Sahara Parkside Limited

Sahara Parkside

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Sahara Parkside on 6 and 7 November 2017. Sahara Parkside is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sahara Parkside is a care home for up to 30 adults with learning disabilities and autistic spectrum conditions. It is arranged as ten three-bedroom flats. At the time of our inspection, 14 people were living there.

The home was last inspected on 12 and 13 April 2017 when it was found to be in breach of three regulations relating to training, need for consent and good governance. An action plan was submitted by the provider after the inspection that included how the breaches would be addressed. During this inspection we found the home continued to be in breach of these three regulations. In addition to the aforementioned breaches, the home was in breach of two more regulations. These breaches related to risk assessments, medicines, staffing, access to healthcare and record keeping.

We carried out this inspection due to the high number of safeguarding concerns we had received about the home.

The home did not have a registered manager. The previous registered manager had left the home in August 2017 and a new manager had been appointed and intended to apply to become registered with us. We were informed that the change of managers had an impact on the running of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Risk assessments for most people who lived in the home included information on how to mitigate identified risks. However, risks were not always robustly managed for one person to ensure they were safe at all times.

Medicines were not being managed safely. We found that people's Medicine Administration Records (MAR) were not always completed in full or accurately. Medicines were not being administered as instructed on people's MAR, or in accordance with the provider's policy.

Staff we spoke to were aware of how to identify abuse and knew who to report abuse to, both within the organisation and externally. However, we were informed that some staff had not received refresher safeguarding training therefore may not be up to date with safeguarding procedures. We also found incidents with medicines that had not been recorded as an incident and relevant authorities had not been notified of this.

Incident records were reviewed and these showed the provider took appropriate action following incidents that had been recorded. However, systems were not in place to analyse incidents for patterns and trends to

ensure lessons were learnt and incidents were minimised.

At our last inspection, we made a recommendation that the home seek and follow best practice guidance from a reputable source about staff deployment. During this inspection, people, relatives and staff continued to raise concerns with staffing levels. Records showed there were enough staff on duty to meet people's needs. However, the way staff were deployed across the building meant there were sometimes delays for people who required support.

Not all staff had received core and specialist training they needed to do their jobs effectively. Supervisions had not been carried out regularly and there were no records of appraisals that had been carried out since 2016. Staff told us that they were supported by the manager.

People did not have access to all the healthcare services. Systems were not in place to ensure people received annual health checks.

People and staff told us that people had choices during meal times. We found the kitchen in two apartments did not contain sufficient amounts of food on both days of the inspection.

Some people who lived at the home were deprived of their liberty under the Mental Capacity Act 2005. Records showed the home continued to not always comply with the conditions imposed on deprivation of liberty safeguard (DoLS) authorisations for one person. Although the majority of recommendations of DoLS were complied with for the person, we found one condition had not been complied with.

Care plans were inconsistent. We found a care plan did not include information about the support people would require in relation to their current circumstances. Pre-assessment forms had been completed in full to assess people's needs and their background. Reviews with key workers were held monthly.

People's needs and choices were not being assessed effectively to achieve robust outcomes. Records showed that a person's goals were not being monitored and reviewed and one person's concerns had not always been followed up.

At our last inspection, we made a recommendation about supporting people with relationships. We found care plans still did not contain information about friendships or other relationships or if people wished to be supported to form new relationships.

Quality assurance systems were in place but were not always effective. The audits, which the service carried out, had not identified the widespread shortfalls we found during the inspection to ensure people were safe at all times. Accurate and complete records had not been kept to ensure people received high quality care and support.

At our last inspection, we recommended the home seeks and follows best practice guidance from a reputable source about recruitment practice. Improvements had been made in this area and pre-employment checks had been carried out for new staff to ensure they were suitable to provide care and support to people safely.

People's privacy and dignity were respected by staff. People told us that staff were caring and they had positive relationships with staff.

At our last inspection, we recommended the home seeks and follows best practice guidance from a

reputable source about resolving complaints. We found complaints were being investigated and staff were aware of how to manage complaints.

Staff told us the culture within the home had improved since the new manager had come in post. People, relatives and staff were positive about the manager.

We identified five breaches of Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this home is 'Inadequate' and the home is therefore in 'Special Measures'. The home will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the home, the home will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not safe.

Risk assessments for most people staying in the home were in place. However, they were not robust enough to ensure they were safe at all times.

Staff were not deployed effectively to ensure people received safe care and support when required.

Incidents had not been analysed to ensure lessons were learnt and to minimise incidents that may impact on people's safety and well-being.

Medicines were not being managed safely.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Pre-employment checks had been carried out to ensure staff were suitable to care for people safely.

Appropriate infection control arrangements were in place and checks had been carried out to ensure the premises was safe.

Is the service effective?

Inadequate

The home was not effective.

People's needs and choices were not being assessed effectively to achieve effective outcomes.

Staff had not received essential training needed to care for people effectively.

Staff had not received regular supervision. Staff told us they were supported to carry out their roles.

People were deprived of their liberty under the Mental Capacity Act 2005 but the home did not always follow the conditions of people's Deprivation of Liberty Safeguards authorisations.

People told us they were given choices during meal times. There was insufficient amount of food in the home for some people.

The home worked in co-operation with other organisations to deliver care and support. However, we found people did not have access to the full range of healthcare services available to them such as annual health checks.

Is the service caring?

Requires Improvement

The home was not always caring.

Care plans did not include people's sexual preference and if they can be supported with this.

Care plans contained information on how to communicate with people.

Staff had a good relationship with people and people told us that staff were caring.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The home not always responsive.

Some care plans were inconsistent.

People participated in regular activities and most people had a weekly activities plan. However, this was not the case for everybody.

Complaints were being investigated. Staff knew how to manage complaints.

Is the service well-led?

Inadequate

The home was not well-led.

The systems in place to monitor and improve the quality of care provided were not robust. Shortfalls in the home were not always identified. Therefore necessary action was not always taken to rectify them to ensure people were safe at all times.

