Mr Charles Otter

Cranhill Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last comprehensive inspection of this service on 5 July 2016 we found four breaches of legal requirements were found. This included risk assessments were not always in place, incidents and accidents forms were incomplete, medicines were unsafe, water temperatures were unsafe, checks were not recorded, personal evacuation plans had not been completed. We also found people were not involved in their care plan reviews, staff were not receiving sufficient training and induction and there was a lack of accurate records and no quality assurance systems in place.

Following this inspection the provider confirmed how they were going to meet legal requirements in relation to these breaches.

At the last inspection, the service was rated requires improvement.

We undertook this unannounced comprehensive inspection on the 3, 7 & 9 August 2017. This was to follow up the previous breaches of legal requirements. At this inspection whilst there were improvements there were still concerns relating to previous breaches including shortfalls in staff training and inadequate staffing. Systems were not always identifying shortfalls found during this inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Cranhill nursing home provides care and accommodation for up to 31 people. On the days of the inspection 23 people were living at the home. The home is on four floors, with a lift or stairs. Some bedrooms have en-suit facilities. There are shower facilities and toilets. Communal areas include one lounge, one dining area and a sitting room. There is also a front garden with a patio area.

People were not always supported by adequate staff to meet their individual needs and three people told us they had to wait 10 minutes for their bell to be answered. At the time of the inspection the home had a number of vacant hours. The home was actively recruiting to fill those shortfalls. Following the inspection we received confirmation that the home always sought the same agency staff for continuity. People were not always supported by staff who had received training or an update to ensure they had the skills and competencies relevant to their role.

Where concerns had been raised these were not always being raised following safeguarding procedures to ensure people were being protected from potential abuse. Three people who were at risk of developing pressure ulcers had incorrect mattress settings in relation to their care. There was no daily check in place to ensure these were accurately set in between the monthly audit.

Two people who were losing weight had no action taken to prevent them from losing more weight.

People ate in the dining room or in their room. People who required assistance from staff had to wait for meals to be delivered to their rooms.

Care plans confirmed if people lacked capacity, however where people lacked capacity there was no best interest decision in place relating to their care and support.

Medicines were not always stored safely as we found thickening agent left in two rooms. We also found records relating to creams administered required improving.

People were supported by staff who had suitable pre-employment checks although there was no system in place that checked staff who had worked for the service for years.

Incidents were not always being recorded where staff were being scratched and injured whilst supporting people.

People's care plans contained important information relating to their likes, dislikes and routines however, one support plan looked at for when a person became upset or distressed could be improved upon.

People felt able to talk to the registered manager and they were accessible. People were supported to maintain relationships that were important to them although they felt activities could be improved.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Where concerns had been raised within the service these were not always being raised within safeguarding procedures.

People were not always supported by adequate staff to meet their individual needs and people had to wait for staff to respond when they called the bell.

Medicines were not always stored safely and records relating to creams administered required improving.

People were supported by staff who had pre-employment checks although there was no system in place that checked staff who had worked for the service for years.

Is the service effective?

Requires Improvement

The service was not always effective.

People could be at risk of developing pressure ulcers due to incorrect mattress settings in relation to their care.

People could be at risk due to ineffective systems where people were losing weight.

People could choose where they ate their meals although people who had meals delivered to their rooms had to wait for staff assistance.

Care plans confirmed if people lacked capacity, however where people lacked capacity there was no best interest decision in place relating to their care and support.

Is the service caring?

Good

The service was caring.

People felt staff were kind and caring.

People's privacy was respected.

People were support to maintain relationships important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans that confirmed their likes and dislikes, including what activities they enjoyed, however one care plan did not confirm what support someone might require when they became upset.

People had access to daily newspapers and books although activities were limited due to the home not having an activities co-ordinator.

People were supported to maintain relations with people who were important to them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Checks and audits were in place to monitor the service although some shortfalls had not been identified prior to the inspection.

Incidents were not always being recorded where staff were being scratched and injured whilst supporting people.

People and staff felt the management team was approachable and supportive.

People and relatives had their views sought although when concerns were raised no action had been taken.

Cranhill Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was an unannounced inspection and took place on the 3, 7, and 9 August 2017. It was carried out by one inspector, an expert by experience on the first day and a specialist advisor on the second day. An expect by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a nurse.

