Mr Stanislav Fajdel

Wyvern Lodge

Inspection report

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Tel: 01934204242

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19 May 2016
23 May 2016
26 May 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was the first inspection for Wyvern Lodge under a new provider. Wyvern Lodge had 11 people living in the home, but during the inspection one of the people went into hospital and remained there. Wyvern Lodge was set over three floors. The ground floor had five bedrooms, two toilets and a bathroom, along with two communal lounges, a laundry room, a dining area, kitchen and access to the outside garden and patio area and the manager's office. The first floor had four rooms, an airing cupboard and toilet and the second floor had five bedrooms. Not all bedrooms had en-suite shower rooms.

This inspection was brought forward because serious concerns had been raised. These included poor staff levels, concerns about the management of the home, cleanliness of the home, people not getting enough to eat, safeguarding procedures not being followed, untrained staff administering medicines, the recruitment procedures for new staff not being robust and lack of staff training. There were four daytime unannounced inspections on 18, 19, 23 and 26 May 2016. Each inspection was carried out by two inspectors. On the first two days a specialist advisor nurse was present. The nurse had a background in elderly care. During the inspection further concerns were raised about staff levels at night so a night time inspection took place between 10pm and midnight by two inspectors.

There was a registered manager in post for five months but had been in post as an unregistered manager for three months previously. 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.

People had not been kept safe. There was a lack of understanding, by the registered manager and staff, about how to keep people safe. Risks to people were not properly assessed, reviewed or managed. There were no systems in place to ensure people were kept safe when concerns were reported.

Some areas of medicines management were not safe. Staff recruitment was not managed safely. Accidents and incidents were not always recorded or followed up to ensure people's safety or improve their care. Health and safety checks on the home were not always carried out which put people at risk.

Some people thought staff were kind and caring. There was a lack of social interaction because most interaction was task driven to meet people's basic needs. Staffing levels were inadequate to ensure people's needs were being met and they were kept safe. At times the staff levels were putting people at risk of harm. Staff did not have clear guidance about their roles and responsibilities.

Some people had access to health care professionals. However, people with specific medical conditions had not been seen by specialists. People's legal rights in relation to decision making and restrictions on their liberty were not upheld.

People did not have a choice of nutritious meals and drinks. Some people's diets were very poor placing them at risk of malnutrition. Other people were at risk of their health being compromised because the meals were not appropriate for their medical conditions.

Most staff had not received adequate and up to date training to keep people safe. Staff were completing assessments and tasks without the correct training. At times, this was putting people at risk of receiving unsafe care based on incorrect information. Staff were not supervised regularly.

Some people did not have any formal system to communicate their wishes or feelings. People were therefore unable, and had not been supported to express their views about life in the home. There were limited opportunities for people to express their views on the care being received. Apart from one complaint, concerns and complaints had not been listened to or responded to. Some people gave up complaining because nothing happened when they did.

People did not receive personalised care which was responsive to their needs. Care planning was confusing and at times out of date. Plans were not reviewed and did not reflect people's current needs. Some records could not be located during the inspection; there was no evidence these records had ever been completed.

The home had been extremely poorly managed. There had been a chaotic approach to management systems, structures and record keeping. The provider had not completed any governance or auditing of the service. There had been a lack of action when the home failed to improve in identified areas. Shortfalls found by external agencies had not always been acted upon. During the inspection both the provider and registered manager left the home. The registered manager was not contactable even to most staff.

There had been a failure to operate the home in an open and transparent way or in accordance with the law. Significant events which adversely affected people's safety and welfare had not been reported to either the CQC or other authorities such as the local authority safeguarding team. This had severely compromised people's welfare and safety.

We raised our concerns about what we found during our inspection with the provider. Over the four days of our inspection the provider failed to take action in response to our concerns or mitigate the major risk to people with regard to their health, safety and well-being. The provider did not take any action to ensure people who lived at Wyvern Lodge were treated with care, respect and dignity and lived in an environment that was caring, fit for purpose, free from risk and safely staffed.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of The Care Quality Commission (Registration) Regulations 2009.

As a result of our findings we applied to Weston-Super-Mare Magistrates Court for an order to urgently cancel the provider's registration under our powers set out in section 30 of the Health and Social Care Act 2008. The Court ordered that the provider's registration be cancelled on 27 May 2016. The home was closed on 27 May 2016.

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 from abuse. Risks were not always assessed, reviewed or managed well.

The provider had failed to ensure people's safety. Staff recruitment was not managed in a safe way.

People were not supported with their medicines in a consistently safe way. The environment was unsafe in some areas.

Is the service effective?

Inadequate

The service was not effective.

The provider had failed to ensure people received the care and treatment they needed.

People's legal rights in relation to decision making and restrictions on their liberty were not upheld. People did not have a choice of nutritious meals and drinks.

Staff did not receive training or support to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and privacy had not always been respected.

There was a lack of continuity of care due to the staff all being new. People's preference about who supported them was not respected.

Not all people were involved in decisions about the running of the home and their care.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not reflect their needs and at times were incorrect.

The provider had not ensured people were involved in planning and reviewing care. People did not receive care and support which was responsive to their changing needs.

People's views were not used by the provider to develop or improve the service.

Some people had stopped complaining because they did not feel listened to. There was a lack of systems in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Management was ineffective. There was a lack of accountability and responsibility with the registered manager and provider.

The provider did not work in partnership with other professionals to make sure people received the care and support which met their needs. People were not part of their local community.

The registered manager's quality assurance systems were ineffective. They failed to ensure people were protected from poor care and any areas for improvement were identified and addressed. The provider did not complete any quality assurance.

The provider and registered manager had failed to operate the service in an open and transparent way. Significant events which had occurred had not been reported to relevant agencies.

Wyvern Lodge

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.

