Portsmouth City Council

Shearwater

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service in September 2015 and found the provider was not meeting the legal requirements in relation to standards of care and welfare for people who use the service. Risks associated with people's care had not always been assessed, people had not always consented to the care they received, records held in the service were not always secure, accurate and complete and staff did not always receive adequate supervision to support them with their working role. The registered provider sent us an action plan detailing how they would address these concerns and said they would be compliant with the Regulations by 1 November 2015. We carried out an unannounced inspection of the home on 25 and 26 January 2017 and found, whilst the provider had made improvements in some of these areas they were not fully meeting all the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provides accommodation and personal care for up to 60 older people, some of whom live with dementia. Accommodation is arranged over three floors with stair and lift access to all areas. At the time of our inspection 52 people lived at the home.

A registered manager was not in post 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 2008 and associated Regulations about how the service is run. A registered manager left the service in March 2016. A unit manager was employed at the home at the time of our inspection and recruitment processes were underway to employ a manager to the home who would register with the Commission. A deputy manager in post had been in the service for more than three years and provided some consistency in leadership in the home.

Medicines and prescribed substances were not always managed in the home in a safe and effective way. Risks associated with medicines and prescribed substances had not always been identified and actions taken to reduce these risks.

Risks associated with people's care had mostly been identified and plans of care were in place, however the risks associated with the safe evacuation of people in the event of an emergency had not been assessed and plans of care were not in place to reduce these risks.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Staff recruitment processes were robust and staff received sufficient support and supervision in the home. However staff lacked training in some areas such as first aid and in the use of some medicines.

People received freshly prepared nutritious food in line with their preferences although further work was required to support people who lived with diabetes. We have made a recommendation about this.

People were encouraged and supported to make decisions about their care and welfare. Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Where people were legally deprived of their liberty to ensure their safety, appropriate guidance had been followed.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. Staff involved people and their relatives in the planning of their care.

Care plans mostly reflected the individual needs of people and the risks associated with these needs, although some information lacked consistency.

People were supported to participate in a wide range of events and activities of their choice.

Effective systems were in place to monitor and evaluate any concerns or complaints received and to ensure learning outcomes or improvements were identified from these. Staff encouraged people and their relatives to share their concerns and experiences with them.

Whilst the service had a good staffing structure which provided support and guidance for people, staff and their relatives, there was a lack of management leadership in the home. Further work was required to ensure senior staff had a good understanding of their roles and responsibilities.

There was a lack of systems and processes in the home to assess, monitor and mitigate the risks associated with people's care and ensure the safety of the service provided.

We found two repeat breaches and two new breaches within two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.
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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines and other prescribed substances were not always managed in a safe and effective manner.

Most risks associated with people's care had been assessed and plans of care were in place to help reduce these risks. However plans were not in place for people in the event of an emergency to support their safe evacuation.

There were sufficient staff available to meet people' needs and all staff had been assessed during recruitment as to their suitability to work with people.

Systems were in place to support staff in recognising signs of abuse and they knew how to report these.

Is the service effective?

Requires Improvement

The service was not always effective.

People received freshly prepared nutritious food in line with their preferences although further work was required to support people who lived with diabetes. We have made a recommendation about this.

Where people could not consent to their care the provider was guided by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff had received training to enable them to meet the needs of people.

Health and social care professionals visited people to support their needs although records of these visits were not always clear.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were caring and supportive of people's needs. Health and social care professionals said staff were caring and supportive of people.

Staff cared for people in a kind and empathetic way and respected their dignity and privacy. They provided time and support for people in a relaxed and friendly manner. People were able to express their views and be actively involved in their care planning.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect the identified needs of people and the risks associated with these needs.

People were supported to participate in a wide range of events and activities of their choice.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way

Is the service well-led?

Requires Improvement

The service was not well led.

There was no registered manager in the home. Interim arrangements were in place for the recruitment to this role.

There were not effective systems in place to ensure accurate and orderly records were in place for people. Audits to ensure the safety of people in the home had not been completed.

People, their relatives and staff had the opportunity to discuss any concerns they may have and any changes in the home

Shearwater

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 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.

