P S P Healthcare ltd

Frome care Village

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

Frome Care Village is a nursing home registered to provide nursing care for up to 60 people. There are two separate units: Parsonage provides support and nursing care for people living with dementia and the Woodlands for people who need nursing care because of physical health needs. At the time of our inspection the Parsonage which is over two floors cared for 13 on the ground floor and 11 on the first the Woodlands cared for 21 people over two floors.

There is a registered manager for the service. 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.

At our inspection of 21 & 22 January 2014 we had found failures in relation to the environment and as a result we made a requirement for the provider to take action. At our last inspection in June 2014 we continued to have concerns about the suitability and safety of the premises in relation to the Parsonage. We required the provider to take action by 1 November 2014. We also found there was a failure to have an effective quality assurance system.

This unannounced inspection took place on the 17 and 29 December 2014 when we found some improvements

Summary of findings

had been made to the suitability and safety of the Parsonage. However there remained significant improvements to be made regarding the environment at the Parsonage and some improvements to make sure there was an effective system for the monitoring of the quality of the service. Changes had been made at the Parsonage so it was more suited for people living with dementia. The decorative state of the communal areas on the ground floor had improved as well as corridors and toilets. However there had been limited improvements on the first floor with regards to making it more suited for people living with dementia such as signage and re-decoration which had taken place on the ground floor. There remained substantial areas of the service as well as personal rooms which required decoration and improvement.

The registered manager did not respond to investigating safeguarding concerns in a timely way. There was a failure to review incidents so any learning and need for improvements could be identified.

Staff did not have adequate individual supervision so their performance could be formally reviewed, to give their views about the service and discuss any concerns about their role in ensuring an effective and caring service.

People told us they felt safe however some people said there were not sufficient staff so they did not always get the care at the time it was needed. People were treated with respect and their privacy was respected however there was not always consistent good practice from staff in making sure people's dignity and confidentiality was upheld.

There were no arrangements for staff to respond in a timely manner, monitor and support people if they were unable to use call bell equipment. There was not the necessary equipment i.e. sufficient call bell units available to ensure people could call for assistance when it was required.

Staff had a good understanding of their responsibilities in identifying possible abuse and reporting any concerns. However, there was a failure to take the necessary action to ensure people were protected following incidents of challenging behaviour from other people in the service.

People did not always feel able to voice their view or make a complaint and feel they would be listened to. However the service had responded in a positive way to concerns from a relative about the quality of care. People told us they found staff caring and kind and visitors were made to feel welcome however we found some aspects of how people were supported or assisted with their care was not always caring or have respect for confidentiality.

There were arrangements for the administering of medicines however some improvements were needed in monitoring the storage arrangements and ensuring the temperature of storage areas was at the required level.

People were confident about the skills of staff. Staff had the opportunity to undertake a range of training to provide them with the skills they needed to meet people's care needs effectively. However they did not have the training, knowledge and skills about the Mental Capacity Act 2005 (MCA) so they could make informed decisions about protecting the care and welfare of people using the service. The records relating to decisions made on behalf of people about their health and welfare did not always ensure people's rights were protected and best practice was upheld.

People had access to community health services and specialists in order to meet their health needs effectively. There were good arrangements to make sure people's nutritional needs were met and any concerns were referred to other professionals for support and guidance. However the service needs to ensure people on the Parsonage are enabled to make an informed choice, as far as they are able to, about their meals.

There was information about how staff could support people in a person centred way and have an understanding of people's lifestyle, routines and preferences. Staff showed a good understanding of how to respond professionally. Respecting the person where their behaviour was repetitive or challenging to staff and the individual did not always understand or appreciate how they behaved because of the impact of their dementia.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Inadequate

The service was not always safe.

People were not fully protected from potential abuse because there was failure to take the necessary action in response to abuse.

Staffing arrangements and equipment did not always ensure people received care and support at the appropriate time.

There was good practice in the administering of covert medicines protecting people's best interests and welfare. However some of the medicine arrangements were not always effective and safe.

Staff had an understanding of abuse and their responsibility to report any concerns about possible abuse.

Is the service effective?

Inadequate

The service was not always effective.

Areas of the Parsonage failed to offer an environment which was suited for people living with dementia.

There was inconsistent knowledge and understanding of the Mental Capacity Act 2005 (MCA) and how this impacted on the rights of people in the service and there was a failure to ensure staff had training in this area.

Staff did not always receive adequate individual supervision so their performance and training needs could be reviewed.