We spoke with twelve people living at the home and four relatives about the quality of the care and support provided. We also spoke with the registered manager, the deputy manager, the cook, the external consultant, the administrator and five staff.

We looked at three people's care records and documentation in relation to the management of the home. This included two staff files including supervisions, training, recruitment records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

Requires Improvement

Is the service safe?

Our findings

Although people felt safe at the home we found when concerns for people's safety were raised safeguarding referrals were not being made quickly and as required. People told us, "Oh yes absolutely safe". Another person told us, "Yes, I feel safe". During the inspection we were told about a recent concern which had been raised with the registered manager on the 19 July 2017. The local authority safeguarding team had not been notified of this incident and CQC had also not been notified as required. By not notifying external parties they were not following current legislation and guidelines designed to monitor the safety of people. The registered manager confirmed on the second day of the inspection they were raising this concern to the local safeguarding team. The home's visiting quality assurance consultant who was visiting on the second day of the inspection confirmed a safeguarding referral was required.

People had fed back concerns to the provider and registered manager in 2016. Within the resident's questionnaire people's comments included, "It is a kind of prison, having to be here." And "Some of the staff who get me up in the morning are a bit rough and hurt me" and "Some of them don't want to take me downstairs." None of these comments had been formally investigated or raised with the local safeguarding team. The registered manager confirmed on the third day of the inspection they had made these referrals.

This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last full comprehensive inspection on the 5 July 2016 we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because, risk assessments were not always in place, incidents and accidents forms were incomplete, medicines were not safely managed , water temperatures were unsafe, daily checks were not recorded, personal evacuation plans had not been completed. At this inspection we found some improvements had been made.

At our last inspection we found medicines were not always managed safely. At this inspection we found improvements had been made to recording medicines along with remaining stock. However we found medicines administered were not always accurately signed as given. For example, people had body maps for where cream should be applied however creams were not recorded on a medicines administration chart. This is important as by having an accurate record of who had administered the cream and when provides confirmation that the cream was administered as required. We also found people who had been prescribed a thickening agent for their drinks did not have this stored securely in their rooms. This posed a risk as thickening agent should be securely locked away to prevent it being unsafely used or accidently ingested.

All other medicines were stored safely and medicines administration records for other medicines were accurate and up to date. Used medicines were returned to the local pharmacy for safe disposal when no longer required.

At the last inspection we found water temperatures were unsafe and over 60 degrees centigrade. This was above Health and Safety Executive guidance. At this inspection we were told that all basins had been

updated with thermostatic mixer valve controls. Temperature checks were undertaken for baths, showers and basins. Records confirmed checks were undertaken and temperatures within recommended guidelines.

At the last inspection we found shortfalls relating to care records where people were unable to use their call bells. At this inspection we found improvements had been made. For example, people's care plan identified they were unable to use their call bell records confirmed, 'Check hourly.' These checks were recorded as being completed in charts in people's rooms.

At the last inspection we found shortfalls relating to personal emergency evacuation plans. At this inspection we found improvements had been made and people had a personal emergency evacuation plan in place (PEEP). The evacuation plans confirmed people's individual support needs. Including if they required assistance from staff or equipment such as a wheelchair, glasses or hearing aids. There were also current gas and electric safety certificates in place. Staff ensured visitors signed the visitor's book. This is important as it keeps a record of who visited and who is in the building.

At the last inspection we found shortfalls with care plans as staff did not always record environmental risks. At this inspection we found improvements had been made to most care plans. Although one person's care plan did not fully explain what support the person required and what equipment they needed to negotiate the transfer onto the stair lift from their room. We fed this back to the registered manager who addressed this shortfall straight away. People's care plans had detailed risk assessments relating to their moving and handling and skin care. This is important as it gives staff guidelines on how to support the person with their individual needs.

People were not always supported by enough staff to meet their individual needs. For example, during the inspection we observed staff supporting people in a task oriented manner. One member of staff told us they were too busy to talk with us. They confirmed they were supporting people with their afternoon drinks and snacks and had two other people to support once they had finished supporting that person. We found two other staff were busy supporting people with their drinks and snacks. During this time two people called their bell. One person required assistance from two staff with personal care. The member of staff had to find another staff member who was free to support them. This meant people during certain times of the day were having to wait until staff were available to provide them with support relating to their individual care needs.

