Ravenswood Care Home Limited

Ravenswood Care Home

Inspection report

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Tel: 01782783124

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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

An inspection of this home was carried out in December 2017, the provider was rated Requires Improvement and was in breach of regulation 12, Care and treatment, 17, Good governance and 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to tell us what action they would take to improve the service and to comply with the regulations. After the publication of this report in February 2018, in March 2018, conditions were imposed on the provider's registration because of the continued breach of regulations.

At this inspection in January 2019, we found the provider had not taken measures to comply with the regulations or the terms and conditions of their registration.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

This inspection was unannounced and took place on 24 January 2019.

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

Ravenswood Care Home accommodates 55 older people some of whom were living with dementia. On the day of our inspection 35 people were living in the home. The home is situated on two floors and was accessible to people who used a wheelchair.

The home had a registered manager who was present on the day of our inspection visit. 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.

The management of medicines continued to be unsafe and people did not always receive their medicines in line with their prescription. People were at risk of potential abuse because safeguarding protocols were not followed to safeguard them.

Where accidents had occurred, lessons were not learned and measures were not taken to reduce the risk of them happening again. People were not assisted to access treatment and this placed their health at risk. Staff were not always available to support people in a timely manner and this meant some people were left in discomfort.

People did not have the opportunity to make decisions about their care and treatment and this meant they were at risk of not receiving a service that met their preferences. Some people did not have access to healthcare services when needed which, compromised their health and wellbeing. Staff were unskilled in some areas of care delivery that was specific to the needs of people using the service. Equipment was not always put in place to ensure people's needs were met. The provider did not always work jointly with other agencies to ensure people's assessed needs were met safely.

Equality, diversity and human rights had not been explored or imbedded in the service provided so people could not be assured their specific needs would be recognised or met. People could not be confident the care and support provided to them at the end of their life would meet their wishes because this had not been discussed with them.

The provider's governance continued to be ineffective to assess, monitor and drive improvements and placed people at risk of unsafe care and treatment. The registered manager did not always comply with the terms and conditions of their registration by reporting significant events to us which they are required to do by law.

Systems and practices were in place to reduce the risk of cross infection. Although safeguarding protocols had not been followed, people told us they felt safe living in the home. People told us that their right to privacy was respected by staff.

People were supported to pursue social activities. Relatives were able to visit the home at any time and were made to feel welcome by staff. People felt confident to share their concerns with the staff and the registered manager.

People were provided with a choice of meals and had access to drinks at all times.

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.

Medicines management was inadequate as people did not receive their medicines as prescribed.

Safeguarding protocols were not followed to protect people from potential abuse.

Risks to people were not managed and lessons were not learned when accidents happened and people remained at risk of further harm.

People did not receive safe care and treatment because medical intervention was not obtained when needed.

Staff were not always available to ensure people's needs were met in a timely manner.

Systems and practices were in place to reduce the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not have the opportunity to make decisions about their care and treatment.

People were not supported to access relevant healthcare services when needed and the lack of working with other organisations compromised the quality of care they received.

People could not be confident that staff would have the skills to meet their needs safely.

People could not be assured equipment would be put in place to improve the quality of service provided.

People had a choice of meals and access to drinks at all times.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Shortfalls identified at this inspection compromised the quality of care provided to people.

People were not involved in decisions about their care so they were at risk of not receiving care and support the way they liked.

People told us their right to privacy was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not involved in planning their care so could not be confident the would receive care and support to meet their preference.

People could not be assured the care and support at the end of their life would be carried out the way they wish because this had not been discussed with them.

People said they would share their concerns with the registered manager and were confident it would be addressed.

People were supported to pursue their social interests.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken action to comply with the breach of regulations identified at the previous inspection. Failure to comply with conditions of their registration meant people received an inadequate service.

The provider's governance was effective to assess, monitor and to drive improvements.

The lack of joint working with other relevant agencies meant people did not receive consistent quality care.

The registered manager did not always comply with the terms and conditions of their registration to notify us of significant

events that had occurred in the home.

Ravenswood Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

Inspection site visit activity started on 24 January 2019 and ended on 24 January 2019, and was unannounced. The inspection team comprised of one inspector, an inspection manager and a medicines inspector (pharmacist). The inspection team also included two Experts by Experiences. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection we spoke with the local authority about information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home.

We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection visit we spoke with ten people who used the service and four visitors. We also spoke with two care staff, the deputy manager and the registered manager. We looked at medication administration records, five care plans and risk assessments. We looked at audit reports with reference to the provider's governance.

Inadequate

Is the service safe?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection this key question was rated 'Inadequate.'

