CareQuality Commission

Wilbraham Limited

Wilbraham House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We completed an unannounced inspection at Wilbraham House on 5 and 6 December 2017. At the last inspection on 6 February 2017, we found a breach in regulation11 because people's ability to consent to their care was not always assessed. We asked the provider to take action to make improvements and we found that there had been an improvement in this area. However, we identified further breaches in regulations and improvements were still needed to ensure that people received a good standard of care.

Wilbraham House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wilbraham House accommodates up to 33 people in one adapted building. At the time of the inspection there were 29 people who were being provided with a service. People who used the service predominately had physical disabilities and/or mental health needs such as a learning disability or dementia.

There was an application in process for a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection our records showed the previous registered manager's name was still against the service. We spoke with the provider who stated that they had requested the previous registered manager to de-register with us (CQC).

We found that the provider had not sustained all the improvements from previous inspections and the systems in place to monitor and manage the service were ineffective. This meant that areas of poor practice had not always been identified.

The provider had not notified the commission of incidents and events without delay as required by law.

Improvements were needed to ensure that records contained accurate and up to date information.

People's risks were not always planned for, which meant people were at risk of unsafe and inappropriate support.

People were not always safeguarded from abuse because staff had not always recognised possible abuse and therefore these incidents had not been reported as required.

Improvements were needed to ensure that people's cultural and diverse needs were considered in the assessment of their needs to enable effective planning and individualised care provision that met people's preferences.

Improvements were needed to the quality of the lunchtime meal to ensure they suited people's individual preferences.

We found improvements were needed to ensure that staff understood the training they had received and how this needed to be carried out as part of their role.

People told us staff were caring towards them. However, provider had not always ensured that people were cared for in a way that protected their dignity and and kept them safe from potential harm.

Improvements were needed to ensure that the provider's complaints policy was up to date and accessible to all people who used the service.

There were enough suitably recruited staff available to meet people's needs in a timely manner.
People received their medicines as prescribed and infection control measures were in place to protect people from potential infection risks.

People were supported to consent to their care and there were systems in place to ensure that decisions were made in people's best interests and in the least restrictive way.

People's health was monitored and health professionals input was sought where needed.

The environment was adapted to promoted people's needs and independence and there were plans in place to make further improvements to the environment.

People's choices were promoted and respected by staff in a way that promoted people's individual communication needs. People's right to privacy was upheld and their independence was promoted.

Planned improvements were in place to ensure that people were supported during their end of life in line with their wishes.

People had the opportunity to participate in interests and hobbies that met their preferences.

People, relatives and staff felt able to approach the registered manager and directors.

Feedback had been gained from people and relatives and the manager had identified some areas within the service that needed improvement.

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 consistently safe.

Staff were not always aware of people's risks, which meant people were at risk of unsafe and inappropriate support.

People were not always safeguarded from abuse because staff had not always recognised possible abuse and therefore these incidents had not been reported as required.

There were enough suitably recruited staff available to meet people's needs in a timely manner.

People received their medicines as prescribed and infection control measures were in place to protect people from potential infection risks.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure that people's diverse needs were considered in the assessment of their needs to enable effective planning of their care.

People gave mixed feedback about the quality of the food. Some improvements were needed to the quality of the lunchtime meal to ensure they suited people's individual preferences.

Staff received training, which was updated as required. However, some improvements were needed to ensure that staff understood the training provided and how this needed to be carried out as part of their role.

There were systems in place to ensure that decisions were made in people's best interests and in the least restrictive way.

People's health was monitored and health professionals input was sought where needed.

The environment was adapted to promote people's needs and independence and there were plans in place to make further

improvements to the environment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were caring. However, people did not always receive caring support because the provider did not always ensure that people were cared for in a dignified way and safeguarded from potential harm.

People's choices were promoted and respected by staff in a way that promoted people's individual communication needs. People's right to privacy was upheld and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a complaints procedure available for people and people knew how to complain. However, some improvements were needed to ensure that the complaints policy was up to date and accessible to all people who used the service.