Accurate, complete and contemporaneous records had not been kept in regards to people's care and support.

Staff, people and relatives were positive about the manager.

Regular staff meetings were being held.	

Sahara Parkside

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.

The inspection was carried out on 6 and 7 November 2017 and was unannounced. The inspection was undertaken by one inspector, a specialist advisor in learning disabilities, a specialist advisor in medicines and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from the local authority safeguarding team and local Healthwatch. In addition, we received concerns from other external stakeholders about the home. We used this information to decide which areas to focus on during our inspection.

During the inspection, we spoke with ten members of staff, which included the manager, two deputy managers, maintenance staff member and six care staff. We also spoke with four people and two social care professionals. We also carried out observations of people's interactions with staff and how they were supported.

We reviewed documents and records that related to people's care and the management of the home. We reviewed seven people's care plans, which included risk assessments and five staff files which included pre-employment checks. We looked at other documents held at the home such as medicine, training, supervision and quality assurance records.

After the inspection, we spoke with two relatives on the phone, to seek their views of the home.

Inadequate

Is the service safe?

Our findings

During our last inspection in April 2017, we found that medicines records for one person who had recently moved to the home were not clear. Staff were unable to identify the medicine that were held, so were not able to administer medicines according to the prescribing instruction. We also received concerns from external professionals that medicines were not being managed safely. During this inspection, we found that medicines had not been managed safely.

Medicines were stored in people's flats. The manager explained that monthly medicines were received on a Friday and were stored in a pharmacy box in a general room, which was locked. Medicines that were received were checked in this area before being taken to people's rooms for the start of the medicine cycle. The provider's medicines management policy section stated, 'The sealed boxes/bags must be stored in a locked room at less than 25 degrees centigrade until they are booked in.' The storage room had no temperature monitoring in place and there was no refrigerator for medicines which required cold storage. There was a risk that if the medicines were not checked in immediately, the medicines that required to be refrigerated, would then have to wait to be taken to people's refrigerators. Therefore, the cold storage chain process would be broken. This meant that there was a risk that the efficacy of medicines may be diminished as there were no controls to ensure they were stored at the correct temperature.

The home returned medicines to their supplying pharmacy. The provider's medicines management policy section stated, 'Medicines no longer required or out of date must be stored in a tamper proof designated medicines collection bin kept in a cupboard prior to collection. A contemporaneous record must be kept in the drugs return book of all medicines disposed of in the collection bin.' Medicines no longer required were placed in a filing cupboard in the same area that medicines were stored upon delivery. The provider had a pharmacy returns book in place. However, there had been no entries since 28 August 2017. On the day of the inspection, there were medicines waiting to be returned that had not been documented in the returns book. The senior staff member who was assisting us with the inspection could not explain the gap but commented, "There are no systems to book in [medicines] properly." This meant that the home had failed to ensure that there was an accurate record of medicines held on site.

We found that there had been issues with the supply of medicines from the pharmacist on 23 and 24 October 2017. This had an impact on people as two people had missed all their medicines during this time and one person had missed one of their medicines that was essential for their mental health needs. However, there were no records that showed that this was raised as an incident or that a safeguarding alert had been raised with the relevant authorities for investigation. Further, there were no records that medical advice had been sought to identify if the missed medicines impacted on people's health. After the inspection, we were informed that medical advice had been sought, although this could not be evidenced on the day of the inspection when requested. The manager informed us, the issues with the supplier had been solved and we found people had received their medicines regularly after 24 October 2017. This showed that the home had failed to manage people's medicines safely.

We found that medicines had not been managed safely for one person between July 2017 to August 2017.

One person who used an inhaler due to their asthma, their MAR (medicine administration record) detailed that two puffs be given twice daily. However, the person's MAR cycle commencing on 28 July 2017 to 24 August 2017, showed the inhaler had been marked as PRN, which meant it was to be taken when needed. The MAR showed that the inhaler had not been administered at all during this cycle. The Summary of Product Characteristics recommends, 'Patients should also be informed that [inhaler] should be used on a regular basis, even when they are asymptomatic.' The MAR chart commencing 25 August 2017 to 27 September 2017 for this person was missing and could not be found. This may impact on the person's safety and wellbeing as the home could not be sure if the person had received their prescribed medicines during this period.

We found a number of missed signatures on people's MAR sheets during October 2017. There were no records that showed that these gaps had been investigated to ascertain if the medicines were administered or if this was a recording issue. The monthly medicines audits had not identified these shortfalls. Specifically, we found that one person's lotion, which was prescribed to treat skin conditions had not been signed since the start of the medicines cycle on 17 October 2017. After the inspection we were informed records of applications had been kept in a Topical MAR chart. This was not given to us on the day of the inspection. For another person, we found a series of gaps on the MAR for a cream to treat the person's skin condition between 14 and 20 October 2017. The cream was in the person's cupboard, which was locked. However, we found another tube of cream that had been kept in the person's room that was not securely stored. The provider's medicines policy section stated, 'Non medicated creams may be stored in resident's bedrooms.' This cream was a prescription only medicine. This shows that the home was not acting in accordance to their medicines policy to ensure people were safe at all times.

For one person, we found a medicine used to treat constipation, that was prescribed to be administered daily, had been amended by staff to be administered every other day. There were no records why this amendment had been made and if this was authorised by a health professional. For another person, who had been prescribed an ointment to be administered for only seven days for skin hydration, their MAR showed the ointment had been applied for 14 days. There were no records on why the ointment had been applied for a further seven days and if this was authorised by a health professional. Over application of this medicine may result in thinning of the skin and decrease in skin pigmentation. This therefore placed the person at risk of skin complications.

We found that some PRN protocols had not been signed. For one person, we found they had a box of 60 paracetamol labelled as dispensed on October 2017 and 70 that was dispensed on August 2017. However, there was not a MAR chart in place. This may impact on the person's health as staff may not be able to ascertain how many PRN tablets had been administered, the reason for administration and the effect it had on them after administration. For another person, we found ibuprofen was administered to them on 24 and 31 October 2017. However, the reason or the effect had not been noted on the person's MAR chart. After the inspection we were informed that this had been recorded on the person's daily notes. However, this had not been given to us on the day of the inspection.