People told us call bells were not always answered quickly. We received feedback from people that they had to wait sometimes up to 10 minutes before they had their call bell answered. During the inspection we heard call bells ringing on one occasion the call bell rang for over 10 minutes and on another occasion for six minutes. People's comments when we asked how long call bells took to answer. They told us, "It varies 10 minutes possibly they can't just come." Another person told us, "10 minutes maybe longer depending on the time, I only use it when I have to." Another person told us, "Yes, I do have a call bell and I've used it and no there isn't enough staff. I have to wait for a long while 10 minutes plus definitely under staffed".

The registered manager confirmed the home was having to use agency staff due to having problems recruiting. People and staff felt agency staff were not always familiar with people's individual care needs. One person told us, "Agency staff are okay but they don't know where certain things are like [Name] night dress. They ask me but I don't know then they have to find a carer that works here." Staff told us, "We have agency help us but it isn't the same and is a lot harder because they just don't know people." The home had a handover sheet that had been developed to assist agency staff. They also reviewed agency staff to ensure they were appropriately trained to work at the home.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff who had checks completed on their suitability to work with vulnerable people. For example the registered manager confirmed some staff had worked in the home for over 30 years. We asked the registered manager what system was in place to check these staff were still suitable to work with vulnerable people. We found there was no system in place to review these staff were still suitable. Those staff who had recently been employed by the home had checks undertaken relating to criminal records, proof of identification and references. We fed this back to the registered manager and external consultant for them to address.

Most staff felt able to raise any whistleblowing concerns with the registered manager. They told us, "I would speak to the matron". Another member of staff told us, "If there is a problem I tell the sister and the matron". One member of staff felt unable to raise any concerns within the service. They were happy for us to raise their concerns with the external consultant. We fed this back to the external consultant for them to support this person and review the concerns they raised.

Requires Improvement

Is the service effective?

Our findings

At our last full comprehensive inspection on the 5 July 2016 we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records relating to people's health care needs were not always complete, accurate and up to date. At this inspection we found improvements were still required.

At our last inspection we found two people at risk of their pressure relieving air mattress settings being incorrectly set in relation to their weight. This ensures the person is comfortable and the mattress can operate effectively. At this inspection we found three people who were at risk of developing pressure ulcers had incorrect mattress settings in relation to their care. For example, on the first day of the inspection we found one person who weighed 33.8KG in July 2017 had their mattress set to 150KG. Another person who weighed 48.8 in July 2017 had their mattress set to 130KG. On the second day of the inspection we observed another mattress set to 30KG when they weighed 44.8KG only an hour later it had been adjusted to 60KG. Following the last inspection a monthly audit had been implemented. However in between this monthly audit there was no system of checks in place that regularly checked people's mattresses were correctly set. This information was also missing from people's care plan and pressure ulceration risk assessment. This meant people could be at risk of developing pressure ulcers due to incorrectly set mattresses. Following the inspection the registered manager confirmed a daily check had been implemented to ensure mattresses were set correctly.

At the last inspection we found daily care charts were not being completed to confirm personal care had been provided to people each day. At this inspection charts recorded if the person had been assisted with bathing, showering or assisted washing.

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's care plans had a record if people lacked capacity. Care plans had been signed by the person. However we found no best interest decisions in place for two people. One person's care plan confirmed they lacked capacity. At times their mobility was variable which meant they were unable to use a stair lift to enable them to leave their room. The registered manager confirmed on the days when they were unable to leave their room all care was provided in their bedroom. This meant they were unable to access the communal lounge area or any activities provided during this time. This meant the person could be confined and isolated to their room. No best interest decision was in place that reviewed if staying in this room was in this person's best interest or the least restrictive option. Another person required support from staff with their mobility, washing and dressing, administering their medicines, which at times they would decline, which included eye drops, hourly checks and four hourly turns at night. They also required assistance from staff with their nutrition and hydration along with specialist equipment such as bed rails and pressure

relieving mattress. The person was unable to consent to their care being provided. There was no best interest decision in place for this person in relation to this care being provided. The deputy and external consultant confirmed they were reviewing the 'Kard-X' to see what paperwork they needed to implement.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been made to the local authority. Three authorisations were in place at the time of the inspection.

