Aegis Residential Care Homes Limited

Ladydale Care Home

Inspection report

9 Fynney Street
Leek
Staffordshire
ST13 5LF

Tel: 01538386442
Website: www.pearlcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 23 June 2016. This was an unannounced inspection. Our last inspection took place in February 2015. At that time we found the provider was meeting the required Regulatory requirements.

The service is registered to provide accommodation and personal care for up to 54 people. People who use the service may have a physical disability, a learning disability and/or mental health needs, such as dementia. At the time of our inspection 48 people were using the service. Three of these people were in receipt of temporary respite care.

There was a registered manager at the home. 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 and associated Regulations about how the service is run.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely.

People were not always protected from the risk of abuse because suspected abuse was not always reported as required.

Most people told us they enjoyed the food. However, we found people's risks of malnutrition and dehydration were not being effectively monitored or acted on.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced. There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves. One person who was unable to make decisions about their care was being unlawfully deprived of their liberty.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours.

There were gaps in some people's care plans which meant staff didn't always have the information they needed to provide safe and consistent care. People and their relatives were not always involved in planning and reviewing their care. This meant we could not be assured that people's care preferences were being regularly identified and met.

People were reluctant to complain about their care and effective systems were not in place to promptly manage complaints to improve people's care.

The provider did not always notify us of reportable incidents and events as required.

There was a programme of social and leisure based activities on offer to people. However, we found some people were not always supported to engage in activities that were meaningful to them when they needed this intervention.

People spoke fondly about the staff and at times, we observed some positive interactions between staff and people. However, we found that people's dignity and independence was not always promoted and people's right to privacy was not always respected.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Equipment and medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples care needs and preferences.

People were not consistently protected from the risk of abuse as suspected abuse was not always reported as required.

Is the service effective?

Inadequate

The service was not effective. Staff did not always have the knowledge and skills needed to meet people's needs effectively. People's health needs were not effectively monitored and managed and, prompt referrals to health care professionals were not always made when people's needs changed.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were not always followed and people who were not always being lawfully deprived of their liberty.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always supported to receive care and support in a dignified manner. People's right to privacy was not always promoted or respected.

People were not consistently treated in a caring manner. Staff were not always available to provide people with the care and support they needed.

People were involved in making some choices about their care.

Is the service responsive?

Inadequate

The service was not responsive. People and their representatives

were not always involved in the planning and review of their care. Care plans did not contain the information staff needed to meet people's individual care needs and preferences.

People were reluctant to complain about their care and complaints were not always managed effectively.

Is the service well-led?

Inadequate

The service was not well led. Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm occurring.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

The provider did not always notify us of reportable incidents and events that occurred at the service.

Ladydale Care 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 was planned to check 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 23 June 2016 and was unannounced. The inspection team consisted of four inspectors.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also liaised with representatives from the local authority and other health care professionals to discuss the concerns they had with quality and safety at this service.

We spoke with 12 people who used the service and eight people who visited the service. We also spoke with, six members of care staff and the registered manager. We did this to check that good standards of care were being met. Following our inspection we spoke with the provider's nominated individual (a senior person, with authority to speak on behalf of the organisation) and the regional manager to share our findings and concerns.

We spent time observing how people received care and support in communal areas and we looked at the care records of nine people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas and training records.

Following our inspection we shared our findings and concerns with the local authority. We did this because we had significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

Some people told us they did not feel safe at Ladydale Care Home because of the behaviours some people who used the service displayed. One person said, "I feel frightened when [a person who used the service] stands over me at night". Another person said, "I just cope with it, it doesn't frighten me, but it does frighten some of the other people here".

We found that risks to people's safety as a result of people's behaviours were not always assessed and planned for. For example, two people who used the service frequently displayed episodes of verbal and physical aggression towards other people who used the service and staff. The risks associated with these behaviours had not been assessed or planned for as no risk assessments or care plans referring to these behaviours were contained in their care records. Staff told us and we saw that they did not know how to manage these behaviours. For example, we observed one person's behaviours escalate over a one hour period. Staff did not follow best practice techniques to manage this person's behaviour. This resulted in the person becoming increasingly agitated and distressed which placed them, other people and staff at risk of harm to their safety and wellbeing.

