Anchor Trust

Maple Tree Court

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

We carried out an unannounced inspection of this service on 18 July 2017. At our previous inspection, on 27 July 2017, we rated the service as 'requires improvement'. At this inspection, we found that the service still required improvement and a number of Regulatory breaches were identified. You can see the action we have taken in response to these breaches at the back of our report.

The overall rating for this service is 'Inadequate' and the service has therefore been placed into '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 service is registered to provide accommodation and personal care for up to 64 people. Care is delivered to people across four separate units. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection we were informed that 50 people were using the service.

The home had 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 and associated Regulations about how the service is run.

At this inspection, we found that the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that unsafe and unsuitable care was not always being

identified and rectified by the registered manager or provider.

The safe staffing levels set by the provider were not maintained to ensure staff were available to keep people safe and meet people's care needs.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed to promote their safety. Effective systems were not in place to protect people from the risks associated with infections.

Safety incidents were not always reported and responded to effectively, which meant the risk of further incidents was not always reduced.

The legal requirements of the Deprivation of Liberty Safeguards (DoLS) were not followed. This meant people were at risk of being restricted in an unlawful manner.

People were supported to access health and social care professionals. However, this was not always facilitated in a timely manner to promote people's health, safety and wellbeing.

Staff received some training to help them support people. However, there were significant training gaps that left people at risk of receiving poor, unsafe care.

People's feedback about their care was not always acted upon to improve the quality of care.

Most people described the staff as kind and caring. However, some people were not always treated with dignity and their right to privacy was not always respected. People were not always supported to make every day decisions about their care.

People did not always receive care in accordance with their care preferences and the information staff needed to provide consistent, effective care was not always available for them to follow. This meant some people were at risk of receiving unsuitable, inconsistent care.

People were supported to engage in leisure and social based activities. However, these did not always meet people's individual needs and were not always enjoyable experiences.

Staff were recruited safely and they knew how to recognise abuse. However, improvements were needed to ensure potential abuse was consistently reported.

People received their regular medicines as prescribed. However, improvements were needed to ensure medicines were managed safely.

People were supported to eat and drink. However, people did not always have positive mealtime experiences.

Staff told us they felt supported by the management team. However some people and the staff did not have confidence in the managers. This meant some people were reluctant to complain about their care.

People's consent was sought before support was provided. Staff understood and applied the requirements of the Mental Capacity Act 2005 which meant people were supported to receive care that was in their best interests when they were unable to make decisions for themselves.

Formal complaints were investigated in accordance with the provider's complaints policy.

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. Safe staffing numbers had not been maintained which placed people at risk of harm to their health, safety and wellbeing.

Risks to people's health, safety and wellbeing were not always assessed, planned for, managed and reviewed to promote their safety. Effective systems were not in place to ensure people were protected from the risk of acquiring preventable infections.

Staff knew how to recognise and report abuse. However, effective systems were not in place to ensure unexplained bruising was reported and investigated.

People received their regular medicines as prescribed. However, improvements were needed to ensure medicines were managed safely.

Safe recruitment systems were in place and people felt safe around the staff.

Is the service effective?

Requires Improvement

The service was not consistently effective. The legal requirements of the Deprivation of Liberty Safeguards were not followed.

There were significant gaps in staff training which meant people did not always receive their care in a safe and effective manner.

People were supported to eat and drink. However, people did not always have positive mealtime experiences.

Advice was sought from health and social care professionals. However, this was not always completed in a timely manner.

People's consent was sought before support was provided. Staff understood and applied the requirements of the Mental Capacity Act 2005 which meant people were supported to receive care that was in their best interests when they were unable to make decisions for themselves.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always treated with dignity and their right to privacy was not always respected.

Some people were not empowered or enabled to make choices about their care.

Some staff were task focussed rather than care focussed and staff did not always have the time to support people with their care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's individual care preferences were not always met.

Care records did not contain the information staff needed to meet people's individual care needs in a consistent and appropriate manner.

There was a complaints procedure in place. However, some people did not have confidence that complaints would be acted on.

Is the service well-led?

Inadequate

The service was not well led. The registered manager and provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to report and manage safety incidents, so action was not always taken to reduce the risk of further harm occurring.

People's feedback about their care was not always acted upon.

The provider notified us of reportable incidents and events that occurred at the service.

Maple Tree Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of Maple Tree Court on 18 July 2017. Our inspection team consisted of three 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 service.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with15 people who used the service, four people who visited relatives at the service and a visiting health care professional. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with staff who worked at the service to gain their feedback about the care and to check they knew how to keep people safe and meet people's needs. We spoke with eight members of care staff, a deputy manager, the registered manager and the provider's district manager. We also spoke with the provider's head of care following our inspection.