Some improvements were needed to ensure people's cultural and diverse needs were assessed and considered to enable individualised care provision that met people's preferences.

Planned improvements were in place to ensure that people were supported during their end of life in line with their wishes.

People had the opportunity to participate in interests and hobbies that met their preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The manager had not notified the commission about incidents that had occurred at the service, such as; safeguardings and events that may stop the service.

We found that the provider had not sustained the improvements from previous inspections and the systems in place to monitor and manage the service were ineffective. This meant that areas of poor practice had not always been identified.

Improvements were needed to ensure that the provider's policies

were up to date and contained sufficient guidance for staff to follow.

Improvements were needed to ensure that records contained accurate and up to date information to ensure that people's risks were mitigated.

People, relatives and staff felt able to approach the registered manager and directors. The recently appointed manager had started to gain feedback from people and relatives and they had identified some areas within the service that needed improvement.

Care Quality Commission

Wilbraham House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on Tuesday 5 December 2017 and Wednesday 6 November 2017 and was unannounced. The inspection team consisted of two inspectors 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. The expert by experience had specific experience of care homes for people with dementia.

We used the information we held about the service to formulate our planning tool. This included 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. We also reviewed other information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns, serious injuries and deaths that had occurred at the service.

We spoke with six people and two relatives. We also spoke with five care staff, the deputy manager, the manager and three directors. We observed how staff supported people throughout the day and how staff interacted with people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We viewed eight records about people's care and four people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, improvement plans and six staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

We found that potential acts of abuse had not always been reported as required. For example; one person's daily records stated that they had reported to staff that they had been hit by another person who used the service. This had not been recognised as abuse by staff and had not been investigated or reported to the safeguarding authority. Therefore, there had been no management plan put in place to lower the risk of reoccurrence. Another person records showed that they had been pushed over by another person who used the service. This had not been reported or investigated to ensure that this person was protected from further harm. The manager told us that they were not aware of these incidents and they would ensure staff understood what scenarios may constitute suspected abuse. This meant that people were at risk of continued abuse because this had not always been recognised or reported as suspected abuse.

We found that some unexplained injuries (such as bruising and skin tears) had not been investigated and/or reported as a safeguarding concern. Some of the instances of injuries had occurred under the previous management and had not been acted on. However, we found recent records under the new management that had also not been investigated or reported as required. For example; one person's records showed that they had a skin tear to their leg and the cause was unknown. There were no records that showed this concern had been investigated or reported to the safeguarding authority. Another person's records showed that they had a small cut to their forehead and the person was unable to say how this had occurred. We also saw that the same person had a bruise on their back. There was no explanation as to the cause of the cut to their forehead or bruise and this had not been raised as a possible safeguarding concern. We fed this back to the manager who told us they had looked into this and the person had fallen from the bed but they had not recorded these details at the time. We saw there were no incident forms in place that showed this person had fallen out of bed and we could not be assured that this person had been safeguarded from harm. This meant that people were not always protected from the risk of harm.

The above evidence shows that people were not always safeguarded from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's mobility/falls plans and risk assessments were had not always been updated after they had fallen. For example; one person's risk assessment stated that they were at risk of falling. Their mobility care plan stated 'uses frame confidently'. We saw that this person's mental health plan stated that the person needed to be supervised when moving around the service. However, this information contradicted the mobility care plan. We observed and staff told us the person was unsteady with their frame and needed support and encouragement when using the frame. We saw that this person was left without supervision from staff and they put themselves on their knees. We observed that staff saw the person mobilising alone and did not stay to offer support and supervision. This meant that this person's mobility risks were not managed or mitigated to keep this person safe from harm. Another person's records stated that they required one member of staff to provide support when mobilising. However, we saw that this person did not always receive this support as stated in the evaluation of their safety care plan. This person had fallen a number of times and their risk assessment had not been updated and reviewed to ensure that this person's risks were managed to protect them from harm. This meant that people's risk of falling was not

always managed or mitigated to protect them from the risk of harm.