Unannounced, daytime inspections took place on 18, 19, 23 and 26 May 2016. On 23 May 2016 we also conducted an unannounced night visit commencing 10pm and finishing at midnight. At each visit there were two inspectors, with three inspectors in total. On the 18 and 19 there was a specialist professional advisor nurse. The nurse was a specialist in elderly care. This was a comprehensive inspection and was brought forward from the planned inspection date due to many concerns being raised with CQC.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to concerns raised the inspection was brought forward so a PIR was not available. We took this into account when we inspected the service and made the judgements in this report. We also looked at paperwork from the local authority and other intelligence we held internally about the home.

We spoke with seven people that lived at the home. We spoke with the registered manager, provider and five staff members. We spoke with three visitors including relatives and a health worker. We also spoke with three health and social care professional on the telephone during the inspection.

We looked at six people's care records and observed care and support in communal areas. We 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 looked at five staff files, rotas to show which shifts staff were working, quality assurance audits and supervision records, health and safety paperwork, medicine administration records, daily logs, incident records and a selection of the provider's policies.

Following the inspection we asked the provider to send us a copy of a service record for the lift in the home and their action plan addressing all the concerns. The lift service record was sent incomplete. A further

request was made for the complete certificate but we did not receive it. An action plan was received but it was basic, did not address all concerns and did not mitigate all the risks to people.

Inadequate

Is the service safe?

Our findings

Before this inspection we received information of concern about recruitment procedures in the home. During the inspection we found people were at increased risk of abuse because there was not an effective recruitment procedure for new staff. The provider and registered manager confirmed their recruitment included advertising for a position, two interviews and an induction after checks. However, staff files did not have two interviews recorded for staff. The provider and registered manager had not completed pre-employment checks which included checking previous employment or gaps in employment. For example, one member of staff had a period of six months without employment; there were no checks by the provider to cover this period. The staff member told us there was a valid explanation of what they were doing during this time. Another staff member had two reference checks; neither was from previous employers declared in their application. This meant the provider had not contacted a previous employer to find out the suitability of the member of staff. The registered manager told us the member of staff's previous employers closed. Following the inspection we found one of the previous employers was still running.

Another concern raised prior to the inspection was staff had been working without a Disclosure and Barring Service check (DBS). A DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. One staff member told us they had started working prior to having their DBS check completed. A staff file showed a second member of staff had not had the correct check completed by the registered manager. We asked the registered manager about this. The registered manager showed us a computer print-out they thought demonstrated the correct check had been completed; it was not the correct check. This meant people were at an increased risk of abuse because there were not sufficient systems in place to help to prevent unsuitable staff working with them.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm and abuse because some staff and the registered manager did not have the correct training or understanding about safeguarding. Safeguarding is when providers safeguard people from abuse or improper treatment. There were no systems in place to manage incidents when they occurred in the home. We found some incidents had not been identified or managed appropriately to keep people safe. For example, there was a body map showing unexplained bruising in an unusual place without a manager's response. Body maps are ways providers can demonstrate on paper, marks and wounds found on a person's body. By not having a manager's response on the body maps it was not clear if the manager was aware and if they were had they taken action to keep people safe. A member of staff told us they had reported the bruising to the registered manager who told them to complete the body map. The person informed us staff had been rough when helping them go to the bathroom. The registered manager had not taken action and there had been no information sharing with the local authority safeguarding team or the Care Quality Commission. During the inspection we made a referral to the local authority safeguarding team.

Another person had a bruise on their forehead. Their records said they had banged their head on a

washbasin whilst walking to the toilet. There had been no referral to a doctor or other health care professional. The registered manager had not completed any investigation or taken any other actions. This meant the person had an injury which had not been investigated or referred to other agencies to prevent reoccurrence and keep them safe.

Staff told us, and records seen confirmed some staff received training in how to recognise and report abuse. Staff spoken with had an understanding of what may constitute abuse and how to report it. However, we asked the registered manager about their understanding of safeguarding. They said their "Immediate action would be to get a description of staff member. Then investigate immediately". There was no knowledge about referrals to other agencies and the importance of preserving evidence. They showed us a certificate to show they had completed a refresher course in safeguarding recently; the training provider had no record of this. In addition, the registered manager told us they had not completed safeguarding training to an appropriate level for a manager. This meant people were at risk of harm because safeguarding training was not always appropriate and systems were not in place.

Before the inspection the local authority had alerted CQC to a number of safeguarding incidents they had raised after monitoring visits. The provider and registered manager had not identified any of these concerns as safeguarding prior to the visits. They had not notified CQC as required by law of any of these concerns raised by the local authority. During this inspection we found two more incidents which caused us to raise safeguarding alerts with the local authority to keep people safe. The provider had not been notifying CQC of all incidents where people were at risk of abuse.

The registered manager and provider had no understanding of safeguarding or their legal obligation to notify CQC and the local authority. This meant external agencies were unable to monitor incidents and make sure people were safe and appropriate actions had been taken by the provider.

This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by sufficient numbers of staff to meet their needs or keep them safe. A person told us "They were short staffed". They continued to tell us when they rang their bedroom call bell they had to wait for staff. Another person said, "Hardly anyone here now. Not enough staff". A staff member said, "They do need more staff". Some staff were telling us about the large amount of hours they worked without a break. For example, one member of staff told us they had worked 39-hours in the space of three-days including a full 24-hour shift awake. Another told us they had completed 230-hours in the space of three-weeks which equated to an average of 10-hours a day over 21 consecutive days. There were staff marked on the rota as working yet they had not come into work. On one day of the inspection two members of staff did not come in and the registered manager was trying to reach them on the telephone. Later the registered manager explained they were ill; but one came in late to work. The staff member told us they were alright and no longer felt ill. This meant there was a risk staff would be too exhausted to work safely.

The registered manager told us two members of staff during the day was enough to meet the needs of people. There was nothing in place to demonstrate how they had decided this was the correct staffing level. Some rotas showed four staff were required each day. The staff employed to deliver care had to complete cooking and cleaning roles because there were not specific staff designated for these roles. For example, call bells were left ringing for over five minutes and people told us they sometimes had to wait for members of staff to help them. On one day of the inspection there were only two members of staff present; one was in the kitchen and the other person was providing hands on care to ten people. This meant people were at risk of not having their care needs met because staff were too busy completing non-care related tasks.

