Whiston Hall Limited

Whiston Hall

Inspection report

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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

The inspection took place on 27 September 2018 and was unannounced which meant the people living at Whiston Hall and the staff working there didn't know we were visiting.

The service was previously inspected in November 2017, when we identified four breaches of regulations. The registered provider did not ensure care was person-centred, did not manage risks to ensure peoples safety, was not meeting the requirements of The Mental Capacity Act and there was ineffective deployment of staff. The service was rated Requires Improvement. At this inspection we found the service had deteriorated and we have rated it Inadequate and it is placed in special measures.

You can read the report from our last inspections, by selecting the 'all reports' link for 'Whiston Hall' on our website at www.cqc.org.uk.

At the time of our inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 from another of the registered providers services was overseeing the service at the time of our inspection.

Whiston Hall is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation for up to 44 people in one adapted building. At the time of our visit there were 32 people using the service.

People were not protected as risks to their health and welfare were not effectively reviewed or managed. The risk assessments lacked detail, and were not always followed. We observed staff providing support to people and found that staff did not deliver the care and support in line with needs. This put people at risk of harm.

The home had a dependency tool in place to determine what staffing hours were required to meet people's needs. However, this was not up to date and had not been completed since August 2018. We identified that there were insufficient staff on duty to meet the needs of people who used the service.

We found the service was predominantly meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We found some people's best interest decisions were clearly documented. However, we found others had not been considered and had no evidence in place to support the decisions made where people lacked capacity to make specific decisions.

We found there had been a lack of leadership and oversight and communication between all levels of staff

had been poor. The registered manager had left and although the provider had acted to provide cover. We found the issues had not been identified in a timely way to ensure the service was improving following our inspection in November 2017.

Systems in place to monitor the service were not always followed and as a result the systems were not effective. People who used the service, their relatives and staff were not provided with forums where they could voice their opinions or be involved in the running of the service.

Systems were in place to manage medicines safely. People were provided with a nutritious balanced diet. However, we found people were not always supported with nutrition, which meant they did not always receive adequate nutrition and hydration.

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and they were confident management would take any concerns they had seriously and take appropriate action.

We observed staff interacting with people and found they were kind and caring, but identified people had to wait for assistance and some staff interactions were not person-centred.

We found care plans were in place and had been updated since our last inspection. However, we found they did not always reflect people's current needs and were not always reviewed when their needs changed.

We observed people engaging in social stimulation and activities. People we spoke with told us they enjoyed the activities.

We looked at records of complaints received and found these had been dealt with appropriately.

We found four breaches; three of these were continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service will therefore be placed 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.

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.

People were not protected as risks to their health and welfare were not effectively reviewed or managed.

There were insufficient staff to ensure people's needs were met.

Staff understood the safeguarding policies and followed procedures. Medicines were managed safely.

The service was in general maintained and clean. Recruitment procedures were followed to ensure the right people were employed to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service was predominantly meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). However, although some people's best interests were documented we found some had not been considered.

We found people were offered a well-balanced diet however; support provided to ensure people received adequate nutrition to meet their needs could be improved.

Staff received training and supervision to fulfil their roles and responsibilities. However, this was not up to date or effective.

Staff monitored people's healthcare needs, and referrals to healthcare professionals were made where appropriate. However, their advice was not always followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff were kind and caring. However, we observed that care and support was not person-centred and staff

did not take into account people's individual needs and preferences.

We saw that staff predominantly respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care needs had not always been identified or reviewed. The care plans did not always reflect people's current needs.

Social stimulation was provided. The registered provider had a complaints procedure and complaints had been appropriately dealt with.

Is the service well-led?

Inadequate

The service was not Well-led.

There was lack of governance and oversight as the service had not been effectively managed.

The registered provider had some systems in place to monitor the service and to identify areas to develop. However, we found that these systems had not always been completed or used effectively.

There were no opportunities for people who used the service, staff, or relatives to voice their opinion or be involved in the service.

Whiston Hall

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.

This was a comprehensive inspection. This inspection took place on 27 September 2018 and was unannounced. The membership of the inspection team comprised of two adult social care inspectors and an expert by experience. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of supporting and caring for older people including people living with dementia.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the registered provider. We also spoke with the local authority and other professionals supporting people at the home, to gain further information about the service.

We spoke with 12 people who used the service and three relatives, and spent time observing staff supporting with people. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out three SOFI observations over the inspection.