We found that people's behaviour that may challenge had not been planned for to ensure that staff provided consistent and safe support. For example; a senior member of staff and the manager told us that there was a risk that one person may display sexual behaviours towards another person who used the service as they believed they were married. We were told that staff needed to try and keep these two people separated and in different lounges. We viewed the care records which did not contain specific details about these behaviours and how staff needed to manage this risk to keep both people safe. We spoke with care staff and asked if they knew about these behaviours and the three care staff we spoke with gave inconsistent answers and were not aware that these two people needed to be in different lounges. During the inspection we saw these two people sat together at lunch and were supported by staff to sit together in the lounge whilst they watched the entertainment. We were unable to assess whether the risk between these two people was managed and whether the support provided was appropriate as there were inconsistent accounts and observations. This meant that people were at risk of receiving inconsistent and inappropriate care because people's care needs were not assessed and recorded to keep people safe from potential harm.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us there were enough staff available at the service. One person said, "The staffing levels are more stable now". A relative said, "Since the new manager the staffing levels are a lot better". We saw people were supported by staff in a timely manner throughout the inspection. Staff we spoke with felt that there were enough staff available and plans were in place to cover shortfalls in staffing numbers. One member of staff said, "Staffing is a lot better than it used to be. There is enough staff about to help people now". The manager had a system in place to assess the staffing levels against the dependency needs of people and they had recently changed the shift patterns to ensure there was always enough staff available. They told us and we saw that they were regularly checking that staff were deployed across the service to enable them to meet people's needs in a timely way. This meant there were enough staff available to provide support to people and staffing was reviewed and changed to meet people's needs.

We saw that the provider had a recruitment policy in place and checks were carried out on staff before they provided support to people. These checks included references from previous employers and right to work permits. We also saw that criminal record checks had been undertaken which ensured staff employed were suitable to provide support to people who used the service.

People told us that staff supported them with their medicines when they needed them. We saw that staff administered medicines in a dignified manner and explained to people what medicines were being administered and why these were needed. The provider used an electronic system to record all medicines administered. This was resourced to make improvements to the way medicines were managed at the service. Staff told us and we saw that this new system had helped to improve the recording and management of medicines. We saw that where people required 'as required' medicines these contained detailed guidance for staff to follow. Medicine Administration Records (MARs) we viewed showed the medicines people needed, the frequency and the amount and we saw the MARs had been completed accurately by staff. This meant that medicines were managed safely.

People and relatives told us that the service ensured all areas were clean. One person said, "It's always kept clean". We saw that the environment and equipment were all clean and there were no mal odours present.

We saw domestic staff regularly cleaning all areas of the service. The manager showed us how they assessed their infection control risks to ensure the prevention of infection and cross contamination. This meant people were supported in a clean environment and they were protected from the risk of infection and cross contamination.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from people about the quality of the food provided. People told us they enjoyed the food at breakfast, but they did not always like the food provided at lunchtimes. One person said, "The breakfast is always good. I have bacon butties every morning. I don't like the new food we have now it can be quite hard at times". Another person said, "I'm not happy with the new food. Its ready meals and we had tasters which we nice but it tastes nothing like it now. I preferred the home cooked meals we had before and I don't know why it changed". We observed lunchtime and saw that some people enjoyed the food. However the was a large number of people that did not eat their food. We heard comments from people which included, "The veg are like bullets I can't eat those" and, "This is never hot pot! There's no gravy and the veg isn't cooked well enough for me". We fed back the comments to the manager and the provider who told us this was relatively new and they were regularly collecting feedback from people about the new menu, and they had organised a further tasting session for people to be involved in. This meant that some improvements were needed to ensure that people were happy with the quality of the food provided.

