Danes Lodge Ltd

Danes Lodge

Inspection report

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Date of inspection visit:
19 June 2018
20 June 2018
25 June 2018

Date of publication:
16 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Danes Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide personal care and accommodation for up to 27 older people, including those with dementia related conditions. It is located in the seaside town of Bridlington, in East Yorkshire. At the time of our inspection there were 25 people living at the home.

This inspection took place on the 19, 20 and 25 June 2018. The 19 June was unannounced and we told the provider that we would be returning on the 20 June. The 25 June was unannounced and during the evening. This attendance was prompted by anonymous concerns that were received by the local safeguarding team. Some of these concerns were substantiated.

The service had previously been rated Requires Improvement in June 2017. There was a breach in regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure adequate standards of cleanliness. During this inspection we have found that there were four breaches in regulations, regulations, 9, 12, 17 and 18.

The service is required to have a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection there was a manager in place and they were in the process of being registered with the CQC.

Processes in place for the administration of medicines at night were not sufficient and put people at risk. There was insufficient staff working at night on a regular basis and night staff were inappropriately trained to meet the needs of people.

Accidents and incidents were not always monitored and investigated effectively to ensure safe practices. Lessons learnt were not evidenced in all incidents. Not all incidents had been notified to CQC or the local safeguarding authority.

There was a lack of provider oversight which meant risks to people's safety were not picked up by the provider.

Morning routines for some people were service led and not person centred.

Staff received training in safeguarding and had knowledge of whistleblowing procedures. Recruitment processes were in place and were found to be robust.

Infection control measures were in place to prevent the risk of infections spreading to people. Although the domestic staff and night staff felt that recent cuts in cleaning hours had impacted on the cleanliness of the service, we found that standards were maintained during the inspection.
Staff aimed to deliver a good standard of care that was caring. Staff demonstrated knowledge of people and this helped them to provide some person-centred care. Feedback from relatives and friends was very positive about the caring nature of the staff.

Care plans demonstrated that the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied. Gaps in the reviews meant some care plans did not contain up to date information. Risk assessments were in place to reduce the risk to people. Peoples wider needs were met by the provision of activities and people's care plans recorded their end of life preferences.

People's nutrition and hydration needs were catered for however, the provider needed to make changes to the meal time experience to ensure that this followed best practice.

The manager had used a variety of methods to assess and monitor the quality of care. However, the governance systems had not picked up all the shortfalls identified during the inspection. Where shortfalls had been identified, action to address these were not clearly identified, recorded and monitored.

We made a recommendation about staff inductions, supervisions and appraisals.

We made a recommendation about provision of activities to meet people's wider needs.

You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medication management did not follow best practice and put people at risk.

Some incidents placed people in the service at risk of abuse from staff.

Not all incidents had been investigated to provide lessons learnt.

Risk assessments were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had been provided with regular supervision or a thorough induction and training to support them to understand their role.

People's mealtime experience required improvement to follow best practice.

Staff sought consent from people before providing support.

Is the service caring?

Requires Improvement

The service was not always caring.

Morning routines for some people were not person centred.

Staff demonstrated knowledge and understanding of people's needs.

Families provided positive feedback about the caring nature of the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place that described their individual support needs but these were not reviewed in line with the provider's policy. This meant some information was no longer accurate.

The service had an activities worker who provided activities to meet people's wider needs.

There was a complaints' policy and procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of provider oversight at the service.

Some staff felt they were not listen to, valued or respected.

Governance systems for assessing and monitoring the quality of the service were in place. However, they were not robust enough to identify all concerns.

There was a manager in post who had commenced the registration process with CQC.

Danes Lodge

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 a comprehensive inspection that took place on 19, 20 and 25 June 2018. The inspection team consisted of two inspectors on all three dates we visited the service.

Before the inspection we reviewed the information we held about the service, such as information notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We sought feedback from the local authority commissioning and safeguarding teams.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. We spoke with three people who lived at the service, three relatives, one senior carer, five care staff, one chef, two domestic staff, one activities worker, the manager, two directors and one visiting professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at two care files in full and four files in part which belonged to people who used the service. We also looked at other important documentation relating to people, such as medication administration records (MARs) and monitoring charts. We looked at how the service used the Mental Capacity Act 2005.