Records relating to decisions taken in people's best interest were not following best practice to protect people's rights and welfare.

Staff had access to training; however staff did not always know how to access training and what was available to them.

Is the service caring?

Requires Improvement

The service is not always caring.

Improvements were needed in how some staff interacted and supported people to make sure people were always treated with respect and had their dignity upheld.

People had their privacy respected and staff made sure people were able to talk about the care they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive and improvement was needed in making sure there was an environment where people felt able, and were informed, about how they could make a complaint.

Summary of findings

Information was available to staff so they could provide care in a person centred way.

Is the service well-led?

Inadequate

The service was not always well led.

Systems for the monitoring and reviewing of the quality of the service to identify where improvements were needed were not always effective.

There had been a failure to take the necessary action following a safeguarding incident and identify potential areas for improvement.

There were inconsistencies in how the registered manager made sure staff were involved in the running of the service and able to voice their views.

Frome care Village

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 17 and 29 December 2014 and was unannounced. The inspection team was made up of three inspectors one of whom had experience of working with people who had mental health difficulties. Before the inspection we asked the provider to complete a Provider Information Return (PIR). 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. The registered manager had not completed the PIR. We also reviewed the information we held about the service.

During the inspection we spoke with 12 people who used the service three relatives and seven staff. We spent time with the registered manager discussing their views about how they managed the service and the quality of the care provided. We looked at a number of records relating to individual care and the running of the home. These included 11 care plans, medication records, records of incidents and accidents and some policies and procedures. We also observed staff interacting and supporting people and how people were supported to have their meals.

We contacted seven social care and health care professionals asking them about their experience of the service and their views on the quality of the care provided by the home. Comments we received from two healthcare professionals have been included in this report.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe living in the home we found the staffing arrangements were not adequate to meet the needs of people and ensure their safety. On the first day of our inspection on the Parsonage there were 14 people on the ground floor with three care staff and on the first floor 10 people with two care staff. On the ground floor a member of care staff always sat in the lounge area so they could support people and respond promptly to any needs for assistance. They were available in case people became distressed or agitated. However this arrangement was not in place on the first floor of the Parsonage. On a number of occasions we were in the lounge area of the first floor and there were no care staff available. We observed people were calling out for help and asking for drinks. We saw a person walking around in a state of undress agitated asking "where do I go" and "I want the toilet". On one occasion the two staff on duty had gone to support a person who needed assistance this resulted in no care staff being available in the lounge or available to respond to other people if needed. Over a period of five minutes we observed people asking for assistance and agitated because there were no staff to respond to them. On a further occasion there was one care staff on the floor because the other staff member was on their lunch break.

The arrangements to make sure people could call for assistance when needed were not satisfactory. On the Woodlands where there were two floors there was a registered nurse, two care staff on each floor, with a senior carer covering both floors. All of the ten people we spoke with told us they "waited a long time" for staff to respond to call bells. They said this was because staff were busy. We stayed with one person who had rang the call bell for 15 minutes before care staff came to assist them. Staff told us they were both in another room and could not hear the bell ringing. They told us there was only one point on each floor of the Woodlands where they could establish which room was summoning assistance. A visitor told us they had concerns about their relative not being able to go to the toilet when they wanted to because staff were not available.

The lack of staff availability to meet people's needs is a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On one occasion a person was shouting and sounded very distressed and we waited for care staff to respond. The person had no hand call bell unit to summon assistance. They were very uncomfortable and distressed. When care staff arrived they told us there were no call bells units available and this person would have been able to use one if one had been available. A visitor told us their relatives call bell unit had been removed. They said their relative would have been able to use a call bell unit if one had been given to them. The manager of the Woodlands said this person could not use a call bell unit however the visitor said if it was placed in the correct position their relative could have used it.

The Woodlands manager confirmed there were not enough call bells units for everybody and there were no arrangements for regular checks for people who did not have the unit. We were also told by the manager the provider was looking at replacing the call bell system but they were not aware of any plans to replace the call bells not working. People were therefore at risk of not receiving the care they needed in a timely manner.

The lack of an appropriate and adequate call bell system is a breach of Regulations 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection the call bell system on the Parsonage was inadequate to support people who needed to call for assistance when needed. During this inspection we found a new call bell system had been installed. There were monitors and pager system in place.