In one person medicine's locker we found an aero chamber spacer device, which was used to administer asthma medicines. The device had not been cleaned and was dirty. Asthma UK recommends, 'Keeping your spacer clean will help you to get the full benefits of your asthma medicines each time you use it. If it's a new spacer, clean it before you use it for the first time, then once a month afterwards and replaced yearly.' This meant that the person may not have been getting the full benefits of the medicines to ensure they were in the best of health. The senior staff member supporting us with the inspection agreed that the condition of these items was not acceptable and took photos to report this to the manager.

The above issues meant that the home was failing to take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe as the home had failed to provide the proper and safe management of medicines.

The manager told us that they were aware of the concerns with medicines and had recently introduced a daily medicines audit. This would include three people's medicines that would be audited daily. We saw these audits were being carried out and had identified recent issues with application of creams and missed signatures.

Records showed one person was administered medicines for the prevention of stroke and systemic embolism. The risks for taking this medicine included bleeding more easily and blood clots. The person's care plan contained a detailed risk assessment relating to the risks associated with this medicine. This risk assessment had not been included on the person's MAR chart. Records showed the staff member who was on duty at the time of the inspection regularly administered the medicine. We asked the staff member about any risks associated with medicine. The staff member told us, "There was none except the service user's epilepsy medicine, which must be taken at the right time." This meant that the staff member may not know the activities to avoid that may increase the risk of bleeding for the person or what to do if the service user bled or had symptoms of a blood clot. The failings to ensure that the staff member was aware of the risks associated with medicines therefore placed the person at risk of harm.

During our last inspection, we found the risk assessments for two people who lived at the home as respite were not robust and did not contain sufficient information for staff to mitigate risks. During this inspection, we were informed by the manager one person stayed at the home as respite. However, after the inspection we were informed that this person was permanent and not staying at the home as respite. We found the risk assessments for this person had not been completed in full. Prior to the inspection, we were informed the person had left the home unsupervised and had not been found. The person was at risk of demonstrating behaviours that may challenge and the risk assessment included that staff should use de-escalation techniques to calm the person, without including the type of techniques that staff could use. In addition, the placing authority referral form stated the person was at risk of financial abuse. However, a risk assessment had not been completed to ensure the person was protected from financial abuse. Furthermore, the person was at risk of leaving the home unsupervised. We noted that the conditions on the person's Deprivation of Liberty Safeguards (DoLS) included that the person should be taken out regularly, while supervised. This had not been included on the risk assessment to ensure the risk of the person leaving the home unsupervised was minimised. These failings to accurately assess and document the risks in these areas placed the person at risk of harm to themselves or others.

The above issues shows that the home was failing to take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe as the home failed to provide the proper and safe management of risks associated with their health and circumstances.

The above issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

For the remaining people that stayed at the home, assessments had been carried out to identify any risks and provided clear information and guidance for staff to keep people safe. Assessments were specific to individual's needs such as on health conditions, mobility, skin integrity and going outside the community. Assessments were regularly reviewed and updated to ensure they were current.

A relative told us, "Person swears a lot but staff always handle it well." There was a positive behaviour

support and traffic light plan for most people that demonstrated behaviour which may put people and staff at risk. The plan listed the behaviour of people during green, amber, red and blue stages and the steps staff should take to avoid or manage behaviours that challenged the home. The positive behaviour support listed triggers, strategies and de-escalation techniques to ensure the risk of behaviour that may challenge the home and people's safety, were minimised.

The home had systems in place to manage people's finances. Financial outgoings were logged and recorded on people's finance sheet. An overall balance was listed. We checked five finance sheets on outgoings for the last two weeks and found the records and balances were accurate.

During our last inspection, we made a recommendation that the home seeks and follows best practice guidance about staff deployment. This was because we found that staff allocations meant that staff were working across different flats, sometimes two floors apart. We had received some concerns from external professions that people were not being supervised when required, which may impact on people's safety. During this inspection, some staff, relatives and people told us the home did not have enough staff. A person told us, "No, especially at night. Sometimes I have to wait two hours." Another person told us, "One male staff member he does not listen. Sometimes when I need changing after having gone to the toilet he goes away and doesn't come back, so I have to call another staff member." A relative told us, "Not always. [Person] is one of three people in the flat and other people have higher needs so [person] can be overlooked" and another relative told us, "I think there could be more staff." One member of staff said, "We are short of staff." Records showed that a number of people required one to one support. The rota and the allocation book confirmed that appropriate staff had been allocated to support people where required. We tested the call bell in one person's room and found the response time satisfactory. However, concerns were raised by staff that, at times, they would need to help other people across different floors. This meant people were left with members of staff that were already supporting another person or they had to take the person with them to help other people. We observed a staff member calling for assistance to transfer a person and they had to wait a 'long time' until another staff member came. The person was distressed due to the delay and the staff member informed that this happened often. During this time, a person who was on one to one support had walked into the flat unsupervised, as the staff member that had been allocated to support them was on alternative duty. The deputy manager then came back with this staff member. The staff member told us that they were called away sometimes to support other people across different flats and they had to take the person with them when they did this.

In addition staff raised concerns about working long hours without taking breaks. Records showed that some staff worked 14 hour shifts on a daily basis. A staff member told us, "We work 14 hours but don't get breaks." Another member of staff told us, "No regular breaks here. I do long hours and only get 20 minutes." Three staff we spoke with told us that sufficient amount of breaks were not included during their working hours, which had an impact on their motivation and productivity levels. Some staff member told us that they had to have their lunch on the go and at times did not have time to eat therefore felt tired and low on energy. This meant that staff may not be able to support and care for people in a safe way. There was no system in place to ensure staff took regular breaks and for cover arrangements when staff took breaks. The manager told us that this had been discussed with the regional manager and systems would be put in place to ensure staff had breaks during shifts.

