One person said, "The food is nice when you get it but we are always waiting." At lunchtime some people were taken to the dining room fifty minutes before their meals were served to them. At breakfast we saw that some people needed support to eat and drink. While one member of staff supported one person another nine people were sat in the room for over half an hour because they needed support with their meal or to move from the room. Other people were distressed and they were shouting or banging the table while they had to wait. One member of staff we spoke with said, "Meals are taking longer and longer because so many people need help and we don't have enough staff".

One person we spoke with said that they were unable to reach the call bell in their bedroom. They asked us to press it for them which we did because it was not accessible to them. After a further ten minutes they stopped a passing member of staff to request assistance, as no one had responded to the call alarm. This showed us that the systems which should be in place for people to use to reduce the risk of harm were not always accessible or responded to.

People told us that they had to wait for staff to meet their needs. One person said, "I have been waiting ages because there's no one around again". Another person said, "I am buzzing the alarm but no one has come because there isn't always enough staff." We saw that there were no staff in communal areas for extended periods of time. For example, there were four people in one lounge for one and a half hours without any staff support. Some of these people were at risk of falls or were not be able to ask for assistance. On another occasion three people were in a room without any staff support for thirty minutes and again they

could not ask for assistance and were at risk of falls. We saw that during these periods staff were supporting people in their rooms or with personal care. One member of staff we spoke with said, "Every time something changes, such as someone who was independent becoming nursed in bed, we don't get more staff". Another member of staff said, "There used to be enough staff but people's needs have changed".

This evidence represents a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities)

People were not always protected from abuse and avoidable harm. In the PIR the provider told us that the majority of staff had completed safeguarding training and that all colleagues understood the importance of reporting any safeguarding. However, when we spoke with staff they did not always recognise potential abuse. For example, we saw that one person had a bruised eye. When we spoke with staff they were unable to explain how the bruise had occurred. We reviewed records and saw that the bruising had been recorded on a body map. When we spoke with staff they said, "We record anything we see on a body map and then the nurse would deal with it." We saw that it had not been reported as an incident and that no further investigation had taken place. When we reviewed records for one other person we saw that body maps had been completed for them six times in one month which recorded unexplained bruises. These bruises had not been reported as incidents, had not been investigated and had not been reported to the local safeguarding authority. After the inspection visit we referred our concerns about people's wellbeing and protection from avoidable harm to the local safeguarding authority.

This evidence represents a breach of Regulation 13 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people when they first started. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. We spoke with one member of staff who had recently started working in the service. They told us the provider had received references and a police check had been carried out to ensure they were suitable to work with people before they started work.

Requires Improvement

Is the service effective?

Our findings

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 or 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 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 looked to see if the provider was working within the principles of MCA. We saw that some assessments had been completed when people did not have capacity to make some decisions for themselves. Decisions had been made with nominated family or friends in their best interest. When we spoke with staff they had some understanding of capacity. One member of staff told us, "When I support [person] I know that they have a condition which impairs their memory and their understanding around long term decisions but they do have a lot of capacity around day to day decisions."

We saw that some people had restrictions to their liberty such as rails on their bed or systems in place to prevent them from leaving the building unsupervised. Four DoLS had been approved and sixteen further applications were with the authorising authority. When we spoke with staff they were not able to tell us which people they supported had a DoLS in place. One member of staff said, "I don't know if there are DoLS authorisations unless I look in the care plans." They were not aware of the restrictions being placed on people or whether they were the least restrictive possible. For example, one person had an application to deprive them of their liberty because they had left the building once and it was felt that they did not have the capacity to understand the risks of being outside without support. There was a risk assessment in place for staff to check the person half hourly and although the person had not attempted to leave again they had not reviewed this risk to consider if it could be managed in a less restrictive manner. The manager told us, "They have done it once and so we have to assume they will try to leave again." This meant staff we spoke with did not understand their responsibilities associated with the Act.

We recommend that the registered manager should ensure that all staff receive further training in MCA and DoLS and that they ensure that staff can demonstrate an understanding of supporting people in the least restrictive way possible.