At our previous inspection we found that people did not always receive their prescribed treatment as directed by the prescriber. The provider was in breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider continued to be in breach of the regulation.

People's health was at risk because they were not supported to take their prescribed medicines as directed by the prescriber. We looked at three medication administration records (MAR). These showed people had been prescribed treatment to manage their pain. We found people did not receive their medicines at the frequency directed by the prescriber. This meant people's pain had not been managed effectively. We shared this information with the registered manager. They were unable to explain the discrepancies.

One MAR showed the person had been prescribed a medicine that needed to be administered at specific times throughout the day. This was to ensure the medicine was effective in managing the person's health condition. We observed this medicine was not administered at the time shown on the MAR. We spoke with the staff member who had administered this medicine. They told us they were unaware of the importance of administering this medicine as shown on the MAR. This lack of understanding placed the person at risk of their health condition not being managed appropriately.

Records showed that six people were receiving their medicines covertly. This meant medicines were hidden in their food. Discussions with the registered manager and the records we looked at confirmed this had not been agreed by a multi-disciplinary team to ensure it was in people's best interest. There was no evidence to show this method of giving people their medicines was discussed with a pharmacist to ensure it was suitable or safe.

People did not always receive safe care and treatment. For example, one person looked unwell. We spoke with a staff member who told us the person had been unwell for a long time. We looked at their care plan and risk assessment and there was no information about the person's ill health or treatment they had received. Details recorded in a diary in October 2018, raised concerns about the person's health. However, discussions with the registered manager confirmed these concerns had not been shared with the GP. This meant the person had not received treatment in a timely manner. We asked the registered manager to contact the GP on this person's behalf.

We spoke with a person who used the service. We found they had not been referred to a dentist and they told us they were unable to eat their meals. We observed the person removing food from their mouth because they could not chew it. The registered manager told us the person required support with all their personal and oral care needs. However, both the staff and the registered manager were unaware they had dental problems. Therefore, this person did not receive prompt support to access dental treatment. This

placed them at risk of discomfort and not eating sufficient amounts to ensure their health. We asked the registered manager to contact the dentist on this person's behalf.

One care record showed the person's skin was damaged. The registered manager was unaware of this and was unable to tell us what treatment the person had received. The care records did not provide staff with information about how to reduce the risk of further skin damage and the registered acknowledged this. This meant the person could not be confident staff would know how to meet their needs. This showed where incidents had occurred action had not been taken to protect people from the risk of further harm.

We found where an accident had occurred lessons were not learned. For example, an accident report showed staff had raised concerns about a sling not fitting the hoist properly. One person had sustained an injury whilst being hoisted. We looked at the person's care plan and risk assessment. These records did not provide information about the appropriate lifting equipment required. These records had not been reviewed after the accident to reduce the risk of this happening again. The registered manager was unable to provide evidence of action taken to ensure the person was protected from further injury.

These issues constitutes a continued breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safeguarded from the risk of potential abuse. Records showed that one person was at risk of abuse. However, the registered manager did not recognise this. Therefore, safeguarding protocols were not followed to ensure the person's safety in the future. The registered manager did not share information of suspected abuse with the local authority safeguarding team to enable them to investigate this. During the inspection we asked the registered manager to make three safeguarding referrals to the local authority safeguarding team to ensure people were protected from further harm.

This was a breach of Regulation 13, Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in December 2017, we found there were insufficient staffing levels to meet people's needs. At this inspection the registered manager told us staffing levels had been increased. However, one person who used the service told us they had to wait two hours for support to go to the toilet. We looked at their daily records which supported what they had told us. The registered manager said they were confident there were sufficient staffing levels to meet people's needs. They assured us the support provided to this person would be reviewed. We received mix comments from other people about the staffing levels. Another person who used the service said, "I don't have to wait too long. They always come quickly." A relative told us, "Sometimes there's enough staff and other times, there isn't." On the day of our inspection we observed staff were nearby in communal areas to support people when needed.

The provider's recruitment process ensured that staff were suitable to work in the home. Discussions with staff and the records we looked at confirmed that Disclosure Barring Service (DBS) checks were carried out before people started working in the home. DBS helps the provider to make safe recruitment decisions. Records provided evidence of two references one of which was from their previous employer.

Although we had identified concerns with safeguarding protocols not being followed, all the people we spoke with said they felt safe living in the home. One person said, "I feel safe here because I am well looked after." Another person told us, "I feel safe because nothing is too much trouble for the staff." All the visitors we spoke with felt their relatives were safe. One visitor said, "(Person's name) is safe, they have put a rail up to stop them falling out of bed and they have a sensor mat in their bedroom." A sensor mat alerts staff when

the person requires support with their mobility.