We found that before a person used the service an assessment of their needs was completed to ensure that the person's needs could be met at the service. We saw that information was gathered from the person themselves, family members and any other representatives that were involved in the person's life. This information included details such as; the person's past medical history, physical and emotional needs and people's likes and dislikes. However, we found that the assessment form did not detail specific information about people's diverse needs such as cultural background, religion or their sexuality. We fed this back to the manager who stated that they would ensure that a care plan was implemented to include an assessment of people's diverse needs. This meant improvements were needed to ensure that people's diverse needs were assessed and planned for.

Staff told us that they had received an induction when they commenced their employment, which included training to help them carry out their role. However, some staff we spoke with had limited knowledge about safeguarding and the Mental Capacity Act 2005 (MCA). We asked staff to demonstrate their knowledge in these areas. One staff member said, "I'm not too sure really. I have a card for MCA (The card contained details of the principles of the MCA)". Another staff member was unable to answer the question asked. The training records we viewed showed that staff had received training but staff's competency and knowledge had not been checked to ensure that they understood the training provided. This meant that some improvements were needed to ensure people were supported effectively.

At our last inspection, we found people's ability to consent to their care had not always been assessed in line with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made.

People who were able told us that they consented to their care and we saw that staff asked people's permission before they provided support. Some people who used the service were not always able to understand specific decisions about their care and we checked to ensure that the staff were following the

principles of the Mental Capacity Act 2005 (MCA). The 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. We saw mental capacity assessments had been carried out when people lacked capacity, which contained details of how staff needed to support people to make specific decisions in their best interests. This meant improvements had been made to the assessment of people's capacity in line with the MCA.

We saw referrals had been made for Deprivation of Liberty Safeguards (DoLS), where people had restrictions in place to keep them safe. 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. Staff were aware of people's individual restrictions in place and we saw staff support people to keep them safe from harm in line with their individual DoLS. This meant that people were supported in the least restrictive way and in line with the MCA.

People told us they were able to see health professionals when they needed to. One person said, "I can see a doctor if I am unwell". A relative said, "They are very good at getting a doctor if my relative is unwell". We saw that where people's needs had deteriorated referrals had been made to health professionals to ensure people received appropriate care that maintained their health and wellbeing. For example; we saw that one person had been referred to a district nurse when their skin had deteriorated and regular visits were in place to enable the nurse to dress the person's skin. We also saw that people had been referred to the continence nurse where they were experiencing continence issues to ensure this was managed effectively. This meant that people were supported to access health professionals to maintain their health and wellbeing.

We saw plans were in place that detailed the individual support people needed to ensure their nutritional needs were met. For example, people who had been assessed as a high risk of malnutrition had a plan in place that detailed the actions required by staff. We saw that people who were at risk of malnutrition were encouraged to eat and assisted throughout mealtimes. People's weight was monitored and where there were concerns actions had been taken to ensure people were supported to maintain a healthy weight.

We saw that the environment had been adapted to help meet people's physical and mental health needs. This included bathroom equipment and grab rails in corridors. We saw that people were able to move around the service and the environment was clear of any hazards that could be a risk to people such as trips and falls. We also saw that the environment had some adaptations to help people living with dementia. For example; the different areas of the service had street names which were clearly signposted for people and doors were coloured to help people differentiate between walls and doors. Some people had pictures of themselves outside their private bedrooms to help them recognise their own rooms. The provider told us they were in the process of making improvements to the environment. This meant that the provider had considered people's needs and was in the process of making improvements to the environment.

Requires Improvement

Is the service caring?

Our findings

We found instances that did not always promote a caring and dignified environment for people. For example; staff had not always recognised potential abuse, which meant people were not always supported in a safe and caring way. We also saw that people had not always been supported to lower the risk of harm to themselves and others. We also saw that people's dignity was not consistently considered. For example; we saw one person's trousers were falling down and they were at risk of their dignity being compromised. We informed the staff and manager of this and we were told this person regularly removed their belt and their trousers, which compromised their dignity. We found that action had not been taken to reduce this risk such as purchasing trousers that were a better fit or that had elastic waistline to reduce these incidents and maintain their dignity. This showed that the provider had not always ensured that people were cared for in a dignified way and protected from potential harm.