The above issued shows the home failed to ensure that staff members at all times were not deployed sufficiently within the service to meet service users' needs and ensure they were safe at all times.

The above issues related to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Prior to the inspection, we received reports that there had been a number of safeguarding incidents involving people that lived at the home. After the inspection we received further safeguarding concerns. These incidents are currently being investigated by the local authority.

People and relatives we spoke with told us they did not have concerns about people's safety. A relative told us, "[Person] has been safer than she has been anywhere else." Another relative told us, "Yes, [person] is safe there." A person told us, "Yes, it's properly safe." A staff member told us, "They [people] are safe." However, a social care professional told us, "No, people are not safe here."

Staff we spoke to were aware of their responsibilities in relation to safeguarding people. A staff member told us, "If something is wrong, like if they are being abused, you can raise with the manager or CQC." Staff were able to explain what abuse was and who to report abuse to. They also understood how to whistle blow and knew they could report to outside organisations, such as the Care Quality Commission (CQC) and the police. There was a safeguarding and whistleblowing policy available, which was displayed in the provider's office. However, we found 20 out of 33 staff had not received training in safeguarding so some staff may not know safeguarding procedures. We were informed after the inspection that staff had received safeguarding training but not refresher training in this area. This was not evidenced on the training matrix. As mentioned above, we also found some incidents with medicines that had not been recorded, what actions had been taken and relevant authorities had not been notified of this. This meant that the incidents could not be investigated to minimise the risk of re-occurrence to ensure people received safe care and treatment at all times.

Incident records were reviewed and these showed the provider took appropriate action for incidents that had been recorded. The details of the incidents were recorded along with the actions taken. During the inspection, there was an incident involving two people. The incident was recorded and appropriate action had been taken by staff and the management team. However, the manager told us that previous incidents may not have been recorded and appropriate action may not have been taken. We found that there had been a number of incidents relating to one person since our last inspection. The incidents were not being analysed for patterns or trends to learn from lessons and ensure risks of incidents re-occurring were minimised. The manager told us that they would be analysing the incidents on a monthly basis and showed us a form that would be used to analyse and monitor incidents.

At our last inspection, we found that recruitment records showed the home did not consistently follow the provider's recruitment policy. We recommended the home seeks and follows best practice guidance from a reputable source about recruitment practice. At this inspection, we found pre-employment checks had been carried out to ensure staff that were recruited were suitable to provide care and support to people safely. The manager told us that staff did not start working at the home until all pre-employment checks had been completed. Staff confirmed this. One staff member told us, "I did not start working here until all my checks had been completed." We looked at five staff records, and found three staff had been recruited since the last inspection. Relevant pre-employment checks such as criminal record checks, references and proof of the person's identity had been carried out as part of the recruitment process.

Regular fire and evacuation tests were carried out. Staff told us that most people were mobile and could evacuate in the event of an emergency. There were records on how to safely evacuate people. Staff were able to tell us what to do in an emergency, such as evacuating people, moving them to the assembly point and ensuring everyone was there and calling the emergency services. There were fire safety procedures displayed throughout the home and smoke alarms were installed, including in people's rooms to keep them safe. We observed that the fire alarm went off during the inspection and staff were calm and patient and gathered people at the assembly point.

We saw evidence that demonstrated appropriate gas, electrical, fire safety and water safety checks were undertaken by qualified professionals. The checks did not highlight any concerns.

People told us that their rooms were clean and staff wore appropriate clothing when supporting them. One person told us, "Yeah, very clean" and another person told us, "Yes, I'm happy with my room and staff members." A relative told us, "Yes, [person] home is clean." A staff member told us that the cleanliness of the home had improved since the new manager started working at the home. The staff member told us, "When [manager] was not here, it was hard for us to find gloves." We received reports that one person's room required deep cleaning and action had not been taken. We visited the person's room and there was a strong odour. The manager told us that this emanated from one person's room. The person had been temporarily moved to another apartment and their flooring had been replaced. Observations confirmed this. However, there was still an odour and the manager informed us that the smell had improved but they would deep clean the apartment to ensure the smell went away. The home carried out infection control and hand hygiene audits that focused on cleanliness in people's apartments. Anti-bacterial lotions and waste bins were used for hygiene and disposal. We saw evidence that the manager was introducing a cleaning schedule to ensure the home was cleaned throughout the day and night. Anti-bacterial lotion slots were available throughout the building for hand hygiene and we saw staff used these slots to clean their hands.

Inadequate

Is the service effective?

Our findings

Most people and relatives we spoke with told us staff were not skilled, knowledgeable and able to provide care and support effectively. One person told us when we asked if staff were trained to be able to look after them, "Some of them, not everyone." Two relatives expressed concerns with staff not being trained. One relative told us, "They [staff] don't seem trained." Another relative told us, "They [staff] are not trained. My sister told them, your staff are not trained."

We received reports from external professionals of unskilled staff being used to cover some shifts resulting in care inconsistencies. During our last two inspections, on February 2016 and April 2017 we found that staff had not received training required to perform their roles effectively. At our last inspection, we noted that due to high staff turnover, the proportion of staff who had received specialist training required to meet people's needs, remained low. During this inspection, the manager told us that three staff had been recruited since our last inspection and there were five vacancies. The home employed 33 staff and this was also reflected on the training matrix we saw. However, after the inspection we were informed the information we were initially given was incorrect and that 12 staff had been recruited since our last inspection and the home employed 44 staff. During the inspection, we found training continued to remain low.

Records showed that some staff had not been trained in core areas required to perform their roles. We found that 20 staff had not been trained in safeguarding, 13 staff had not been trained in moving and handling, 11 staff had not been trained in the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, 17 staff had not been trained on first aid and basic life support and 21 staff had not been trained in fire safety. The overall core specific training compliance was 71%. We spoke with the manager who told us this had improved from 57% since they came into post.