Discussions with staff and our observations confirmed they had access to essential personal protective equipment (PPE) such as disposable gloves and aprons. The appropriate use of PPE helps to reduce the risk of cross infection. The provider had an infection, prevention and control (IPC) lead in place. The IPC lead is a member of staff who was responsible for monitoring and ensuring hygiene standards within the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection this key question continued to be rated 'Requires Improvement.'

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. At the previous inspection we found that some people were receiving their medicines covertly. However, records did not show which medicines had been agreed to be administered in this way. At this inspection we found where medicines were being administered covertly this had not always been agreed by a multi-disciplinary team to ensure this was in the person's best interests.

At the time of the inspection we looked to see if people were involved in decision making. One person told us they did not have the opportunity to make decisions about their care and treatment. We shared this information with the registered manager. They told us the person did have capacity to make some decisions. However, they were unable to evidence the person's involvement in decisions about their care and treatment. Another person who used the service said they were not given the opportunity to make their own decision, they said, "The staff tell me what to do." All the people we spoke with told us they were not involved in making decisions about their care or treatment and were not present in meetings held about them.

This was a breach of Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with had a good understanding about how to support people to make decisions. For example, giving people a choice of clothing to allow them to point at what they wanted to wear. We observed a staff member showing person two drinks so they could choose which one they wanted. However, the views of the people who used the service did not support what staff told us.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The deputy manager told us the majority of people who used the service had a DoLS in place. This was because they lacked capacity to make decisions about their care and treatment. At our previous inspection we found where a DoLS was in place, there was no evidence of a mental capacity assessment. At this inspection there was evidence of a mental capacity assessment. This assessment ensured the application for a DoLS was appropriate. The staff we spoke with had a good understanding of DoLS. They were also aware of restrictions imposed on

people and the reasons why.

People could not be assured that all the staff would have the skills to meet their needs. For example, the provider's website showed they offered a service for people living with dementia. However, the training record showed only two staff members had received dementia awareness training. One relative said, "Staff have a lot to learn about dementia care."

Although the registered manager told us that no one was receiving end of life care. The care records we looked at and discussions with staff identified some people had serious health conditions. We also observed that, 'Do not attempt cardiopulmonary resuscitation' (DNACPR) were in place for these people. However, staff had not received palliative care training to ensure they had the appropriate skills to care for people at the end of their life.

The registered manager told us that staff who were responsible for the management of medicines had received training and the staff we spoke with confirmed this. However, skills learned were not put into practice because we found people did not always receive their medicines as directed by the prescriber, which placed their health at risk.

This was a breach of Regulation 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the assessment and care planning was not detailed to ensure staff were provided with relevant information about how to meet people's needs. For example, where people had specific health conditions their care plan did not tell staff how best to care for them or when medical interventions may be necessary. This was of concern because one person sometimes refused their prescribed treatment which, could have serious implications on their health. The provider also used agency staff and this meant they would not have access to relevant information. The registered manager acknowledged care plans were not in place with regards to people's specific health conditions.

This was a breach of Regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had identified equipment to enhance the quality of the service provided to one person, action had not been taken to put this in place. This meant the person did not receive care and support to meet their needs.

The care records we looked at did not contain any information about protected characteristic under the Equality Act. People told us the care they received varied in relation to which staff supported them. This showed there was not a continued practice to ensure people's needs we met.

We found that the provider did not work with other healthcare organisations to ensure people received effective care and support. Relevant healthcare professionals were not consulted to ensure people received appropriate treatment. On the day of our inspection we asked for these professionals to be contacted on some people's behalf. Where people were at risk of abuse, this information had not been shared with the local authority to ensure their safety. This meant the care and support provided to people was not person-centred to meet their specific needs.

We identified some good practices where one person had mental health needs and had access to a community psychiatrist nurse (CPN). Staff had monitored the person's treatment and had worked alongside

the CPN and GP to discontinue a treatment they recognised contributed to the falls they had sustained.

Staff told us that since the appointment of the new registered manager they received regular supervision sessions and the records we looked at confirmed this. Supervision helps staff to understand their roles and responsibility. One staff member said, "If you do something wrong the registered manager will tell you but in a nice way."

We looked at how new staff were supported in their role. The registered manager told us that new staff were provided with an induction and the staff we spoke with confirmed this. Induction is a process to assist new staff to understand their roles, responsibility and to ensure they know how to meet people's needs.

The home was situated on two floors which were accessed by stairs and a passenger lift. Grab rails were situated in some areas of the home to assist people with reduced mobility. Where people had been identified at risk of falls, sensor mats were located in their bedroom to alert staff when they required support to walk. Communal areas were located throughout the home where people could entertain their visitors. Nurse call alarms were fitted in each bedroom so people could alert staff when they required support.