We found that effective and prompt action was not taken to identify and manage people's risk of falling. One person told us, "I've had a few falls". Care records showed there had been at least 31 unwitnessed falls in April and May 2016. One person had fallen 16 times since the beginning of 2016. Their falls care plan was only changed to reflect their increased risk of falling after their sixteenth fall which meant prompt action was not taken to ensure staff had access to the information they needed to reduce this person's risk of falling. Another person had fallen on two occasions in April and May 2016. These falls had not triggered a review of their falls risk or any changes in their mobility care plan. This meant people could not be assured that the provider was effectively managing their risk of falling.

Where risks to people's safety had been recognised and planned for, we found that care was not always delivered in accordance with their agreed care plan. For example, one person required regular repositioning to prevent skin damage and promote wound healing. Care records showed they were not supported to change their position as often as planned. Staff told us and care records showed one person required, 'constant supervision' due to their behaviours that challenged. We saw this did not happen as there were multiple occasions when this person was unsupervised in communal areas. This meant people could not be assured that they would receive their care as planned to promote their safety and wellbeing.

We saw that equipment at the home was not effectively checked or maintained to ensure it was safe for use. We found one of the slings used to help people to move was damaged and three commodes did not have non slip ferrules at their bases to prevent the commode from moving or causing injury if the commodes were to fall. The registered manager told us equipment was checked for safety concerns prior to each use, but the unsafe equipment we saw was in use and had not been identified by staff, the registered manager or provider.

We found that effective systems were not in place to ensure people's medicines were managed safely. Staff

did not always reassure people that their medicines were safe and needed. We observed one person ask the staff member who was administering medicines what their tablets were for. They also asked the staff member if the medicines were, "poison". The staff member did not answer this person's questions. This person's care records showed they were occasionally confused which meant they sometimes needed reassurance from staff about their wellbeing. Although the person took their medicine after a short period of time, the staff member did not provide them with the reassurance they requested as they did not answer their medicines related questions.

We saw that people's medicines plans were not always followed to ensure they received their prescribed medicine. We observed one person decline their morning medicines. Their care plan advised staff to, 'Try again later' if the person declined. This person was not approached again until lunch time when they also declined their lunchtime medicines. This showed the person's medicines care plan was not followed to encourage them to accept their prescribed medicines.

We saw that medicines were not always stored in accordance with the manufacturer's safety guidelines. This meant the provider could not assure people that their medicines were safe to be administered. Accurate records were not maintained to ensure the provider could account for all the medicines at the home. This meant people could not always be assured that they had received their medicines as prescribed.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff did not understand their responsibility in identifying, recording and reporting suspected abuse. We found at least six incidents of alleged physical abuse that had not been discussed with or reported to the local authorities safeguarding team in accordance with local and national guidance. There was also no evidence to show that the registered manager or provider was learning from incidents of alleged abuse to prevent further incidents from occurring. For example, care records showed one person was assaulted by another person because they felt frightened by the person's behaviours. No action was taken to prevent the same incident from occurring again and care records showed that a second similar incident had been suspected to have occurred just three weeks after the first incident had taken place. This meant people were not protected from the risk of on-going incidents of suspected abuse.

The above evidence shows that people were not consistently protected from the risk of abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not always receive their care and support in a timely manner. One person said, "They don't always come straight away, it can be up to 15 minutes". Another person said, "They are a bit pushed to be honest. At times I have to wait a while". Another person told us they had to wait over two hours on the morning of our inspection to be assisted to wash and dress. They said, "I like to get up at 6am. I first pressed my buzzer at 7:15am". We saw that this person was not supported to wash and dress until 9:20am. This person also needed support to change their position and they told us they were uncomfortable because of this delay in receiving the support they needed. Staff confirmed they were unable to meet this person's care preference on the day of our inspection as they had other tasks to complete. One staff member said, "They like to get up at 6am, but they were very late today so they were upset" and, "We have quite a few doubles [people who required assistance from two staff] at the moment who were all in bed".