Two inspectors, a specialist advisor and an expert by experience completed this unannounced comprehensive inspection on 25 and 26 January 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. On 8 September 2016 the registered provider completed a Provider Information Return (PIR). This 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 reviewed the PIR for this home.

Some people who lived at the home were not able to talk with us about the care they received. We observed care and support being delivered by staff and their interactions with people in communal areas of the home. We spoke with eight people and three relatives to gain their views of the home. We spoke with staff including the unit manager, the deputy manager, two shift leaders, two assistant managers and five members of care staff, an activity coordinator and a member of kitchen staff.

We looked at the care plans and associated records for ten people. We looked at medicine administration records for 20 people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, eight staff recruitment and training files and policies and procedures.

Following our visit we received feedback from three health and social care professionals who supported some of the people who lived at the home.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they were safe in the home. One person told us, "Knowing there are people around you at all times is so reassuring, they look out for you," and another told us, "Of course I am safe, they (staff) are all terrific". One relative spoke of how much more settled their loved one was since coming to the home as they felt safe and secure. Health and social care professionals told us they felt people were cared for by staff who understood how to keep them safe.

At our inspection in September 2015 we found the registered provider had not always assessed the risks associated with people's care and provided details as to how staff could reduce these risks to ensure their safety and welfare. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would address this matter and be compliant with this Regulation by 1 November 2015. At this inspection we found whilst some risks had been assessed, the risks associated with some people's medicines and related care had not been identified and plans of care in place were not fully informed by these risks.

Assistant managers and shift leaders had completed appropriate training for the safe administration of medicines and these were stored safely, however we found some medicines and prescribed substances were not always administered safely. The risks associated with the administration of some medicines and prescribed substances had not been identified and information was not available for staff as to how to reduce these risks.

For six people who were at risk of choking, their medicines administration records (MAR) showed they had been prescribed a substance called "Thick and Easy". This substance thickens food and fluids to a consistency which allows people who are at risk of choking to take them safely, reducing the risk of choking. This substance is prescribed by a GP under the guidance of a speech and language therapist and does not need to be documented on a MAR.

Care staff, shift leaders and assistant managers had received no training and did not demonstrate a good understanding of the safe use and administration of this substance. For example, we observed one shift leader give a person who required their fluids to be thickened some tablet medicines with un-thickened water. When the person started to cough the shift leader told us, "She coughs a lot but does not choke. It's not a swallowing difficulty." For another person a member of care staff told us, "We add one scoop of the thickener usually, but if [person] is having a bad day we add two." Care records did not clearly identify the thickness of fluids this person required. An assessment completed by a speech and language therapist of this person's abilities to swallow had not been used to ensure this substance was administered safely.

We spoke with the unit manager and deputy manager about our concerns with the safe use of this substance. They told us this would be addressed immediately. Following our inspection the unit manager provided information to show they had taken steps to ensure the safety and welfare of people who required this substance."

Some people had medicines which were prescribed to be given as required (PRN). There were not always protocols in place for these medicines which meant there was no clear guidance for staff on when and how to administer these medicines safely. For example, for one person who was prescribed a medicine to help with their anxiety and two people who were prescribed medicines for pain to be given PRN there were no protocols in place to support the administration of these medicines.

For two people who were receiving a medicine to thin their blood, there was no information available for care staff on the risks associated with this medicine which can include excessive bleeding and bruising if they injure themselves, or how these risks should be managed. Care staff who did not administer medicines told us they were not aware this medicine was being administered to these people or of the increased risks of injury or harm to these people should they fall or injure themselves.

The lack of clear guidance in place for the safe use and administration of medicines and other prescribed substances to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Care Act 2008 (regulated Activities) Regulations 2014.

The risks associated with the safety of people in the home in the event of an emergency had been assessed and a robust business continuity plan dated December 2016 was in place to ensure staff were aware of the actions required in the event of a power failure or other serious event in the home. This included a safe place for people to be moved to in the event an evacuation of the home was required. However, there were no personal evacuation plans in place for people. This meant that in the event of an emergency there was no clear information available to guide staff or emergency services on the support and care people would need to remove them from potential danger in a safe and efficient way.