Staff were provided with some training opportunities to develop the skills and knowledge they required to care for people effectively. Staff we spoke with had mixed opinions about the training. Some staff didn't like the online training and others found it difficult to recall what they had covered. One member of staff we spoke with said, "I think the mental capacity act is on the computer but I can't remember if I have done it." Another member of staff told us about end of life training they had recently completed which helped them to focus on people's dignity. We saw that one person had a diagnosis which meant that they needed to be supported in a certain way. When we asked staff about this they were unaware of this diagnosis or what it meant. We asked managers if training had been provided in it and they said that it hadn't, it wasn't on the

online system and would need to be organised locally. This showed us that although there was training available it did not meet all staff's learning needs and didn't cover all of the subjects to understand the people they supported.

People were not always provided with a choice of food at mealtimes. We saw that some people were not asked at all and were given a meal. Other people were asked about the menu, for example, if they wanted a roast but then they had all of the vegetables put on the plate. One person said, "I can't eat all of that, it is enough to feed a family." Another person said, "I don't like gravy and I have to keep reminding them." People told us that the food was of a good quality. One person said, "I have some lovely dinners here." A relative we spoke with said, "The food is lovely and my relative enjoys it."

People had their healthcare needs and referrals were made to other healthcare professionals when required. We saw that one person was unwell and that the provider made phone calls to the relevant professionals so that they could be examined. One visiting healthcare professional said, "We are here today because they asked us to come and show them how to use equipment to manage people's skin." This showed us that the provider requested additional support to meet people's healthcare needs when needed.

Requires Improvement

Is the service caring?

Our findings

People were not always asked about the care they received or given a choice. One person told us, "I don't like people telling me what to do and here they don't ask they tell you." We saw that people were moved in their wheelchairs without being asked. On one occasion when the room was crowded we heard one member of staff ask another, "There's not enough room, shall I move some?" They then moved four people without asking them. On another occasion one person was wheeled into a room and left in front of another person so that they could no longer see the activity taking place. Other people had clothes protectors put on without asking if they wanted them. We saw one person's clothes protector taken off from behind which meant that they had no warning that it was about to happen, and we saw they seem startled. One person had indicated that they wished to sit in a chair and when staff responded we saw that they told the person, "No, it's time for activities". They then took the person from the room in their wheelchair without them consenting. This showed us that people were not always involved in making decisions about their care.

People were not always treated with dignity and respect. When we asked what one person's name was, the member of staff replied by calling out to another member of staff, "It's [name] isn't it this one?" and they pointed at the person. We asked another member of staff a question about people who used the service and they responded by room number rather than people's names. Staff spoke about people in front of them without their permission. For example on member of staff said, "[name] gets very impatient and wants everything now." On two occasions people asked staff what their meal was going to be and staff responded that they did not know and they did not find out for them.

People's privacy was not always respected. We saw that seven people were eating their meals at set dining tables when staff brought other people into the room and started to put them in a circle around the room to prepare for an activity. This meant that people's mealtime was not respected and that they were rushed so that the room could be used for another purpose. On another occasion one person was being supported with personal care in a bedroom with the door open onto a communal corridor. This meant that their human right to privacy was not upheld as people could see intimate care from the corridor.

This evidence represents a breach of Regulation 10 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Visitors were welcomed to visit at any time. One relative we spoke with said, "They always welcome me and I have my meals here too which is really kind." We saw that relatives visited at different times throughout the day and knew staff well.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that met their needs and preferences. We saw that one person was supported to drink a prescribed nutritional supplement. The person indicated that they did not want the drink on several occasions. Staff continued to encourage the person and three different staff sat with them and put the straw in their mouth over a twenty minute period. The person continued to remove it and move the drink away. One member of staff then said, "They don't really like this flavour; they prefer the other one". The drink was not replaced with the other flavour. This meant that the person was encouraged to drink something which staff knew was not their preference.

We observed that one person was distressed because they asked to sit in a chair and they were not supported to do so for over one hour. When they were transferred to the chair they were no longer upset and seemed contented. When we spoke with the deputy manager they told us, "They like to be in the chair because they are worried that they will be taken back to their room. Routine is important to them." This showed us that although some staff understood people's preferences not all staff did, and people did not always receive the appropriate support.

