

Snow Peak Limited

# Pensby Hall Residential Home

## Inspection report

347 Pensby Hall Road  
Heswall  
Wirral  
CH61 9NE  
Tel: 0151 648 9730

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### Ratings

#### Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Requires improvement



Is the service caring?

Inadequate



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

This was an unannounced inspection carried out on 9th February 2016. Pensby Hall Residential Home provides personal care and accommodation for up to 30 older people. Nursing care is not provided. On the day of our visit, there were 24 people who lived at the home.

We carried out an unannounced comprehensive inspection of this service on 17 and 18 August 2015. During this visit multiple breaches of legal requirements were found. We found breaches in relation to Regulations

9, 10, 11, 12, 13, 15, 17, 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was rated as inadequate and placed in special measures. Services that are placed in special measures are inspected again within six months to ensure that significant improvements have been made to meet the legal requirements.

During this visit we followed up the breaches identified at the August 2015 inspection.

# Summary of findings

Pensby Hall Residential Home is a detached house situated within walking distance of local shops and public transport. Accommodation consists of 30 single bedrooms. A passenger lift enables access to all floors for people with mobility problems. On the ground floor, there is a communal lounge and dining room for people to use and a conservatory. Specialised bathing facilities are also available.

On the day of our visit, there was no registered manager in post. 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.' We found however that a new manager had been appointed. They told us they had submitted an application to The Care Quality Commission to become the registered manager. We saw evidence to confirm this. This application was still in progress at the time of our visit.

**During this visit, we found that although some improvements had been made to the service, there were still a number of significant issues that caused us considerable concern. We found continued breaches of Regulations 10, 17, 18 and a new breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

For example, we looked at five staff recruitment files and saw that staff were not always recruited safely, inducted into their job role appropriately or trained sufficiently. This meant the provider could not be assured that these staff members were safe and suitable to work with vulnerable people. This caused us considerable concern as staff may not have had the skills, knowledge, experience or attitude to work with vulnerable people safely and effectively.

We found staffing levels and deployment still required further review to ensure they were safe and people's needs were met. During our visit, we observed significant periods of time when people were left sat on their own in communal areas with no independent means of calling for help and no staff in the vicinity to support them. This

was a concern raised at our last inspection and we found no evidence that any significant improvements in how the staffing levels were determined and deployed had been made.

People we spoke with were happy with the care they received and told us staff looked after them well. From our observations, we saw that staff supported people in a kind and unhurried way but sometimes failed to ensure that the person's right to dignity and privacy were respected and their care preferences adhered to. We found that some people were woken and got up early despite their preference to stay in bed, some people were left sat for long period of time without any social interaction and some people's personal care needs were not supported in a dignified manner. This again was an issue we raised at the last inspection with the provider and we spoke to the manager again about our concerns. They assured us they would investigate these issues.

These examples indicate that further improvements were still required at the time of our visit in respect the management of the service. We did not consider the service therefore to be consistently well led.

We did find that the new manager in post had made some improvements to the way the service was provided. For example, we found improvements in the way some people's care was planned, risk assessed and managed. Some care plans were now person centred and it was clear that people had been involved in discussing their support needs and preferences. We saw that where advice had been given on how to manage people's needs and risks, this advice had been followed by staff to ensure people received the care they required. This new system of assessing and planning people's care however was still in its infancy and not all of the people who lived at the home had had their care and risks reviewed in this way. We spoke to the manager about this and they agreed to complete this work without further delay.

The manager had started to assess people's capacity to make informed decisions where their ability to do so was in question. It was obvious from this information that people had been an active participant in this assessment process. This was an area of improvement from our last inspection and showed the beginnings of good practice

# Summary of findings

in relation to the implementation of the mental capacity act and deprivation of liberty safeguard legislation at the home. Further work was still needed however to ensure this legislation were fully understood.

The décor of the home had been refreshed and some of the carpets at the home had been replaced following our last visit. The home was clean throughout and there were no malodorous smells which had been an issue raised at our last inspection. The specialised bathing equipment which had been out of use at our last inspection was now accessible and we saw evidence to demonstrate that people were now in receipt of regular baths and showers. The provider has also replaced the home's gas boiler and had a valid certificate of inspection to show it was safe.

Fire safety arrangements had been reviewed and there were a range of new audits in place to identify and manage any potential risks to people's health, welfare and safety.

