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Shalden Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This comprehensive inspection was unannounced and took place on 21, 22, 26 and 30 September 2016.

Shalden Grange provides accommodation, care and support for up to 35 people. At the time of this inspection there were 33 people living in the home.

The home has a registered manager in post. 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.

This inspection was brought forward from the planned date because we received information of concern and safeguarding alerts from the local safeguarding authority. At our last inspection in February 2015 we found the service was running well and rated it as good.

People told us they felt safe living in the home and that staff were mostly kind and caring. We found issues with poor maintenance of the building and equipment which meant that the fire alarm system was not adequate and many people had not been able to have a bath or shower for a number of months. There were also problems with the provision of hot water to some rooms and portable electric items had not all been risk assessed or tested to ensure they were safe to be used. Much of the furniture was old and damaged and many rooms had damage to ceilings and walls.

People were not always protected from the risk of harm and abuse. Staff had carried out assessments that had identified that people were at risk of things such as dehydration and pressure sores but had not always taken action to reduce and manage the risk. Not all staff had been trained to recognise and understand signs that a person may be being abused and the action they should take if they suspected this.

People were not protected against the risks associated with the unsafe management and use of medicines. Care plans and medicine records lacked detailed information and guidance for staff and errors were not identified through the audit process that was in place. This also meant that there was a risk that people were not having help to ensure that all of their needs were properly met.

People's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005. The service was caring but needed some improvement because some staff interactions and written information did not always respect people and uphold their dignity.

Staff were not always recruited safely and were not receiving regular and effective supervision and support. Most of the people we spoke with told us they had confidence in the staff and felt that they had the knowledge and skills to meet their needs. However, some people said they did not always feel that staff understood their needs. Not all staff had received training in the essential areas of care required for their

role.

People told us that meals were good and the menu showed there were alternative options if someone did not want what was on the menu. We saw an evening meal and two lunches being served. Meals looked and smelt appetising and people were offered choice where one was available such as different sandwich fillings for the evening meal.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People had also been regularly supported with chiropody care.

There were some positive interactions between staff and the people they were supporting. Observations showed some staff had a good rapport with people. Most people told us staff were caring. However written records were not always completed in a way that upheld people's dignity.

People's needs were assessed before they came to live at the home. People's assessment information was used to develop care plans about how someone wanted or needed to be supported. However, we found that people's care needs were not always fully assessed and planned for. Some care plans were person centred and told staff how to support those people, but other care plans included insufficient information to enable staff to fully meet people's needs.

Information about making a complaint was displayed in a communal area of the home and was also included in the information that was given to people when they moved into the home. Records had not been maintained of the date the complaints were received, how they were acknowledged and investigated and the outcome of the complaint.

Quality monitoring systems were not effective. The audits and management processes had not identified any of the issues found during this inspection. The registered manager responded to the concerns raised at this inspection but had not taken action to proactively assess and monitor these shortfalls prior to our inspection.

Some records contained errors and omissions and some were illegible. This meant that staff may not always have important information available to them.

The occurrence of some incidents and events must be reported to CQC. The registered manager had not made the required reports. This meant that the CQC were had not been made aware of important information about the service and the actions the service had taken with regard to the incidents and events.

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.

Premises and equipment had not been properly maintained and equipment suitable to meet people's needs had not always been provided.

People were not always protected against the risks associated with the unsafe management and use of medicines.

Staff recruitment systems to ensure the suitability of staff were not used effectively and consistently.

People were not always protected from the risk of harm and abuse. Staff had not been trained to recognise and report any concerns.

Is the service effective?

Requires Improvement

The home was not fully effective.

Staff had not received the training, supervision and support they required to deliver care according to people's needs.

The home required improvement to ensure staff adhered to the principles of the Mental Capacity Act 2005.

People told us that meals were good and the menu showed there were alternative options if someone did not want what was on the menu.

People had been supported to see their GP or nurse when required.

