Lawford House Residential Care Home

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Inspection report

Lawford House
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Ross-on-Wye
Herefordshire
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Tel: 01989566811

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22 November 2016

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

Lawford House is located in Ross-on-Wye, Herefordshire. The service provides personal care for up to 15 older people. On the day of our inspection, there were 11 people living in the home.

The inspection took place on 18 and 22 November 2016. The inspection on 18 November was unannounced. The inspection on 22 November was announced because we needed to ensure the provider would be at the home.

There was no registered manager at this service, and there had been no registered manager in post since March 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection on 12 April and 23 May 2016, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, dignity and respect, person-centred care, receiving and dealing with complaints, and good governance. As a result, we asked the provider to complete an action plan to detail the steps they would take to improve the quality of care provided to people. The home was also placed into special measures, meaning significant improvements were required, or enforcement action would be taken.

At this inspection, we found that people were not always protected from harm or abuse. Where people had suffered harm or abuse, the relevant authorities had not been notified and action had not been taken to protect people from further abuse or harm.

There was no mechanism in place for determining adequate staffing levels, or deployment of staff. Staffing levels were not sufficient to meet people's needs or ensure their freedom was promoted.

People did not have choice in the meals provided. Food was not stored appropriately and food items in the home were not safe for human consumption as they had passed their expiry dates.

People's privacy was not always respected and maintained. People were not always treated with dignity, and were placed in undignified situations.

People could not always enjoy their hobbies and interests. Although people's feedback was captured, it was not always acted upon.

The provider had not rectified the issues and concerns we had previously brought to their attention, nor had they identified additional shortfalls in the quality of care provided. The provider did not comply with their regulatory responsibility to notify the CQC of allegations of harm or abuse.

People had access to healthcare professionals when required. People received their medicines safely.

People enjoyed positive relationships with staff. Staff knew people's needs well and how to meet those.

Staff were positive about the training they had received and the ongoing support from the acting manager.

The overall rating for this service is 'Inadequate' and therefore, the service remains in special measures.

Services in special measures will be kept under review; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

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 is not safe.

People were not protected from harm or abuse. Where there were concerns about abuse, these were not always reported to the relevant authorities.

There were not enough staff to meet people's needs. Staff expressed concerns over unsafe practice due to the amount of hours they had to work.

People received their medicines safely and as prescribed.

Is the service effective?

Requires Improvement

The service is not always effective.

People did not have a range of nutritious and appetising food. People's preferences were not catered for. Food was not stored appropriately, which meant people sometimes ate stale food and food which had passed its expiry dates.

People were supported by staff who had received training relevant to their roles. People had access to health professionals when required.

Is the service caring?

Requires Improvement

The service is not always caring.

People's privacy and dignity was not consistently maintained or respected.

People enjoyed positive relationships with staff. Staff knew people's individual preferences and communication styles. People's independence was promoted as much as possible.

Is the service responsive?

Requires Improvement

The service is not always responsive.

People could not always enjoy their hobbies and interests.

Although people had enjoyed in-house social events, these had been infrequent. People's feedback was not always acted upon,

There was a system in place for capturing and acting on complaints, but this the complaints procedure was not visible for people and had not been shared with relatives.

Is the service well-led?

Inadequate

The service is not well-led.

The provider had not identified shortfalls in the quality of care people receive, nor had they acted upon feedback and concerns. The provider was not up to date with maintenance and safety issues within the home.

There had been no Registered Manager in post since March 2015.

Although the provider was aware of their requirement to notify the Care Quality Commission when people had suffered harm or abuse, they had not notified us of a recent incident.

Staff were positive about the support they received from the acting manager.

Lawford House Residential 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 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.

We made an unannounced inspection on 18 November 2016, and an announced inspection and meeting with the provider on 22 November. The inspection team consisted of two Inspectors.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

We asked the local authority if they had any information to share with us about the care provided by the service. Due to ongoing concerns regarding the care people receive, there was a local authority action plan in place with the provider.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with six people who use the service. We spoke with the provider, the acting manager, three cooks and four care staff. We also spoke with two relatives and two health professionals.

We looked at two care records, which included risk assessments, capacity assessments and guidance from health professionals. We looked at the medication administration records and comments and feedback

received.

Inadequate

Is the service safe?

Our findings

We looked at how risks associated with people's care and support needs were managed and how people were protected from harm and abuse. Although there were individual risk assessments in place to highlight how to safely meet people's needs, we found that action was not always taken when needed to protect people. For example, one person's risk assessment recorded that they were at risk of financial abuse. This person was subsequently financially abused at the home. Although the provider was aware abuse had occurred, they did not report this to the relevant authorities, nor did they notify the police. This inaction meant that people living at the home were not protected from further abuse as there was no investigation into how the abuse had occurred, or who by.