People living at the home had a number of health conditions such as diabetes, epilepsy, swallowing and learning disabilities. A number of staff had not received training in these specialist areas to ensure they could provide effective support and care to people. For example, 14 staff had not been trained in autism and the management of challenging behaviour, 23 staff had not been trained in swallowing difficulties, 14 staff had not received training in epilepsy and nine staff had not received training in learning disabilities awareness. Also, 22 staff had not received Makaton training. Makaton uses using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. One person's care plan stated that they used Makaton to help them communicate. However, the staff member that supported the person told us they had not been trained in Makaton and were not aware the person used Makaton. The overall service specific training compliance was 67%. The manager told us that this had improved from 32% since she came into post.

The manager told us the compliance level for training should be over 90%. After the inspection we were informed that this information was incorrect and that the compliance level should be over 70%. The overall service specific training compliance was under 70%. This shows that staff were not being supported to undertake training, learning and development in specific area's to enable them to fulfil the requirements of their role.

After the inspection, we were informed due to the change in manager the training matrix had not been updated with training completed and therefore the training matrix seen on the day of the inspection was incorrect. We were informed training was much higher on the day of the inspection than the information given. We were informed that there was evidence of training certificates in the service to confirm that 38 staff had received MCA/DoLS training, 32 staff had been trained in equality and diversity, 40 staff had been trained in safeguarding, 37 staff had been trained in moving and handling, 38 staff had received first aid training, 38 staff had received fire safety training. 20 staff had received training in learning disabilities, Challenging behaviour training had been provided to 36 staff and epilepsy training had been given to 20 staff. However, we were not informed of this during the inspection and we did not see evidence to support this and our concern still remain that not all staff had received essential training in relation to Makaton and learning disabilities. Although the provider informed us a high number of staff had been trained, we found some staff we spoke to were not aware of the principles of the MCA and some incidents had not been reported with medicines.

This meant that staff still had not received all the training and knowledge required to perform their roles effectively, which may put people at risk of harm.

The above issues related to a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

One staff member told us, "During induction, I shadowed other members of staff and read people's care plans." Another staff member told us, "I had a very good induction." Records showed new staff that had started employment since our last inspection had received an induction. Induction involved looking at care plans, training staff on roles and responsibilities and shadowing experienced members of staff. The manager told us that she planned to allocate an experienced care staff to mentor new staff members for a period of three to six months depending on staff progression.

Supervisions were not being carried out regularly. The provider's policy showed that staff should receive six supervisions a year. We found approximately 20 staff had not received regular supervisions according to the providers policy. The manager acknowledged that supervisions had not been regular and had developed a supervision matrix that provided dates on when supervisions would be completed. We saw records that some supervision had been carried out. This included discussions on staff performance and training needs. Records showed that 24 staff members had been working at the home for over a year and we were unable to evidence if they had received annual appraisals. The manager informed us that she did not know if appraisals had been carried out and where the records were but planned to schedule appraisals for staff soon. Staff told us that they were supported in their role since the new manager started working at the home. Comments from staff included, "I am supported now. You can go to [manager] if you need anything" and "I am supported, if there is any problems, I can ask for help."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were

being met.

Staff we spoke with told us that they always requested consent before doing anything. A staff member told us, "Of course, we ask for permission. You can't decide for them. They know what they want." People and relatives we spoke with confirmed this. A relative told us, "They do ask for permission, they do not just do things." We asked one person if staff asked for permission before supporting them and they told us, "Yeah, for instance they check with me first."

Care plans provided information about people's memory/cognition and recorded whether people might struggle to make decisions. Where people struggled to make a decision, records showed that people were supported or prompted to be able to do so. Out of the six staff we spoke with, three staff were unable to tell us of the principles of the MCA. This meant that not all staff were familiar with the principles and codes of conduct associated with the MCA, and may not be able to apply those when appropriate, for any of the people they were caring for. The manager was aware of the principles of the MCA and records showed that MCA assessments had been carried out to assess people's ability to make decisions on specific areas. Where a person did not have capacity to make a specific decision, then a best interest decision had been made on their behalf.

During our last inspection, the home was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found that records showed that the conditions on people's DoLS authorisiations were not being adhered to. During this inspection we found where people lacked capacity to consent to their care, appropriate applications had been made to deprive them of their liberty. However, we found that one person's DoLS condition was not being adhered to. The DoLS authorisation stated that it was a condition they access the community in a particular area. The manager could not confirm if the conditions was being adhered to. Records showed they had not been supported to do this and therefore the conditions of their DoLS authorisation had not been followed.

The issues above shows that the home was still failing to ensure DoLS conditions were being met at all times to make sure that people's needs were being met effectively.

The above issues related to a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. We found letters from hospitals and physiatrist that showed appointments had been made with people to monitor their health. Where staff had more immediate concerns about a person's health, they called for health professional to support the person and support their healthcare needs.

However, a social professional told us, "[Person] has not had a health care check since being here." People aged 14 and over who have been assessed as having moderate, severe or profound learning disabilities, or people with a mild learning disability who have other complex health needs, are entitled to a free annual health check. People with learning disabilities often have difficulty in recognising illness, communicating their needs and using health services. Regular health checks for people with learning disabilities may often uncover treatable health conditions. This is to ensure that the person was at the best of health and any health conditions identified at an early stage could be treated. The annual health check is also a chance for the person to get used to going to their GP practice, which increases familiarity and reduces their fear of going at other times. Records showed that letters had been sent to the GP in 2016 to initiate an annual health check for people, however this had not been followed up and there was no evidence that people had received an annual health check. The manager and deputy manager told us that this had not been

arranged. The manager informed that this would be arranged with the GP.

The above issues related to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Pre-admission assessments had been completed prior to people receiving support and care from the home. Information was obtained on people's health conditions and background.