People who visited the service also told us there were not always enough staff available to keep people safe

and meet people's needs. One relative said, "Sometimes when I visit there is no one [staff] here. They see to people in their rooms so people in the lounge are alone and they could fall". We saw and staff confirmed that a staff presence in communal areas to promote people's safety was not always maintained. One staff member said, "There's supposed to be someone in the lounge all the time, but there's not enough of us. You can't be everywhere at once". Records showed that six of the 31 unwitnessed falls in April and May 2016 occurred in communal areas. This showed staff were not always available to keep people safe.

We asked a senior staff member why one person's 15 minute safety checks had not consistently occurred during the morning of the inspection. They said, "I should have allocated someone to do the 15 minute checks, but I haven't". This showed that staff were not effectively deployed to ensure people's needs were consistently met.

The above evidence shows that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Most people told us they were able to dine and drink in accordance with their individual preferences. One person said, "I'm very impressed with the food. There's a good selection and you can always have more". We saw this person was given a second breakfast when they asked for this. Another person said, "The food is quite nice" and, "I enjoy the food". However, we found that people's risk of malnutrition was not being effectively monitored or managed. One person whose records showed they had lost weight and had a concerningly low body weight had not been weighed since October 2015. Staff had recorded that they were unable to weight the person, 'due to frailty'. No other forms of weight monitoring, such as measuring the person's arm circumference were being used to identify if this person had continued to lose weight. Another person whose records showed they had lost a significant amount of weight had not been weighed since April 2016. The person's care records showed and we saw that they frequently declined meals. This meant the registered manager and provider were not monitoring these people's weight to identify if any further weight loss had occurred.

We saw people didn't always get the support they needed to eat and drink. For example, we observed one person was not supported to eat in accordance with their care plan. This person had recently lost a significant amount of weight and their care plan stated, 'At times requires prompts to eat as they can forget'. We saw that over a three hour period kitchen staff served and reserved the person their breakfast on three occasions. The person made no effort to eat their breakfast and staff did not prompt the person to eat their breakfast as stated in their care plan. At lunch time the person's uneaten toast was removed.

We found that people's risk of dehydration was not being effectively monitored or managed. People whose care plans stated they needed their fluid intake to be monitored did not receive this planned monitoring. This was because people's daily intake was not being calculated by the staff. Staff also told us they did not know how much fluid people needed to drink to keep them safe and care plans did not contain this guidance.

We found that prompt referrals to health and social care professionals were not always made in response to peoples' changing needs. For example, one person's records showed they were fully mobile. However we saw staff pull this person up from their chair as they were unable to follow the staffs' verbal instructions. Pulling a person up from a chair could cause injury to the person and the staff. Staff told us this person's needs had changed and they often forgot how to stand and walk. We asked staff if this change in the person's skills had triggered a referral to a health care professional for an assessment of their mobility needs. Staff told us no referral had been made. This meant we could not be assured that staff were supporting this person in the most suitable manner as they had not sought professional advice in response to the person's changing needs. We also found that professional advice was not always followed. One person's care record's showed staff had recently been advised to encourage one person to drink a specific amount of fluids every day following some blood test results. This person's fluid intake was not being recorded or monitored and the staff member responsible for this person's care on the day of our inspection told us they did not know the person's fluid intake needed to be recorded or monitored.