Is the service caring?

Requires Improvement

The service was caring but needed some improvement. This was because some staff interactions with people and written information did not always respect people's dignity.

There were some positive interactions between staff and the people they were supporting. Observations showed some staff

had a good rapport with people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had their needs assessed before they moved to the home. Some care plans were detailed and person centred.

People were at risk of their needs remaining unmet because assessments were not robust and care plans lacked information and detail. This meant that staff may not have the required information to fully support people.

The service had a complaints policy but had not established an effective system for identifying, receiving, recording, handling and responding to complaints.

Is the service well-led?

Requires Improvement

The service not been consistently well-led.

The registered manager responded to the concerns raised at this inspection but had not taken action to proactively assess and monitor these shortfalls prior to our inspection.

Quality monitoring systems were not effective and record keeping required improvements.

Shalden Grange

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 inspection took place on 21, 22, 26 and 30 September 2016. Two inspectors and an inspection manager undertook the inspection.

Before the inspection we reviewed the information we held about the service; this included any events or incidents they are required to notify us about. We also contacted the local authority safeguarding and commissioning teams to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion as the inspection was brought forward in response to the concerns received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with and met 13 people who were living in the home. Because some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We also spoke with six staff, as well as the registered manager and one of the registered providers. We looked at six people's care and medicine records in depth and sampled a further 13 people's care and medicine records. We saw records about how the service was managed. This included nine staff recruitment, supervision and training records, staff rotas, audits and quality assurance records as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they were comfortable in the home and felt safe living there. However, we found that appropriate steps had not always been taken to keep people safe.

We received information of concern regarding fire safety at the home. We asked Dorset and Wiltshire Fire and Rescue Service to visit and check these concerns.

After their visit they told us that: The existing fire alarm was not suitable because it may not give sufficient warning to people in time to escape safely. Additional smoke detectors and manual call points were required and must be linked into the upgraded fire alarm system. Fire doors were not fully closing to latch or were obstructed. Escape doors could not be easily opened. People did not understand what to do in the event of a fire and there was no evidence of satisfactory fire procedures or fire drills. Staff had not been trained to put fire procedures into effect and there were not enough people to do this. The fire alarm, emergency lights, fire fighting equipment, external fire exits and fire doors were not properly tested and maintained. There was no satisfactory fire risk assessment.

The Dorset and Wiltshire Fire and Rescue service issued an enforcement notice under the Regulatory Reform (Fire safety) Order 2005: Article 50. This means that the works must be completed within a fixed timescale or further action will be taken against the provider by Dorset and Wiltshire Fire and Rescue Service.

The registered manager took immediate action following this. A new fire risk assessment was completed in September 2016 and contractors were engaged to complete the required works. Staff training was booked for October 2016.

During a tour of the building we found a number of issues and concerns. Many of the rooms had damage to ceilings and walls either from water leaks or general wear and tear. Much of the furniture in the bedrooms was old and damaged or worn. Some drawers to chests of drawers and doors to wardrobes would not close properly or had missing handles. None of the wardrobes that were checked were fixed to the wall. Some of the older wardrobes were unstable and others, in the older part of the home, were on uneven floors which also made them unstable. There were three first floor windows that had not had opening limited to prevent people from falling from them.

Due to the type of door frames on the external doors, some people in wheelchairs told us they were not able to exit the home without considerable difficulty and help from staff. One person told us they had not been able to come in and out of the home independently for more than nine months and that an Occupational therapist (OT) had visited to discuss a ramp but this had not been provided. The registered manager stated that staff mainly managed to get wheelchairs over the door frame but this is not always possible. They agreed to purchase a ramp.

The home had three bathrooms with standard domestic type baths. Two of the baths had portable electric bath seats. We found that these had not been serviced because the suppliers had told the registered

manager that they were too old to be maintained. Discussions with staff also revealed that none of people living in the home were able to use these.