We spoke with a senior care worker, five care workers, the activities coordinator, the cook, the domestic, the acting manager and the registered provider. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at five people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At our last inspection of November 2017, this key question was rated as requires improvement. This was because sufficient numbers and deployment of staff did not ensure people's needs were met in a timely way. People did not receive safe care and treatment and were not protected against the risks associated with the management of medicines and infection control. The registered provider sent us an action plan telling us how they would improve these areas.

At our inspection of 27 September 2018, we found that whilst infection control issues had been addressed, concerns remained in the other areas and it has deteriorated to inadequate.

Risks associated with people's care were not managed effectively to ensure people were safe. We looked at care records and found they were contradictory which made it difficult for staff to understand what care people required. For example, one person who was at risk of falls had a risk assessment in place to identify this. The risk assessment indicated that a sensor mat should be in place to alert staff when the person mobilised. This person had suffered a fall which had led to a fracture and were being cared for from bed, therefore the sensor mat was not used. The person had bed rails in situ, however, this was not stated in the care records.

We looked at care records and found that some people required assistance to mobilise using a stand aid or a hoist. However, care plans did not give information regarding the type and size of sling that should be used. We also saw that there were no details regarding the loop configuration required.

We observed two care workers assisting two people using the same sling. The sling was a toileting sling and should only be used when assisting people to use the toilet. Both people were of a different frame and statue. We looked the care records belonging to one of these people and found they had a care plan for mobility which had not been reviewed since May 2018. This stated that the person required a grey sling with yellow piping. There was no detail regarding loop configuration or the size and type of the sling required. We spoke with staff who told us the service was short of slings. We raised this with the acting manager who informed us that there were slings available and everyone should have their own.

Accident and incident analysis was not taking place and there was no evidence that trends or patterns were being identified and a lack of evidence of any actions taken to reduce hazards in relation to people's care.

This is a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Risks associated with people's care were not always managed effectively.

The service did not ensure that there were sufficient numbers of staff available to support people and keep them safe. We observed staff interacting with people and they were task orientated and did not support people in a person-centred way. One care worker we spoke with said, "We are busy and some people may have to wait, but everyone gets help." Another care worker said, "There are enough staff and senior staff are

always on hand to help too."

We found staff were not always available in communal areas to assist people. People told us they had to wait for a considerable time for support when they required it. For example, one person explained how they liked to go to bed at 6.30pm, but said this was not always possible due to staffing constraints. They said, "I have waited to go to bed until 11.30 and 12.15am. When you go to bed that late you don't want to get up early, but they come and get me up around 8am, they come in and pester you and put the light on and say, 'it's time to get up'. I think this is due to staffing." The person explained that they felt if they did not get up when requested they would have to wait a long time so did consent.

Another person's we spoke with said, "There is definitely not enough staff when you pull the call bell it takes 10 minutes or longer and they say they couldn't get here any sooner and you have to accept it. A lot of staff have left lately. They have their coats on [before their shift has finished] and I ask, 'can you take me to the toilet' and they say 'I'm finishing now and don't do it. So, I ask the next shift, but they all go upstairs for their tea, so I have to wait."

We also found examples when people were not given assistance with eating and drinking and as a result the people did either not eat the meal or had a cold meal. We observed staff were not available to offer the assistance people required.

We identified lack of leadership and direction for staff to be effectively deployed to meet people's needs.

Relatives we spoke with also raised concerns regarding staffing. One relative said, "There are not always enough staff and there's too much turnover, it's constant. I am not sure the bathing is adequate as there are not enough staff. I have queried it in the past, there used to be a list in the bedrooms but that has gone now."

Staff we spoke with told us they felt at times they needed more staff to be able to meet people's needs. One staff member said, "It is in the mornings, it is really busy, we struggle to get people up, bathed, and having breakfast. We need more staff at this time." Another staff member said, "Lunchtimes can be difficult as some people like to stay in their rooms so we are not able to always give the assistance required as there is not enough of us."

We asked to see the dependency tool, however, this was out of date and did not reflect the current occupancy. The manager acknowledged this and agreed to look at the tool taking into consideration the layout of the service to ensure adequate staff were available to meet people's needs.

This is a continued breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing, insufficient staff and ineffective deployment of staff meant people's needs were not met in a timely way.

We found medication procedures were in place to guide staff and ensure medicines were administered safely. We found predominantly these systems were followed. Medication was recorded on receipt, administration and any that was returned was also recorded. However, we found some minor errors. We found staff were not always recording the reason why medication was refused or why a medication which was prescribed to be administered when required was given. This meant it was not possible to tell if the medication was effective. The acting manager had identified this and were addressing the issues with staff.