The lack of risk assessments in place to ensure the safety and welfare of people in the event of an emergency was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place to identify the risks associated with people's care including nutrition, falls, moving and handling and choking. For people who lived with specific health conditions such as diabetes, epilepsy and dementia the risks associated with these conditions had been identified. Plans of care in place gave staff guidance on how they should support people to reduce these risks, however we saw these were not always followed by staff, for example for people who required a diabetic diet diabetic foods were not always available and or for people who required the use of thickener in their fluids, this was not always followed in line with prescribed amounts.

There were sufficient staff available to meet the needs of people. The deputy manager told us there was no assessment made of the dependency of people and how this linked to the number of staff required to meet their needs. However, we a saw a team of staff was allocated to each floor of the home and staff rotas showed staffing numbers were consistent. Whilst some external agency staff worked at the home, the deputy manager told us they tried to ensure the same staff worked at the home to provide continuity for people. People and their relatives felt there were sufficient staff to meet the needs of people and staff told us they had sufficient time and support to ensure people's needs were met.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. They said they were confident to report any concerns to the interim or deputy a manager who they said would take any necessary action immediately. Staff had received training on safeguarding and were able to identify the types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC. Staff were aware of the provider's whistleblowing policy and said they would be happy to go to more senior management if they felt their concerns were not addressed appropriately by the unit or deputy manager.

Requires Improvement

Is the service effective?

Our findings

People we spoke with felt they were able to express their wishes and were involved in their care. One told us, "I make choices all the time, my food, when I get up and what I want to do in the day. There's lots of choice and I am very happy here." Relatives told us they were very involved in the care their loved ones received and worked with staff to ensure they received choice in line with their needs and preferences. People and their relatives spoke highly of the food choices available to them. Health and social care professionals felt staff requested their support appropriately and followed guidance provided for them to ensure the safety and welfare of people.

At our inspection in September 2015 we found the registered provider had not always ensured people's capacity to make decisions had been assessed in relation to the restriction of their movements within the home. This was a breach of Regulation 11 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would address this matter and be compliant with this Regulation by 1 November 2015. At this inspection we found the registered provider had taken sufficient action to address these concerns and there was no longer a breach of this regulation.

Where people had the mental capacity to consent to their treatment, staff sought their consent before care or treatment was offered and encouraged people to remain independent. Whilst people were not always able to verbally agree to their care, staff had a very good understanding of how people expressed their wishes and consented to their care. For example, for one person who displayed anxiety and distress when asked too many questions, staff were aware of this reaction and how to ensure they supported the person appropriately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Staff had a good understanding of the processes required to ensure decisions were made in the best interests of people.

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 MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For several people who lived at the home these safeguards had been authorised and care records reflected any conditions associated with these. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

At our inspection in September 2015 we found the registered provider had not always ensured staff received sufficient supervision to support them in their working role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would address this matter and be compliant with this Regulation by 1 November 2015. At

this inspection we found the registered provider had taken sufficient action to address these concerns and there was no longer a breach of this regulation.

A program of supervision sessions, induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. However, we found only shift leaders and assistant managers had received training on the management of choking and first aid. There were eight people who lived in the home and were at risk of choking and care plans identified actions for any staff member to take should an incident of choking occur. However, staff would require training to complete these actions effectively and only senior staff had received this training. The unit manager told us they would address this concern immediately. Following our inspection they provided information to show training was being completed for all care staff in basic life support and choking. The registered provider required all staff to complete the Care Certificate. This certificate is an identified set of standards that care staff adheres to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People enjoyed a varied menu of home cooked meals. One person told us, "You get very well fed here; it's lovely as the food is cooked fresh every day." Another told us there was always a choice of meal and, "there is always lots of fruit available too if we want any." The cook had access to fresh fruit, vegetables and ingredients as they requested. People were offered a choice daily as to their preferred meal and alternatives were available. We saw visual aids were used to prompt people to choose their preferred meal. Care plans identified specific dietary needs, likes and dislikes of people and the cook was aware of these.