We looked at a selection of documentation relating to the management and running of the service. This included four staff recruitment files, training records, the staff rotas, minutes of meetings, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the

environment.

After the inspection, we contacted two healthcare professionals to seek their views and opinions, both provided feedback.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we rated this domain requires improvement as the provider did not ensure adequate standards of cleanliness and when people administered their own medicines, they were not stored safely. Although we found that the provider had improved in these two areas we found a number of other concerns.

We found unsafe practices were taking place for the administration of medicines. The local safeguarding team had received some anonymous concerns about the safety of medicines administration on an evening. We visited the service on 25 June 2018 to check whether practices on a night time were safe.

We found that medication had been pre- potted for people to take later that evening. This is called secondary dispensing and is not considered acceptable due to risk. The night staff who had been left the medication to administer were not trained or assessed as competent to carry out this task. Medication had been left insecurely and we witnessed medicines being dropped on the floor and put back in the pot to administer to a person. This staff member's lack of medication training meant they did not know that this was not acceptable. We observed that medication records had been falsely signed to say that medicines had been administered when they hadn't. One of the medicines which had been secondary dispensed was a controlled drug. Controlled drugs have different procedures and require two signatures when being administered. Two staff members on the day shift had signed this record to say the medication had been administered at 8pm when it hadn't.

We found that people who had medicines to take, only when needed, were unable to access this on an evening as no staff were competent to administer it. When a person asked during our inspection for some pain relief they were advised by staff that they were unable to administer this for them.

We found one person had been prescribed an emergency drug for seizures. Although the night staff advised us that this person usually suffered seizures in the evenings, no staff on shift that night would be able to administer this emergency drug. Staff also told us they were unsure what to do if someone needed their inhaler during the night. They said, "We haven't been told what to do if someone needed it."

During the second day of inspection we were shown evidence of protocols for medicines to be taken only when needed. However, there were none in place for the people whose records we looked at on the third day of inspection, which included the use of emergency drugs and people's pain relief. Some people in the service received their medicines covertly (in food or drink and without their knowledge). We found that one person's care plan had not been updated to reflect that one medicine was no longer being given covertly. We observed that the precise time of administration of time bound medicines was not being recorded, increasing the risk of possible overdosing.

Following this inspection, we made three alerts to the local safeguarding team as we had concerns people were not receiving their medication in a safe way.

We spoke with and wrote to the provider immediately after the inspection and requested reassurances and an action plan about the safe management of medicines in their service. We were given assurances that more night staff were undergoing training and competency checks to ensure that people would have access to their prescribed medicines on an evening. The provider also stated that they would investigate and take action regarding the concerns we found during the inspection.

The registered provider had systems and processes in place to record accidents and incidents. We identified one incident where a service user had been restrained by two members of staff. There was no plan in place for this and it was not authorised by management. Staff had not received training in restraint but felt they needed to do this to keep the person safe. We asked the provider what action they took following this incident. The provider failed to evidence an understanding of the seriousness of this incident as they had not investigated the incident and it had not been referred to the safeguarding team. Staff told us that they were not provided with supervision or a debrief after the incident. We wrote to the provider again to ask for further reassurances. The provider told us a more robust process is now in place to ensure that information of this nature is communicated to all relevant people including the directors. After the inspection we completed a safeguarding alert for this incident.

The above demonstrated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We look at whether the service has sufficient staff in place to keep people safe. Staff told us that they had concerns about staffing levels at the service. This related to either levels of care staff and/or levels of domestic staff.

Staff told us that they needed three staff on a night to make people safe. The needs of people using the service required this. Of the 25 people, living at Danes Lodge, nine required two staff for all personal care. Six of these people and an additional two people, also required two staff for all transfers (from bed to a chair for example). One person required two staff always due to safeguarding. Staff told us, "This person buzzes for assistance constantly and there has to be two of us each time we respond. When there are only two staff on we have to tell this person, only buzz if it's an emergency."