People told us they had a choice of meals and we heard staff offering them a choice. One person told us, "The food is excellent. You couldn't wish for better." A visitor said, "I've never tasted the food but it always smells delicious." We observed a staff member take the time to explain to a person what food they had on their plate and where it was located. People told us they had access to drinks at all times. We observed drinks being offered to people throughout the day.

Where concerns were identified with how much people ate and drank discussions with staff and the records we looked at evidenced the involvement of a dietician and a speech and language therapist. These professionals provided people and staff with information about suitable meals with regards to their health condition and swallowing difficulties.

Requires Improvement

Is the service caring?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection the provider continued to be rated 'Requires Improvement.'

During this inspection we identified concerns with the management of people's medicines and found appropriate action had not been taken after an accident to reduce further risk of harm. Protocols were not followed to safeguard people from the risk of potential abuse. The provider had not responded and purchased some equipment which would have enhanced a person's quality of life and ensured their safety. This did not demonstrate a caring and compassionate manner when providing care to people.

We heard shouts coming from a bedroom for a long time. However, staff did not acknowledge the person was in distress. We shared our concerns with a staff member who told us the person had mental health needs. When the staff member approached the person, they calmed down. This showed that people were not always provided with care and reassurance when in distress.

Although we observed care plans were in place, people told us they were not involved in making decisions about their care, support and treatment. The care plans we looked at did not provide any evidence of people's involvement. This meant people were at risk of not receiving care and support the way they liked.

One person raised concerns about not receiving support when needed and this meant at times they were in discomfort. Other people told us the quality of care and support received depended on what staff delivered it. However, other people told us that staff were kind and caring. One person said, "We couldn't wish for better staff." We observed some staff interact with people in a kind manner and took the time to talk with them. During the inspection we heard staff ask people about their preferences about what channel they wanted to watch on the television. We observed people's choice was respected.

A visitor told us how nice it was that staff took the time to celebrate people's birthday. Another visitor said, "Generally the staff are caring and good." One person was living with dementia and we heard a staff member talk with them in a kind and compassionate way whilst using 'doll therapy.' Doll therapy is used with people living with dementia. In some people this can create a pleasant feeling of reminiscence of affection when they had young children.

People could be assured their right to privacy would be respected. A visitor told us when their relative required support with their continence needs, this was carried out in a way to preserve their privacy. One person who used the service said, "Staff always knock on my door before they come in." We observed staff knocking on people's bedroom door before entering. A visitor told us, "When staff use the hoist, they always cover people with a blanket to ensure their dignity." A person who used the service said, "The staff cover me up when they help me to have a wash."

People who used the service could maintain contact with people important to them. The relatives we spoke with told us they were able to visit the home at any time and were always made to feel welcome by staff.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection the provider continued to be rated 'Requires Improvement.'

We reviewed how the provider promoted equality diversity and human rights (EDHR). The care records we looked at did include information about people's diverse needs or if and how they had been implemented. For example, one person told us they were unable to use the nurse call alarm to ask for assistance when needed. Appropriate measures were not put in place to assist this person to ask for support when needed.

Discussions with people who used the service and the records we looked at did not provide evidence that EDHR had been explored or imbedded in the service provided to people. Therefore, people could not be assured their specific needs would be met.

The deputy manager told us no one was receiving end of life care. We identified that one person had a serious health condition. We saw a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) in place for this person and for others. However, the registered manager told us that end of life care had not been discussed with anyone and there was no written plan in place for the people. This meant people's wishes at the end of their life may not be known or respected.

We looked at how people were supported to pursue their social interests. One person had a Deprivation of Liberty Safeguard (DoLS) in place with conditions imposed. One condition told staff as a distraction method, the person should be helped to do painting. We did not see any evidence that the person had been supported by staff to pursue this activity.

This was a breach of Regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had access to a variety of social activities. One person told us, "I can take part in activities if I fancy." Ball games were available to people to promote gently exercise. Singing sessions took place and people had the choice to partake or just listen. On the day of the inspection we observed people playing bingo which they appeared to enjoy. People had contact with staff from their local supermarket who visited the home to do food tasting sessions. Consideration had been given to people who were unable to eat certain foods due to their health conditions and allergies. This enabled everyone to participate in these sessions which, people told us they enjoyed.

The provider had appointed a staff member to explore people's social interests and to help them to pursue them. However, on the day of this inspection this staff member told us they were leaving. The registered manager told us they were advertising this post to ensure people were supported to pursue social activities. Discussions with people and the records we looked at confirmed they could practice their religious faith. People from different places of worship visited the home on a regular basis.