However, for people who lived with diabetes we found these specific dietary needs were not always catered for. Care plans reflected that staff should encourage people to choose foods which were suitable for a diabetic diet. However, the cook told us they did not prepare any foods specifically for those who lived with diabetes. They prepared meals with fortified milk and cream to enhance the nutritious value of foods for people and all desserts contained normal sugar levels. The cook told us staff supported people to make choices from the set menu and people who lived with diabetes received yoghurt, fruit or a smaller version of a sweet. This meant for people who lived with diabetes their choice was limited and there was a risk they may not receive foods which were in line with their specific needs.

We recommend the registered provider seeks further guidance on the preparation and presentation of meals for people who live with diabetes and update their practices accordingly.

Health and social care professionals told us they were well received at the home and staff did not call them inappropriately. They felt staff had a good understanding of how to meet people's needs and followed advice and guidance they provided. However, whilst records of visits from health and social care professionals including GP's, speech and language therapists, social workers, specialist nurses and community psychiatric nurses were available and informed plans of care, they were not always kept in a methodical and organised way.

Good

Is the service caring?

Our findings

People and their relatives said staff were very caring and had a good understanding of their needs. One person told us, "Staff are kind and caring, they look after me. They are terribly respectful." Another told us, "The 'girls' are lovely they bend over backwards for you." A relative told us how well staff knew their loved one and took time to understand her needs and look after them in line with their wishes. Another said, "I can't fault the staff at all, they are very good." Health and social care professionals said staff had good caring relationships with people.

Staff knew people well and used good communication skills as they addressed people by their preferred name and took time to recognise how people were feeling when they spoke with them. For example, one person became very agitated whilst in a communal area of the home and this was distressing for others as well as the person. A member of staff went to the person and spoke calmly, quietly and slowly with them, reassuring them they were there to help and encouraging them to express themselves whilst respecting others in the room.

Whilst staff were busy, they took time to interact with people as they moved around the home or sat in communal areas. A member of staff was present in communal areas when people were there and encouraged people to interact with each other and engage in other activities such as reminiscing and singing along to music. Staff took time to engage with people and encourage them to remain independent whilst ensuring their safety and welfare.

Staff told us they felt people received good care at the home. One told us, "You treat them [people] as part of your family," and another said, "Definitely caring; on this floor in particular we are like one big family." A third told us, "I think the care is excellent here."

Health and social care professionals said staff were caring and kind and provided good support for people. They spoke of staff who knew people well and understood how to meet their needs and preferences.

Staff had a good understanding of the need to ensure people were treated with respect and dignity at all times. One person told us, "They [staff] always knock on the door before the come in and if they help me to the toilet they close the door and wait for me to call. They are all just lovely."

People and their relatives were involved in providing information to inform their care plans. Care records showed staff interacted with people to understand their needs, views, preferences and dislikes. Relatives were involved in the planning of care for their loved ones and health and social are professionals were consulted to ensure plans of care fully reflected people's needs.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were encouraged to express their views and be involved in making decisions about their care. Staff knew people well and understood how to support them to be as active and independent as possible whilst maintaining their safety and wellbeing. Relatives told us there were opportunities to discuss any concerns or ideas they may have with regards to the care of their loved ones. Health and social care professionals said staff knew people well and understood their needs.

People were assessed prior to their admission to the home and these assessments were used to inform plans of care for people. Health and social care professionals were involved in assessments of people prior to their admission if required to help identify their physical and mental health needs.. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them although they did not always identify who needed to be involved in their lives and in helping them to make decisions.

Care plans were mostly person centred and provided staff with information on how people liked to be supported through the day, including their night time routines. However, for people who were at risk of choking and required fluids to be thickened to reduce this risk we found care plans did not always hold accurate information on how staff should do this for each person. Whilst staff knew people required assistance with the preparation of these drinks we found they were unclear how to assist people with this individual need. We have addressed this concern in the safe and well led sections of this report.