There was a bathroom with a shower on the ground floor. There was a steep step up into the shower. Staff confirmed that the majority of people were unable to access the shower as they could not manage to climb the step safely. Staff told us that this had been the situation for some months and that a number of people had not had a bath or shower in this time.

Service records for the through floor passenger lift dating back to September 2013 referred to work that was required to be done to ensure the safety of the lift. The registered manager was not aware that this work had not been completed but arranged this to be undertaken as soon as this was highlighted to them.

The home had two stair lifts. There was a service record for one of the stair lifts dated 24.9.14. There were no other records available for either stair lift. The registered manager stated that there was no service contract and no services had been carried out as the company had visited a number of times to repair the stair lifts and had left them in a safe and useable condition. The registered manager confirmed later in the inspection that a servicing contract had been arranged and would start in October 2016.

There was no policy or no risk assessment for the testing and checking of portable electrical equipment items in accordance with Health and Safety Executive guidance. The registered manager stated that they had carried out visual checks of electric profiling beds, hoovers, lamps, TV's, microwave, hot water urn and computers. With the exception of the electric profiling beds, the registered manager had not kept a record of which items had been checked. The registered manager had not checked items owned by people living in the home although these could still present a hazard.

The hot water temperature in the wash hand basin in one of the bedrooms was running hot to touch and we were concerned there may be a risk of someone being scalded. There was no hot water to either the bath taps or the wash hand basin in one of the shared bathrooms and no hot water to the wash hand basin in one of the bedrooms. In another bedroom we found that neither of the taps worked and taps in two other bedrooms were constantly dripping. We chatted with one of the people whose tap was dripping and they told us that they had repeatedly asked staff to fix this but no action had been taken. Surfaces to vanity units around wash hand basins, bedside tables and chests of drawers had unsealed and cracked surfaces which created an infection control risk. There were no foot operated waste bins to allow disposal of paper hand towels to be thrown away without contamination. This meant that surfaces could not be easily and effectively cleaned and people and staff would not have been able to wash their hands and dry them properly to ensure possible infections were not transferred.

This was a breach of Regulation 12(2)(d)(e) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that the premises and equipment is safe to use and was used in a safe way. Suitable equipment to meet people's needs had not always been provided.

Some people had been assessed as being at risk of malnutrition or dehydration. Staff were keeping records of the amount people ate and drank over each 24 hour period. However, there was no guidance or information in a care plan to instruct them what were acceptable levels of food and fluid intake and what to do if people did not eat or drink enough. This meant that effective measures to mitigate the identified risk had not been put in place.

Some people had been assessed as being at risk of developing pressure ulcers. There was no information

about the specific equipment provided to reduce the risk or the settings that equipment should be set at. Staff recorded in daily records that air mattresses were checked. They told us that they were reporting that the mattresses were working and not that they were on the correct setting. Two people had assessments which indicated that they should sit on pressure relieving cushions. We found they were not sitting on these and there were none in their rooms.

These shortfalls were a breach of Regulation 12(2)(a) and 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

There were systems in place for the management and administration of medicines but we found that these had not always been followed. We looked at the medicines administration records (MAR) and found that these were not always signed by staff to confirm that the items had been administered or a code letter had not been used to explain what had happened in the event that a medicine had not been administered.

The service used two types of MAR; one for general items that were kept in locked medicines trollies and one for topical items, such as prescribed creams, that was kept in people's bedrooms. New MAR's were started for everyone living in the home on 28 September 2016. During visits to rooms on 30 September it was noted that some rooms did not have new charts and therefore no recording had taken place since 27 September 2016. Other rooms had new charts but entries to confirm administration had not been made in accordance with usage instructions. For example, prescribed creams that should have been applied twice a day, so should therefore have had five signatures to confirm administration at the time we checked them, had only one entry and in some cases, no entries.