During the inspection further concerns were raised by the local authority about staff levels at the home at night. There was an unannounced inspection at 10pm to check the concerns. The registered manager was at the home with another member of staff. They told us the registered manager was completing the sleep-in shift whilst the member of staff was working a waking night shift. This meant the registered manager would be on call but asleep at the home and the staff member would be awake all night. Again, the registered manager said there were enough staff at night. They told us no one needed two staff to support them. However, one person had been assessed by the local authority as needing two members of staff to help them with mobilise including attending to personal care. Personal care is when support is provided to complete tasks such as washing, getting dressed or using the toilet. During the visit the registered manager assisted this person on their own for over ten minutes with personal care.
Another person had to wait in the morning to get up until there were enough staff. A member of staff said, "[Name] needs two members of staff so they're the last person we do in the morning" and "The time they're done will depend when staff get in." This meant people were at risk of harm and poor care at night because the staff levels did not meet their needs, and people were not able to make choices around what time they wanted to get up in the morning.

There were not enough staff to cover the weekend following the final day of inspection. One member of staff told us they would be doing a 24-hour shift without a break. Another informed us they would not be coming in for two 12-hour shifts they had been asked to work because they were tired and had already completed many hours. The registered manager had instructed the acting deputy manager that no agency staff could be used to cover shifts. We were unable to speak with the registered manager because they left the home half way through the inspection and became uncontactable. Prior to this the registered manager said they were living in a spare room at the home and completed sleep-in shifts seven nights a week. The proposed weekend staff levels meant the home would be dangerous because it would not have enough staff to keep people safe from harm and have their care needs met.

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

Before the inspection we had been informed people were not receiving safe care and treatment. Concerns raised included staff were administering medicines without the correct training, the home was unclean, there was poor infection control and people's medical needs were not understood. Infection control means measures are in place to ensure the protection of those who might be vulnerable to acquiring an infection.

At this inspection, we found no untrained members of staff administering medicines. However, we found staff were unaware of some people's medical needs and staff were not familiar with specialist equipment such as a machine to test blood sugar levels. There were concerns with medicine management.

Some people had specific medical conditions and most staff were not aware of these. A person had a plan for their medical condition but a member of staff was not aware of their diagnosis. The staff member told us they had never seen the plan before and were unaware what processes should be followed to prevent harm. No other staff knew the way to support this person and others with the same medical condition. One person's plan for this medical condition said they should be checked hourly during the night. Daily log record sheets showed for at least six nights there was no record of this occurring and other daily logs could not be found. One member of staff said they had been told what to do by the registered manager if the person required support during a medical emergency related to their condition. The registered manager had no record of completing training which demonstrated they were qualified to train other staff, or even that they had the correct up to date knowledge. This meant people were at serious risk of harm because their medical needs were not understood and staff had not received appropriate training to keep them safe.

Some people required specific tests to be completed to monitor their health. No staff knew how to complete these tests because they had not received the appropriate training and there was confusion how frequently the tests should be completed. For example, for one person a member of staff said the tests should be every other day and another said they should be weekly. Their care plan had not clarified the frequency and there were irregular records of when the tests had been taken place. Four dates showed the test occurred weekly, and then there was a gap of three weeks. Following this there were three days of tests in a row with the middle date having two tests. This meant people were at risk of harm because monitoring of their health was not being completed in line with their needs and by staff with no training.

People were at risk of harm because no staff knew how to check the specialist equipment was working correctly. The registered manager said the way they tested the machines was to turn them on. There was no mention of the use of specialist fluid to check the readings were accurate. This meant people were at risk of harm because deterioration to their health could occur without it being detected, because staff were not able to use the equipment safely.

We observed two medicine rounds completed by staff that had training in medicine administration. They checked medicines against the prescription, waited for the person to take them and then completed the medicine administration record (MAR) chart. However, during the medicine rounds members of staff were repeatedly interrupted. This meant people were put at risk of mistakes around their medication because staff were being distracted. Staff did not have their competency assessed for medicine administration regularly to make sure their practice was safe.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. However, during the inspection we saw an unlocked office contained two large unsecure zipped bags. The registered manager told us this was next month's medicine which had just been delivered. A member of staff said they would be kept in the office "Until we need them, then they are all put into the drug trolley". No checks had been made of the content of both bags to ensure the delivery was correct. During the first day of inspection on numerous occasions and for long periods of time, the office door was propped open with a chair, unoccupied and the bags were in full view. The registered manager was made aware of the danger of these medicines being taken accidently or tampered with; they said they, "Had no room" when asked about the drugs trolleys. During the second day the office still contained full medicine bags and was open and unoccupied on several occasions which meant they were unsecure and unchecked. People were at risk of moving or taking medicine which did not belong to them.

Risks to people had not always been considered and there were few risk assessments such as for moving and handling. For example, people were at risk of not being transferred correctly between two surfaces such as an armchair and a wheelchair. One person told us how they were moved, "A [person] looks after me at night. [They] put [their] hands around my back as I can get my legs down the side onto the floor". They continued to tell us in the past they used a special piece of equipment. By not using the specialist equipment any more this person was at risk of being injured unnecessarily. A second person required two members of staff to help them with all transfers. They used some special equipment to help them stand and turn between an arm chair and a wheelchair. On a number of occasions the person and staff struggled to use this piece of equipment because they had limited movement in one hand. On one occasion the person put their hands on special handles on the piece of equipment to help themselves move, but their hand kept slipping off as they were unable to grip. Another time the member of staff meant to be controlling the transfer looked confused and appeared to have never used the equipment before. The registered manager took control of the situation but did not effectively communicate what was happening with the staff member. This meant the person was at risk of being hurt during the transfer and did not have the benefit of any explanations of what was happening.

Neither person observed had a moving and handling risk assessment in place. This meant risks to moving people had not been identified nor had measures to reduce risks. The registered manager told us the acting deputy manager was responsible for assessing and creating the moving and handling assessments. The acting deputy manager had no training from this provider or qualifications from previous places of work.