The local authority became aware of the financial abuse during a monitoring visit at the home, weeks' after the incident. They told the provider to report the matter to the police, the Safeguarding Team and to the Care Quality Commission, which the provider subsequently did. Due to the length of time in reporting the incident to the police, they were unable to investigate the matter. We spoke to the provider about this incident, and they told us they had not reported the matter as they planned to investigate it internally. They told us, "I should have informed the police and safeguarding initially, I was at fault. I reported it to the police who said I should have reported the matter sooner and in future to report all matters straight away." At the time of our inspection, no internal investigation had been carried out into the abuse.

After our inspection, we became aware of a further incident which had not been reported to the relevant authorities, including the CQC. In May of this year, a person had gone missing from the home and was found on a path by the home. It was not safe for this person to go out unaccompanied. The provider was aware the incident had occurred, but did not notify the relevant authorities to ensure the person was kept safe. Although the provider had subsequently secured the front door so that people were unable to unlock it without assistance, the risk was not shared appropriately to ensure that additional safety measures could be put in place, where applicable.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at whether there were enough staff to meet people's needs, keep them safe and also maintain as much of their freedom as possible. People told us they did not feel there were enough staff on duty to meet their needs. One person told us, "There isn't enough staff on duty night or day, they are always busy." Another person told us, "I really like to be taken out and get some fresh air, but they don't have the staff." A relative we spoke with told us they had concerns about the staffing levels and the effect that had on people's care. They told us, "The manager does try hard. But [person's name] is not always showered every day so I come up and make sure I do it. It's not a big ask, is it?" The relative told us that staff had been too busy that day to notice the fact their relative needed help with personal care, which they told us had happened before.

Staff and the acting manager told us the difficulties in ensuring there were sufficient staff on duty at any time. One member of staff told us, "Staffing has been a struggle having to cover a lot of one or two extra

shifts a week." Another member of staff told us, "They definitely need more staff. They only have two staff in the afternoon and evening. When there are only two of you, you are busy all of the time."

We asked the acting manager if a dependency tool was used by the provider to ascertain staffing levels and ensure there were enough staff to meet people's needs. As there was no dependency tool in place, we asked the acting manager to look at the current available staffing hours and give us the details of how many staffing hours were required per week, and how many were currently available; these figures showed there was a deficit of around 30 hours per week. We saw that this staffing deficit affected the care that people received. For example, one person needed staff to support them with a hospital appointment. As there were only two staff on duty, this meant the acting manager had to take the person to their appointment, with the cook then having to stop work in the kitchen to enable them to work alongside the care staff. Although the cook had been trained to cover care shifts, they had not been due to work in that role on that day. The acting manager told us, "If something out of the ordinary happens, such as a medical appointment for someone being re-arranged at short notice, we can't cover it and it is chaos."

Our conversation with the provider confirmed that no dependency tool was used, nor was there an understanding of the need for such a mechanism. As such, staffing levels were not determined by an assessment of individuals' needs. We observed that people who need staff assistance to mobilise did not always receive this assistance promptly as there were no staff available. The acting manager told us they did not have the autonomy in their role to arrange additional staffing, including booking agency staff when required, or to arrange additional staffing hours. This meant there were not always sufficient staff on duty.

At the time of our inspection, the acting manager had created four weeks' worth of rotas. We saw these rotas contained several gaps where it had not been possible to cover the shifts, including forthcoming night and weekend shifts. Staff we spoke with told us they frequently were asked to work on their days off and during their annual leave. One staff member we spoke with told us they were concerned about how many hours some members of staff worked, and that this was unsafe practice due to the fact mistakes could happen when staff were very tired. Although no incidents had occurred at the time of our inspection, one member of staff told us, "It is a disaster waiting to happen." We saw that there were members of staff who worked twelve hours over their contracted hours per week on a regular basis.

The acting manager had been unable to cover shifts with agency staff as they told us the provider did not allow them to do so. We spoke with the provider about the staffing levels and gaps in the rota. They told us that shifts were always covered by existing staff members without any difficulties and that they offered extra hours to their own staff before using agency staff. We expressed concern to the provider that their planning for staff cover seemed to be about 'crisis management' and that they relied on the goodwill of existing staff. We shared staff concerns with the provider about the amount of hours they had to work to ensure shifts were covered. The provider told us they used agency staff when required. However, we saw that agency staff had not been used for over five months. We asked the provider to contact a local agency to ensure cover for the shifts that week which staff were unable to cover. Although the provider ensured us they would do so, we discovered from the local authority they did not do so and instead, they had arranged for existing staff to cover the shifts.