On speaking to the provider about staffing levels they advised us that three staff on a night was their intention. On reviewing rota's, during the 28-day period leading up to our inspection we found only 11 nights had been staffed with the required three people. All other nights had only two staff on duty. Staff told us, "We are very privileged to have three staff on tonight, there has only been two on all weekend."

One person told us, "There is a strain as there isn't always enough staff. Occasionally standards slip. One night when only two staff were on duty I was told I would have to wait to go to the toilet."

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

On discussing this with the provider they assured us that there would be three staff on duty each night .

On the first day of inspection we walked around the premises and looked at communal areas of the service including bedrooms, bathrooms and toilets. We observed some areas of the bathrooms were not clean. However, when we visited on the second and third day of inspection we found that standards had improved. Staff told us that the provider had recently reduced domestic hours by 10 hours a day, however the provider told us it was four hours a day. Staff told us that standards had started to slip and they found it impossible to

keep the service and the bedrooms clean. Staff told us, "We are struggling, we don't get chance to do any deep cleans. You can see on the records we aren't getting things done. Everyone is stressed." Records of daily cleaning charts showed that there were a number of days in the last month that the domestic staff were unable to complete any cleaning due to supporting with breakfasts, lunches and then spending the rest of the time in the laundry. There were also some days where domestic staff had to cover care staff as they were short staffed.

A reduction on domestic staff had impacted on the night staff who also completed laundry and cleaning during their shifts. Staff told us, "We manage but it's a nightmare. We all want to hand in our notice" and "We can lose someone to the laundry for up to six hours some nights and you can't hear the call bells going from inside the laundry."

A number of risk assessments were in place for people, these included; falls risk, moving and handling, nutritional risk assessment, leaving the home and behaviour. These were effectively used to remove risk to people.

The provider safely recruited staff. They made sure new staff completed an application form, had an interview and provided references from their previous employer. Disclosure and Barring Service (DBS) checks had been completed before new staff started work. These help employers make safer recruitment decisions by providing information about staff who may be barred from working with vulnerable people.

Safeguarding and whistleblowing (telling someone) policies were in place at the service and staff we spoke with demonstrated knowledge of what to do if they had concerns.

Maintenance records showed safety checks and servicing had been completed on the gas supply system, hoists and slings, the passenger lift and the electrical installation. We found there were plans in place to respond to any emergencies that might arise. The provider had devised a continuity plan and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises.

Requires Improvement

Is the service effective?

Our findings

Whilst some staff received training, not all staff were sufficiently trained or supported to carry out their role effectively. Staff had not received training which provided them with the skills to meet the needs of the people at night time.

Of the five staff on duty at night only one of these had been trained and assessed as competent to administer medicines. One person in the service suffered seizures, however only three staff on days had received training on this. Only one member of night staff had received training on behaviours that challenge yet there were people in the service who displayed this type of behaviour. When we spoke with the night staff about training they told us, "I don't feel I have had enough training from here." One staff member told us, "I have requested medication training numerous times." We checked the training matrix that confirmed this member of staff had not received the training. Staff raised concerns about the quality of competency checks, "I was signed off but no one observed me." Following the inspection, the provider took steps to ensure that more night staff had received medication training and were assessed as competent to administer medicines.

New staff completed an induction when they started working at the service which was recorded in an induction checklist. We found that checklists where not completed or monitored to ensure that everything had been covered on the induction. Records showed that staff supervision meetings had not been held in line with the provider's policy. Of the records we checked staff had only received one supervision in 2018. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. When we raised this with the manager they stated they were unsure why this had not happened but assured us that they would monitor inductions and supervisions moving forward.

We recommend that the service seek guidance and advice from a reputable source about the implementation of effective inductions and providing support through supervisions and appraisals.