People told us they were happy with the support they received and staff were caring towards them. One person said, "I find it very good. I get support here and carers have time to chat. They [staff] are very polite". Another person said, "They [staff] do very well for me. I love it here and I'm very pleased with the care I get. That's why I'm very happy here". We saw caring interactions between staff and people who used the service. For example; we saw staff sitting with people when they needed to talk with them and staff asked people how they were feeling and if they were okay. People were seen smiling and were comfortable in staffs' presence and enjoyed spending time with staff who showed interest in people's thoughts and opinions.

People told us that they were given choices in how and when their care was carried out. One person said, "The staff always ask before they help me and I feel I have choices in how things are done". Another person said, "I was asked if I was happy for male carers to help me and the staff listened to my choices with regards to this". We saw that people were given choices throughout the day by staff who were patient and listened to what people wanted. We heard staff asking people in a way that promoted their understanding and repeated questions if people hadn't heard or understood the question. People responded well to the way staff interacted and staff had a good understanding of people's physical ways of communicating their needs. One person had difficulty communicating and they liked to write down what they needed, we saw this person had a notepad with them throughout the inspection and they used this to effectively communicate with staff. This meant that people's communication needs were met to promote choice and involvement.

People told us they were able to maintain their independence where able and staff respected their privacy. One person said, "I can go to my room when I want to, sometimes I like time on my own". Another person told us that staff always spoke with them in a caring and dignified way and gave them time to respond to questions. People also told us that they were able to access their own rooms throughout the day if they needed some time alone and one person told us they walked to the local shop on a daily basis to get their papers. This person told us they liked to be as independent as possible and the staff respected their wishes. This meant people's independence was promoted and their right to privacy was up held.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they knew how to complain and they felt confident that complaints would be dealt with. One person said, "I am confident to raise issues and they are usually acted upon and resolved". We viewed the provider's complaints policy and complaints records. The policy stated that verbal complaints were to be recorded in the 'niggles' book. However, when we asked for this book it was not in operation. We also found that the policy contained the previous manager's contact name. There was not an easy to read version of the policy available to ensure people who had cognitive impairments were able to understand the procedure to complain. This meant improvements were needed to ensure the provider's complaints policy contained up to date information for people to follow which was in a format that was useable to all people that used the service.

We found that people's diverse needs were not always being assessed before they started to use the service and this important information was not available to staff. For example; one person's records we viewed contained information about their religious needs and the importance of this in their lives. We saw that this person was supported to attend church on a weekly basis and liked to study scriptures on a daily basis. This person's care records contained clear information about this person's cultural needs. However, we found that people's other diverse needs such as sexuality had not been considered at the assessment stage and people's sexual orientation were not detailed in the care records. Staff and the manager told us that they were not fully aware of people's sexual orientation. The manager said, "Most people have been married so we go by this, but I agree this needs to be considered and this will be considered whilst I am re-assessing people's needs". This meant that improvements were needed to ensure people were receiving a fully personalised service in all aspects of their life.

At the time of the inspection there was no one receiving end of life care. However, we found that some advance plans were in place and information had been gained from some people or their relative's that stated specific wishes and preferences at their end of life such as; family contact and the person's wishes after their life has ended such as burial or cremation and whether the person had specific clothing. The manager told us they were in the process of re-assessing people's files and would ensure each person has an advance plan in place. This meant that improvements were being made to ensure that information regarding people's wishes at the end of their life was available for staff to follow.

People told us that they participated in activities within the service. One person said, "I like the regular keep fit exercises and we watched a performance of 'Annie' which I really enjoyed too". One person showed the expert by experience the Christmas centre pieces that they had made for the tables and also said they liked to read and borrowed books from a small library within the home. We also saw a carer who was a singer provided the afternoon entertainment and people commented how they had enjoyed listening to her singing. We saw that staff sat with people and chatted with people in a way that met their needs. Staff knew people well and had a good insight into their past lives, which enabled them to have meaningful conversations. This meant people were supported to access a variety of interests and hobbies that met their preferences.