When we spoke with staff they were not always able to tell us about the people that they supported. We asked one member of staff whether one person had an order in place which described whether they wanted to be resuscitated. The member of staff responded that they did not know if there was one in place. When we asked what they would do if there was an emergency situation and this knowledge was required they responded that they would ask the manager. This meant that the member of staff may not know what someone's preference was in an emergency situation and that it could impact on the successful treatment of the individual.

One member of staff we spoke with told us that one person took their medicines covertly. This means that they are not aware that they are taking them and they may be hidden to ensure that they take them. We spoke with other staff and reviewed this person's records and found that they did not take their medicines in this way. This showed that some staff were not always aware of the current medicine plans to support people.

We spoke with other staff about people's care and asked questions about their health and wellbeing. One member of staff told us that they did not know how someone had received a bruise to their face because they had been on annual leave. When we reviewed records we saw that the person had a fall four days earlier and was taking regular painkillers as a consequence. Another member of staff told us that they did not know about people's medicines because they worked on a part time basis and had not been given that information. This meant that some staff were providing care to people without knowing about possible changes to their health and wellbeing, which could impact on their care needs.

When we reviewed records we saw that they were not always reviewed when incidents or changes to people's wellbeing occurred. For example, we saw that when one person fell twice in one twenty four hour period that their care plan had not been updated to reflect whether they should be left unsupported in the

bathroom at night.

This evidence represents a breach of Regulation 9 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People were supported to pursue hobbies and interests. One person we spoke with said, "I am taken to the pub by the activities co-ordinator occasionally which I really like". We saw that there were two activities organised which people joined in with. One person showed us what they had made and told us, "Yes I am enjoying doing this, it's fun." We spoke with the member of staff who was employed to focus on activities and they told us, "We fill in a booklet about people's previous life when they first join and I try to use that to plan activities. I keep a record of who has joined in throughout the week and then on Friday I do one to one with people who haven't taken part and also with people who are cared for in their rooms."

People and their relatives told us that they knew who to speak to if they needed complain. One person told us, "I was disturbed through the night and so I have asked to speak to the deputy manager because they get things sorted". We saw that a copy of the complaints procedure was displayed in a communal area. In the PIR the provider stated that they had received four complaints and described the actions they had taken to respond to them. When we spoke with the manager they confirmed that the complaints had been responded to within the timeframe set by the provider. For example, they had put measures in place to ensure that families were aware of activities within the home by providing them with a copy of the four week programme. They also kept a record of concerns that were raised and recorded how they had responded and managed those.

Inadequate

Is the service well-led?

Our findings

Staff we spoke with told us that they did not always feel listened to. They told us that they had raised concerns about staffing levels but that no action had been taken. In the PIR the provider told us that through their annual survey with relatives they had received feedback that people had to wait too long for call bells to be answered. When we reviewed records we saw that the provider's response to this concern was to ask staff to acknowledge the call bell and re assure the resident that they will come and see them as soon as possible. One member of staff we spoke with confirmed this approach had been taken by stating, "When anyone says that they have had to wait we are just told to hurry up. They don't listen to us when we say things aren't right."

Staff told us that they had raised concerns about the flies in the dining room and they did not know what response had been taken to deal with the concern. We saw that there were flies in the dining area and other communal areas of the home. People were eating meals in these areas and food was also prepared there, whilst the flies were present. We intervened to remove flies from one person who was unable to do so for themselves on three occasions. One person we spoke with said, "I don't like the flies, they are everywhere. I suppose they are after the food." We spoke with the deputy manager during the inspection visit and they were unable to give us a detailed action plan but stated that they had checked the building to see how they were getting in. After the inspection visit the manager informed us that they had been informed of the concern two days earlier and they had ordered a new bin because that may be the cause of the flies. However, we observed that the bin they were concerned about had not been removed from the room on the day of the inspection visit. This showed us that when people gave feedback about the quality of the home action was not always taken to improve it which put people at risk of harm to their safety and wellbeing.