Another person was at risk of becoming disorientated due to confusion and a history of falls which staff had told us about and there was some information in their care plan. Their bedroom was on the top floor of the home right next to the stairs. We raised concerns about the risk to this person to the registered manager. The registered manager said they were not worried the person would fall downstairs and continued to say the person's mobility was good.

Where risk assessments were in place they had identified some of the risks to people. One person had been identified as being unsafe in the community without support because there was a risk of tripping and falling due to their health conditions. However, there were occasions when the risks had not been considered or included in people's risk assessments. For example, one person's risk assessment had been reviewed in May 2016 for mobility and dexterity. Staff told us this person had recently had falls in the home but there was no information about them in their risk assessment. This meant people were at risk of harm because when there were moving and handling assessments they were at risk of not being in line with their needs or best practice.

People were at risk of pressure sores. Pressure sores are a type of wound people get when they have poor mobility and their skin gets damaged. For example, one person's care plan said they should be "Nursed on their left and right side". It also had information they should be turned every two to three hours. These actions were to reduce the risk of the person getting pressure sores or marks on their body. There were no daily turn charts to demonstrate the person had been routinely checked or turned when they were in bed. No staff were aware how to turn this person or their needs from their care plan. This meant the person was at risk of harm because staff were not familiar with their needs.

During this inspection, staff were wearing gloves and aprons when completing personal care to reduce infections spreading. However, people were at risk of infections spreading because the home was not regularly being deep cleaned. No member of staff was employed specifically as a cleaner. Unless a staff member was named on the rota the care staff were expected to undertake the cleaning. Another staff member told us deep cleaning did not get done because care staff did not have time. The cleaning schedule paperwork was incomplete and did not contain records of deep cleans occurring. This meant people were at risk of harm from the chance of infections spreading in the home.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People with specific needs had care plans which did not help staff to provide appropriate care. For example, two people had medical conditions which could lead to a sudden deterioration in their health. To reduce the likelihood of harm to them there should have been plans in place for staff to follow including details about when to call an ambulance. Neither person had this plan in place at the beginning of the inspection. During the inspection, after we raised our concerns with the registered manager, a plan was found. A member of staff said they had never seen this plan. This meant people were at risk of significant harm if their health deteriorated because there were no emergency plans and staff were unaware what to do in the event of an emergency.

This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Errors were found in records for medicines and medicines which required additional security. For example, one person had a handwritten note by staff in their record that they were allergic to a type of medicine. On the same MAR chart, underneath the handwritten note, staff had been administering the medicine repeatedly that the note stated the person was allergic to. We spoke with staff and the registered manager who were unaware of the written note saying they were allergic to a specific medicine. The registered manager said the GP had prescribed the medicine and the person was not allergic. During the inspection the registered manager consulted with the GP to clarify the person was not allergic and the medicine could continue to be given. So this meant the incorrect information was recorded on the record.

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

People were at risk of harm because the home was potentially unsafe to live in as routine checks had not always been completed for the building and equipment. For example, one of the hoists in the home did not have the correct safety check in place. A hoist is a specialist piece of equipment to transfer people with poor mobility from one place to another. The training provider who had recently delivered moving and handling refresher training refused to use the hoist because it was unsafe. The lift in the home had not been serviced but was still in use by people. This meant people were at risk of being hurt by using equipment which did not have up to date safety checks in place.

People were at risk of harm if there was a fire because people's evacuation plans did not always reflect their needs. For example, one person was unable to walk and this was considered by the provider a medium risk during a fire. Their personal evacuation plan for a fire said, "Can be slow to respond" but had little information about how to help the person in a fire. During the inspection the person was seen requiring two members of staff and a specialist piece of equipment to transfer between an armchair and wheelchair. This meant their plan was inaccurate and had not fully assessed the risk or put in place full instructions for staff to follow in the event of a fire.

A recent whole home fire risk assessment had not been completed by the provider to ensure the safety of the building had been assessed. No fire alarm tests, emergency lighting tests or evacuation practices had occurred since 2013. The registered manager found a folder in the office where some fire drill practices had been recorded from January, March and April 2016. However, there was no record of which staff had participated in the practice. This meant the provider or registered manager had no way to know who had attended fire drills.

Staff had not demonstrated they understood how a fire drill worked or how to record it. This meant people were at risk of harm in a fire if staff were not following the correct procedures. In the records, there was a section for duration of the fire drill practice. Within the duration of the drills section there was a range of times recorded for each one rather than a specific length of time the evacuation took. This meant records had not demonstrated staff recording the details of the length of fire drills knew what they were doing. Some staff told us they had completed online training for fire safety however there were no records of this.

When we visited in the evening three fire doors were found propped open with items. The purpose of fire doors is to remain shut so in the case of a fire provide a seal to the room and limit the spread of the fire. We spoke with the registered manager who was not aware of doors being propped open with items. After a short time we looked again and all the items had been removed from the doors. This meant people were at risk of harm in a fire because fire doors were not being used correctly to protect people.

During the inspection we raised our concerns with the fire and rescue service. They completed a site visit and found areas of the home to be dangerous. They served an enforcement notice for work which needed to occur in the building to make it safe. They also served improvement notices in relation to the records and training. This meant people were at risk of harm during a fire because the building was unsafe, staff had not been trained, records were inadequate and risks had not been considered to people.

This is a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Before the inspection we had been told staff were not receiving adequate training to support people. This included information that some staff training had expired. Staff were not having an induction, the Care Certificate had not been used for new staff and the registered manager had no training records. The Care Certificate was introduced by Skills for Care to ensure all health and social care workers have a minimum level of knowledge to deliver good care. A member of staff told us, "I have done all sorts. All online. No practical training". Another said, "I don't like the online training. Don't check competencies". A third explained they had completed lots of training including health and safety, safeguarding and fire training.