There were records of three incidents which had taken place on the Parsonage. These were incidents which would be viewed as potential abuse. One where a person had behaved in a challenging manner to another person and this had resulted in minor injuries to one person. A second where a person had behaved in a sexual manner towards another person. The third incident, recorded in the daily notes, was where a person had been "physically abused by another resident" and sustained bruising. The person had been seen by their GP. The provider's Protection Of Vulnerable Adults (Safeguarding) policy states the "home manager must inform Somerset Care Direct" of any "abusive act". The policy also state how "Any actions taken will follow local multi-agency guidelines regarding investigation of abuse." We discussed these incidents with the registered manager and he was aware they had taken place. Whilst action had been taken regarding these

incidents by contacting the GP and the review of their medicines, the local safeguarding team had not been advised of any of these incidents. It is the manager's responsibility to ensure such incidents are notified to the local authority safeguarding team under the Safeguarding Adults at Risk multi-agency policy and procedure. These incidents had not been reported to the local authority safeguarding team.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff demonstrated an understanding of what is considered abuse and their responsibility to report any concerns about possible abuse. Staff were very clear about reporting any concerns to "the nurse or manager". Staff told us they had completed safeguarding vulnerable adults training and this was confirmed by records.

People's health needs were identified and assessment of associated risks had been completed. For example, Skin integrity and nutritional needs. The information from these provided staff with guidance on how to reduce the risks. For example, regular repositioning, promoting and monitoring fluids. There were also procedures in place to ensure people's health and welfare was protected in the event of an emergency such as flood or fire.

On the Parsonage we looked at the arrangements for the administering of medicine which required extra security and management. We observed a senior care worker sign a record that such medicines had been given to a person at a point when the medicines were removed from the package but not actually being given to the person. The unit manager told us it was normal practice for the senior staff member to witness the medicines being given. However a senior care worker said they did not witness medicines being given to people and they signed the record "always before being given". This meant the registered manager could not be assured people were receiving their as prescribed medicines.

The temperature of the fridge used for storage of medicines had not been recorded for a period of five days and medicine storage room temperature had been recorded regularly however the first floor room was above recommended temperature. This could reduce the efficiency and life of medicines stored in the storage room.

The stock controls of "as required" (PRN) medicines were not well managed. There were no brought forward stocks recorded for PRN medicines therefore no accurate record of stock used and held. This meant the arrangements the administering and control of PRN medicines were not robust. Administering records of non PRN and prescribed medicines had been completed as required on both units and accurately reflected stock.

Some people had their medicines given covertly. This is where the person is not aware they are being given medicines and lacks mental capacity about making decisions around the need for medicines. At a previous inspection we had identified concerns about the practice of giving medicines covertly. At this inspection there were improvements to this practice with covert medicines plans in place and the appropriate procedures being followed. This meant people's best interests and welfare were being protected when being administered medicines covertly.

Inadequate

Is the service effective?

Our findings

We had told the provider they needed to improve the environment of the Parsonage at our inspection of January 2014. Following our last inspection in June 2014 we again told the provider they needed to improve the Parsonage so that it was more suited for people living with dementia. The provider had commissioned a report from a dementia specialist about how these improvements could be made and they had made a number of recommendations. There had been some improvement on the ground floor with the lounge, dining and corridors being redecorated. This redecoration reflected the needs of people living with dementia through the use of contrasting colours, blending of doors into the same colour as walls and removal of handles so people would not try to enter areas which were not appropriate or safe. Other improvements had been made, again on the ground floor, with signage, lighting and making facilities such as toilets more suited for people living with dementia. There had been some improvements made on the first floor including corridor lighting. However there remained significant improvements to be made to ensure the premises are suitable and dementia friendly.

We had identified at our last inspection how many of the rooms on the Parsonage required decoration and improved maintenance. There had been outstanding repairs to areas such as tiling, holes in walls and general poor decorative state. We found on this inspection some rooms had been redecorated however there remained a majority of rooms which had not been redecorated or had repairs undertaken.

The lack of dementia friendly premises is a breach of Regulations 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were confident about the skills of care staff. One told us “They are very good they seem to know what they are doing”. Another told us “I trust the staff they are good with me”.

Staff told us they had undertaken a range of training including dementia care and training related to caring for people who had health needs such as diabetes. A diabetic nurse had given training to some staff. The registered manager told us a training session had been organised by a nurse about meeting nutritional needs and pressure area care. Records confirmed staff had undertaken core skills training: moving and handling, infection control, first aid awareness, fire safety and food hygiene awareness. Some had completed person centred care training and were in the process of undertaking a professional qualification.