There was a very wide range of activities available for people who lived in the home. An activities coordinator worked in the home five days a week and had a very passionate approach to including people and all staff in the activities they organised within the home. There were several areas of the home which had been adapted to provide stimulation and entertainment for people, particularly those who lived with dementia and these included; an indoor garden, a pub, areas of interest such as armed forces, theatre and dancing, and a shop. People told us there were many activities they could participate in if they chose to, including painting, art and music. During our inspection we observed people enjoy activities such as papier mache making, reminiscence therapies, singing and watching a film. For some people who chose to remain in their rooms the activities coordinator told us how they provided one to one support if this was required and encouraged people to be involved in the planning of new activities and themes in the home. External entertainers such as local school choirs and visiting theatre companies and the church visited the home regularly.

The complaints policy was displayed in the entrance to and around the home. People and their relatives were aware of the policy and felt able to discuss any concerns they may have with staff. One person told us, "I don't need to complain, they will always help me with any question I have and there are no problems here." Relatives knew they could approach any member of staff and discuss any concerns they may have.

Systems were in place to monitor and evaluate any concerns or complaints which were received in the service. We saw the service had received three complaints in the twelve months prior to our inspection and these had been dealt with in line with the registered provider's policy.

Staff welcomed visitors in a warm and friendly way and encouraged them to express any views about the service their relatives received. Relatives felt able to express their views or concerns and felt these would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives said they felt able to talk to staff and managers if they had any concerns and that these would be dealt with promptly. They were aware there had been several changes in the management of the home and that a new manager was being recruited. Staff felt supported in their roles. Health and social care professionals felt the home was led in a professional manner.

At our inspection in September 2015 we found the registered provider had not always ensured records held in the home were secure, accurate and complete. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would address this matter and be compliant with this Regulation by 1 November 2015. At this inspection we found the registered provider had not taken sufficient action to address these concerns.

Care records in place for each person were not held together and often information was not clear and lacked order. Information for each person was held in one of five different places depending on the nature of the information. Care plans and daily records were easily accessible for care staff. However, all other information with regard to medical interventions, mental capacity assessments, Deprivation of Liberty Safeguards, observation charts including those following a fall, incidents and accidents and any other personal information was held in a variety of places. For example some notes were held securely within cupboards in communal areas of the home, some within the staff office on each floor and others were kept in the main home office on the ground floor. Some of these notes were duplicated to provide management staff with copies of records although this was not consistent practice. This meant information with regard to the care people required and received was not always consistent or readily accessible for any member of staff or visiting health or social care professional. Staff were unable to readily locate assessments of people's needs from a health care professional which we requested to inform their care plans. Staff were not always aware of where records were held, or where to find them.

Care records lacked order and staff were not always clear of their responsibilities in the completion of these records. For example, records of people's fluid and food intake, position changing or interventions following a fall lacked information and often had gaps. This meant we were not assured people always received the care and support they required as records failed to identify any actions taken.

For example, on the first day of our inspection we saw one person had fallen and records showed they were to be under observation for 48 hours. There was no information for staff to follow on what these observations should be, how frequently they were required and what they should do if they were concerned about the person during these observations. We asked a member of care staff what these observations entailed. They told us, "The senior staff do these and record them in the office." We asked a shift leader what these observations entailed and they told us they asked staff who were with the person all the time how they were and then recorded this; however we saw these records lacked consistency and details about the observations of this person. We saw this person remained asleep and seated in a communal area of the home for most of the day and staff recorded this every four hours without any other activity or intervention noted.

On the second day of our inspection we saw four people were being observed by staff on one floor of the home following falls within the past 24 or 48 hours. We saw these records were not completed regularly and remained in the locked office. A senior member of staff told us these records should be competed every four hours or more frequently if staff were concerned about the person. We saw there was no information on these records as to how often an observation of the person should be recorded and what should be recorded to ensure the safety and welfare of the person. Staff told us they had a high number of people who fell in the home and this was usually due to infections or their dementia.

Records to ensure the safe administration of medicines and other substances were not always up to date. Allergies were not documented on medicine administration records and in some cases we found people had an extensive list of allergies which was not reflected in their medicines administration records or their care plans. An assistant manager rectified these records during our inspection.