People we spoke with told us they received their medication on time and staff supported them to take it.

One person said, "I always get my medication on time, regular as clockwork."

Staff had received training in safeguarding vulnerable adults form abuse and staff we spoke with were knowledgeable about safeguarding people from abuse. Staff also knew about the registered provider's whistle blowing policy. People we spoke with told us they felt safe. Relatives we spoke with also felt people were safe. Although they said the staffing issues could impact on this. One relative said, "I'm confident that [relative's name [is safe, because of the staff, I've got to know them over the years, but I've come today and I don't know most of the staff. I feel confident in [they named two staff]." From speaking with people who used the service and relatives it was clear they felt safe but thought the staffing could impact on this if it wasn't resolved.

The provider had safe recruitment procedures in place to ensure staff were not employed until all the necessary checks were completed and that they were satisfactory. This ensured people's safety.

We found the service was generally clean and well maintained. Since our last inspection many areas had been redecorated. People told us the service was clean. Staff were aware of infection control procedures and we observed they adhered to these.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of November 2017, this key question was rated as requires improvement. This was because consent was not always sought in line with legislation and guidance. We also found that support required to ensure people received adequate nutrition to meet their needs could have been improved. The registered provider sent us an action plan telling us how they would improve these areas.

At our inspection of 27 September 2018, we found that these concerns had not been fully addressed and were still evident and other issues relating to healthcare could be improved.

People's needs were assessed and where required health care professional's advice was sought and referrals made. However, their advice was not always followed. For example, one person who had suffered a recent fall and a fracture had been visited by the physiotherapist who had recommended the person to get out of bed for one hour a day. We looked at the daily charts and there was only one occasion where this had occurred.

This person also had a poor appetite and had been referred to the dietician who visited at the beginning of August 2018. Their advice was to ensure the person had a fortified diet and to offer fortified shakes to drink. The care plan indicated that the person should receive a fortified diet if they start to lose weight, their weight monitored monthly and diet and fluid charts to be completed. We saw the record for weights and found there was no record of weight for August 2018. We asked staff for food and fluid charts and were told the person did not require them. This showed the advice from the healthcare professional and care plan was not being followed.

Another person had been visited by the falls team on 2 July 2018 in relation to mobility and falls. Their advice was to try to encourage the person to use a walking frame and to refer to the falls team if falls continued. Between 2 July 2018 and 19 September 2018, the person had a further seven falls before staff referred the person back to the falls team on the 19 September 2018. This showed there was a delay in accessing healthcare professionals. This person's care plan did not reflect the support advised by the falls team.

Meals were designed to ensure people received nutritious food which promoted good health but also reflected their preferences. Mealtimes were observed to be comfortable and pleasant experiences for most people. People we spoke with told us the food was very good. One persons said, "Very, very, nice, most of the food you couldn't better it." Another person said, "It's very nice."

However, we found where people received their meals in their rooms the experience was not the same. We found people were left without support to eat their meals. For example, we observed one person left in their room to eat their meal in bed, the meal was on a table over the bed but they were not sat up properly and were spilling food down them every time they took a forkful to their mouth. We requested staff sit the person up to be able to access the meal without spilling it. Staff moved the table but did not attempt to do anything else to make it easier for the person. This person would have benefited from assistance with their meal.

We also found some people in the dining room were left without support. For example, one person was sat in a bucket chair. Their drink was in a specialist cup on the arm of their chair where they were unable to see it or feed themselves. The whole time we were observing the cup was still on the chair arm untouched.

We identified there were no menus on the tables, there was one on the wall. This menu board was in the hallway and was not displaying what was served.

We found people's needs were not always met by the adaptation, design and decoration of the home. The registered provider had not always considered the needs of people living with dementia. The corridors were bare and signage could be improved. However, the activity coordinator was looking to improve this as they had been allocated a budget to be able to facilitate this.

This is a continued breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. People did not receive care that met their needs in a person-centred way.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at documentation and found that care plans were in place to support people who lacked capacity. We saw some best interest decisions had been documented however, we saw some were not in place. Staff we spoke with were aware they should be considered but we found nothing documented to support the decision that had been made where people lacked capacity. For example, one person's care plan stated they could have their medication covertly as they spat it out but nothing was documented to show what decision had been made and if it was in their best interests. The manager was aware of this and told us they were addressing this with staff.