Communication was not always effective within the staff team. For example, the staff team were not informed of the planned maintenance work in one person's room which put the person at risk of harm. Staff told us that they had team meetings but some staff said they did not feel like they could state their opinions or raise their concerns in that meeting. One member of staff told us that they were not allowed to use certain equipment to assist people to move because it was wrongly used by some staff. They said, "We have been stopped from using them which makes it even busier because moving people is more difficult. The managers made that decision and told us and I don't know how long it will be for." Another member of staff we spoke with was not able answer questions we asked about one person's care and said, "The nurse deals with that, not us." This meant the communication between members of the staff team was not always well managed to ensure that people were supported effectively.

We saw that there was often a task focussed approach to supporting people within the home. Staff told us that they were encouraged to complete tasks quickly and had little time to spend with people. We saw that this impacted on people's dignity because they were sometimes not fully supported when staff were rushing. For example, we saw three people being pushed into a room in a wheelchair and staff rushing to the next task without checking that the chair had stopped that the person was where they wanted to go and settled.

People's records were not always monitored and reviewed to ensure that they were receiving the care and support required. When people were required to drink a certain amount of fluid to maintain their health actions were not taken to ensure that they did. For example, one person needed to drink a specific amount of fluid per day and we saw that staff had recorded amounts significantly lower than this on two consecutive days. No staff had taken responsibility to check whether the person had drunk enough or to ensure that the records were completed correctly. People's records were not kept securely to protect their confidential information, during the inspection we saw they were kept on a shelf in an unlocked office.

Safeguarding concerns were not managed transparently and staff did not always understand their responsibilities to protect people from potential abuse. Records were completed which demonstrated that there was potential harm to people but nobody had acted on them. For example, when we spoke with staff about some people's bruises they told us that they were unable to give an explanation and that it was other staff's responsibility to investigate or report. After the inspection visit we raised safeguarding concerns with the local authority because we were not satisfied that the provider recognised the potential risk to people's safety.

There was an audit programme in place to monitor quality. We identified some medicines errors through incident reporting but these were not included in the audit that we saw or identified on an action plan. When we spoke with the manager they said that they considered it to be low risk and had managed the situation on a one to one basis with the staff member. As the error involved the omission of prescribed drugs the learning from this should have been shared with the wider staff team and measures put in place to avoid repetition. In the PIR the provider told us that each audit had a corresponding action plan but on this occasion no action plan had been produced. They also told us that there had been one medicines error when there had been two.

When we spoke with the deputy manager about the number of falls that people had they were unable to demonstrate that these had been analysed recently or that they had considered trends and themes in line with the provider's guidelines. The manager told us that they used a dependency tool to plan the staffing levels to meet people's needs. When we reviewed individual dependency tools they did not always correlate to people's current needs. For example, one person was scored as lower dependency for moving than they currently were because we saw that they required two staff to support them to move. This meant that although there were audits in place they were not always completed regularly or accurately to enable the learning from them to drive improvement within the home.

In the PIR the provider described the quality systems that were in place in the home to ensure that people received a good service. These included a daily walk around by the manager, a monthly review by the area manager and support from the provider's quality team. The registered manager was required to complete reporting which should alert the provider to improvements that were required and where the management team required support. We saw that all of these had been completed and had not raised any major concerns and the service was considered to be good. However, we saw that some of the information was not recorded where it should be and some of it was inaccurate and therefore the quality systems were not effective in identifying improvement areas.

This evidence represents a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

To comply with their registration requirements the registered manager must send us notifications about important events which happen in or affect the running of the home. During the inspections we identified that the registered manager had not always complied with this statutory requirement to keep us fully

informed. For example, we had not received notifications that people had safeguards in place to deprive them of their liberty.

This is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

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 provider did not notify CQC of all significant events required as part of their registration..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment which met their needs or preferences.

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

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 People were not always adequately protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to comply with regulations were not always operated

adequately to monitor the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff deployed to meet people's needs effectively.

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
Treatment of disease, disorder or injury	People did not receive care and treatment in a safe way because risk to their health and safely was not adequately managed.

The enforcement action we took:

Warning notice