We found people did not receive care and support from staff who had the skills and knowledge to meet their needs. The registered manager told us all staff had recently attended refresher training for key skills such as safeguarding and first aid. The training provider told us it was chaotic trying to train the staff because there were constant interruptions and some staff left after only a few topics. Only two staff members completed the full day of training. This meant most staff did not always have the knowledge and skills to keep people they supported safe and provide good care. The registered manager explained they were in the process of creating training records and would provide them during the inspection; we were never given the records. The registered manager had no systems in place to identify current knowledge of staff and their training needs.

Staff had not received training to meet people's identified needs around their medical conditions which meant people were at risk of harm. There were shortfalls with staff knowledge and understanding of pressure care. Pressure care is proactive measures to prevent pressure sores from developing and how to help the healing process if a person has one. People had special assessments to determine the risks of pressure sores to them completed by members of staff and the registered manager. However, three of these were incorrectly filled in by members of staff who told us they had not received training in how to complete them. For example, one person's assessment of risk changed to high risk when correctly completed. There was nothing in place to mitigate the risks to this person around pressure care. Another person at risk of pressure sores had a note to say their specialist mattress should be "set at its lowest" with no rational as to why. The mattress was set at four out of eight and the registered manager said this was how the engineer set it. There had been no further checks to the mattress by members of staff or the registered manager. We spoke with the registered manager who had no records of pressure care training for staff. This meant people were at risk of harm from pressure related injuries because staff did not have the correct training.

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

Before the inspection concerns had been raised with us that people were not getting enough food to eat. This included concerns that the type of food being offered was not appropriate to meet people's health needs if they had specific medical conditions. We checked the fridge and freezers at the beginning of the inspection. We saw poor quality, frozen food was available, including ready meals from the budget ranges in shops. The fridge was nearly empty apart from a bag of potatoes. There was no other fresh fruit or

vegetables in the home. During the inspection more fresh fruit appeared in the lounge.

People had mixed views about the food. Some people said, "The food is excellent", "Food is rubbish, not cooked properly" and "Food is freshly made out of the freezer". Another person told us they were sometimes hungry because they did not eat all day. They continued to tell us staff had not always brought food to them when they were in their bedroom. A member of staff said, "When I am in the kitchen I cook from fresh. I refuse to cook with all the frozen things".

We found people's nutritional needs were not always assessed so people were at risk of receiving a diet which did not meet their needs and wishes. The care staff were responsible for the cooking. They did not have an understanding or training for people requiring different diets to meet their health needs. For example, one person required a low sugar diet due to their medical condition. During the inspection they were given the same food as everyone else including jam and rice pudding without adjustments to ensure the sugar level was reduced. Another person was being assisted with their meal due to mobility difficulties. There was no plan in place to provide guidance for staff to support this person to eat. A third person was given a special drink which was a food supplement. They were also given cakes and biscuits because the staff struggled to get them to eat. At almost midnight the registered manager brought a large piece of cake, biscuits and a glass of squash. This person had not lost weight because of the food supplement, but they were not receiving a healthy, balanced diet. There was little guidance and no plan in place for staff to overcome the barriers of the person refusing to eat a healthy balanced diet. This meant people were at risk of health conditions exacerbated by poor food choices.

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

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. Best interest means a decision is made by others for a person considering what will be the best option for them. We checked whether the provider and staff were working within the principles of the MCA. During the inspection we found when people lacked capacity the principals of the MCA were not followed. For example, five people lacked capacity to make decisions about their medicines. The provider had not demonstrated people's rights had been considered around taking or choosing to refuse their medicine. No capacity assessments had been completed nor had their best interest been considered. It was not clear if the least restrictive option was in place for each person where they lacked capacity. Two members of staff told us no one had a capacity assessment or best interest decision in their care plan because they had not been completed. This meant people had not had their human rights considered when they lacked capacity and if the staff were unsure they had not assessed it.

On the second day, one mental capacity assessment and best interest record was shown to us by the registered manager. Although this was for a person who lacked capacity it was not decision specific, nor did it demonstrate the option chosen was the least restrictive. Decision specific means that each important decision a person needs to make is considered separately rather than all decisions grouped together. There was no record of the professionals and relatives who had been involved in the best interest decision. When we spoke to a member of staff they had no knowledge of this capacity assessment and best interest decision. They told us they were unaware of any best interest meeting happening. This meant people who lacked capacity had not had their human rights protected in line with the MCA.

This is a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application 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 and they were not.

The registered manager was going to start to use a special piece of equipment for a person, who was at risk of falls and had a medical diagnosis which meant they lacked capacity. This would alert members of staff when they left their bed. Therefore, they were being consistently monitored and it would breach their human rights without their consent. We asked if there was a capacity assessment, best interest decision and DoLS assessment in place for this piece of equipment and there was not. The registered manager told us they had not completed a DoLS application and began to ask us what this meant. We directed them to the MCA and DoLS codes of practice. During the inspection they made a telephone call to a social care professional and the questions they were asking demonstrated they had no understanding about the correct process in line with the MCA. Only one person out of 11 was free to leave the building without the support from staff. Five of these people required supervision at all times in the home. Therefore at least five people were having their human rights breached without an authorised DoLS. We told the registered manager about this who said, "All of them can leave the building as long as a member of staff goes with them." Other staff explained to keep some people safe they would need support from members of staff if they left the building. This meant the registered manager and staff did not understand by constantly monitoring people and preventing them leaving without supervision it was depriving people of their liberty.

However, during the evening visit we checked a person who had been identified as at risk of falls with a bedroom on the top floor next to stairs. Their bedroom door was blocked by a chair placed at an angle with the back under the door handle. We showed this to the registered manager and member of staff who were shocked. The registered manager immediately removed the chair and then propped the door open with the chair. By blocking the person in their room they were being restrained. There was no DoLS application or authorisation in place for this practice. This meant their human rights were breached.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had access to health professionals. For example, one person was found to have problems eating so the registered manager arranged for them to see the dentist. They explained they wanted their teeth checked first to ensure that was not the problem. Another person had the ambulance called for them because their health declined over a short period of time. The registered manager explained they wanted to make sure they were alright. Following this the person was admitted to hospital for a short stay.