People's views about the quality of the service had been sought and the results were openly displayed in the entrance area of the home for all to see. A copy of the provider's complaints procedure was also displayed. Records showed that any complaints received were responded to appropriately by the manager.

People told us they felt safe at the home. Safeguarding incidents were now appropriately documented and reported and we saw that staff had received training in how to recognise and respond to allegations of abuse. Record keeping overall had improved at the home but we found that further improvements were still required.

We spoke to the manager about the progress the service had made since our last inspection and where further improvements were required. The manager acknowledged that further work was still required. The service will remain in special measures as the overall rating for the service is still inadequate.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe

Safeguarding incidents were appropriately investigated and reported and people told us they felt safe at the home.

Some people's risks had been more reviewed but further work was still required. We saw evidence that risk management advice was followed.

Some staff were not recruited safely. Staffing levels and their deployment required further review to ensure they were safe and satisfactory.

Staff were trained to administer medication. We saw evidence to indicate people received the medication they required.

Some improvements to the safety of the premises and its equipment had been made.

Inadequate



### Is the service effective?

The service was not always effective

Staff recruitment was not always safe. Staffing levels and deployment required improvement to ensure they were sufficient.

New staff employed since our last visit had not been appropriately inducted, trained or supervised. This placed people at potential risk.

The beginnings of good practice in relation to the Mental Capacity Act had been implemented but further work was required.

People received enough to eat and drink and the service catered for people with special dietary requirements.

Requires improvement



### Is the service caring?

The service was not caring

Staff were observed to be kind and patient with people who lived at the home but did not always provide care in a dignified manner.

People social needs were not always met and some people spent long period of time with limited social interaction.

People's ability to independently move around the home had improved.

End of life care arrangements had been discussed with the person and documented for staff to follow.

Inadequate



### Is the service responsive?

The service was not consistently responsive.

Requires improvement



# Summary of findings

The care plans we looked at were now person centred and holistic but at the time of our inspection, not everyone's care plans had been reviewed in this way.

Activities were advertised at the home. We saw some evidence they took place but on the day we visited we saw that people sat for long periods of time with nothing to do and minimal social interaction.

The provider's complaints procedure was displayed and any complaints received had been responded to appropriately by the manager.

## Is the service well-led?

The service was not always well led.

Some improvements in the way the service was run had been achieved by the new manager in post, but further work was still required.

Audits were not in place to monitor the quality and safety of the service and people's views on the service provided had been sought.

The recruitment, training and management of staff still required further improvement to ensure it was safe.

Staff practices and attitudes to the provision of care did not always respect people's preferences, dignity and right to privacy.

**Requires improvement**



# Pensby Hall Residential 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 9 February 2016. The inspection was unannounced and carried out by an adult social care inspection manager and an inspector. Prior to our visit we looked at any information we had received about the home to enable us to plan for our visit.

During our visit, we spoke with five people who lived at the home, a relative, three staff members and the manager. We looked at the communal areas that people shared in the home and visited a selection of individual bedrooms. We looked at a range of records including six care records, medication records, five staff personnel files and documentation relating to the quality and safety checks undertaken by the manager or provider.

# Is the service safe?

## Our findings

We asked people who lived in the home if they felt safe. They all told us that they did. Comments included “It’s safe and warm here” and “Yes. It’s very safe here. A relative we spoke with also told us they no longer had concerns about the service.

We looked at the way staff were recruited to work at the home. We looked at five staff recruitment files and found that safe recruitment practices had not always be followed. For example, one staff member’s recruitment file indicated that they had been working at the home for five months. There was no evidence in this staff member’s file that previous employer references had been sought for the person prior to employment to ensure they were suitable for the post. This meant that the provider had not checked that the person had the skills and experience to work with vulnerable people.

We spoke with a member of staff who had just commenced working at the home. We asked to see their recruitment file but the manager was unable to show us one. The manager told us that there had been an error and this person had accidentally commenced working in the home before any previous employer references had been received and before the necessary criminal records checks were completed. This meant that the manager could not demonstrate that the person was suitable to work with vulnerable people and provide the care they needed. The manager assured us that this staff member would not work any further shifts at the home until the appropriate checks were carried out and their suitability demonstrated.