People told us if they had any concerns they would share them with the staff or the registered manager. They told us they were confident measures would be taken to address their concerns. The registered told us they had received one complaint within the last 12 months about the care and support provided to a person. The registered manager said they were not provided with sufficient information to allow them to investigate this concern.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection this key question was rated 'Inadequate.'

Since the last inspection in December 2017, conditions were imposed on the provider's registration to ensure people received a safe and effective service. At this inspection we found the provider had not complied with all the conditions.

The provider was required to ensure people received their medicines in line with their individual prescription. However, we found people did not always receive their medicines as directed by the prescriber, placing their health at risk. For example, people's pain was not managed effectively because they did not receive their treatment as prescribed.

The provider was required to ensure appropriate action was taken after an accident or incident. However, records showed an accident had occurred and the person sustained an injury. However, no action had been taken to avoid this happening again and the person remained at risk of further harm.

At our last inspection we found the provider's governance was ineffective to ensure people received a safe service. The provider was in breach of regulation 17, Good governance. At this inspection we found the provider had not taken any action to improve their governance and this placed people at risk of receiving inadequate care, support and treatment.

The governance was not effective to assess or monitor the management of people's prescribed medicines or to comply with the conditions of their registrations. The registered manager had sent us monthly audit reports regarding medicines practices. However, these audit reports did not identify the shortfalls we found that had an impact on people's health.

Appropriate systems were not in place to monitor accidents and to ensure action was taken to avoid a reoccurrence. Quality audits carried out did not ensure staff had access to relevant information about people's care needs and equipment required to assist them safely. For example, where people required equipment to assist with their mobility. Care records did not include detailed information about the appropriate hoist and sling to be used to ensure people's safety. This resulted with one person sustaining an injury.

The provider's governance did not assess, review or monitor people at risk of skin damage or to take action to prevent this. One care record showed the person had skin damage. However, the registered manager was unable to tell us what action had been taken with regards to treatment or preventative measures.

Quality assurance systems were not in place to ensure people had the opportunity to make decisions about their care and treatment.

The governance did not assess or monitor practices to ensure staff were aware of when to involve healthcare professionals in people's care. Discussions with people and our observation identified that not everyone had access to relevant healthcare services when needed and this compromised their health and wellbeing.

Quality assurance systems did not ensure staff received the necessary training. Therefore, staff may not have the appropriate skills to meet people's needs. For example, dementia awareness and end of life care training. Staff told us they were not given time to undertake training and the registered manager confirmed this. It was the provider's expectation that staff carried out training in their own time and some staff refused to do this. This meant people could not be confident that staff would have had training they required to be able to care for them effectively. This placed people at risk of inadequate care and support. We identified concerns of potential abuse. The provider's governance did not monitor the safety of people to safeguard them from the risk of abuse.

The provider had not taken action to comply with the breach of regulations identified at the previous inspection. They had not worked closely with other agencies to improve the service provided. For example, other healthcare professionals. This meant improvements had not been made and people remained at risk of inadequate care.

As part of the registered manager's terms and condition of their registration they are required by law to inform us of any significant events that have occurred in the home. Discussions with the registered manager and the records we looked at evidenced they had not always complied with the terms and conditions of their registration. The registered manager was unable to give a reasonable explanation why we had not been notified of concerns of abuse and when a person had gone missing from the home.

The registered manager told us staff meetings were carried out and staff confirmed this. However, staff's involvement in decisions about running the home did not make an impact on improving the quality of service provided to people. We found people's wellbeing was compromised because of insufficient care, support and the lack of recognition of when other professionals needed to be involved in their care.

Although a staff member described the culture of the home as "homely and a welcoming place and everyone is like an extended family." We found insufficient action had been taken to improve the care and support people received. Staff told us that since the appointment of the registered manager they felt more supported within their role. However, this was not reflected in the quality of service provided to people.

We have shared our findings with the local authority who will review the care and support provided to people.

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

People had some links with their local community such as local supermarket and people visiting from various places of worship.

After the previous inspection in December 2017, a condition was imposed on the provider's registration in March 2018, to have a registered manager in place. The provider had taken action to appoint a manager who registered with the Commission in December 2018. The registered manager told us they had been in post since July 2018. However, not everyone we spoke with were aware of who was running 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 9 HSCA RA Regulations 2014 Person-centred care The care and support people received was not person-centred and this meant their specific needs were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care and treatment of people was not always provided with their consent. People were not given the opportunity to have a say in the care and support they received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with the appropriate training to ensure they had the skills to meet people's assessed needs.