We spent time observing how people received care and support in communal areas and 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 the care records of 14 people to check they were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

After our inspection, we shared our concerns and findings with the local authority. We did this because we believed people had been placed at risk of significant harm to their health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

People told us that staff were not always available to provide them with the care and support they required in a timely manner. Comments from people included; "There are staff around but I have to wait a long time" and, "Staff are not always available and once I had to wait to 12.00pm before I got help to get up". Three of the four relatives we spoke with expressed concerns about the staffing levels at the home. One relative described staffing levels as being, "Atrocious". Comments from other relatives included, "There is definitely not enough staff. At night it's bad as you often see no staff and people are walking about asking how to get to the toilet" and, "On occasion, [Person who used the service] is unable to return to their room because of the staffing levels". Staff confirmed that they did not always have the time they needed to meet people's care needs in a timely manner. For example, one staff member told us they hadn't supported a person to change their position as often as planned as they hadn't had the time to do this. This meant that people's care needs were not always met as planned or in a timely manner because staff were not always available to do this.

People also told us that staff were not always available to promote their safety. On one unit at the service, two people told us another person who used the service often entered their room at night. Comments from these people included; "I never know what [person who used the service] are going to do" and, "I have to tell [person who used the service] to get out". Staff rota's showed that for at least a one month period, four staff were on duty at night. Staff told us that a staff member was placed onto each unit. However, during the night they had to leave their units unstaffed on a regular basis to provide care and support to people who needed the assistance of two staff. This meant that on a regular basis, some units were left unstaffed so staff were not always available to respond to people's behaviours that challenged or safety needs. This placed people at risk of harm to their health, safety and wellbeing.

The above evidence demonstrates that effective systems were not in place to ensure adequate numbers of staff were consistently available to keep people safe and meet people's care needs in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns about staffing levels with the registered manager during our inspection. They said, "I am told by [the provider] that for the amount of people in the building, four staff is enough (for nights)" and, "I work to what [the provider] gives me on the rotas". We therefore raised our concerns with the provider immediately after our inspection. They responded immediately to our concerns by increasing the staffing levels whilst a review of the care needs of people who used the service was completed. This action meant the immediate risk of harm to people through unsuitable staffing levels was reduced. We will check that safe staffing levels have been sustained at our next inspection.

We found that risks to people's safety and welfare were not consistently assessed, monitored and managed. For example, one person's care records showed they had recently fallen from their bed on at least four occasions. On three of these occasions, their injuries required assessment and treatment from paramedics. Care records showed and staff confirmed that these falls had not triggered any action to be taken to reduce

this person's risk of further injury from falling from their bed. We shared our concerns about this person's safety with the registered manager. They responded by saying, "I will look into that for you". The deputy manager later informed us that they had made a referral to a health care professional in response to our feedback. This meant that some action had been taken to assess this person's risks, but this action did not respond to the immediate risk of harm posed to this person, leaving them at risk of injury and harm.

Another person's care records showed they had been assessed by a health care professional as requiring a modified diet to reduce their risk of choking on food. We saw and care records showed that this person regularly ate foods that had been classified as unsafe for them. The staff we spoke with about this person's dietary needs were not aware of the diet that had been prescribed by the healthcare professional. This was because it was not recorded correctly in the dietary summary sheet they followed. We shared our concerns about this person's risk of choking with the deputy manager who immediately updated the dietary summary sheet, updated staff and requested a reassessment from a health care professional. This reduced the immediate risk of harm posed to this person.

We observed two members of staff support a person to move in an unsafe manner. The staff we spoke with about this had not initially recognised that the transfer was unsafe, so continued to support this person in an unsafe manner for a second time, despite the person showing signs of discomfort and distress by shouting out during the transfer. We shared our concerns with the deputy manager about this person's moving and repositioning needs and they requested an assessment from a health care professional in response to this. This meant that some action had been taken to assess this person's risks, but this action did not respond to the immediate risk of harm posed to this person, leaving them at risk of injury and harm.

Some people who used the service displayed behaviours that challenged, such as verbal or physical aggression. We found that these behaviours were not always effectively assessed and planned for, to promote people's safety and wellbeing. For example, we saw that one person had recently assaulted another person who used the service. This had not triggered a review of this person's risks, so action had not been taken to prevent a similar incident from occurring again. This meant that the risks associated with this person's behaviours that challenged towards other people who used the service had not been assessed and plans were not in place to guide staff on how to protect people from these risks.