A third staff file we looked at contained an application form, a set of interview notes, a health questionnaire and previous employer references all written in the same hand writing. The person’s name was not documented on the references and the referees’ signatures were illegible. This meant there was no evidence that the references in this person’s file belonged to them or that the references had been completed by a verifiable source. We asked the manager about this.

The manager told us that they had not been involved in the recruitment of this staff member. The manager rang the provider who had been the acting manager at the time of this person’s employment. After speaking to the provider, the manager told us the provider had said that they knew

nothing about this person’s recruitment and was also unable to explain why all the recruitment documentation was written in the same handwriting. This caused considerable concern as we could not identify who had recruited this person and whether the appropriate checks had been followed.

**This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that the appropriate checks were carried out prior to staff commencing work at the home to ensure people were protected from potential harm.**

At the previous inspection in August 2015, we found that safeguarding incidents were not appropriately documented or reported and there was no evidence staff had been trained in what to do should an allegation of abuse be made.

Records now showed that staff had been trained in safeguarding following our last inspection. Staff we spoke with they told us they understood about safeguarding and what action they needed to take to protect people at risk from potential harm or abuse.

We looked at the provider’s safeguarding records. We saw that the manager had maintained an audit trail of any alleged safeguarding incidents and had appropriately reported these incidents to the local authority and CQC. However we did note that at times the manager seemed confused about what constituted a safeguarding concern. The manager told us that they would revisit the guidance and seek advice when they were unsure in the future.

Prior to our visit, we had received information of concern about people’s care. We looked into these concerns during our visit and found no evidence to substantiate any of the concerns reported to The Commission.

At our last inspection, people’s care files contained information about people’s needs and risks that was often duplicated and contradictory. This made it confusing for staff to understand and follow. At this inspection, we looked at three people’s care records and saw that some improvements had been made to the way people’s risks were assessed and managed.

The manager had made a start on simplifying people’s risk management information. Duplicated and contradictory information had been removed and we saw that where

## Is the service safe?

people's risks had been reviewed by the manager, simple risk management advice had been given to staff on how to manage these risks. We saw documented evidence that this advice was followed. For example, one person required help to reposition themselves during the night in order to prevent pressure sores. We saw evidence to indicate that regular checks and repositioning support was given to this person in accordance with their risk management plan. This demonstrated the person had received the support they required to keep them safe.

We found however that the manager had not yet reviewed everyone's risk management information. This meant there was still further work to be done to ensure that each person's information was up to date and accurate. We spoke to the manager about this to ensure this work was completed without further delay.

We looked at staff rotas. We saw that three care staff were on duty each day with two care staff on duty at night. The majority of people we spoke with said there were enough staff on duty to meet their needs. At our previous inspection however we found that the deployment of staff 'on the floor' required improvement. At this inspection we found that no significant improvements had been made.

During our visit we found there were long periods of time when people who lived at the home were sat in communal areas without any staff in the vicinity and no means of requesting support. The majority of these people were unable to mobilise without support so were unable to leave the communal area to go to their room or access the toilet without help. We saw from the staff message book that staff had noted their concerns about the lack of staff available in these areas and had left messages for all staff to be aware. The lack of available staff in communal areas was an issue identified at the previous inspection and we could not see that any action had been taken to resolve these concerns.

We also saw from the rota, that the manager was often included in the staffing numbers. This meant they were trying to carry out two roles at once, one as a manager and another as care worker. This impacted on their ability to carry out their managerial role as they were often 'on the rota' to assist the care staff team with care worker duties.

We asked the manager how they analysed the needs of people to work out safe and sufficient staffing levels. The manager was unable to answer this. They told us that the

provider had employed an external consultant to assist them with making improvements at the home following the last inspection. They told us that the consultant had put together a dependency tool to work out what safe staffing levels were but said that they did not understand how the tool worked. We looked at the dependency tool and also found it to be unclear.

At our last inspection we had concerns about the safety of the premises. At this inspection we found that improvements had been made. The heating system in the home had been replaced and had a current gas safety certificate in place to show it was safe. The electrical appliances in the home had been tested and the water systems at the home had been checked for the presence of Legionella bacteria and found to be free from infection. A fire risk assessment had been completed by an outside contractor and any actions identified had been completed.

We did a tour of the building and found that the standards of cleanliness in the home had improved. There were no malodorous smells and some carpets had been replaced. The specialised bathing equipment on the first floor of the home which had been out of use at our last visit, had now been made accessible to people who lived at the home. We saw from people's care records that people now received an opportunity to have a bath or shower on a regular basis.