The registered manager showed us a care practice manual. This provided a system for undertaking, reviewing and monitoring of staff training. The manual covered training such as care planning and documentation, “see me not just dementia”, privacy and dignity and complaints. However the manager was not able to show us any completed manuals. Some staff were unclear about where and how to access relevant training they needed to complete. Others did not know what training was available and what process was in place i.e. individual supervision to review additional training they needed to undertake.

Some staff told us they had regular individual supervision session however others could not recall their last session. One staff member told us they had had one session in three months. Records showed some staff had not received individual supervision for a period of up to four months. The staff handbook said staff will have supervisions two monthly.

Some staff raised concerns with us about their induction saying it was not long enough. They had one day of training that covered areas such as moving and handling, use of equipment and then shadowed experienced staff for two or three days. One staff member told us they would have liked more time shadowing experienced staff and longer to complete the basic training. They told us they had not had the opportunity to read care plans before starting to care for people. Another said it was “very intense” and a third said “just too much to take in in one day”. They told us there was no induction pack or plan. We were given records which showed staff had completed induction amounting to three days. The registered manager told us there was no induction policy and they were reviewing the induction arrangements.

On Woodlands and Parsonage there were inconsistencies about staff awareness and knowledge of the Mental Capacity Act 2005 (MCA). Staff also confirmed they had not received training in MCA. The MCA provides the legal framework to assess people’s capacity to make certain decisions, at a certain time. It also sets out how where individuals lack capacity to make specific decision “best interest” decisions can be made. One staff member told us “We never use the MCA and do not complete capacity

assessments." Some staff were aware the act related to "protecting people's liberty" and "informing people about choices". One told us they tried to give people choice everyday "even if it is about what clothes to wear and whether they want to get up

Staff were not aware of the arrangements which were required to deprive people of their liberty under Deprivation of Liberty Safeguards (DoLS). Staff told us they had not completed training in DoLS. This lack of knowledge meant people's rights may not be protected and there was a potential risk of people not receiving appropriate care to protect their health and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospital. DoLS provides a process (authorisation) by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was aware of the impact of changes about deprivation of liberty safeguards. The registered manager told us one individual had had a DoLS authorisation approved. We looked at the records regarding this authorisation and there were no conditions attached to the authorisation. The registered manager told us applications for other people were in the process of being applied for.

On the Parsonage there were two individuals where best interest decisions had been made in relation to personal care and the use of bed rails. The best interest documentation stated "anyone with an interest in their welfare including close relatives" should be consulted. The documentation asked for confirmation about who had been consulted and the date and time. This had not been completed. There was no evidence in the records the decision had been made with the involvement of relevant others.

The lack of appropriate information in people's records is a breach of Regulations 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had access to community health services and specialists. People told us if they needed to see a doctor then staff arranged this quickly. Records showed some people had been referred to a dietician because of concerns about weight loss and nutrition. People received support from the community mental health team where this was needed.

We looked at the arrangements for meeting people's nutritional needs in both areas of the home. Care plans included information about people's dietary needs and identified any concerns about people's health related to nutrition. Nutritional assessments identified any concerns and specialist advice had been sought from professionals such as speech and language therapists. Some people received supplements or a fortified diet where there was concern about people's weight or having a balanced diet.

We observed people on the Parsonage having lunch. There was a choice of one meat or vegetarian meal. Staff told us they knew what people liked and who was vegetarian. People were not offered a choice either verbally or shown the meals available. Some people were told what they were being given whilst others were only asked for their choice of desert. People were not given a choice of drinks. One person sat for ten minutes with their meal and had not started to eat their meal. After this time a member of staff prompted the person to eat their meal. Another person needed assistance to have their meal. A staff member sat with them and provided assistance in a sensitive and appropriate way talking with the person and telling them what they were eating.

On the Woodlands most people ate their meals in their rooms and needed support from staff. Staff were patient with people and did not hurry them to eat their meal taking the time people needed. People on the Woodlands told us staff were caring and tried to help when they could but were very busy.

People on the Woodlands told us they did not get any choice about the meals they had and had not been asked their views about the meals provided. Menus were written in advance by the group chef manager to ensure people were offered a nutritionally balanced diet. Food was ordered directly by the chef of the service with fresh meat, fruit and vegetables coming from local suppliers. Staff and people confirmed there were alternatives like omelette or sandwiches if they did not like the choices of the day. One person was heard asking for porridge, this was mid-morning. This was given to them however they told us they had not had any at breakfast time and sometimes did

Inadequate

Is the service effective?

not get porridge. Another person told us they get "their drinks and meals missed and they had to go and get them on occasion". Some people did tell us the food was good and they usually liked the choices available.