Although we saw that the necessary pre-employment checks were carried out by the provider, including references and criminal record checks, the provider did not demonstrate an understanding of the need for new staff to undergo an induction process. When we asked the provider how the staffing issue would be resolved, they told us that two new members of staff would be available once their background checks were completed. We explained to the provider that new staff could not be expected to cover shifts immediately, without having an induction and working alongside existing staff members in the first instance,

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

We looked at how people received their medicines. People told us they received their medicines when they should. One person told us, "I get my medication on time, they are very good like that." Staff told us they had received training in the safe administration of medicines and that their ongoing competency in this area was kept under review. We saw that people received their medicines safely, and as prescribed by their GP. We saw that staff offered people their 'as required' medicines and ensured these were available for people when they needed them.

Requires Improvement

Is the service effective?

Our findings

Before our inspection, we received information of concern from the local authority about people not receiving enough nutritious food. We asked people about the food they received, and we looked at the food people typically received during the course of our inspection.

People told us they were not always offered the food they would choose for themselves. One person told us, "We don't have a choice; you have what's cooked for you." One person told us, "I would like a cooked breakfast every day if I could. But I have cereal instead and one slice of toast." A person told us, "I love fish. I would like to have salmon, and kippers for breakfast." Another person told us, "I love to eat all different kinds of vegetables." We saw that people were not involved in decisions about the menus, and that there was a lack of choice provided. For example, on the first day of our inspection, people were offered chips and baked beans with either egg or fish. There was only one choice of dessert. One person requested a banana for their dessert, but there were no bananas available.

Staff told us they were concerned about the food provided. One member of staff told us, "There is never enough food available, when it comes to supper they are given what is available and there is no choice." Although people told us they were happy with the food provided and they had enough to eat, at the time of our inspection, one person living at the home had been identified as being at risk of malnutrition and their weight loss was being monitored. We saw that staff members had raised concerns about the food during their monthly one to one meetings with the acting manager, but no action had been taken by the provider.

We spoke with three cooks over the course of our inspection. One cook told us that as there was often insufficient food in the home to make meals, they brought in their own food items from home to ensure people had enough to eat. Another cook told us, " I have to keep asking for food and for cleaning materials." Two cooks told us told us the food budget was insufficient. On the morning of the first day of our inspection, we checked the food cupboards to see what was available for people. We found that the cereals people had eaten for breakfast had been stored in containers without lids on, and were therefore stale. We asked for these to be discarded and for new cereal to be bought for people. On the second day of our inspection, although more cereal had been bought, it was still in a container with no lid. The containers were also dirty and we asked for these to be replaced.

We were concerned about the lack of food we found in the cupboards. Additionally, whilst checking the food, we found that multiple items had passed their use by date and their 'best before' dates.These items included tinned produce, as well as fruit, vegetables and frozen beef burgers; the burgers had a 'best before' date of 21 July 2016. These items were all thrown away during our inspection. As there was no system in place for stock rotation and checking and monitoring use by dates, this meant that out of date food had been served to people.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received a lot of training since the last inspection. One member of staff told us, "We didn't use to have much training but, in the last 18 months, things have improved significantly, you can never have too much training. I am trained in first aid, moving and handling and medication." Another member of staff told us, "Training is getting better and I have had a lot more recently. I feel more valued now than before." Staff told us they had received training in areas such as frailty and falls, end of life care, dementia and the Mental Capacity Act. Staff told us this training helped them to ensure they had the up-to-date knowledge required in their roles.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. Staff had a good understanding of the Act and how it relates to their roles. One member of staff told us, " In supporting people to make decisions, I explain everything so that they have some understanding. I am aware people can make certain decisions, such as around food, but are unable to make decisions about the personal care they need, for example. Where people were unable to make decisions for themselves, decisions were made in their best interests.

At the time of our inspection, every person living at Lawford House had been assessed in respect of their individual care and support needs, and the acting manager had ensured DoLS applications had been submitted accordingly. We reviewed a sample of these applications and saw that each application was specific to individuals' requirements. Staff understood which people had a DoLS in place, and why. Staff also had an understanding of the different conditions on people's DoLS authorisations, and what these meant for people's care. On the day of our inspection, one person was visited by their Relevant Person's Representative (RPR). An RPR is someone who is appointed under the MCA to represent and support people who are deprived of their liberty.