One item was prescribed for use as a soap substitute for a person. There should therefore have been at least daily entries on the MAR for its usage. For the period of 31 August 2016 to 27 September 2016, there were only 17 entries to confirm that this had been used.

Another person had two types of prescribed creams in their room but no MAR chart to record that they had been administered.

A further person had two prescribed creams in their rooms. Both items had been prescribed for other people living in the home not for the person whose room it was.

Some people were prescribed medicines to be taken as and when they needed them (PRN). There were no care plans for PRN medicines and no information to guide staff about when to administer them if the person for whom they were prescribed was unable to request them. One person was prescribed a medicine that could be used twice a day when required. The MAR showed that this had been given to the person twice everyday for over one month. We asked staff why this had been given so frequently and whether the person's condition should be reviewed if they needed the medicine all of the time. Staff were unable to answer this.

Some medicines were prescribed to be given in variable quantities. There were no care plans for this and no information to guide staff about how much they should administer or the maximum quantity that should be given over a 24 hour period. MAR charts also did not always record the quantity that had been administered. This meant there was a risk that people could take too much of the medicine.

Some people had been prescribed medicines which must be taken at very specific times. There was no recognition of this in care plans and where the required times varied from the general times that medicines

were administered to other people in the home, this was not clearly highlighted on the MAR. When we asked staff about this, they said they were not aware of different times.

One person had a specific diagnosis and a specialist had reviewed their medicines. A letter had been sent on 1.6.16 confirming that doses of a medicine should be changed and gave instructions about this. The MAR chart that was current at this inspection did not reflect the changes made by the specialist.

Another person was prescribed a medicine with the instruction that it should not be given within two hours of other medicines and should be taken after meals. MAR records showed that this was being given at the same time as the other medicines this person was receiving.

On the last morning of the inspection, we asked to see the folder containing the MAR for everyone living in the home at 10.55 am. The member of staff in charge of medicines at that time stated that they had not yet signed the records for the administration of the morning/breakfast medicines. This meant that administration records had not been signed at the time people were given their medicines.

Handwritten additions to the MAR did not always include the full name of the prescribed item, the dose and full information that would have been on the prescription label and should therefore have been transcribed onto the MAR. Entries had not always been signed and there was no second signature to confirm that the entry had been checked and was correct. This meant that a system to check for possible errors was not in place.

It is good practice to have a current photograph of each person with their MAR to enable ease of identification for staff when giving medicines. Only 10 people had photographs.

Staff had been trained in the administration of medicines and records showed that their competency to administer medicines safely had been checked regularly. However, none of the shortfalls in medicines identified during this inspection had been highlighted by staff. The registered manager had completed audits of systems to manage and administer medicines in January 2016 and July 2016 and had not identified any issues of concern.

This meant that people may not have received some of their medicines as prescribed.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

We looked at the records for three recently recruited members of staff. Within each file we found the service had obtained proof of the person's identity and had a copy of a recent photograph. There was limited evidence of satisfactory conduct in previous employment or good character. This was because references had been provided by colleagues rather than the applicant's previous employer or line manager. One of the registered providers said they had obtained a verbal reference for one of the applicants but no record had been kept. Testimonials had been accepted. That is, a letter written to no specific person by a referee about the general qualities of the person and not specific to the job the person had applied for. The registered manager had not obtained complete employment histories and where there were gaps in applicant's employment, had not sought explanations.

One person had provided a copy of their Disclosure and Barring Service (previously known as the Criminal Records Bureau) check from a previous employer which was more than a year old. This was not valid

because the registered manager had not taken action to check there were no changes to the record. Additionally, the employer shown on the person's DBS record was not shown as a previous employer on the employment history that had been given in the application form and the registered manager had not explored why this was.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe recruitment of staff.

People and staff told us that they believed there were not always sufficient staff on duty to meet people's needs. Staff said they felt they had to rush from one task to another and people told us that staff were often rushing from one job to another and rarely had time to spend with them. This was an area for improvement.