However, the home did not always arrange for people to see health care professionals according to their individual needs. Other people who had identified heath issues had not received care from a health professional. For example, four people had specific medical conditions, such as epilepsy and diabetes, but were not regularly seen by specialists because no referrals had been made by the provider. Another person had a number of recorded falls; we found evidence they had at least three falls but the paperwork was not clear. We spoke with the registered manager to see whether a referral to the falls team had been made. The falls team are health specialists who assist providers when someone is at high risk of falls to proactively reduce risks to the person. The registered manager told us they had not made contact with the falls team

but were planning to make a referral. We shared our concerns about the risk to these people with the local authority safeguarding team.

Requires Improvement

Is the service caring?

Our findings

People were not always supported by kind and caring staff. There were mixed views about the staff. Some people were positive and said, "Staff are alright" and "Staff are ok. At least I haven't had any problems". Whilst another person was negative and said, "Staff are rubbish". They continued to tell us kindness and skills of staff changed when the new provider arrived.

People's privacy was not always respected but all personal care was provided in private. Most staff knocked on people's doors before entering their bedrooms. Some people told us staff knock before entering their bedroom. However, one person said, "Staff don't knock on my door they just barge in". When people required support to go to the bathroom staff responded kindly. However, some people had to wait for a member of staff to be available due to a limited number of staff on shift. A person explained when they ring their call bell, "They don't come straight away". We observed call bells ring at times for over 10 minutes and then the registered manager explained they would go and answer it.

One person told us they preferred a female member of staff to support them with personal care; they said they had to get used to a male supporting them at night because there was no choice. Another person said, "I don't want males bathing me and I want to go somewhere closer to the toilet". Neither preference had been recorded in their care plan or acted upon. Both people had a preference for the gender that supported them which was not met. There were no female staff working a night shift repeatedly over a number of weeks. This meant when people stated preferences about the gender of staff supporting them, their choices were not respected.

People's dignity was not always respected. Some staff tried hard to greet people and check they were alright. However, due to the limited number of staff they were task driven and did not take time to have general conversations with people. This meant staff responded when people required support such at meal times but there was no social interaction away from tasks like serving food or helping them eat. When people were struggling staff had not identified this so did not help them to preserve their dignity. For example, one person had cling film left on their food at lunch and was struggling to remove it. No staff identified this as an issue or offered to help.

People had limited interactions with staff and others. One person told us they stayed in their bedroom most of the time because only one other person would speak with them. They continued to say this person went to bed early so they were left with no-one to talk to. Another person said, "There is nothing to do. No one to talk to". During parts of the day where social interaction could be promoted such as during a meal, there was little or no interaction taking place. For example, at lunchtime most people were moved to the dining room. Staff only interacted on a task-based level to serve food and ask whether they wanted a drink. Once they had done this they left the area to complete other tasks. This meant people were not always treated in a caring and compassionate way by staff.

All staff had been employed in the last three months apart from a member of bank staff. Bank staff are casual staff who may not work regularly at the home but are still employed by the provider. There was no

continuity of care for people because all staff were new. Most staff had some knowledge of people's needs. However, some staff displayed a lack of knowledge of people's needs and how to care for them. For example, some staff were not familiar with people's likes and dislikes including the food they enjoyed or whether they wanted a television in their bedroom. The registered manager also lacked familiarity with people's needs. They were not aware of people's preferences about the gender of staff they would like to support them. This meant people were not always having their care needs met and preferences followed.

There was a notice board in the main lounge near the medicine cabinets. Information about people including personal details was clearly on display. Another piece of paper contained staff contact details. This meant anyone visiting the home could access confidential information about people and staff without authorisation. One staff member laughed when we told them and said it was not their personal mobile just a work mobile number. The staff member displayed a lack of importance of keeping personal information safe by not recognising the public display of personal information. We spoke with the registered manager who had not realised and by the second day had removed all personal information from the public board.

People were at risk of their confidential paperwork being seen by unauthorised people. Care plans were stored in a filing cabinet in the main lounge. Another filing cabinet contained a chaotic amount of paperwork including food and fluid charts, daily logs and incident records. There was no logical order because it contained random pieces for all the residents in no particular order. None of the filing cabinets containing personal and confidential information about people were locked for most of the inspection. This meant anyone could access personal information about another person without permission. We spoke with the registered manager explaining it was not protecting people's privacy. They said they were unlocked because we were there. No staff knew which keys to use for the filing cabinets to lock them.

This is a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some people could make choices about where they wished to spend their time and when they wanted to get up in the morning. One person preferred not to socialise in the lounge area so spent time in their bedroom. Another person said, "I can get up when I want and go to bed when I want". A staff member said, "People can have choices if they want to stay in bed. I can ask people if they want to get up or not". However, other people who required more support were moved to the lounge, then to and from the dining room without being offered a choice. We spoke with staff who informed us this was because the person needed to move to prevent pressure sores so it was good for them to move and not be in the same position all day. Staff did not demonstrate an understanding of choice because they were moving the person for a functional reason. At no point did they ask where the person wanted to move to for their lunch. This meant choices were being offered to some people but not others.

People were not enabled to express their views about their care. If people had communication difficulties staff did not provide alternative methods of communication to assist people to be involved. For example, when lunch was served people were not offered options for the main course because there was not any.. When people had given their views they were not always listened to by staff. One person said, "[The registered manager] insists I am clean shaven, but it's my face". They explained they did not want to be clean shaven every day. No one had their care reviewed on a regular basis to ensure it was meeting people's needs and preferences. The acting deputy manager had identified this as a concern and was trying to introduce care reviews on a monthly basis.

People told us they were able to have visitors at any time. One person said, "People can come whenever they want". Each person who lived at the home had a single room where they were able to see personal or

professional visitors in private. During the inspection people saw visitors in the lounge and their bedrooms depending upon their choice.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. Staff would take us to an empty bedroom or away from people when they were talking to us. If they were near people they would lower their voices or try and involve the person with what was being discussed. This meant staff were making sure people's confidentiality was respected when talking to others.