Requires Improvement

Is the service caring?

Our findings

Whilst people told us they found staff caring, kind and respectful. We found on the Parsonage one person in a state of undress and agitated with no staff available to respond to their distress. We saw another person being assisted by a member of staff and the person's trousers were falling down whilst they were walking with the care worker however they had made no effort to make sure their clothing was on properly. This meant the dignity of these individuals had not been upheld.

People's right to have recorded information kept confidentially was not respected. For example, personal information in the form of daily care records was accessible to anyone in the dining room of the Woodlands. Staff told us the room was used by visitors and professionals. The unit manager told us this information was put there so staff could read it.

However we did observe staff speaking in a respectful and caring manner with people. On the Parsonage we observed staff responding sensitively and with understanding towards people's, at times, repetitive behaviour. On a number of occasions an individual was calling out for help. A staff member responded to this person and each time they checked with the person if they were alright even though the person denied they had called for help. The staff member did not make any negative judgement or statements about this repetitive behaviour and told us they knew it was because the person had dementia.

People on the Woodlands told us they could spend time in their rooms when they wished. One person told us they were always "in my room, staff know it is my decision". Another person told us they were able to get up when they wished and could tell staff if they wanted to stay in bed longer and "they respect my decision, my choice, I like that". A third person said "I think staff are very caring here even though they are so busy."

People told us they could make choices about their daily routines. Staff said how they tried to ensure, particularly for people on the Parsonage who were not always able to verbally express a choice, were given choice. One staff member said they knew it was important for people they always looked nice and they were always shown a choice of clothing to wear so if able they could make their own choice. We observed staff checking with people and involving people where they wanted to sit in the lounge.

A relative told us they were always made to feel welcome and how "staff are so friendly". Another relative told us how they frequently came to the home and always felt comfortable visiting. A staff member told us when asked what they believed was caring and good care "I think this could be my mum and hope I look after people like I'd look after my mum."

Requires Improvement

Is the service responsive?

Our findings

We found an inconsistent approach and understanding of how people could voice concerns or make a complaint. The unit manager on the Woodlands was not able to describe the complaints process. They said they thought there was a complaints policy but they did not know what it said. They also told us there was no "specific feedback forms" for people to use to make a complaint or raise a concern. They said the process was for people to speak with staff and they would write up a complaint. However we found feedback forms in the office of The Woodlands to be used by people who wanted to raise a concern to make a complaint.

Some people told us they were happy to make a complaint and "something would be done". However some told us they had told staff they were unhappy about something and nothing had been done. They did not want us to speak with the unit manager on their behalf as they thought it "would be a waste of time". A relative told us they had not been happy with a specific aspect of the care being given. They had a meeting with the registered manager and as a result changes had been made and their relative was "a lot happier and it suits them much better." The relative said "The manager has done everything we asked and we feel they are now being looked after." However another relative told us they did not know how to make a complaint. There was a complaints procedure on display in the reception areas along with suggestions boxes and the manager "has an open door policy". We were told all people have a copy of the home's brochure, which has the complaints procedure in the back, given to them when they arrive at the home.

There was information about people's history, lifestyle, occupations and interests. People told us they had been asked about their preferences about getting up and going to bed. One person said "They really try and work around me." Staff were able to tell us how one person's previous occupation affected their daily routine. One member of staff was able to tell us how they supported a person in particular way "because then they will accept the care and that is really how they like it".

On the Parsonage care plans had been completed with specific information about how staff should respond to people when it was challenging to staff or others. For one person this set out how to ask, using simple phrases and sentences, if they wanted a drink, were in pain and other choices which they were able to respond to. Staff confirmed to us they had used this approach with the person and it "helped".

On the Woodlands there were "personal care plans" kept in people's rooms. These set out the specific needs of people such as food and fluids being monitored or encouraged. Care provided was recorded showing how specific needs for the individual had been met. This helped staff provide personalised care to people.

People told us there were activities they enjoyed. One person told us "We have quizzes and things I enjoy". Another person said "I enjoy the art". The service had a full time activities organiser working on the Parsonage. They told us they spent a lot of their time doing one to one activities with people: "sometimes just sitting and having a chat is what people enjoy". Currently there is a vacancy for this position on the Woodlands.

Inadequate

Is the service well-led?