The lack of accurate, complete and orderly records in place to provide staff with clear information they required to care for people and ensure their safety and welfare was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents and accidents which occurred in the home were recorded on forms and then held on people's care records and in the unit manager's office. We asked the deputy manager how these events were reviewed and any learning identified from these incidents. They told us they reviewed these events when they received the incident forms and ensured these were logged correctly in care records and care plans were updated to reflect these. However, we found care plans did not always reflect these incidents and any amendments required to people's care. For example, incident and accident forms for one person showed they had fallen on 20 occasions between 12 November 2016 and 24 January 2017. A "Falls Screening Assessment" tool had been completed on 12 and 23 November 2016 for this person and showed they did not require a detailed risk assessment of their falls to be completed. The assessment of care needs for this person had not been reviewed and updated to reflect the risks associated with their care. A falls risk assessment review sheet identified each of these falls and stated "No additional control measures were required" to support this person. Care plans had not been updated to reflect the high number of falls this person continued to have. Whilst staff told us this person fell regularly and they were being monitored for this, records showed no learning had been identified from previous incidents to inform their care or ensure their safety and welfare.

We looked at accident and incident records reported in the three months prior to our inspection. Whilst we noted a high level of unwitnessed falls in the home, and a high number of calls to 999 services when people fell, there was no information available to identify any patterns or trends in these incidents across the home. Whilst data was being collected to identify any trends or patterns in incidents and accidents this was not being used to inform the care people received in the home.

Whilst the registered provider had a schedule of audits which were to be completed in the home, we saw these had not been completed and systems in place to monitor the quality and safety of the care people received had not been completed. We asked the unit and deputy manager why these were not up to date. They told us the regular changes and absence of regular management meant these had not been completed. There were no audits of medicines, infection control practices, health and safety in the home or records within the home in the eight months prior to our inspection. There had not been sufficient assessment of the service provided to ensure the concerns we found during our inspection had been identified by the registered provider.

The lack of systems and processes in the home to assess, monitor and mitigate the risks associated with

people's care and ensure the safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a clear structure of staffing in the home. The unit manager and deputy manager provided senior leadership in the management of the home. Three assistant managers were assigned each to one floor of the home and took management responsibilities for the floor with regard to care plans, records, audits and support of staff. Shift leaders on each of the floors took day to day responsibility for the floor when they were at work, completed medicines and supported staff with the care of people. Whilst this structure created a supportive role of delegated duties, we found senior staff did not always have a clear understanding of their roles and responsibilities, in particular with the management of audits and records within the home.

Assistant managers and shift leaders accessed and updated all other records for people such as health care professional visits and medical information. However, this information was not readily available to care staff working with people. The deputy manager told us assistant managers were responsible for the management of audits and records within their units. However, we found there was a lack of clarity in what was required of the assistant manager to ensure audits and records were maintained accurately. For example, the deputy manager told us assistant managers completed infection control audits of their units. There were no records of these audits and whilst assistant managers were aware they needed to monitor the infection control practices in the home they were not aware they were required to complete formal audits.

The interim manager and the deputy manager promoted an open and honest working culture in the home. They told us they had identified the need to work with staff that were concerned about the recent changes in leadership in the home and promote stability. They recognised this was a challenge as a new manager was to be appointed in the near future. Regular meetings were held between management, staff and with people and their relatives to ensure they were aware of any changes in the service and provide them with the opportunity to give feedback on any concerns they may have. A newsletter was available for people and gave up to date information on new activities, previous events and any changes in the management of the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of clear guidance in place for the safe use and administration of some medicines to ensure the safety and welfare of people. Risks assessments had not been completed to ensure the safety of people in the event of an emergency.

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 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure adequate systems and processes were in place in the home to assess, monitor and mitigate the risks associated with people's care and ensure the safety of the services they provided. Records held in the service were not always accurate, complete or in good order to ensure staff had access to the clear information they required to care for people and ensure their safety and welfare.

The enforcement action we took:

We served a Warning notice on the registered provider requiring them to be compliant with this Regulation by 8 May 2017.