Inadequate

Is the service responsive?

Our findings

Before the inspection concerns were raised that people's care plans were not complete, accurate or in line with people's needs, likes and dislikes. There were further concerns because some of the care records were found to be stored in a variety of locations in the home. All these were unsecure and it meant staff would not have the information about a person in one place. During the inspection we found people did not receive care that was responsive to their needs and personalised to their wishes and preferences. Some people said, "I have heard of a care plan but I haven't been involved with it" and "I don't see my care plan". Another person said, "I have never seen my care plan" they continued to say they did not know who their key worker was. A key worker is a member of staff assigned to a person to ensure their needs and preferences are maintained.

Everyone had a care plan stored in a filing cabinet which was located in the lounge. Some care plans had more information in them than others. There were a variety of formats in the care plans which could cause confusion amongst the staff team. A member of staff told us they were in the process of updating all the care plans. This meant some of the formats were the old version and some were the new version. However, daily records were not kept in order and were stored in different areas of the home; some in a file stored in the dining room and others in filing cabinets and the registered manager's office. There were many incomplete daily logs including food and fluid charts used to monitor the amount of food and fluid people had received. This meant staff were unable to monitor the health and well-being of people because records were not easily located and were not accurately maintained.

Two people had assessments in their care plans for the risk of pressure sores. However the assessments were incorrectly completed and identified the wrong risk levels. One person was using a specialist mattress for someone at lower risk of pressure sores. Their risks had not decreased despite their care plan saying they had. This is because the risk assessments were incorrectly completed. We spoke with two members of staff who both thought the care plans were correct until we showed them the errors. Both staff members told us they had not received training to complete the charts in the care plans. The registered manager was informed of our concerns. They were also unable to identify the correct level of risk for people. For example, they told us one of the people was at low risk but our specialist advisor identified when correctly calculated their risk was very high. This meant people were at risk of harm because staff were not correctly completing their care plans and unaware of the risks to those people.

Care plans were not personalised to each individual and did not contain information to assist staff to provide care in a manner that respected their wishes. A member of staff had identified care plans did not contain information about people's likes, dislikes and preferences, but was planning to change this. They showed us one person's care plan they had started changing. However, they said the registered manager did not understand the importance of care plans so they were not allocated the administration time to complete the changes. We raised our concerns about the care plans during the inspection with the registered manager. By the second day the registered manager had started reviewing a number of care plans. They had no auditing system in place to demonstrate how they were completing these changes and communicating them to others. There was no information about how people were involved in the updates.

This meant people were at risk of the care plans not reflecting their needs or preferences.

People did not have the opportunity to participate in activities. They were at risk reduced mental well-being because they were left doing nothing for long periods of time. People told us, "Not often have activities. Not been out very often", "I rarely go out" and "I do my word books and TV. No one comes up and does anything with me". Another person when asked in the afternoon what he had been doing today said, "Nothing".

A staff member said they understood there were not many activities but had organised a saxophonist to come in and entertain people. This happened in the afternoon of the first day and people appeared to enjoy it and sing along. The staff member told us there had been other entertainers who did 'singalongs' once a month. A person told us, "Some people come in and do a sing-song. I don't like it personally but I join in". However, these entertainers had not been in for a while. There were limited records to demonstrate any activity planning occurred at the home. A March 2016 activities sheet was totally blank. This meant there was limited activity occurring in the home for people to be involved with.

One person told us they were unable to watch television or listen to the radio which they liked to do. We checked the equipment in their bedroom and found there were no sockets for the television to be plugged into. There was no radio in the bedroom. The person continued saying they did not like watching television in the lounge because they could not choose what to watch. When the television was on in the main lounge staff did not ask people what they wanted to watch. In the other lounge one person had the remote control and chose what to watch without checking with the other person. At one point there was a television on silent with music on in the background. The registered manager joked with one of the people about whether they were listening to the music or watching the television; the person did not know, but had not put either on. This meant people were not having their preferences and likes checked or respected.

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

The registered manager did not seek people's feedback and did not take actions to address issues raised. Some people told us, "I haven't made a complaint but I know how to", "I don't like complaining but sometimes you have to" and "Never made a complaint but I assume I speak to [the registered manager's name]". No-one had been shown how to make a complaint. However, where people had complained they had not been listened to. Another person said, "I haven't complained about anything else; it's a waste of time" and continued "I complained to the registered manager – [they] did nothing". Other people said, "Not often I complain as it does no good" and "What's the point of complaining nothing gets done anyway". A member of staff said, "I am not sure what [the registered manager] does with the feedback or complaints" and "No-one complains about anything here. If they did, I'd have to ask the manager what to do".

People and their relatives had few opportunities to raise concerns or suggest improvements. There were no monthly meetings for people who lived at the home and their relatives. The registered manager and provider said they did not send out a regular questionnaire to people and their relatives. This meant there were no formal opportunities given for people to express their opinion and suggest improvements in their home. The provider and registered manager had no way of knowing if people were happy with the care they received and if they felt their needs were being met.

We asked the registered manager how many complaints they had received since they had been at the home; they were unable to tell us. We found a record of one complaint from March 2016. This had been resolved by the registered manager. However, there were no systems in place for recording and managing complaints.

This meant people and staff were at risk of not being listened to when they complained. When we told the registered manager and provider the feedback we received from people and members of staff they were surprised. They told us they did not feel it was good no one wanted to complain.

This is a breach in Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

A provider and registered manager have a legal duty to be open and transparent about the care and treatment a person is receiving. Prior to the inspection concerns were raised the provider and registered manager were creating documents and not being truthful. During this inspection the registered manager was asked for copies of recent staffing rotas because there were concerns about staff levels. The registered manager wanted to amend the most recent rota before making a copy. They said, "I will get [a member of staff] to come in earlier" which followed us having a discussion about staff levels. Other rotas were not recognised by members of staff who saw them. This meant the staff rotas were not an accurate reflection of the staffing cover which were on shift.