Our findings

Following our inspection in January 2014 and our last inspection in June 2014, we required the provider to take action to improve areas in the home, particularly around the environment. We had taken enforcement action in January 2014 regarding the issues around the environment. In June 2014 we found some improvements had been made but not all. We took further enforcement action setting a time scale for improvements to be made in the Parsonage by November 2014.

The provider had an action plan in response to our enforcement action. This had identified the areas for improvement on the Parsonage. We were given, at the time of this inspection, an updated copy of this action plan which set out the actions to be taken and the progress. Whilst some actions had been "completed" it identified areas were "on-going" for example "redecoration of Parsonage based on report" and "toilet doors to all be same colour". There were no specific dates set for completion of the actions whereas we had said the improvements were required to be completed by 01 November 2014. Whilst we found at this inspection, significant work had been completed, our expected deadline for improvement had not been achieved. The provider had not contacted us to inform us they had not met the time scale deadline. They have told us they have plans in place for further improvements.

Following an incident which had resulted in a safeguarding concern the registered manager had failed to provide to the local authority safeguarding team, a report of the provider's investigation into the incident in the time requested. This led to a further request for this report; following this second request the registered manager provided the report. A healthcare professional told us in relation to this safeguarding incident: "Because of the delay in responding appropriately to this (request) in terms of an investigation, my view would be that I would have concerns around the competency of senior staff in following up and implementing learning and change, acting in a timely way when things go wrong."

We discussed with the registered manager and unit managers if there had been any changes or learning from this incident in ensuring practice was appropriate and fully protected people from potential harm. A report had been requested by the local authority safeguarding team identifying any learning from the incident. The registered manager told us they had not completed the requested report. The registered manager and unit managers told us they were confident of their practice in the area of concern as it related to basic nursing care but they had not identified any learning from this. There had also been no formal meeting or discussion about the event to identify any need for changes in policy, procedures and practices. This meant we had not been able to establish how the service had learnt from the incident and if they needed to make any improvements to ensure people's health and welfare was protected.

The registered manager had failed to notify the Care Quality Commission of incidents which the service is required to do by law so we could take any necessary action to protect the health and welfare of people using the service.

This is a breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before this inspection we asked the provider to complete a PIR this request was made under our powers which required the provider to provide such a report. We did not receive the report and the registered manager acknowledged he had failed to complete this report. We subsequently received this report.

There was no system to review accidents and incidents so the service could make any necessary improvements. There were no arrangements to look at staff practice particularly on the Parsonage. There were a number of audits completed on a monthly basis including care plans, pressure skin care and medicines. However the last medicine audit had been completed in August 2014. This meant the quality assurance system was not effective in identifying failures and the breaches of regulation we have highlighted in this report.

This is a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were differing views about the management of the service. Some staff described the registered manager as "very approachable" and "they are getting things done". However some said communication with management was a problem saying "communication is a major issue". One

Inadequate

Is the service well-led?

member of staff said they did not feel comfortable speaking with the registered manager. Others said they felt supported by the registered manager who was "approachable and listened" to what they had to say.

The registered manager told us they wanted to see a service which was safe for people and where staff treated people with respect and upheld their dignity. We have commented on shortfalls we found in these areas during our inspection. Staff told us how they wanted to see a "home from home". One told us when asked what they wanted to provide in terms of a good service was "Caring for people which is more about living than just existing". Some staff told us the registered manager and unit managers had spoken in staff meetings about the service they wanted.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person failed to take proper steps to ensure people are protected against the risks of receiving care or treatment that is inappropriate by the planning and delivery of care to meet people's needs and ensure the welfare and safety of people. Regulation 9 (1) (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person failed to protect people against the risks of inappropriate or unsafe care by having an effective system to regularly assess and monitor the quality of the service and identify, assess and manage potential risks to the health, safety and welfare of people using the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person failed to ensure people are safeguarded against the risk of abuse by responding appropriately to any allegation of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Enforcement actions

The registered person failed to ensure people who have access to the premises are protected against the risks associated with unsafe or unsuitable premises by having suitable design and layout and adequate maintenance. Regulation 15 (1) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered person failed to make suitable arrangements to ensure equipment is available in sufficient quantities in order to ensure the safety of people and meet their assessed needs. Regulation 16 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person failed to ensure that people are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information through an accurate record in respect of each person which shall include appropriate information in relation to the care and treatment provided to the person. Regulation 20 (10 (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person must notify the Commission without delay incidents of any abuse or allegation of abuse in relation to a person using the service. Regulation 18 (1) (2) (e)