During the inspection we found where two people had a DoLS authorisation in place. Conditions within the authorisation as were not being met. For example, two people require support and assistance with their nutrition and hydration. They had been losing weight. We found no action had been taken prior to us raising this within the inspection process. One person's records confirmed they had lost 8.3KG in the last six months. Another person had lost 6.5 KG in the last five months. We discussed the weight loss with the deputy and registered manager, they confirmed no action had been taken following their weight loss. Both individuals required the service to ensure all aspects of their nutrition and hydration needs were being meet. This was recorded within their deprivation of liberty authorisation. We asked the registered manager and external consultant to take immediate action relating to this concern.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found staff were not receiving refresher training as required. At this inspection the registered manager and external consultant confirmed some staff still required training and training updates. For example, 11 staff required safeguarding adults, five required moving and handling, 14 mental capacity and DoLS and 12 required infection control training. A number of other staff required refresher training. For example, a total of 13 staff required safeguarding adults, 16 staff moving and handling, 13 mental capacity and DoLS and 10 in infection control training. This meant staff were not receiving training or an update to ensure they were competent and skilled to undertake their roles.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the provider had not introduced the Care Certificate or something of a similar standard with new staff who had recently been employed. At this inspection we found improvements had been made. All new staff received training in line with this identified industry set of standards that health and social care workers should adhere to when performing their roles and supporting people.

Staff felt supported and received supervision and appraisals. Supervision and appraisals were an opportunity for staff and the manager to discuss any work and development opportunities. However, on reviewing one member of staff's supervision record only one area had been recorded as a discussion. The registered manager confirmed staff were able to raise any concerns or discuss various other work and personal topics but some choose to not have these recorded due to being private. Staff had clinical and general supervision and there was also a supervision policy in place.

People were happy with the meals and were supported to make choices about what they ate and when. People told us, "The food is excellent and we get a good choice of menu and no I don't get hungry at night but I always have a Horlicks and a biscuit at about 8pm or 9pm". Another person told us, "Well the food here is very good we get a choice and we choose what we like and no I don't have a favourite meal and I don't get hungry at night". However people who required support from staff for their meals, snacks and drinks at times had to wait for assistance.

For example, during the inspection we observed eight people eating their lunch in the dining area. During the inspection we observed lunches being served at 12:40 in the dining area. When we went upstairs at 13:45 we found people were still having their lunches sent to their room. Some of these people required assistance from staff and had been waiting until staff had finished supporting someone else before they could help them.

Good

Is the service caring?

Our findings

People all felt the staff were kind and caring and that they did a good job. People told us, "The nurses are lovely. It is a kind place" and "Staff are nice. The odd job man is helpful he built this table for me." Another person told us, "Very very nice place." Relatives were also happy with the care and they spoke highly of how supportive care staff were. They told us, "It is very caring. We are pleased with the care and staff." Another relative told us, "The staff here are very good".

People felt staff treated them with dignity and respect. They told us, "Yes, they always knock on my door and they always close the curtains and the door if they are doing anything for me". Another person told us, "They always respect my dignity and they always close my curtains and the door if they are doing anything for me". One relative told us, "I would say they respect his dignity because when they're doing anything for him the door is always closed and I have to wait to go into his room".

During the inspection we observed staff knocking on people's doors and closing people's doors. Where one person liked to have their door open the registered manager explained a screen had been provided to maintain the persons' privacy. We observed staff communicating with people during lunch. Most conversations were positive and gave people choice and support if they wanted it. For example, people were asked, "Would you like me to help you with your vegetables" and "Would you like soup today [Name]?." We observed one member of staff ask if the person wanted a protective cover to stop their clothing becoming stained. They asked, 'Can I put this on. You don't want to make a mess of your jumper – do we?' Before they had replied the member of staff had already put it on. We also saw another member of staff who stood over people instead of getting down to people's eye level and talking to them. Getting down to people eye level is important as it means people can hear and see you as well as ensuring people do not feel intimidated or overpowered. We fed this back to the registered manager for them to review staff practice.

People's care plans recorded people's individual diverse needs. The home was visited by a local vicar once a month. Staff were able to explain their understanding of equality and diversity. One staff member told us, "It is about treating everyone equally. Being considerate at all times. It is about the Equality Act and showing respect for people's gender, religion, sexuality and religion".

People were supported to maintain relationships with friends and family. During the inspection we observed friends and family visit throughout the day.

People were supported to make decisions and choices about their care and support. People made daily choices about how they wished to spend their day. Only a few people spent time in the lounge and dining room area. Most people chose to spend time in their rooms. People went out into the local community with family if they wanted or spent time with their families and visitors in their rooms.