Cleaning schedules were in place and infection control audits were now being undertaken. We saw that any issues identified in the infection control audits had been dealt with by the manager to prevent the spread of infection. Further improvements however we still required. For example, one toilet had a carpet in it that was very unhygienic and some of the other carpets were worn.

We looked at how medicines were managed in the home. The concerns we had identified at our previous inspection had been rectified as we did not find any prescribed creams in people's bedrooms. We saw that some people were given their medication covertly. The covert administration of medication means that the person's medication is likely to be crushed in the person's food or drink without their knowledge. We looked at how the decision to give people their medication covertly had been arranged. We saw that appropriate medical advice had been sought and the correct legal processes followed to ensure that covert administration was in the person's best interests.

## Is the service safe?

Staff training records showed that staff administering medication had now been trained to do so. This was an improvement from our last inspection. We observed a medication round. The staff member administering medications did so in a discreet and patient manner but we found that some staff members did not observe the

person taking the medication before they signed the person's medication administration record. This meant the person's medication record was not accurate. Accurate record keeping is essential to safe medication administration practices.

# Is the service effective?

## Our findings

All of the people we spoke with during our visit made positive comments about the staff that supported them. People felt that staff knew them well and knew how they liked to be cared for. Their comments included “The staff are lovely. I can’t complain about them” and “They bought me a budgie and a cage and I love it.” A relative we spoke with told us “My mum has a good relationship with the staff. She takes the mickey out of them.”

At our last inspection in August 2015, we found that staff had not received an appropriate induction or training to do their job role effectively and received inconsistent support and supervision in their job role. At this inspection, we looked at these arrangements again.

We looked at five staff files and found that the provider’s induction procedure was still very poor. In all of the files we looked at, only one staff member had completed a recorded induction. This meant there was no evidence that some staff had been appropriately introduced to the service and their job role. We found that some of the new staff working at the home were also doing so without any adequate training. This meant there was a risk that they did not have the skills and knowledge to provide safe and appropriate care. This placed people at risk of potential harm.

For example, we saw that one staff member had commenced work at the home in October 2015 and had not received any training. In addition, there was no evidence that this staff member had received any previous health and social care training prior to coming to work at the home in any of their previous job roles. This meant there was no evidence that this staff member had the skills and experience to care for people safely.

**This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that the staff were adequately trained and had the skills to carry out their job roles safely.**

The manager told us that existing staff had undertaken training since our last visit. We saw that a training schedule was now in place to record the training each staff member completed. This was an improvement since our last visit, when no adequate records relating to staff training had been maintained. We looked at the training schedule and

saw that it demonstrated that the majority of staff who had been employed at the home for some time had completed lots of training since our last inspection. The staff we spoke with confirmed this. They said access to training opportunities had improved.

We asked the manager about staff support and supervision. The manager was very honest and transparent. They explained that they had not individually supervised the day staff but had plans to do so. They told us that they had undertaken a group supervision with the night staff and we saw evidence to support this. Staff we spoke with during our visit said they felt supported in their job role by the manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

At our last inspection, the provider had no arrangements in place to ensure that people’s legal consent was obtained in accordance with the MCA and DoLS legislation. Applications had been submitted to the Local Authority to deprive people of their liberty without following the correct legal processes and information in people’s ability to consent was contradictory and confusing. This meant people’s human rights had not been appropriately respected.

At this inspection, we looked again at the information in people’s files about their mental health needs, their ability to make informed decisions and their involvement in any decision making. We found some improvements had been made.

For example, there was evidence that the manager had reviewed the care of some people and had actively encouraged the person’s involvement during this process. This was a significant improvement since our last inspection, wherein people’s care plans were limited and lacked any person centred information. We found that care plans and risk assessment information now contained people’s views and wishes and it was obvious that the process of reviewing the person’s care had been a two way discussion between the manager and the person

## Is the service effective?

concerned. This demonstrated that the person had had the opportunity to express their own values, beliefs and preferences with regards to their care. Further work was required however to ensure that each person at the home had their care reviewed in this way. We spoke to the manager about this.