Assessments were also carried out on the level of support people would require. Using this information, care plans were developed. The home assessed people's needs and choices through regular key worker meetings. A key worker is a staff member who monitors the support needs and progress of a person they had been assigned to support. The review meetings with the key worker included important details such as people's current circumstance, health and well-being, activities, interaction and monitoring goals and objectives to ensure care and support was delivered in line with standards to achieve effective outcomes. There was a 'service user support plan' that included objectives people had been set, how this would be achieved and if any support would be required. However, we found some areas where information had not been followed up during these reviews. For one person, records showed that the person did not like some of the staff that supported them. There was no evidence that this had been followed up to identify why the person felt this way. After the inspection, we were informed that there was records that showed this had been followed up. However, we were not informed of this during the inspection and neither provided with these records. Records showed for another person their support plan had been completed in December 2016 and included information on their interests. For example, the person enjoyed horse riding. However, this had not been discussed or monitored during key worker meetings and neither the support plan had been updated to reflect if it was feasible to go horse riding. This meant that people's needs and choices were not being assessed effectively to achieve effective outcomes.

The home worked in co-operation with other organisations to deliver on-going care and support, when required. The registered manager told us about supporting one person, whose skin condition had deteriorated. Referrals had been made to health professionals and emergency services to ensure the person received effective care and support. The manager told us as a result of this the person's skin condition had improved. One person's care records showed the home had been concerned by the decline in their nutrition intake. As a result, input had been sought from a dietician. Instructions had been obtained on how to support the person to eat regular nutrition meals with staff support. We observed on the day of the inspection that the person was being supported to eat their meals. There was also an NHS grab sheet that could be used in between transition of services, which provided information on people's personal information, health conditions, communication, their next of kin and allergies. This meant that people would receive continuity of care when transferring services.

People told us that they had choices during meals times and did not raise concerns with the quality of the food. One person said, "Yeah, I have a menu from that I tell them what I want to eat and they make it. Sometimes, I go out to the shops to get ingredients." A relative told us, "They offer [person] choices with food." A staff member told us, "They get the food they want." We were informed that menus were devised with people weekly on their food preferences. However, for three people we found that weekly menus had not been created since August 2017. The manager informed us that this would be created as soon as possible. Care plans included details of people's likes and dislikes with meals in addition to how people should be supported during meal times. Records included people's dietary requirements in accordance with people's religious beliefs and health conditions. We observed one person was being supported during mealtimes and the staff sat down with the person and engaged in conversation with the person. People told us that they were offered fluids throughout the day and there was a fluid intake chart that recorded the

amount people drank. One person told us, "Yes, always they offer me drinks."

Concerns had been raised on the lack of food kept in one person's apartment. We checked the person's kitchen with the manager and found the fridge and storage cupboards were almost empty. Two people lived at this apartment. We checked another apartment where two people lived with the manager and found the kitchen area did not have much food or items, such as fruits or vegetables. The manager informed us that the home ordered general shopping weekly but it was up to the staff members that supported people to take them shopping for daily groceries. The manager informed us that staff had been told to stock people's kitchen with food. Daily records of care recorded what people ate and showed people were supported to eat a balanced diet. However, these records did not include the amount people ate and if food was refused then what alternatives had been offered. This meant that the home would be unable to monitor people's food intake to ensure their nutritional needs were being met at all times.

People had their own apartments and access to the communal lounge, where they could participate in activities with other people or spend time with staff and people. We observed that people's photos had been displayed in the front of their apartments, which also included the number of the apartment. There were window restrictors in people's apartments. There was accessibility for adapted baths and showers for people that may need extra support to use the bathroom. There was a laundry room in apartments and we observed that this was kept clean and staff were able to tell us that people's clothing were washed separately. Staff also told us that soiled clothing would be washed at a higher temperature to ensure infection control was maintained. People had access to lifts and lifts had been serviced regularly. We observed people using the lifts independently and also with staff support when needed. Cleaning substances had been securely stored.

Requires Improvement

Is the service caring?

Our findings

During our last inspection, we made a recommendation that the home seeks and follows best practice guidance about supporting people with relationships. This was because care plans did not include people's preferences with relationships and their sexuality. At this inspection, we found that this was still the case. We asked staff if people living in the home identified as lesbian, gay, bisexual or transgender as this was not recorded in people's care plans. A staff member said, "No, I am not sure about this." This meant there was a risk that people continued to not be supported with relationships they had or wished to pursue. The manager told us this change may not have been made as the previous manager had left. They informed us that people would be spoken to in regards to their sexuality and preferences with relationships and this would be included on their care plans.

People were protected from discrimination within the home. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. People and their relatives we spoke with confirmed that they were treated equally and had no concerns about the way staff approached them.

A relative told us, "Yes, the [staff] communicate well with [person]." No concerns had been raised by people and relatives about staff communication. All organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people who have a disability, impairment or sensory loss receive information that they can access and understand. None of the staff we staff we spoke to were aware what the AIS was but were able to tell us how they communicated with people. We spoke to the manager about how people could receive information in a way that they can access and understand. The manager told us they were in the process of putting systems in place so people would have access to information that could be read easily and with pictures. Records showed that communication needs had been identified and recorded in people's care plans with information on how to meet those needs.

Care plans included how people communicated and how staff should communicate with people. Care plans included sections called, 'Important things you need to know about me and my communication' and 'Best way for you to support me with my communication'. Information included that staff should use picture exchange communication systems to communicate with people if required. There were pictorial aids available for staff to interact with people. In addition, where people had difficulties with conversing, a communications dictionary was in place that provided information on how people would communicate with staff. For example, one communication plan said, 'When a person held a staff member's arms then staff member should follow person.' For another person, one plan said, 'If they stuck out their bottom lips then it meant that they were unhappy.' There was also an NHS grab sheet that included people's ability with communication that could be shared with other organisations if needed.

People told us staff were caring. One person told us, "They are ok. They are friendly." Another person commented, "Yes, [staff] very polite." A staff member told us, "When you help people, it makes you a better

person."

Staff had positive relationships with people. Staff told us they maintained relationships with people by looking at their care plans and finding out about their interests and talking to them about them. A staff member told us, "When I go in, we talk about their interests. Person I helped today, we spoke about football." A person told us, "They [staff] are good." We saw staff having regular conversation with people in a caring way such as speaking in a soft tone, maintaining eye contact and being attentive.