We were told by the registered manager that no one at the time of the inspection was receiving end of life care. People's care plans confirmed people's end of life wishes and if required there was a Do Not attempt Resuscitation (DNACPR) in place. The provider's information return confirmed the home could receive

support from the local hospice if required.

Requires Improvement

Is the service responsive?

Our findings

At our last full comprehensive inspection on the 5 July 2016. We found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not person centred, did not involve people or their relatives when appropriate or were not written in an appropriate way. At this inspection we found improvements had been made although one person's care plan required an individual support plan to guide staff when they became upset and agitated.

For example, during this inspection staff confirmed one person would get upset and agitated during personal care. There was no specific support plan in place that confirmed what support staff needed to provide when they became upset or agitated. Their personal care support plan confirmed they could become upset, bite and scratch however they had no specific support plan or guidance for staff to follow. Staff were able to explain how they support the person however there was no specific guidelines in place so all staff followed the same guidance.

People's care plans provided staff with guidance on people's individual likes and dislikes. For example, one person enjoyed attending the activities but would choose to spend the rest of their time in their room. Another person's care plan confirmed their daily routine, including when they normally get up, how they like to spend the morning and afternoon and what time they like to go to bed in the evening.

Most people chose to spend time in their bedrooms during the day. The home had a lounge and separate sitting room but we saw these were only used daily by a few people living at the home. Some people had TV's and radios in their rooms, others had books to read and people told us they enjoyed reading these. One person told us how the library visited the home this they felt enabled them to access a wider range of books they enjoyed. Another person told us how they have daily newspapers delivered to the home. This was important to them. The home also bought daily newspapers which were left in the lounge for people to read.

People's care plans recorded what activities were important to them and what they did not like. For example, one person's care plan confirmed how they would demonstrate they were not enjoying the type of music they were listening to.

Although the home had an activities programme people had mixed views and some felt activities were limited. People told us, "Activities, we have singers who come in and play keyboards. We also do gardening. We did the flower boxes for our window. I love gardening". Another person told us, "Yesterday we did flexercise and we have been out for a picnic and to the lake but that's about all, I would like to do watercolour painting. I used to do that at home but I haven't been able to do that here yet". Another person felt there were not many activities. They told us when we asked them if there were activities, "No not really. My daughter comes and sees me she lives quite near and she can come and go as she feels like it". One relative when asked if there was anything they would change at the home. Told us, "Yes, activities there are not many and trips out would be good".

The registered manager confirmed they were actively recruiting for an activities co-ordinator but at the time of the inspection this post had not been filled. People's care plans recorded what activities people had participated in. We found care plans recorded limited activities people had participated in. For example, one person's care plan confirmed for the month of July they had participated in four activities throughout the month. This meant although the home provided some activities these were not always available due to the home not having an activities co-ordinator.

People felt able to raise concerns or complaints if they needed to. People told us, "I have no complaints". Another person told us, "Yes, the matron's lovely very helpful and I think she's doing a good job". Where complaints had been raised these had been investigated and recorded to prevent a similar occurrence from reoccurring.

People were supported to maintain relationships that were important to them. Family and friends could visit any time and we observed friends and family visiting during the inspection. People and relatives were happy with the visiting arrangements. People told us, "I have lifelong friends that visit me here". Another person told us, "I have family that visit regularly". Two relatives confirmed how they visited every day around lunch time they both felt this was important to the person they were visiting as it was time used to sit and talk to the person as well as offer support should they need it.

Requires Improvement

Is the service well-led?

Our findings

At our last full comprehensive inspection on the 5 July 2016. We found there were no internal systems in place to monitor the health, safety and welfare of people living in the home. At this inspection we found these systems were now in place but the home had not identified shortfalls found during this inspection.

The provider was being supported by an external consultant once a month. They had reviewed the home's policies and updated them following our last inspection. These now related specifically to the care home. They had also undertaken checks and audits including, call bell checks, accident and incident monitoring, updates to the health and safety file, monitoring of the recruitment, water temperature checks and a comprehensive audit in September 2016.