Requires Improvement

Is the service well-led?

Our findings

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service, for example; expected and unexpected deaths, serious injuries, Deprivation of Liberty Safeguards (DoLS) and alleged abuse. During the inspection the inspector identified that the lift at the service was out of order. The provider stated that this was out of order awaiting the repair to be carried out. We were told the actions in place to ensure people were able to access the communal areas safely. However, we had not received a notification to alert us that there was an issue at the home that may stop the carrying on of the regulated activity and how this had been dealt with prior to our inspection. We also identified from the provider's safeguarding file that a referral had been made to the local safeguarding authority regarding five people who used the service. We had not been notified of this safeguarding incident by the provider prior to our inspection. The manager told us that they would ensure they would report as required in the future. We will continue to monitor to ensure that incidents are reported appropriately as required by law.

The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

We saw that incidents and accidents were audited monthly by the manager. However, this was not effective. For example; we saw from the incident records that one person had fallen on numerous occasions since September 2017. The incident audit completed by the manager stated that staff needed to check the person hourly and assist them to the toilet and ensure they were using their frame. We looked at their care plan and risk assessment and found that the care plan contained details about the person's change in equipment from a stick to a frame, but did not include the hourly checks and support when accessing the toilet. The risk assessment had not been updated with this new information and the monthly reviews had not identified that this person's needs had changed. The evaluations completed by staff stated the care plans 'remained effective' and no changes had been made to ensure this person was receiving care that met their change in needs. We observed this person walked to the toilet unaided, whilst a member of staff was in the lounge observing. We saw this person arrived at the toilet and was having difficulty manoeuvring their walking frame which was trapped in the door frame. We called a member of staff for assistance who helped this person to move safely. Staff we spoke with were unaware of the changes in this person's support needs and the actions required to keep them safe. This meant that the system in place to analyse and act on incidents and accidents was not effective in mitigating people's risks.

We saw that staff had received training. However, we found that there was not a system in place to monitor their understanding and competency after they had undertaken training. For example; staff told us that they had undertaken safeguarding training, but we found that staff had limited knowledge when they were asked to explain this area of care. We found that incidents of alleged abuse between people that used the service had not always been recognised as abuse and therefore had not been reported to the local safeguarding authority. We also found that some instances of unexplained bruising had not been reported or investigated as required. Staff had received training on the Mental Capacity Act 2005 (MCA) and the manager had provided staff with prompt cards which contained information about the MCA. However, staff we spoke with

were unable to explain what the MCA meant and how they needed to support people in line with the principles. This meant that people were at risk of unsafe and inappropriate care because there were not effective systems in place to ensure that staff were carrying out support in line with the training received.

We saw that accurate records had not been kept when people's needs had changed and reviews were ineffective. We found that care plans and risk assessments contained different information about people's needs and did not contain sufficient up to date information. Staff we spoke with gave inconsistent accounts of how they needed to support people to in line with their needs. For example; one person's records stated that they required one staff member to provide support when mobilising. However, we saw that this person did not always receive this support as stated in their safety care plan evaluation. This person had fallen nine times and their risk assessment had not been updated and reviewed to ensure that this person's risks were managed to protect them from harm. We saw that another person had fallen three times and their most recent fall had resulted in a cut to their head. We saw that this person's risk assessment and care plans had not been updated since April 2017 and the monthly evaluations that had been carried out stated that the risk assessment remained effective. There was no information regarding this person's falls and what actions staff needed to take to keep them safe from further harm. This meant that reviews were ineffective and people's records did not contain an accurate reflection of their current support needs to mitigate the risk of harm.