The above evidence shows that people's health needs were not effectively monitored and managed to promote people's wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received some training to help them to meet people's needs. However, they told us and staff records showed there were significant training gaps. For example, staff told us and we saw that they did not have the knowledge and skills required to meet the needs of people who displayed behaviours that challenged. One staff member said, "I've not had training in behaviours, I just use my own experience and try and move them away from other residents". Another staff member said, "We've not been trained [in meeting a person's needs who displayed behaviours that challenged], we are just expected to get on with it" and, "No one knows how to deal with [a person who used the service who displayed behaviours that challenged]". We observed one person's behaviours escalate over a one hour period. Staff did not follow best practice techniques to manage this person's behaviour. This resulted in the person becoming increasingly agitated and distressed which placed them, other people and staff at risk of harm to their safety and wellbeing. The registered manager told us training in behaviours that challenged had been booked for August 2016. This showed that although training had been booked, staffs' training needs were not being met in a timely manner to ensure people's safety and wellbeing needs were being effectively met. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the requirements of the Mental Capacity Act 2005 (MCA) were not always followed or met. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although staff were able to tell us the basic principles of the Act, people's care records showed these principles were not always followed. Care records did not always evidence that people's ability to make specific decisions about their care had been assessed. Records also did not always show that plans made on behalf of people who may not have had capacity to make decisions were made in their best interests. For example, one person's mental capacity care plan stated, '[Person who used the service] makes some decisions themselves. Family will make more pressing decisions to avoid worrying or upsetting [person who used the service]'. There was no reference to what decisions this person was able to make and there was also no reference to what decisions the 'pressing issues' would relate to. There was also no evidence to show that involvement of the person's family was in the person's best interest. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us and we saw that people were restricted from moving freely around the home. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us they placed restricted some people who used the service to keep them safe. We saw that DoLS referrals had been made for some people to ensure these restrictions were lawful. However, this was not always the case. We saw one person attempt to exit the lounge to enter the garden. This person described the home as a, "Prison". The door was locked, so they waited for a 10 minute period for staff to enter the room. They then asked staff if they could go outside into the garden and also asked a member of staff if it was raining. The staff member replied, "I wouldn't let you out if it was raining". After a short delay the door to the garden was opened and the person entered the garden with another person who used the service. The door was then locked behind them, so they were unable to freely enter the building again. The staff member told the person to, "Knock when you want to come back in". However, staff were not always present in the

communal area to know when people wanted to re-enter the building. We asked staff why the door to the garden was locked. They told us it was locked to keep people safe. We saw and care records suggested that this person's ability to make decisions about their care fluctuated. This meant a DoLS referral was required to ensure staff acted lawfully when the person was deprived of their liberty when they were unable to make decisions about their care. However, no DoLS request had been completed which meant this person was at times being deprived of their liberty in an unlawful manner. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Although some people told us their right to privacy was respected, we saw that staff did not always promote or respect people's right to privacy. At lunch time we saw that staff enabled a podiatrist to visit and treat one person in a communal area where people were eating. We also saw a staff member discuss a person's health and wellbeing needs on the phone at the dining table whilst sitting next to other people who used the service.

We saw that people's right to independence was not always promoted. For example, we observed one person was not eating their lunch as they were falling asleep. This person's care records showed they could eat independently. We saw another person who used the service assist this person to eat by placing food into their mouth. A member of staff prompted the person to stop offering their assistance, but the staff member then left and the person then continued to provide this assistance. This meant the person who received this assistance was not encouraged to maintain their independent living skills and they were also placed at risk of choking as they were not sufficiently alert to eat in a safe manner.

People's dignity was not always promoted. One person's care records showed they had undressed in front of other people or urinated in other people's bedrooms on at least 6 occasions in June 2016. No plan was in place to help staff to manage this person's behaviour and as a result, the person's dignity was not being consistently promoted.

The above evidence shows that people's right to be treated with dignity and privacy was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the staff were kind and caring. One person said, "The staff are very helpful". Another person described the staff as, "Wonderful". However, we found that staff were not always available to provide people with the care and support they needed. For example, we observed two people who used the service arguing with each other. As a result of this, one of the two people became tearful, but no staff were present to offer this person the reassurance they needed. We saw another person falling asleep whilst sitting at a table. We intervened and called for staff assistance to prevent the person's head from hitting the table.