The registered manager said they were responsible for checking the competency and training of other staff. This was to ensure people were receiving safe care. We checked the registered manager's training certificate from the recent refresher course. It was a photocopy which showed they had completed all the modules. The training provider told us the registered manager had not completed the training so they had not issued a certificate. This meant the registered manager and provider were not being open and transparent about the training they had undertaken.

Two other people had been involved in incidents which the provider and registered manager had failed to inform other health and social care professionals about. Neither person had been supported after the incidents or given information about actions being taken. This meant the provider and registered manager were not fulfilling their responsibility by law to be open and transparent.

This is a breach in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people thought the registered manager and provider were good. They said, "[The registered manager] is okay" and "There is [name of registered manager] and the owner. [They] are excellent". Staff had mixed opinions about the registered manager. Some members of staff said, "I can talk to the registered manager", "[The registered manager's name] is okay" and "The registered manager is approachable". Whilst another said, "[The registered manager] has bitten off more than [they] can chew" and continued "maybe at times [they] need to listen".

The staffing structure in the home did not provide clear lines of accountability and responsibility. A member of staff told us about the staff structure with the registered manager and provider in charge followed by the acting deputy manager and then the carers. However, the registered manager said some staff were cleaners, but the staff members told us they were carers too. Other staff told us they were meant to be cooks as well as carers and the registered manager confirmed this. There was no one specifically employed to cook or clean. The staff had not received training nor had the appropriate time to fulfil these roles. Staff did not have clearly defined roles and were not given job descriptions or contracts when recruited. We asked the registered manager for a staff structure but they failed to produce one during or after the inspection. This meant people were not supported by staff that understood their roles or were clear about who they should

report to.

The registered manager did not have a clear vision for the home. There were poor communication systems between staff and management. Some staff said they thought there had been staff meeting whilst others did not remember any. There were no records of any staff meetings. Some staff said they had never had supervisions with the manager. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Some supervision records were kept loose on top of the staff files in the main office, but lacked signatures from members of staff. This meant the registered manager and provider did not have complete systems in place to support staff and identify areas for improvement.

There were audits and checks in place to monitor areas of the home such as health and safety, medicine administration and a monthly meals and nutrition audit. There had been two medicine audits in April 2016. The medicine audit had not identified some of the shortfalls found on inspection. The health and safety audit completed in April 2016 identified lifting equipment was due to be serviced However, no servicing of lifting equipment had occurred. The audit incorrectly identified all accidents are investigated by the registered manager because during the inspection we found incidents which had not been investigated. The food audit from April 2016 said menus were displayed; however no menus were displayed during the inspection. Finally, it identified food as freshly cooked, but little fresh food had been found in the home. There was a dignity audit which had the box marked yes for "Staff never administer inappropriate medication". During the inspection staff were administering a medicine to which the person could have been allergic. This meant the audits had not identified the shortfalls found during the inspection. When issues had been identified there had been no action taken to rectify them. There were no audits for fire safety, pressure care and risks assessments so shortfalls found during the inspection had not been identified by the registered manager.

The provider said they completed no additional audits to check the registered manager's audits were correct. They had no systems in place to ensure completed audits were accurate. The provider told us it was the registered manager's responsibility to run the home. This meant even though audits were being completed they had not identified shortfalls and people were at risk of unsafe care and treatment. The provider was not fulfilling a legal responsibility to ensure the home was meeting statutory requirements.

People were at risk of poor care and safety to their health because shortfalls identified had not been resolved. Prior to this inspection environmental health had rated the home one out of five stars, with zero being the lowest. The registered manager and provider had made some improvements such as staff using correct aprons and all staff completing a basic food hygiene course. However, a few months before the inspection local authority representatives had informed the registered manager and provider about the concerns in relation to training. There were no training records to identify completed and planned training for staff to ensure safe care was being delivered by staff with the appropriate skills. The registered manager explained she had received a deadline from the local authority to complete this record which was the same date as the first day of inspection. On the second day of inspection the registered manager said, "Give me an hour and they will have a training record"; this was never produced.

The registered manager was a registered nurse but they had not kept their skills and knowledge up to date. They were registered with the Nursing and Midwifery Council (NMC). The NMC is the national regulator of all nurses and midwives which set standards of education, training, conduct and performance. All nurses registered are expected to follow the code of practice laid out by the NMC. This includes treating people with dignity and respect. There was positive interaction when people required help. For example, one person

needed support during a transfer between a chair and wheelchair. The registered manager helped a member of staff. However, during the inspection the registered manager did not provide appropriate support to a person who disclosed potential abuse to the inspection team. Instead of checking the person was alright they immediately went and made a phone call. Later we learnt the registered manager had served notice on the person with the local authority because they felt the home could no longer meet the person's needs. The person said, "I am not in trouble am I?" to an inspector after notice had been served.

Another requirement in NMC code of practice included keeping people safe and raising an alert if a person is considered unsafe. The registered manager was not notifying relevant people and had not received appropriate training in safeguarding to understand their responsibilities. A registered nurse should be updating their knowledge and skills in line with best practice and recent research. Apart from one training certificate for refresher training which they had not attended, the registered manager was unable to show us any training or information to demonstrate they had been keeping up to date with best practice. The registered manager told us they were showing other staff how to complete medical procedures and support people with specific conditions. This meant people were at risk of receiving unsafe or inadequate care from the registered manger and other staff. Following the inspection we informed the NMC of our concerns and they have subsequently suspended the registered manager's nurse registration pending an investigation.

During the inspection both the provider and registered manager left the home. Their location was unknown to us. We no longer were able to contact the registered manager. There was minimal contact able to be made with the provider. This meant staff were left without clear leadership or access to finances to run the home. During limited communication with the provider we asked for information about how the serious risks to people found on the inspection were going to be immediately reduced. No full responses were received. Copies of recent services and safety certificates for specific equipment were not received or incomplete. This meant there was no guarantee the lift or moving and handling equipment were safe to be used in the home. The provider's responses had not assured us the risks would be reduced for people. People continued to be put at risk of serious harm and poor care. Therefore, the decision was reached to use our urgent powers.

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