We found that the provider's policies and procedures were out of date. The last reviews were undertaken in July 2017 and we found there was insufficient information included in some of the provider's policies. For example; we saw that the safeguarding policy did not contain sufficient guidance for staff to follow such as; what may constitute abuse and the procedure staff needed to follow when abuse may be suspected. We also saw that the provider's equality and diversity policy concentrated on anti-discriminatory practice. However, there was no specific guidance on the process the provider and staff needed to follow to ensure that people's diverse needs were considered and assessed in accordance with the Equality Act 2010. We also found that the provider's notifications policy did not include the requirement to report serious injuries to the Care Quality Commission. This meant that the provider had not always ensured there were clear processes in place to provide guidance for staff.

We found that improvements that had been made following our inspections carried out on the 16 September 2016 and 6 January 2017 had deteriorated. We found that where improvements had been made to the systems to monitor the quality of the service these had fallen behind and were no longer effective. For example; care file audits, food and fluid chart audits and monitoring of people's behaviour charts had all fallen behind, which meant that there was a lack of overview of the service people received. A new manager had commenced at the service in October 2017. The manager told us that they were aware that there were improvements needed across various areas within the service and they had plans to reassess all of the care files to ensure people's needs were met. They stated they had not been at the service long enough to ensure all these changes were made but were confident that this will be completed as soon as possible and they would ensure effective monitoring systems were maintained under their management. However, these had not been completed in a swift manner for people who were at high risk prior to our inspection and we were unable to assess the effectiveness of the manager's planned improvements. This meant that the provider had failed to ensure that previous improvements made at the service were sustained and the systems in place to monitor and mitigate risks to people were no longer effective.

The above evidence shows the provider did not have effective systems in place to manage and monitor the service to mitigate risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relative's told us that the newly appointed manager was approachable. One person said, "The new manager seems very friendly and they come and say 'Hello' and ask if we are okay". One relative said, "The new manager is very nice and they will go the extra mile, even some of the carers too. I think they will turn things around. The Directors are working with her". Another relative said, "The new manager has brought more staff in and promoted some of the existing staff which is good". One relative told us they had spoken with the owners and suggested that both residents and relatives should play and role in interviewing for a new manager and this was taken up. The relatives were part of the interview process. They were impressed with the leadership displayed by the Directors and the new manager. A visitor told us that the owners were very supportive and were present in the service at least 2-3 days a week. They felt that the directors were open to and receptive to ideas and suggestions and were eager to help. This meant that people and relatives felt they could approach the management team.

Staff told us the manager and directors were approachable. One member of staff said, "The manager is quite new, but they seem approachable and they often help us if needed which is good". Another member of staff said, "I feel I could approach the manager and directors and they would take action if I had any issues". Staff told us they had received formal supervision with the manager and they had found this useful. One staff member said, "We discussed my performance". Supervision is a session for staff to discuss their practice and other issues such as their development needs. This meant that staff felt supported to carry out their role effectively by a management team that was approachable.

We saw that people and their relatives had completed a survey in November 2017 about the care received. The results of this survey had not been analysed by the manager at the time of the inspection. The manager told us this was due to be looked at as they had only just received the surveys back from people. A relative told us that within a couple of weeks of the new manager being appointed the manager had looked through previous CQC reports and drawn up an Action Plan to improve performance. The manager had invited all relatives to a meeting to outline the plans in place to make improvements. The relative told us this was well attended and well received. We saw records that confirmed this had taken place and an action plan had been developed. However, this had only focused on specific areas of care and a full action plan had not been implemented at the time of the inspection visit. We received a full action plan from the providers after the inspection. We will assess the effectiveness of this action plan at our next inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not planned, monitored or mitigated in a way that kept them safe from harm.

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 not always safeguarded from potential abuse, because staff had not always recognised potential safeguarding incidents that needed reporting.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission of incidents as required.

The enforcement action we took:

We served a fixed penalty notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to manage and monitor the service to mitigate risks to people. Records were not accurate and up to date and reviews were ineffective.

The enforcement action we took:

We served a warning notice to request that action was taken to make improvements within a specific timescale.