Staff told us they treated people like they would treat their own family. One staff member said, "I treat them like I treat my nan and granddad". We observed some caring interactions between staff and people. For example, we saw a staff member try and gently wake a person up so they could have their medicines. They gently knelt down next to a person, held their hand and quietly asked them if they were going to open their eyes. However, we saw that people were not consistently treated in a caring manner. For example, we saw the same staff member respond to a person's distress in two different ways. On one occasion when a person replied to being asked if they were okay, by saying no; the staff member appropriately responded by saying, "Why? Are you going to tell me?". However on another occasion when the person told the staff member, "I don't feel very well today", the staff member ignored the person and walked away.

Most people told us and we saw that they were given choices about some parts of their day to day care. For example, one person said, "I chose toast this morning, I like toast". Another person said, "I get to choose the clothes I wear each day" and, "I chose to come and sit in this lounge today". We observed a staff member asking a person how they wanted to access the toilet. They said, "Do you want to walk a little bit or do you want a wheelchair?". The person made the choice to walk and the staff member respected their decision.

Inadequate

Is the service responsive?

Our findings

Some people told us they did not feel able to raise concerns and complaints about their care. One person said, "I don't get on with the manager, I speak to my relative instead". Another person said, "I would tell my GP if I had a complaint". Some people and their relatives also told us that complaints were not always managed effectively or promptly, and we found that the complaints system in place was ineffective. One person told us they had shared concerns about their care with a senior member of staff. When we raised this with the registered manager, they knew nothing about this person's concern. This meant concerns and complaints were not always reported or escalated effectively.

We asked to view the complaints records relating to two complaints that had been bought to our attention prior to our inspection. We found that one of these complaints had not been effectively managed. The concerns and safety risks raised in the complaint had not been managed and two safety incidents had occurred as a result of this. The registered manager was unable to tell us about or show us the records relating to the other complaint that we asked to view, so we were unable to identify if the complaint had been managed effectively.

The above evidence shows that effective systems were not in place to manage people's complaints about their care. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they were not involved in the planning or review of their care. Because of the lack of involvement of people and their relatives in the care planning process, care records did not always contain the level of detail required to inform staff about how people wished to receive their care and support. For example, some people couldn't always verbally tell staff how they wanted to receive their care because of their health conditions. Care plans did not always detail how people liked to receive their personal care, such as what clothes and accessories they liked to wear and what toiletries they liked to use. Although most staff knew people's preferences well because they had been working with people for long periods of time, new staff would not have this knowledge. This meant there was a risk that people would receive inconsistent care that didn't meet their care preferences, because people's care preferences were not recorded in their care records.

People's care records were not always reviewed or updated in response to changes in people's needs. For example, one person had recently started to display new behaviours that challenged. These behaviours included aggression towards people and disinhibited behaviours, such as undressing in communal areas and other people's bedrooms. This person's care plan had not been reviewed or updated in response to these changes, so no guidance was available for staff to follow to ensure they were managing these behaviours in the most safe and effective manner. Care records showed that these behaviours were not being managed effectively as they continued to be frequently displayed. This meant people were at risk of receiving unsafe or unsuitable care.

There was a planned programme for leisure and social based activity provision at the service. Some people

told us they were enabled to participate in social and leisure based activities that were meaningful to them. One person said, "I get to do some of the things I like, like bingo, painting and drawing". Another person told us about a trip they had recently been on with the staff that reflected their interest in trains. However, people were not always supported to engage in activities that met their preferences when their behaviours indicated the need for engagement in meaningful activities. For example one person who staff told us required, 'constant supervision' was observed at times to be restless and seeking staff support. On the morning of our inspection, this person was not supported to engage in activities that were meaningful to them and at lunch time they became agitated and distressed which resulted in an incident that placed other people who used the service at risk of harm to their safety and wellbeing.

Inadequate

Is the service well-led?