We looked at how people's health and wellbeing was maintained. On the day of our inspection, people were visited by a health professional and offered the influenza vaccination. We spoke with a visiting district nurse, who told us that staff were quick to notice any changes in people's health and always sought medical advice if they had concerns. We saw that people had been supported to attend recent medical appointments.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people were not always treated with dignity and respect. The provider was asked to complete an action plan which described the actions they would take to meet the regulation. The provider's action plan told us that training would be arranged for staff in this area, and that it would be discussed in staff supervision sessions and form part of 'on the job' training.

At this inspection, we found that staff had received training on dignity and respect. We also saw the acting manager had discussed its importance with staff members on a one to one basis. However, we found that people were still not always treated with dignity and respect.

At our last inspection, we asked the provider to ensure one of the communal bathrooms had its lock replaced as it was broken and people were unable to lock the door and have privacy; we showed the provider which bathroom we were referring to. On this inspection, we found that although a sign had been put up to say "please knock before entering", the room still did not have a working lock for people to use. We again highlighted this to the provider. The provider told us they had not known which lock had needed replacing, and that they were unaware it was still an issue as "No-one had told me." This lock was fitted by the second day of our inspection. However, there had been a period of six months where people had not been afforded privacy when using this room.

Not all interactions we saw between staff and people promoted dignity and respect. For example, one member of staff carried out a personal care task in front of other people and visitors, which placed the person in an undignified situation. We brought this matter to the acting manager's attention, who addressed this with the member of staff. The member of staff recognised it had been inappropriate, but had thought the communal lounge was a convenient area for the person.

At the time of our inspection, the tumble drier in the home had been broken for over a week. A relative we spoke with expressed concern that their relative was wearing damp clothes, despite having a chest complaint. We raised this with the provider, who told us they would ensure the tumble drier was fixed or replaced. The acting manager told us they would remind staff of the need to check people's clothes were fully dried before helping people to dress.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed their interactions with staff. One person told us, " We have a bit of a laugh and joke with them (staff)." A relative we spoke with told us they felt their relative was happy at the home and well cared for. Staff we spoke with knew people well, both in terms of their care needs and their likes, dislikes and preferences. We saw that staff knew what subjects people would like to discuss and how they preferred to be addressed. Staff also demonstrated an understanding of people's individual

communication needs and styles. One member of staff told us, " With people who can't speak, you get to know them. We point and use body language to find out what they want. I have one (person) who used to work in a post office. I have found out they love counting coins, so I brought some in. They love to count them." A health professional we spoke with told us, " Staff have a really good insight into people's needs."

Staff explained to us how they promoted people's independence, where possible. One member of staff told us, I support people with dementia in making choices so that they can be independent. One person loves collecting cups and washing them up. I will often supervise them, they love it." Another member of staff told us, " I will put people's clothing on the bed and allow them to choose, which makes them more independent."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people did not always receive care and support which reflected their individual preferences or met their needs. The provider was asked to complete an action plan which described the actions they would take to meet the regulation. The provider's action plan told us that a weekly activities plan would be displayed for people and that people would be asked what their requirements and preferences were.

At this inspection, we found that although some improvements had been made, people were not consistently able to enjoy social and leisure opportunities. One person told us, "We do the odd thing here and there, but there's never a great deal to do." A relative we spoke with told us, "No activities, not really. There was some music for Halloween and Christmas. There is not enough interaction with my relative, but they do play games. The staff have jobs to do, but they could spend more time with people." Another relative told us, " They try their best with limited resources. I think [person's name] is safe, but they complain a bit about the lack of staff and not going out enough."

We saw that people had been asked what hobbies and interests they had and would like to pursue. However, although people had been asked, this information had not been acted upon. For example, one person had said they enjoyed playing with plasticine. We asked the acting manager whether any had been bought for the person, but they told us it had not. Staff and the acting manager told us the current staffing levels meant that people who needed staff support to go out were not able to do so.

The acting manager told us they had tried to increase the social opportunities for people, but they were not given the required funds by the provider to do so. We raised this with the provider, who told us they had thought there was a separate activities budget in place. We brought it to their attention that there was petty cash only, which was being used for activities, where resources allowed. The provider told us they would address this.

The acting manager had introduced residents' meetings so that people's comments, suggestions and feedback could be captured. Although some of the suggestions had been acted upon, there were instances where they had not. For example, one person had stated they enjoyed curries. The acting manager explained that as they did not have control over the menus or food budget, this person's preference had not been met.