Staff had received training to fulfil their roles and responsibilities. However, the manager told us this was not up to date. They had identified this when the previous registered manager had left and was addressing the shortfalls. We were assured that although training was not up to date the relevant courses had been booked and staff given dates to attend the training. Staff we spoke with told us they had not received training for a while but did tell us they were aware it had been booked. Staff also told us they had not felt supported and had not received supervision or appraisals recently. This meant staff were not given the opportunity to discuss their development and objectives to identify any training needs.

This is a continued breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Staff did not receive appropriate support, training and professional development.

Requires Improvement

Is the service caring?

Our findings

At our last inspection of November 2017, this key question was rated as requires improvement. This was because staff were rushed and task orientated. The registered provider sent us an action plan telling us how they would improve these areas.

At our inspection of 27 September 2018, we found these concerns were still apparent.

People told us mostly the staff were kind and caring but lacked time to be able to deliver care and support in a person-centred way. We observed staff interacting with people who used the service and found they were focused on tasks and did not always deliver person-centred care. For example, following the lunch time meal three people using wheelchairs were assisted back to the lounge by staff. The three people then had to wait in their wheelchairs until staff were free to assist them with the equipment they required. We observed one care worker enter the lounge with a hoist saying, "Right, who's first." And proceeded to assist one person to use the hoist with another care worker. The care workers gave very little instruction and never checked if the person was comfortable.

Staff we spoke with told us they would respect people's privacy and dignity by closing doors and curtains whilst attending to personal care. One care worker said, "I treat people here like I would want my own mum and dad to be cared for. We have a laugh and a bit of banter." Another care worker said, "It is important to listen to people and support them in the way they want." However, this was not reflected in what care and support we observed.

We found staff did not ask people for their choice or preferences and did not give them time to respond to questions if asked. For example, one person was in the dining room, their meal was brought to the table and they said that they didn't want it, the meal was still put down in front of them. No other meal was offered and about five minutes later a care worker was walking past and said, 'Come on [name], eat.' picked up their cutlery and put a mouthful of food into the persons mouth. The care worker then walked off. The person spat the food out. The same care worker did the same again five minutes later and said, 'You are not eating [name], and again put food into their mouth and walked off. The person again spat in out onto their plate. We spoke with the person after their meal and they told us they did not want the meal. The persons choice was not respected and no other options were offered this was not person-centred.

People told us they liked to do things and feel useful, but here was not always that opportunity. One Person told us they had asked if they could do a job. They said, "I asked if there were some jobs I could do and they said I could fold serviettes, they never brought any. So, I was not able to do it" This meant people's potential was not understood and lack of concern for people's wellbeing and mental health.

Staff recognised when people required and needed support but this was not always completed in a timely way. Staff told us they struggled to meet people's needs at all times. They told us this was due to staffing constraints. One staff member said, "I really struggle in the mornings as we are so busy. I know we rush at times and don't have time to listen, but if we did we wouldn't get everything done."

This is a continued breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. People did not receive care that met their needs in a person-centred way.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of November 2017, this key question was rated as requires improvement. This was because care records identified people's needs, however, they did not always reflect the person's current level of need. The registered provider sent us an action plan telling us how they would improve these areas.

At our inspection of 27 September 2018, we found these concerns had not been addressed.

We looked at care records belonging to people and found they were not a true reflection of people's current needs. For example, one person was at risk of developing pressure areas and had a care plan in place for this purpose. On the 19 September the care plan stated the person was nursed in bed on a special mattress and could sit out of bed for one hour at a time. We looked at the persons position chart and could only see this happened on one occasion. However, on 26 September 2018, the record stated the person was moved from bed to a wheelchair at 7.20, at 3.20 transferred from wheelchair to chair and taken from the lounge to bed at 6.30. This did not evidence that the care plan was being followed in line with the person's needs.

One care worker said, "We read care plans to ensure we know what we are doing." However, we saw care plans were not always a true reflection of the care and support people required.

People's communication needs were mostly met. The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss. There was a call bell system in the home that had been improved since our last inspection. People were supported to use this. People who had hearing difficulties were referred to an audiologist and staff were aware who required hearing aids and the need to ensure they were working properly and worn. However, we found one person should have had in two hearing aids and was only wearing one. Staff told us the person does not always keep them, in but it was not clear if it was the person's choice or if staff had omitted to put one hearing aid in.