Following the inspection we were sent the home's checks undertaken by the external consultant over the last year. These quality management systems had been set in their frequency and ranged from every month to every six months. These checks had been undertaken in line with the home's set frequency and covered areas such as customer survey, safeguarding people, medication, mental capacity assessment, activities, nutrition and catering. Although the home had these checks in place either the frequency or the quality of the checks had failed to identify shortfalls found during this inspection. For example, we found shortfalls in a number of areas including acting on people's feedback, safeguarding people, air mattress settings , medicines storage and , lack of best interest decisions and people at risk of losing weight. For example, where people's feedback had been sought at last year's survey, three people had raised concerns regarding their care experience. The registered manager confirmed no action had been taken even though the comments were of a serious nature. There had been no investigation or had the information been raised with the local safeguarding team. The registered manager confirmed on the third day of the inspection they had made these referrals. This meant although people's views were sought the process had not resulted in action to improve the quality and safety of people's care.

We also found shortfalls during the inspection with medicines management. The last full medicines audit had been undertaken in January 2017. This audit had confirmed thickener was being stored unsafely in one person's room and the fridge had no medicines stored within it. Following the inspection the provider sent us monthly checks that had been undertaken following the January 2017 audit. These had failed to identify and address the issue of thickening agents being stored unsafely.

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

The registered manager and external consultant were aware of the shortfalls relating to vacancies and staff training. They confirmed they were actively recruiting but at the time of the inspection there had been little interest. They also confirmed staff who worked at the home on a zero hours contract they were in the process of requesting their training certificates. This was so they could identify what training the member of staff had undertaken and what they needed to undertake.

The home had some hand written audits that were not always legible and easy to read. For example, hand written templates were in place for legionella and temperature checks, bed rails, window restrictors, people's diets and meals options. One record relating to people's diet and meal options had various words crossed through or had correcting fluid which made the record difficult to read. We fed this back to the registered manager and external consultant so they could address this.

A registered manager was responsible for the service. They were a registered nurse. They were supported by a deputy manager who was also a registered nurse. There was also a team of nursing staff, care staff and an office administrator.

People and staff spoke positively about the management of the home. They felt the registered manager was approachable and nice. People told us, "The matron is the manager here and [Name] is the assistant manager. They are very easy to talk to and yes I think they are doing a good job". Another person told us, "The matron and I get to talk. Yes I think she's doing a good job". Staff also felt the registered manager was supportive. They told us, "It is a small home the matron is always here, really supportive. Another member of staff told us, "I go to the matron".

The registered manager confirmed they caught up with staff once a week in a non-formal staff meeting. They confirmed there was no set day for this but it was an opportunity to discuss any issues. They also saw staff at daily handovers or whilst having a break. The registered manager confirmed there was no record of these meetings. This meant there was no audit of what was discussed or any actions required. The registered manager confirmed staff had a formal meeting once a year. This meeting had been recorded with issues raised and actions taken.

People and relatives were invited once a year to a residents meeting. This was an opportunity for people to raise any concerns or make suggestions about the home. People we spoke with confirmed resident meetings were a positive experience. One person told us, "Yes, there's been one and I was surprised how open and good they were. Listening to the resident and to be honest I don't think there's anything else they could do for us".

Incidents and accidents were logged. Although daily incidents relating to staff being scratched or injured were not always being recorded. For example, staff confirmed some people could become upset and distressed whilst supporting with their personal care. They told us, "Some people are physically aggressive and will bite or go for your face". We spoke with the registered manager about where these incidents were recorded. They confirmed staff incidents were logged into an incident book. There was no record or system in place that recorded these daily types of incidents. We fed this back to the registered manager and external consultant for them to address.

Prior to this inspection the provider had submitted various notifications to inform us of events that occurred at the service. We checked these details were accurate during the inspection. We found we had not received all notifications when people and staff had raised concerns. We also found these concerns had not been raised with external parties. . We checked the registered manager was familiar with when to report incidents to us. They confirmed when they notified us and said they would address this shortfall. This meant notifications were not being made when required by law.

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 11 HSCA RA Regulations 2014 Need for consent Where people were unable to make decisions relating to their care and treatment no best interest decisions were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring people were supported by adequate staffing. Staff were not always receiving training to ensure they were competent and skilled to undertake their roles.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of abuse due to concerns not being raised and no action taken by the service. Where people had a DoLs authorisation in place the service was not ensuring people had these conditions met relating to their nutrition and hydration.

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 Audits were not identifying shortfalls found during this inspection. Relating to administering medicines, mattress settings, lack of best interest decisions and weight loss.

The enforcement action we took:

Warning notice.