Where people lived with dementia or had short term memory problems that may have impacted on their ability to make informed decisions, we saw the beginnings of good practice in relation to the mental capacity act. There was now a system in place for assessing people's capacity to make informed decisions in relation to their care and it was clear that people had been involved in the assessment process. We found however that the assessment of the person's capacity was a general assessment of the person's ability to make informed decisions as opposed to assessing the person's capacity to make a particular decision at any given time. We spoke to the manager about this, who acknowledged that further development work was required to ensure that the principles of the MCA and DoLs legislation were fully implemented at the home.

We looked at how the home catered for people with special dietary needs or people at risk of malnutrition. We saw that

care files contained an assessment of people's dietary needs and risk. Some of this information however was inaccurate. For example, one person's weight was incorrectly stated which meant that the level of risk had not been assessed properly. We saw that one person had a special dietary requirement due to a medical condition that required them to avoid certain foods. Information in relation to this had improved since our last inspection but still required further detail to ensure that care staff had clear information about the diet this person required and the signs and symptoms to spot in the event of ill-health.

We found that people's weight was monitored regularly and that they were given enough to eat and drink. People at risk of malnutrition were given fortified milkshakes to promote a healthy weight and people's dietary requirements for example, diabetic or soft diet needs were known to the chef and catered for.

People's daily notes showed that staff were observing people's health and wellbeing on a daily basis and that people had prompt access to medical and specialist support services as and when required.

# Is the service caring?

## Our findings

At our last inspection we found that although staff were observed to be kind and caring, they were not always mindful of people's right to dignity and respect. Our observations of care during this visit were similar. We found little evidence that sufficient improvements had been made.

We saw that staff supported people in a kind and unhurried way. They spoke to people pleasantly and supported them at their own pace. It was clear from what we saw that people who lived at the home were relaxed and comfortable in the company of staff. People we spoke with confirmed this. They told us that the staff were caring and treated them well. One person said "I'm very happy here. Another person said "they care for me well, like family".

We saw that people's ability to mobilise independently about the home had improved. At our last visit, the majority of people's mobility aids were stored in their bedrooms and people were transported around the home in a wheelchair. We saw in the dining room and lounge that people's mobility equipment was now in use. End of life care had been discussed with people and we saw that their wishes in relation to how and where they would like to be cared for in the event of ill health had been discussed and documented.

During our visit however, we had concerns over how the dignity, privacy and choices of the people who lived in the home were respected by the staff. We observed that people's dignity was sometimes compromised and that people's preferences in how they lived at the home were not always followed.

For example, we commenced this inspection at 6.30am. We saw four people were already up, washed, dressed and sitting in the dining room. Two of them were fast asleep. We asked one person why they had got up so early and they replied "I didn't want to get up. I was happy in bed".

We asked the two staff on duty why these people were up so early and we received conflicting answers. We checked the care records of these four people. Only one person's care record stated that they liked to get up early in the morning. The other three people's care record indicated that people liked to stay in bed until 8.30am or later. We asked the manager about why these people's preferences had not been adhered to. The manager could offer no suitable explanation and could offer no rationale as to why people were sat downstairs at 6.30am in the morning. At 8.20am we saw that the four people who had been up before 6.30am were all fast asleep in the lounge.

We observed two other people being brought into the dining room by 6.45am. One person was sitting in a chair facing a wall. They remained sitting in this chair all morning and was still there at 12pm. The only interaction this person had with other people or staff, was when a staff member gave this person a drink or something to eat. There was no meaningful communication for this person with anybody during the period we observed.

During the inspection we saw two staff members walk into a person's bedroom early in the morning, put the light on and loudly wake them up. They then proceeded to support this person with intimate personal care with their bedroom door open. This did not respect the person's dignity or privacy. They also accessed another person's continence products to support this person's personal care needs.

These observations demonstrated to us that people's choices were not respected and that there were staff practices at the home that were there for the convenience and benefit of the staff as opposed to the people who lived there.

**These examples demonstrate a continued breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.**

# Is the service responsive?

## Our findings

At our last inspection, people's care plans were poor. They contained little information about people's individual needs, risks and preferences and failed to ensure staff understood how to care for the people safely and in accordance with their wishes.

At this visit, we found improvements had been made with regards to some people's care plan information but not everyone's care file had been reviewed, updated and improved by the time of our visit. We spoke to the manager about this. We asked the manager to ensure that everyone's care information was reviewed without further delay. Inaccurate and poor care plan information places people at risk of receiving inappropriate and unsafe care.