We observed the meal time experience. We were told by staff that people chose where they wanted to eat their meal. We observed people eating in the main dining room, the lounge and some people chose to eat in their rooms. People were asked and encouraged to choose what they wanted to eat however, there was no menu displayed and people with dementia were not shown food options. Visual aids, such as pictorial menus, and non-verbal communication skills were not used to support people with dementia to make informed choices about their meals. Food options included the choice of two hot meals. We observed some people struggling to make decisions and these people were heavily prompted by staff. We observed people were not prompted or encouraged to eat when that support was needed. Some people were observed playing with their meal with little or no intake of food and lack of communication from staff. After the inspection the provider told us that pictorial menus were being created to support people to make informed choices.

People who used the service gave positive feedback about the food they received. Their comments included, "This meal is wonderful" and "The food is good, there are two chef's and both are good." Relatives

we spoke with felt the food was good. One told us, "My relative has put weight on here. This is brilliant as we had concerns about their weight before. The staff really understood what [name of person] needed from their dining experience and made sure this happened. This has had such a positive impact on [name of person]."

Care plans we reviewed clearly identified people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack 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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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. We found that care plans reflected the principles of the MCA and we observed staff seeking consent from people prior to providing care or assistance. People who were being deprived of their liberty had a valid DoLS in place and we saw evidence that the manager had systems in place to monitor these applications.

Records showed a range of healthcare professionals were involved in the care and treatment of people who used the service. We saw contact in care plans relating to dietetics, the community mental health team and speech and language therapists. A visiting health care professional told us, "We have come here for a review today and [name of person] seems settled. The room is nice and the staff have the relevant charts in place to monitor this person. My thoughts are this person seems content here."

Requires Improvement

Is the service caring?

Our findings

We observed staff at the service had a desire to 'care' for people. Staff had good knowledge of the people that they supported and of their needs. One person told us, "The ethos of this place is lovely. When things go wrong it's not because staff don't care, it's because there is not enough staff."

Some of our observations of staff were that they were heavily task focused. Staff were observed to be very busy during the inspection and time spent with people was mainly focused around tasks including supporting people to move and providing people with food or drinks. Although staff were observed to be task focused at times, the presence of an activities worker meant there were, on occasions, available staff to accommodate people's wider needs when necessary. One staff member told us, "To be honest we don't have time to sit and chat and get to know people, however our activities worker is able to do this, but they are on holiday next week."

During our inspection we completed a SOFI observation. We observed a group of five people in one communal lounge for a period of 30 minutes. During the observation there was an altercation between two people for a period of 10 minutes before staff intervened. Staff intervention was observed to be effective. However, throughout this incident one person sat and cried and was clearly distressed by the situation but staff did not interact with them.

We spoke with staff about how they maintained people's dignity. Staff provided us with examples of how they respected people's dignity. Their responses included "I know to keep bathroom doors closed and to knock on people's doors before entering. People told us that they felt they were treated with dignity and respect. Comments included, "Yes, they do [treat me with dignity and respect], they know when to leave me alone and when to come back."

Relatives spoke positively about the staff. Comments included, "I can't speak more highly of the staff here. Every member of staff knows [name of person] well and I can talk to any of them. Night staff have [name of person] in a great routine", "The staff really do care about people here" and "The staff are very respectful and sympathetic to people's needs."

Relatives also described strong relationships between people and the staff. One relative told us, "[Name of staff] really took to [name of person] straight away. That member of staff is fabulous. It's like an extended family. All of the staff know us all when we come in and we are welcomed by everyone."

People's friends and relatives were welcome to visit, there were no restrictions to the amount of time they could spend at the service. Relatives we spoke with said, "We all come and visit at different times and it's never a problem."

We discussed with the manager whether anyone had an advocate. Advocates provide independent support to help ensure that people's views and preferences are heard. Although no one at the time of the inspection had an advocate in place the manager demonstrated knowledge of the benefits of advocates.

People's cultural and religious needs were considered when care plans were being developed. Information about people's likes and dislikes and their religious beliefs was included within the care plan. The provider had an equality and diversity policy setting out a commitment to equality and diversity principles. One person received visits from a local religious leader.

Requires Improvement

Is the service responsive?