The service had policies in place to protect people from abuse. Staff we spoke with told us they had received training in safeguarding and knew the different signs and symptoms of abuse. They told us they knew how to report any concerns they might have. Training records showed that of the 19 staff employed directly by the provider, only 10 had completed safeguarding awareness training within the past year. Three staff were employed through an agency and the provider did not have evidence that they had completed refresher training in this area. This meant that some of the staff may not be aware of the signs of abuse or the action they should take should they suspect someone was being abused.

These shortfalls were a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not been provided with appropriate training to enable them to recognise abuse and raise concerns.

Requires Improvement

Is the service effective?

Our findings

Most of the people we spoke with told us they had confidence in the staff and that they had the knowledge and skills to meet their needs. Some people said they did not always feel that staff understood their needs. For example, one person told us, "I had two new staff yesterday that didn't know how to use my [a piece of equipment]".

The registered manager told us that all staff received in house induction to familiarise them with the people living there, the premises and working practices. There were brief, handwritten notes about the induction for the three newest members of staff. There was no evidence that any staff employed at the service had completed the Care Certificate or the previous qualification, the Common Induction Certificate. This is the nationally recognised care industry induction training which sets the minimum standards of knowledge and competence that staff should achieve on completion of the course.

A spread sheet of staff training showed that some staff had received refresher training in essential areas such as safeguarding adults, first aid, the mental capacity act, infection prevention and control, moving and handling and fire prevention. We compared this document with the names of staff on the rota for the period of the inspection. There were 22 staff on the rota which included three staff supplied by an agency. Of the 19 staff directly employed by the home, only 10 staff had completed training. Those staff employed through the agency also undertook their training through the agency. The registered manager did not have any evidence that these staff had completed regular refresher training in the areas of essential training. Some of the people in the home had health needs such as Parkinson's disease and diabetes. No specific training had been given to staff in any of these areas. This meant that staff may not always be able to deliver care and support to people safely and appropriately.

Staff received supervision once a year as part of their annual appraisal. They had not signed the record of the supervision/appraisal to confirm they had taken part in the appraisal and agreed with what was discussed. Some of the shortfalls found during this inspection suggest that staff were not always competent in their roles and they required more guidance, support and supervision. The registered manager stated that they managed any issues with staff on a day to day, informal basis and had not kept records of any issues or concerns he had raised with individual staff members.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with appropriate induction, regular training and supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to make decisions for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when required. 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. Examination of records and discussions with staff highlighted that there was not always a sufficient understanding of the processes to assess capacity, make decisions in people's best

interests where necessary and to accept that people have the right to make unwise decisions. For example, some people had bed rails fitted to their beds. This meant that people may not be able to get out of bed without assistance. The potential restriction to the person's freedom had not been assessed in accordance with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the home was not meeting the requirements of the Deprivation of Liberty Safeguards. The registered manager confirmed that they were aware of the safeguards and had previously made applications. They confirmed that one person was living in the home with an authorisation from the managing authority to deprive them of their liberty. Discussions with staff and health professionals highlighted that there were other people living in the home who may have been deprived of their liberty. The registered manager had not submitted applications to the managing authority to enable full assessments to be carried out.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

People told us that meals were good and the menu showed there were alternative options if someone did not want what was on the menu. We saw an evening meal and two lunches being served. Meals looked and smelt appetising and people were offered choice where one was available such as different sandwich fillings for the evening meal.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Records showed that people had seen their GP or nurse when this was required and that staff recognised when people may need medical support and sought help appropriately. People had also been regularly supported with chiropody care.

Requires Improvement

Is the service caring?

Our findings

Most people told us staff were caring. Some people said that they sometimes had to wait longer than they would like for assistance. One person said, "The cleaner is super, the food is excellent but some of the service can be a bit lax." Another person told us they had hoped to make friends in the home and have people to chat with but this had not happened and they were disappointed.