We looked at six care files. We saw that the manager had implemented a new risk management and care plan format that was easier to read and understand. Care planning information was person centred and it was clear that the person had been consulted with and had input into the development of their new care plan.

The care plans we looked at contained information about people's needs and preferences. For example, people's moving and handling needs, skin integrity care, personal hygiene needs and mobility. We also saw that staff now had an 'at a glance' guide or summary of people's needs that enabled them to quickly check what people's care requirements were without having to read the person's whole care plan. Some improvements were still required in certain areas for example, dietary needs, mental health information but overall, the care plans we looked at were however satisfactory. The manager's new method of assessing and designing people's care however needed to be implemented and maintained for everyone who lived at the home.

Records showed that people were referred to other healthcare professionals in support of people's physical and emotional well-being. For example opticians, chiropody, falls prevention team and dietary services as and when required.

There were monthly activity reports in people's files to indicate that people had access to activities or one to one chats with the activities co-ordinator. But on the day of our visit, a number of people who lived at the home time sat in the communal lounge for significant periods with nothing to do and with minimal social interaction. Staff were not a visible presence in this area for long periods of time and people simply sat in silence. This was not conducive to their mental well-being. We saw that there was an activities timetable displayed in the entrance area of the home but on the day of our inspection the planned activities did not take place.

We saw that the provider's complaints procedure was displayed in the entrance area of the home. The complaints procedure was easily accessible and contained the relevant information about how to make a complaint and who to address any complaints to. People we spoke with during our visit told us that they knew how to complain but had no complaints or concerns about the service they received. One person told us "If I have a problem then the manager sorts it out." We looked at the complaints procedure and saw that it was displayed in the hall areas of the home.

We looked at the provider's complaints log. We saw that appropriate complaint records were maintained when a complaint was received. We looked at a sample of the complaints received. We saw that the manager and the provider were doing all that was reasonably practical to resolve people's complaints to their satisfaction. We did note that the manager was referring complaints as safeguarding concerns to the Local Authority and Care Quality Commission which was not always the required course of action. We spoke to the manager about this.

# Is the service well-led?

## Our findings

At our last inspection, the management of the service was inadequate. The provider was the manager of the home at the time of this inspection and had failed to ensure the home was well led. This placed people who lived at the home and staff at potential risk of harm. The provider had also failed to apply to become the registered manager despite a number of reminders, which meant they had breached their conditions of registration.

Since our last inspection, the deputy manager had taken over the role of manager at the home. We checked that an application to become the registered manager had been submitted to The Commission in accordance with the provider's conditions of registration. They told us an application it had and we saw evidence to demonstrate this. The application was still in progress at the time of our visit.

Since the new manager had come into post, a number of improvements to the way the service was run had been made. For example, we saw that improvements to the way in which people were consulted about their care had been made, people's care plan information was now satisfactory and the manager had made some progress in supporting people's mental health needs and legal right to consent to the care they received.

A number of premises improvements had been completed and the home was now satisfactorily clean with on-going infection control checks taking place. We also saw that the manager had worked hard since our last inspection to ensure staff training opportunities for existing staff were made accessible.

The manager had sent out a satisfaction survey to people who lived at the home and their relatives, the results of which were openly displayed in the entrance area of the home. This indicated that there were systems in place to seek people's views on the quality of the service provided so that improvements could be made.

During this visit, however we found that significant improvements were still required in a number of fundamental areas before the service could be considered well led.

The way in which new staff members were recruited required significant improvement to ensure persons employed were safe and suitable to work with vulnerable people. New staff members had not always appropriately inducted or trained to do their job roles which placed people at risk of receiving safe and appropriate care and support arrangements for both new and existing staff was still not consistently provided.

No significant improvements had been made to the way staff were managed and supervised at the home in order to ensure accessible and appropriate support for people at all times. For example, we saw that some staff practices operated for the benefit of staff and not the people who lived there. This meant people's right to choose how they wished to live their life at the home were sometimes disregarded. We also saw that the way in which care was provided sometimes did not respect the choices, dignity and privacy of people who lived the home. These were ongoing concerns from our last inspection and little managerial action had been done to address them.

At this inspection, breaches of the regulations were still identified demonstrating that insufficient progress in reaching legal requirements had been made. This meant the service failed to always be safe, effective, caring, responsive and well led.

**These examples demonstrated that the home still required further improvement to be considered well led and were a continued breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**