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

At our previous inspection, we found the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because there was not a system in place for receiving or acting on complaints. The provider was asked to complete an action plan which described the actions they would take to meet the regulation. The provider's action plan told us they would ensure all

relevant complaints information would be displayed in the hallway for people, and that a letter would be sent to relatives, outlining the complaints process to them. At this inspection, we found that although there was a complaints procedure in place, it had not been displayed for people, nor had relatives been notified of the process. We brought this to the attention of the acting manager, who ensured the complaints procedure was displayed and that people and relatives were made aware of how they could complain. However, this had not been displayed for a period of six months, nor had relatives been told how to complain. Although no complaints had been received, it had not been made clear to people how to raise a formal complaint.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because there was no system in place to monitor the quality of care provided to people, a lack of clarity and direction for staff in terms of their job roles and how to carry these out, and a lack of awareness by the provider for a need to maintain oversight of the day-to-day running of the home. The provider was asked to complete an action plan which described the actions they would take to meet the regulation. The provider's action plan told us that a quality assurance system was now in place and that staff supervisions had been implemented.

At our previous inspection, there had been no registered manager in post since March 2015. There was still no registered manager in post at the time of our inspection. A manager had been appointed after our previous inspection and had left after being in post for three months; they had not started the process to become a registered manager. At the time of our inspection, the deputy manager was in the role of acting manager whilst the provider recruited a registered manager. The acting manager had been asked by the provider to consider becoming the registered manager, but they had declined due to the ongoing concerns with the running of the home. By not having a registered manager in post, the provider was in breach of their CQC registration requirements. We wrote to the provider on 19 September 2016 to remind them of their registration requirements. As a result, the provider started a recruitment process to appoint a registered manager.

At this inspection, we found the acting manager had implemented a quality assurance system and that this was used to gather feedback, concerns and suggestions from people, staff, relatives and health professionals. However, whilst this feedback had been gathered and concerns shared with the provider, action had not been taken as a result. For example, we saw that the acting manager had received feedback from relatives who were concerned about the food provided at the home. The acting manager had shared this feedback with the provider. When we discussed the shortfalls we had identified in respect of nutrition with the provider, they told us, "I had no idea. How was I supposed to know?" We explained to the provider it was their responsibility to monitor the quality assurance system, particularly in the absence of a registered manager. Whilst the provider did visit the home on a weekly basis, they did not use this as an opportunity to carry out quality assurance checks, or to review the findings of the acting manager's own quality assurance checks. We told the provider they had access to staff supervision notes, quality assurance records, and feedback received and that this information should be familiar to them.

We showed the provider safety, maintenance and cleanliness issues we had identified during the course of our inspection. This included a broken stair lift, which staff and the acting manager told us had not been working for around three months. Although the stair lift was not the main stair lift for people in the home, it being broken meant that people who struggled to use steps could not access a particular part of the home safely. The provider told us they had been unaware of this, but that they would ensure it was fixed. We ensured the provider arranged an engineer to visit the home as a matter of urgency. We also showed the provider cleanliness issues in the kitchen area and asked for unsuitable utensils to be replaced immediately. The provider told us, "I can only apologise. I haven't had my finger on the pulse."

After our inspection, we provided the provider with formal feedback as to the immediate action we expected to be carried out. This included covering gaps in the staffing rota, and changing the way that food was bought and stored. Although the provider gave us assurance these issues would be rectified, we became aware they had not been and we had to raise the issues again with the provider a week after our inspection. The provider told us that agency staff had now been booked to cover one night shift. However, there was still no system in place to monitor the food dates, the cleanliness of the kitchen, or to ensure people's preferences were reflected in the menus planned and food bought.

Relatives we spoke with told us they had noticed difficulties in respect of the running of the home. One relative told us, " I've noticed they do get a few managers here. I don't really have any concerns as such, but they are struggling though, and that is how it seems." Another relative told us, " In my view, (the providers) have gone along too long without spending any money."

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider demonstrated to us an awareness of when statutory notifications should be reported to the Care Quality Commission, they had failed to notify us of a recent safeguarding concern. This had resulted in a continuing risk of further abuse happening to people in the home. The provider told us they knew this was not in accordance with their regulatory requirements, but they had planned to investigate the matter internally instead; no investigation had occurred.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff, relatives and health professionals we spoke with were positive about the acting manager and the support they got from them. On member of staff told us, " I do feel very supported and valued by the manager. I don't see (the provider) very often." Another member of staff told us, " I get supervisions with the manager, who is easy to approach about anything." Staff told us if they had any concerns about unsafe practice or wrong doing within the home, they would discuss this with the manager in the first instance. Staff were aware they could also contact the local authority and the Care Quality Commission.