There were some positive interactions between staff and the people they were supporting. Observations showed some staff had a good rapport with people. One member of staff joined four people at the dining table at the end of the meal and laughed and joked with them. Another member of staff told us about the needs of one of the people and it was clear that they had a genuine interest in people and their welfare.

We also observed that some staff were task oriented and did not interact with the people they were supporting. For example, a staff member was pushing someone in a wheelchair down the corridor. The person in the wheelchair said loudly, "I wish I was somewhere different where they look after you". The member of staff did not acknowledge the person and continued to wheel them down the corridor. During one lunch time a member of staff wheeled someone into the dining room. A conversation took place with another member of staff above the person's head. The staff member said "I was going to put her on that side so I can feed her". There was no acknowledgement to the person sitting in the wheelchair or explanation of what was happening.

One of the documents used as part of care planning was entitled 'This is me'. It was designed to help staff get to know and understand people when they moved into the home. We found that this was often not completed until some months after the person's admission and was only very brief with little information about their lives, past careers or interests.

Written records were not always completed in a way that upheld people's dignity. We found a number of entries in care plans and daily records that were not person centred and indicated that staff had a lack of understanding of the person and their needs. For example, one person's care plan said, '[person's name] can get verbally aggressive to the staff. Quite temperamental', another care plan stated, '[person's name] screams very often to staff or other residents for minor things due to the fact that he is very impatient and short tempered'.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff interactions and written information did not ensure that people were treated with respect and dignity at all times.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the home. This was to make sure staff understood their needs and were confident they could meet them.

However, we found that people's care needs were not always fully assessed, planned for and met. For example, people with conditions such as diabetes, dementia and Parkinson's disease did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur. One person told us they had lived in the home for more than nine months and they had only received strip washes in their room during this time because they could not access the bath or shower.

People's assessment information was used to develop care plans about how someone wanted or needed to be supported. Care plans covered a variety of needs including skin integrity, nutrition and hydration, continence, and mobility. Some care plans lacked detail and provided staff with limited guidance about what help or support the person needed, other care plans contradicted information that was in other care plans for the same person. For example, people's preferences for gender sensitive care were not always recorded and some care plans referred to a different resident to the one whose care plan was being looked at. One person's dementia care plan stated that the person has little short term memory and appeared to have no awareness of their current environment. However, there was contradictory information within the night time care plan which stated that bed rails were in place and 'these have been fitted to her bed. She does understand the purpose of the bed rails and do agree to them'.

There was little or no information about people's wishes for end of life arrangements and care plans did not refer to whether person may have a DNAR order in place. Some people exhibited behaviour that could be challenging to others. Behaviour care plans did not identify triggers and suggest ways of helping the person. Continence care plans did not specify how the person should be supported with things such as regular reminders to visit the lavatory and what products people used to help them manage their needs. Moving and handling care plans did not always specify what equipment should be used and the size of any slings that should be used.

One person's care plan stated that they should keep their legs elevated as much as possible but that they mostly refused to do this. We visited the person's room twice over the four days of the inspection and found that on both occasions, their feet were not elevated and there was no footstool or other piece of furniture in the room to allow them to elevate their feet. There was no reference in the daily records for the previous seven days, that the person had been encouraged to elevate their legs.

This meant that people may not always have their needs fully met and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

Some care plans were more person centred. For example, one person sometimes chose not to receive

personal care and could become distressed. The care plan told staff to reassure the person and give explanations about what they were doing which usually meant that the person would accept the help they needed. This information would have supported staff to care for the person in an individualised way.

Care plans were regularly reviewed and changes were made where these were required.

Staff also completed daily records. These provided staff with information about how the person had been during the day including what they eaten and drank and what personal care support they had received.