Our findings

Some staff members raised concerns about how person centred the morning routine was. One staff member told us, "The one thing I disagree with is that we get people up at 5am. I see people asleep at the breakfast table. It is standard practice. They usually start with those who require hoisting. For some people it is their choice but not all of them." Another staff member told us, "If there are three staff on at night we can start the morning routine at 5am. If only two staff we have to start at 4:45am. I believe people are happy to get up at this time. By the time we have got them up to go to the toilet they are awake anyway." Another member of staff told us, "Most of the time I think it is people's choice to get up at this time. It is tit for tat with the day staff, if we don't get people up in the morning then they won't get people ready for bed for us. That's just how it is." This practice suggests that these morning routines are in place to meet staff needs and not those of the people that use the service. This is not respecting people's dignity.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection process the provider advised us; 'It has always been the policy of the provider to allow people to decide when they would like to get up or go to bed. It has been re-iterated many times that this should not be task focused and steps will be taken to ensure this doesn't happen. Person centred care training has been arranged for all staff.'

A pre- admission assessment was completed before people moved into the service. This included a summary of needs for all areas of support the person may require. The service had an electronic care plan system in place. We observed that all staff had a good understanding of how this worked and how to navigate around the system to find the information that they required.

These plans included information about people's individual needs, such as; communication, daily life, mobility, nutrition and continence. We found care plans to be person centred and respected people's ability to make their own choices. The manager provided us with a copy of one person's care plan that was being written by that person. This was in the process of being transferred onto the electronic system.

The provider's expectation was that reviews of care plans would take place monthly. We found gaps in this over the last three months. When we discussed this with the provider they advised us that this was because of the new manager in post. They were reviewing one person at a time to go through their support needs and also have discussions with staff, by holding a resident of the week meeting.

A lack of reviews had resulted in some people's care plans not being up to date, for example, one person no longer received their medication covertly, however this had not been updated in the persons care plan. The provider took action to address this during the inspection. Another care plan had not been updated in relation to risk management measures in place for self-medicating. We have addressed this further in the well-led domain.

The service aspired to meet people's wider needs through the provision of activities. The service had one activities worker in post and one vacant post. The activities worker offered a variety of group and individual activities depending on people's choice and preference. We saw activities had taken place including, an animal experience visit, entertainers, pampering and physical and mental agility sessions. One member of staff told us, "We always promote choice, when people move in we ask about their beliefs and their interests. If people don't want to do group activities that's fine and we make sure we offer them lots of one to one. We revise activities continuously and the new manager had brought in lots of new ideas." One staff member told us, "When the activities worker is on a day off or on annual leave, activities don't take place. The care staff don't have enough time to do that as well as care for people." One person told us "There is not enough activities, as staff get diverted onto care tasks, there is only one activities worker now and she is going on holiday soon." The provider advised us that they were currently in the process of trying to recruit a second activities worker. The National Institute for Health and Care Excellence quality statements on dementia advises; People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.

We recommend that the service seeks guidance and support from a reputable source regarding the provision of activities to meet people's wider needs.

The provider had a complaints policy and procedure in place and this was on display within the service. Three complaints had been received in 2018, these were recorded on a complaints log and there was a monthly analysis of complaints. The manager had dealt with all complaints received and provided a timely response to the complainant. One of the complaints raised by a person living at the service questioned whether there was enough staff on during the night when there were only two workers. The provider responded advising that there would be three staff on a night shift where possible and that they would continue to monitor the staffing levels at night.

There was the option within people's care plan to record their end of life preferences. Where information was recorded it provided person centred information about who was to be informed, the person's religion and funeral preferences.

Inadequate

Is the service well-led?

Our findings

We found that there was a lack of managerial oversight by the provider which had led to some unsafe practises. The provider had failed to create a culture within the staff whereby people and staff felt listen to and respected.

The provider had no registered manager in post since August 2017. There was a new manager running the service who was in the process of registering with CQC.