People accessed social stimulation and activities. We spoke with the activity coordinator who told us they worked 30 hours a week, usually this was Monday-Friday, but occasionally working at weekends for special events. For example, when they organised the Band Festival in July and the children in need event organised in October.

The activity coordinator explained that there was a monthly activity plan in the office. They said they were organising a weekly planning board as the pictures have been lost so they needed to take some new ones to be able to put this together. They also said they had a £300 a month activity budget. This meant they were able to organise outside entertainers to come to the home to provide entertainment. They had an entertainer twice a month.

People told us they took part in activities of their choice. For example, they liked playing Bingo with prizes of toiletries. The activity coordinator said, "This was at the request of people who live in the service."

People also took part in quizzes, playing crib, skittles, reminiscence, target and gentle exercises which we saw taking place on the day of our inspection.

The home also has links with a local special school and students visit the home to befriend people and play games. The people we spoke with enjoyed this interaction with young people.

On Friday mornings the activity coordinator also allocated one to one time with people who liked to stay in their rooms or who were nursed in bed due to their health. This meant people were not socially isolated. Although there could be more stimulation for people who stayed in their rooms as many said they didn't do much. For example, one person said, "It's nice to talk [to us]. The staff don't get much chance. I like just having a chat."

The provider had a complaints procedure that staff were aware of and we found complaints had been dealt with appropriately. People we spoke with said they would raise issues with the staff. Relatives said they felt confident to raise concerns and felt they would be listened to. Although some relatives said the laundry was a constant problem with clothes going missing. One relative said, "I have complained that clothes have gone missing I asked on Monday [three days prior to our inspection] and they still have not returned. They do normally turn up. The laundry's not good."

The service provided care and support for people at the end of their life. We saw there was information in care plans regarding the decision to not resuscitate (DNAR). These had been drawn up by the person's GP and included the person where relevant and their families. There were end of life and advanced care plans being completed. However, these were not all in place and the ones we saw could be more detailed and person-centred to ensure preferences and choices were detailed.

Inadequate

Is the service well-led?

Our findings

At our last inspection of November 2017, this key question was rated as requires improvement. This was due to recent changes in the management team. Monitoring systems had been improved but required embedding into practice.

At our inspection of 27 September 2018, we found this key question had not improved. We found issues form our last inspection which are detailed throughout the report had not been addressed. This showed lack of oversight and governance by the provider. This domain has deteriorated to inadequate. We have asked the registered provider to provide us with information to assure us the issues of concern are being addressed. The registered provider has sent us an interim response which gave us some reassurances they are taking the concerns seriously.

At the time of our inspection the service did not have a registered manager. 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. There had been recent changes and the last manager was no longer working at the service. The provider had a manager and a deputy from another service who were overseeing the running of the home. There were plans to recruit a new manager. Since our inspection we have been informed a new manager has been recruited and will commence on 29 October 2018.

The service had a system in place to monitor the home. However, audits were not always effective and did not always identify the concerns we had raised as part of this inspection. For example, care plan audits did not identify that risk assessments and care plans were not reflective of people's current needs. Audits had not identified that there was a lack of staff available to meet people's needs in a timely way.

We saw some audits, scheduled to be completed monthly, had not been completed since June/July 2018. This showed a lack of oversight from the registered provider.

We saw an accident and incident audit had been completed. However, this had not identified any trends or patterns and although people had fallen on several occasions, the audit recognised the amount of times the incidents had occurred but no actions had been completed.

The service did not have a weight audit in place to ensure people at risk of losing weight had been identified and action taken to address any loss. This could put people at risk of losing weight and no-one having oversight to ensure the correct actions were taken to support people. This meant there was not always joined up care, as people's changing needs were not always identified to ensure appropriate information was shared with other agencies to support care provision.

We found the provider did not always ensure the service continuously learned lessons, as areas that required improvement were not identified to ensure improvement and sustainability.

People who used the service and their relatives, were not involved in the service. The last meeting minutes available for the resident and relatives meeting was from December 2017. There were no further dates advertised. Staff we spoke with told us they had staff meetings to discuss work related topics.

This is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. There was lack of effective oversight and governance by the registered provider to ensure the service improved.

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 provider did not ensure the care and support provided was person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the risks to people were managed to ensure their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient staff that were deployed effectively and that they were suitably skilled and supervised to meet people's needs.

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 provider failed to ensure there were effective systems to quality monitor the service. There was no oversight or governance by the provider to ensure the service continually improved.

The enforcement action we took:

We issued a warning notice.