Information about making a complaint was displayed in a communal area of the home and was also included in the information that was given to people when they moved into the home. The registered manager had brief records of three complaints made to them in the last two and half years. There were no records of the date the complaints were received, how they were acknowledged and investigated and the outcome of the complaint. This was also not in accordance with the provider's stated policy for handling complaints.

This meant that an effective system for identifying, receiving, recording, handling and responding to complaints had not been established and was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service well-led?

Our findings

There were arrangements in place to monitor the quality and safety of the service provided. However, these were not fully effective.

Feedback from people had been gathered through the use of quality assurance questionnaires. The registered manager told us that they gave people living in the home a survey once a year to complete about the quality of the food, the premises, care and support, management and daily life. In January 2016, 12 surveys were given out and all were returned. The registered manager had analysed the responses and completed an overall summary. People had scored the service highly in all areas. At the time of the survey, there were more than 30 people living in the home.

There was a lack of consistency in how the service was managed and led. The registered manager responded to the concerns raised at this inspection but had not taken action to proactively assess and monitor these shortfalls prior to our inspection.

The provider's quality assurance policy stated that the service would seek the views and opinions of others such as relatives and visiting professionals. This had not been done. The policy also identified that the service would have an annual development plan as a method of identifying issues and planning improvements. The registered manager confirmed that they had not created a development plan for the service.

The registered manager told us that there was a programme of refurbishment of the home taking place at the time of the inspection. We saw that some rooms had been redecorated and new furniture had been purchased. We asked to see a plan of how and when other areas of the home would be refurbished but one was not available.

At this inspection we have found breaches ten regulations. Audits and management processes have not identified any of the issues found during this inspection.

Infection control audits undertaken in February and June 2016 and monitoring of the premises undertaken in June 2016 did not identify the risks posed by broken and damaged furniture and fittings such the areas surrounding wash hand basins. It also had not identified the issues with the water system and that foot operated waste bins should be provided.

Care plan audits had been carried out in January, May and September 2016. They did not specify how many or which care plans were checked and did not identify any of the issues that were found.

Audits that had been carried out contained an outcome and did not include what was looked at. For example, hot water checks did not make clear that some checks were of sentinel points, carried out by a maintenance person and involved removal of the thermostatic mixer in order to check the temperature of water circulating in the system.

During this inspection a number of different records were examined. These included care plans, daily records, medicines and staff records. A number of these records were not dated, timed or signed. In addition, some records were illegible. Records also lacked detail and information. For example, records of staff meetings did not include a record of the staff that attended or their signature to confirm their attendance. We saw staff meeting records for 2 June 2016 and 20 January 2016. Staff spoken with during the inspection said they were not aware of any staff meetings being held this year and had not attended any.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

We had not received any notifications from the home since 7 December 2015. The registered manager stated that none of the events that should be reported had taken place. We had found that at least one person had passed away and two people were living in the home with an authorised condition to deprive them of their liberty.

This was a breach of Regulation 18 (2)(a)(b) (e)(4)(4A)(a)(b) of the Care Quality Commission (Registration) Regulations 2009 because the registered manager had not notified us of all incidents.

From 1 April 2015 providers have to display the home's ratings. Throughout this inspection the rating was not displayed. We raised this with the registered manager who told us that they had displayed this by the front door but this must have been taken down by someone and they had not noticed this.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had not displayed the rating of its performance assessment following the inspection in February 2015.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified us of all incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff interactions and written information did not ensure that people were treated with respect and dignity at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The provider had not ensured that the premises and equipment is safe to use and was used in a safe way. Suitable equipment to meet people's needs had not always been provided.

People were not protected against the risks associated with the unsafe management and use of medicines.

The risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system for identifying, receiving, recording, handling and responding to complaints had not been established.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected against the risks associated with the unsafe recruitment of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments

The service had not displayed the rating of its performance assessment following the inspection in February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported with appropriate induction, regular training and supervision. Staff had not been provided with appropriate training to enable them to recognise abuse and raise concerns.