A relative told us, "They do the best they can to get [person] to make decisions on [person's] support." As far as possible, the home supported people to express their views and be actively involved in making decisions about their care and support. The manager told us people, when required, had advocate involvement due to their communication needs. They attended formal meetings, to help represent the person's wishes. During the inspection, we observed a meeting was being held with a person's advocate.

Independence was encouraged and records showed that staff should encourage people to support themselves. Staff told us they supported people to make choices in their day-to-day lives with personal hygiene and care. We observed a staff member asking a person if they wanted to go outside. The person said no and this was respected. We observed that people were encouraged to be independent and saw people using the lifts by themselves and helping with cleaning the home. A staff member told us, "I try to get [person] to make their own lunch and if [person] needs help, I am there." Another staff member told us, "I encourage them to clean their dishes after meals or put it in the wash." A person told us, "I do most of it by myself, like make my bed, get ready, shower, brush my teeth, things like that yeah. The staff do my cooking."

Staff ensured people's privacy and dignity were respected. People told us that staff treated them with respect. One person told us, "Yeah, in all ways." A relative told us, "I think they respect [person's] privacy." Records showed that most staff had been trained in privacy & dignity. Staff told us that when providing particular support or treatment, it was done in private and people we spoke with confirmed this. A person told us their dignity was respected and said, "All the time yeah, yes they do." A staff member told us, "If I am giving personal care, I shut the door and also cover them up as much as possible." We did not observe treatment or specific support being provided in front of people that would have negatively impacted on a person's dignity. We observed that staff knocked on people's doors regularly before going inside. A person told us, "Staff knock before coming into my room."

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were knowledgeable about them. One person told us when we asked them if staff knew them well, "Well, yes course they do." Another person commented, "Yeah." Most staff we spoke to were aware of people's preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "I find the care plans helpful. It helps us look after people." Care plans detailed the support people would require and people's general health. There was also an 'All about me' booklet that provided information on important people in their life and a section on 'Things you need to know', that provided information on how to support people. In one person's care plan, information included the triggers that may upset them and that if staff wanted to touch the person they needed to ask. In another person's care plan, information included that when a person cuddled staff, then staff were to count up to three so the person was aware when the cuddle would be over. However, we found inconsistencies with one care plan because they had two care plans in their file relating to their skin condition. One detailed the person's diagnosed skin condition and the second care plan related to general skin care. The general skin care plan had been in place since April 2016 and had been signed to say regularly reviewed, with no changes needed. However, there had been changes to the person's skin condition and treatment during this time. This meant that without up to date information, staff would not be able to provide personalised care to ensure the person was at best of health.

Care plans also included people's sensory abilities, allergies, nutritional information, mobility needs, and details of their next of kin, health professionals and whether people preferred male or female carers. There was a personal profile section that included people's ethnicity, religion, likes and dislikes. People were provided with guides about the home and the type of support offered and information on the local community.

For one person, their DoLS conditions included accessing the community and carrying out meaningful activities. We observed the person access the community during the inspection. There was an activities log that staff completed. However, the activities logs had not been completed in full. The daily records of the person showed that the person accessed the community and did a number of in house activities, which had not been included on the person's activities log. We could not locate the activities log for the week commencing 30 October 2017. We noted the person went to the day centre three times a week; this had not been recorded on the daily logs regularly. Staff told us that the person went to the day centre and we observed the person going to the day centre on the first day of the inspection. The manager informed that this was a recording issue and would be communicated to staff to ensure daily logs were an accurate reflection of people's daily activities.

For another person, their DoLS condition included that the home explore meaningful activities for the person. We did not see records that showed the person carried out regular activities and if an activities programme was in place. Therefore we could not be assured if the person was involved in meaningful

activities. This meant there was a risk that people's interests in activities was not being promoted and explored for their well-being and to provide stimulation.

A person told us, "I go to the park, cinema, and day centre on Fridays." Another person told us, "I went to the cinema yesterday to see a horror film, there was four of us that went." A relative told us, "[Person] likes to party. They play music and she gets up and dances." A staff member told us, "I think activities wise, we are quiet good here. They go cinema, we have movie nights, we take them to the park." Records showed that the management team had organised a number of group activities for people. These included a coffee morning on a Friday, disco night on a Saturday, movie nights on a Sunday and a weekly music and dancing class. The manager was also in the process of creating a football team that would consist of staff and people to play in community tournaments and leagues. There was an activities room and we observed throughout the day people accessed the room for activities such as board games, playing the guitar and ball games. People played music in the activities room and danced with staff and each other. We observed people were offered to be taken outside by staff.

Complaints were being managed. A person told us, "I got no complaints." During the last inspection we made a recommendation that the home seeks and follows best practice guidance from a reputable source about resolving complaints. During this inspection, records showed that one complaint had been received since the last inspection. This was being investigated by the manager and we saw evidence that a response had been prepared and would be sent to the complainant. Three people told us that they did not know how to make complaints. A person told us when we asked if they were aware on how to make complaints, "No, but I haven't t got any complaints." The manager told us that this would be discussed during residents meetings. The manager and staff were aware of how to manage complaints. A staff member told us, "If someone complains to me, I will listen to their concerns and record this. I will then let my manager know to investigate."

Inadequate

Is the service well-led?

Our findings

During our last inspection, we found that the provider had introduced a new programme of monitoring the quality of the home, which included reviewing training records. These audits had identified that training records were not being completed to the required standard and had implemented actions to address them. However, during this inspection we found that training still remained a concern as a number of staff had not completed training in core and specialist areas required to perform their roles effectively. Records showed that the regional manager had carried out audits since the last inspection on records and observations against the CQC Key Lines of Enquiry on Safe, Effective, Caring, Responsive and Well-Led. A daily report was also sent to the regional manager by the manager with information on staffing levels, incidents, injuries, nutrition, medicines and infection control. However, issues we found during this inspection had not been identified or addressed. There were continuing issues identified from the last inspection, such as training, record keeping, staff deployment, medicines, access to health care services, nutrition, complying with DoLS conditions and the shortfalls we found with risk assessments for a person that was on respite care. This meant that the quality assurance systems were not robust enough to identify shortfalls to ensure people were safe and well cared for at all times. This was required to ensure that people received safe care and there was a culture of continuous improvement.