During the absence of a registered manager the provider had failed to provide the oversight to ensure consistent and safe management of the service. The provider informed us following the inspection that they were unaware that the previous manager had stated only senior staff could administer medicines and this meant there was only one member of staff who could administer medicines at night. This led to the unsafe medicines practices as described. More robust provider oversight should have highlighted this sooner. Meeting minutes on 8 March 2018 demonstrated that staff raised concerns directly with the provider about this situation. After the inspection the provider stated they had believed that more staff would be trained and competency checked in medicines and the situation would be resolved. However, this was not followed up or checked by the provider until we brought it to their attention during the inspection.

The provider failed to listen to the staff team, people in the service and professional's advice regarding suitable staffing levels in the service. Staff in the service consistently told us that there was insufficient staff to meet people's needs, especially on a night time. Comments included, "The night staff complain about not having enough staff. Sometimes it is horrific for them" and "At the moment we do need three staff on a night shift, as we have lots of people up during the night that require care." Another staff member told us, "I spoke to the manager after a really bad shift. They were sympathetic but it's [name of director] and the way they are running the place staff wise is appalling."

One person using the service had made a formal complaint to the provider stating that two staff on a night time were insufficient. The service had responded to this complaint advising they would continue to monitor the staffing levels at night. The provider had received written confirmation from the local authority who felt that two staff was not sufficient to ensure people's safety during the night and that they would not recommend reducing the number from three. Despite this information we found that in the four-week period leading up to our inspection the majority of night shifts were completed by only two staff. We read the manager's meeting minutes from 10 April 2018 were the provider stated, 'If you have anyone ring in sick, don't worry if you still have two staff, as it is not the end of the world and the home can run with that.' The provider showed no commitment to ensuring that the home was staffed sufficiently to meet the needs of people on a night time. Following feedback at the end of our inspection the provider assured us that they would be committed to ensuring there were three staff on each night shift moving forward and provided evidence of rotas for the next three months confirming this.

The provider's systems for monitoring accidents and incidents needed to be more robust. The provider was unaware of the incident where a person had been restrained by two members of staff. Following our

inspection, we wrote to the provider to request further information about how this incident had been dealt with. Insufficient information was provided so we wrote for a second time. The response evidenced that the provider had failed to ensure that correct steps were followed following the incident. The provider advised us that they fully understood the seriousness of this incident and that a director now had access to monitor incidents remotely to provide the oversight that was necessary.

Although there were many detailed audits in place these sometimes lacked the actions and timescales to address issues as necessary. In addition, audits had not picked up all the shortfalls that we identified during the inspection.

We found there had been a lack of consistent supervision and development of the staff team. Gaps in knowledge, skills and competency had impacted on the safe delivery of person centred care that met the needs of the people who used the service.

A lack of good governance of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff we spoke with told us that morale was low and staff told us there was high levels of stress and work overload. The majority of the staff we spoke with didn't speak highly of the provider or felt that they could go to them for support. Comments included; "For [name of director] it's all about the profit, I know it has to be a business and make enough money but there are ways to do that without putting people at risk and making us stressed." Another staff member told us, "We have raised it with senior management, but they don't listen or give us the resources we need."

However, some staff spoke positively about the manager and the provider. Comments included "I think the new manager is open and approachable. The provider comes through to the service and they have spent a lot of money on improving the building. I feel I could go to the provider with any concerns." Another worker told us, "I have found the provider to be very supportive, I feel I could go to them with a problem."

One person told us, "The new manager seems nice, but it's all economics with [name of director] and I do not feel that I can approach them, as I am sure I will be out."

The provider sought feedback from people and their relatives. In February 2018 a survey was sent out to residents and feedback was summarised and an action plan put in place. Feedback included that staff were busy but found time to help individuals when needed, staff attitude was mainly positive but some concerns were raised about how long it took staff to respond to requests, and all staff were approachable.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. As the service had failed to notify safeguarding and CQC of the incident where a person was restrained, the service had failed to meet this requirement. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are looking at this matter outside of the inspection process.

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 People's morning routines were service led and not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Unsafe medicines practices were in place that put people at risk. Accidents and incidents were not reviewed or investigated when things went wrong. They were not reported to the correct people and lessons learnt were not identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality audits failed to identify shortfalls. The provider failed to listen to feedback to evaluate and improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staffing to meet people's needs at night.