Our findings

Safety incidents were not always appropriately reported, investigated or managed to prevent further incidents from occurring. For example, staff were not recording incidents where people had been assaulted on incident forms. This meant these incidents were not investigated or monitored by the registered manager to reduce the risk of further incidents from occurring. Lessons were not learnt in response to incidents. For example, incident records showed there had been 31 unwitnessed falls in April/May 2016. This showed that on 31 occasions staff were not available to respond to people's risks of falling. The registered manager confirmed that this had not triggered a review of why these falls were occurring or a review of staffing levels or staff deployment to help manage peoples' risk of falling. This showed that lessons were not always learned from incidents to improve people's safety and wellbeing.

We found that the risks associated with staff living in rooms next to people who used the service had not been assessed. Following our inspection, the provider and regional manager told us this risk assessment should have been completed by the registered manager to ensure any risks posed to people were managed.

We found that people's needs were not fully considered when staff numbers were calculated. The registered manager showed us the tool they used to calculate the numbers of staff needed to keep people safe. This tool identified people's individual dependency levels. However, the registered manager told us the results the tool gave did not always accurately reflect people's dependency levels. We found that people's additional needs such as the need for; constant monitoring, 15 minute observations or hourly support to change their position had not been considered when the staff numbers had been calculated. Staff told us they struggled to provide this support due to their workload. Care records and our observations also showed people did not always receive the monitoring and support they required to keep them safe. This meant we could not be assured that there were enough staff available to keep people safe.

The information contained in people's care records was not being effectively monitored or analysed by the registered manager or provider to ensure people's needs were being managed effectively. For example, the registered manager and provider had not identified that plans were not in place to help staff manage people's behaviours that challenged. They had also not identified that incidents relating to behaviours that challenged, such as, assaults on people were not being appropriately reported.

The registered manager and provider had not identified that people were not always receiving their planned care. For example, people were not always supported to change their position as often as planned to promote their safety and wellbeing. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

Effective action was not taken in response to concerns identified through medicines audits. For example, the medicines audit completed in May 2016 identified bottled medicines were not always labelled with an opening date. It is important to label the date of opening so that medicines that people can be assured that

their medicines are safe to use if they are time limited. Three of the five bottled medicines we looked at were time limited and had not been dated to show when the bottles had been opened. This showed the concerns identified through audit had not been effectively addressed and people could not be assured that their medicines were safe.

Effective systems were not in place to ensure equipment was safe to use. The registered manager told us equipment was checked for safety concerns prior to each use. They also told us equipment would be immediately taken out of action if it was unsafe. However, we found these checks were either not being completed or they were completed ineffectively. We found four pieces of equipment that were unsafe for use. All four pieces of equipment were in use and had not been identified by staff, the registered manager or the provider as being unsafe. This meant people were placed at risk of harm to their safety and wellbeing.

Staff told us they had regular meetings with the registered manager to review their development needs. However, we found that significant gaps in the staffs' knowledge and skills were not being addressed in a prompt manner to ensure people's needs could be met in a safe and effective manner. For example, staff told us some people who used the service displayed behaviours that challenged that posed risks to people's health, safety and wellbeing. One person's care records showed their behaviours were complex and had been on-going since November 2015. However, training to help staff to manage these behaviours had been planned for August 2016. This meant staffs' training needs were not promptly addressed and people were at risk of receiving unsafe and unsuitable care.

Staff told us the registered manager was approachable. However, some staff told us they did not always act on their concerns. Comments from staff included, "We feedback to the manager, but get no response. We just have to get on with it, they don't help us" and, "We are always saying there should be more of us, but we are not listened to". This showed staff did not feel the registered manager was responsive when they shared concerns. This meant there was a risk staff would stop reporting concerns to the registered manager.

Some people told us they attended meetings where they discussed their thoughts on the activities and food at the home. However, we could not always see that people's feedback was acted upon. For example, minutes of one of these meetings showed one person thought the food was, 'Atrocious'. The records also stated, 'No one else thought this was the case'. There was no evidence to show any action was taken in response to the person's feedback about the food to ensure the food met their personal preferences. This meant we could not be assured that people's feedback was consistently used to assess, monitor and improve the quality of care.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the registered manager and provider understood the responsibilities of their registration with us. The provider had failed to notify us of at least four incidents of alleged abuse as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.