During this inspection, we found widespread shortfalls, some of which were continued breaches. The provider had failed to ensure that, despite the change of manager since the last inspection, appropriate systems were in place to address the previously identified shortfalls. They had failed to prevent additional breaches of the regulations from occurring.

The manager told us that they had introduced systems that included auditing the whole content of the care plans regularly. The audits would review three care plans weekly. This would ensure any issues or discrepancies within care plans would be identified and addressed immediately. We saw evidence that a care plan audit had been completed on one care plan recently and were informed that this would be completed on all the care plans.

Records were not always kept up to date. We found daily logs and activity logs had not been completed in full to reflect people's daily activities. Appraisals that may have been completed for 24 staff members could not be located. We found a number of gaps in people's MAR sheets and one person's MAR between August to September 2017 could not be found. Furthermore, risk assessments had not been completed in full for a person on respite, in order to ensure staff had the relevant information to keep the person safe.

During the inspection we provided feedback to the manager on the shortfalls we found during the inspection. Immediate action was taken after the inspection to address some of the concerns found during the inspection. However, due to the lack of progress in addressing the breaches in the regulations found at the last inspection and the further breaches we have identified, we currently lack confidence in the provider to be able to ensure that improvements are sustained and embedded.

The registered person (provider or manager) must send notifications about incidents that affect people who

use services to CQC without delay. This includes safeguarding issues. The manager was aware of when to send notifications to the CQC. We found that there had been incidents within the home that may affect people's safety and that the management team had sent notifications of these incidents to CQC as required. However, we found that there had been instances whereby people had missed their medicines for a prolonged period of time and there was no record that showed that this had been recorded as an incident and relevant authorities had been notified of this.

The consequences of not having in place robust quality assurance processes and not keeping an accurate, complete and contemporaneous record to service users can be very serious or can cause irreversible damage if staff are not able to support people safely and meet their needs. People will or may be exposed to the risk of harm because the home was failing to ensure that people were safe at all times and ensuring their needs were being met.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Quality monitoring systems were not in place. We did not see records to show if people, relatives or staff were able to provide feedback on the running of the home. The manager told us that they were not sure if this had been completed but were looking to send questionnaires to people and relatives for feedback. This was important to ensure that there is a culture of continuous improvement to ensure high quality care was being provided at all times. After the inspection, the manager sent evidence that demonstrated surveys had been sent to people and relatives.

The home did not have a registered manager. Since our last inspection, the previous registered manager had left the home in August 2017. The deputy manager had also left. The regional manager overseeing the home had remained consistent over this period. The provider had recruited a new manager who had recently started at the home. There had been three managers employed by the home since 2017. The current manager had managed the home previously so had good knowledge of it. The manager was aware of the issues of the home and had introduced a number of changes to make improvements such as introducing group activities, care plan audits, a supervision matrix, daily medicine audits, daily record booklets, and staff communication books. The provider had recruited two deputy managers to provide managerial support. The deputy managers were supported by senior carers. There were reporting structures in place to ensure the management team always had oversight of the home and the management structure with lines of responsibility. The manager recognised the issues and informed us time was needed to make improvements. People, relatives and staff were very positive about the manager.

Staff told us that they enjoyed working at the home. One staff member told us, "I do enjoy working here." Another staff member commented, "I am enjoying working here."

Prior to the inspection, we received concerns of alleged culture of collusion amongst staff. During the inspection we found the manager had identified issues with staff culture and was addressing these through individual supervisions and team meetings. Staff told us that since the manager had been employed they were supported in their role and the culture of the home had improved. They told us there was an open culture, where they could raise concerns to the manager and felt this would be addressed promptly. However, some staff told us they had to work long hours without taking regular breaks. The manager informed that this was being addressed. Staff were encouraged by the employment of the manager as some staff had worked with the manager previously. We observed the relationship between staff and the management team to be professional and respectful. Comments from staff included, "She [manager] is going to change this place, she is good", "I can see the difference since she [manager] has become a

manager" and "She is excellent, always friendly, always approachable."

People and relatives we spoke with had no concerns about the management of the home. A person told us, "She's [manager] really nice, very helpful." Another relative told us, "I know her [manager] quiet well, I really like her." Another relative told us, "She [manager] is very good, you can talk to her."

Staff meetings were held regularly. The meetings kept staff updated with any changes in the home and allowed them to discuss any issues. Minutes showed staff held discussions on record keeping, staffing, personal care, updates on CQC, conduct, meals and holidays. A staff member told us, "I find these meetings useful as we can talk together as a team of our concerns and how this can be tackled." This meant that staff were able to discuss any ideas or areas of improvements as a team, to ensure people received high quality support and care.

Residents meetings had been held. A recent meeting had been held on November 2017 and people discussed meals, activities and Christmas. The manager informed us that they were not sure if residents meetings had been held prior to this but would now be held during coffee mornings every Friday. This would enable them to get people's feedback and involve them with decisions on the care and support they received.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider was not ensuring that people had access to the full range of health services that they were entitled to. Regulation 9(1)(2)(3)

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 11 HSCA RA Regulations 2014 Need for consent The registered provider was not making sure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the MCA, and are able to apply those when appropriate, for any of the people they are caring for. The conditions on deprivation of liberty safeguard authorisation were not being met. Regulation 11 (1)(2)(3)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(a)(b). The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines Regulation 12(1)(2)(g)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was not robustly assessing, monitoring, improving the quality and safety of the service users and mitigating the risks relating to the health, safety and welfare of service user's who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b). The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c).

The enforcement action we took:

Impose Urgent Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not comprehensively assess the needs of people to sufficiently deploy suitably qualified, competent, skilled and experienced persons. Regulation 18(1)(2)

The enforcement action we took:

Warning Notice