The majority of people we spoke with told us they felt the service was clean. However, some people raised some concerns with infection control and prevention practice. One person said, "Hygiene could be improved. Now staff wear gloves and aprons but not consistently". The service had recently had a significant infection outbreak. Staff told us they knew how to manage the risk of the spread of infection. However, we observed some poor infection control and prevention practice. For example, we saw one staff member who was responsible for serving meals, leave the dining room in their blue serving apron and gloves and they entered a person's bedroom who had not yet been cleared of their infection. The staff member then left the person's room, changed their gloves without washing their hands and continued to serve other people wearing the same apron. This meant there was a risk they could spread infection to the people they continued to serve.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately after our inspection, we shared the concerns around safety at Maple Tree Court with the provider. They told us they had taken immediate action to reduce the risks associated with the above risks. The action they described was appropriate and responsive to our feedback. They also informed us that a full

review of people's risks would be completed. We will check that these reviews have been effective and sustained at our next inspection.

Staff told us how they would recognise and report abuse and care records showed that on the whole, incidents of alleged abuse that had been recorded and reported to the management team and provider, were reported to the local authority as required. However, we found that effective recording and reporting systems were not in place to respond to unexplained bruising. Care records showed that at least four people had body maps that recorded recent unexplained bruising. These bruises had not been reported to the management team, so no action had been taken to investigate the cause of the bruises, or to safeguard these four people from any potential safety risks, such as abuse. One staff member told us they did not report unexplained bruising as an incident because, "We don't know how they've done it". This meant effective systems were not in place to ensure people were consistently protected from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines as prescribed. One person said, "I get medicines regularly. They are for my own good. I get paracetamol for pain if I ask". Medicines records showed that people's regular medicines were administered as prescribed. However, we found that some improvements were required to ensure medicines were managed in a safe manner. For example, we saw that time limited medicines did not always contain opening dates, so staff were unable to identify when a medicine had become unsafe to use. We also found that the information needed to guide staff in how to administer people's 'as required' medicines were not always detailed enough to ensure these medicines were administered consistently and appropriately. The provider had already identified these areas of concern and had recommended that action was taken to make these improvements. However, action had not been taken by the management team at the service to address these concerns. Following our inspection, the provider told us how they would ensure these improvements would be made.

People told us they felt safe around the staff. Comments from people included, "I trust everybody" and, "The staff are very nice and have a smile on their face. We have never heard staff shout at anyone". Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. This showed that safe recruitment systems were in place.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we told the provider that improvements were required to the way the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were applied and followed. At this inspection, we found that some improvements had been made, but further improvements were still required.

Some people who used the service had some restrictions placed upon them to keep them safe and well. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We saw that where restrictions had been placed upon people, applications under the DoLS had been made. However, effective systems were not in place to ensure that any conditions that had been placed on authorised DoLS had been met. One person's DoLS showed that a condition had been placed on their DoLS in January 2017. This condition had not been met at the time of our inspection. This meant that the legal requirements of the person's DoLS were not being met as required. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt the staff were suitably skilled to meet their needs. However, some people thought that this was not the case. For example, one person told us, "The staff are novices". Staff told us they had received training to enable them to support people who used the service. However some staff told us and training records showed that there were training gaps. For example, some staff told us and training records showed that there were significant gaps in dementia care training. These gaps were evident from our observations of people's care experiences. Staff told us and we saw that some staff did not know how to manage people's behaviours that challenged that were associated with their dementia. For example, staff did not know how to respond in accordance with best practice when a person who used the service frequently requested to go home. We saw staff either ignored this person or told the person they could go home later. None of the staff responded to this behaviour as a potential sign of discomfort or agitation and no staff members were seen to ask the person why they felt that they wanted to go home.

We saw that when training had been delivered it was not always effective. For example, staff who told us they had received training in moving and repositioning and infection control were seen using unsafe practice. Staff who told us they had received safeguarding training, had not reported unexplained bruising as potential safeguarding incidents.

The above evidence shows that staff were not always suitably skilled to meet people's care needs in a safe and effective manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the management team told us a plan was in place to address training gaps and following the inspection, the provider also told us how they would up skill the staff. We will check this action has been effective at our next inspection.

The majority of people told us they enjoyed the quality and quantity of the food at the service. One person

said, "I get enough food. There is a choice of meals. It's brilliant". Another person said, "There is plenty to eat and drink. Staff ask if you have had enough". However, some people told us and we saw that some people's meal time experiences were not always positive. For example, one person said, "Food was good for a while but is going down again. I can't chew the gammon I got today and nobody cuts it. I can manage sausage and mash. They know I can't chew". We saw that mealtimes were mostly positive in three of the four lounges. However, in one lounge people experienced very different experiences. For example, some people were not offered all the choices available to them and we saw that food which had been used as demonstration plates and/or offered and declined by people were then served to other people who used the service. This meant that improvements were needed to ensure all people who used the service experienced pleasurable meal time experiences.

People told us they could see doctors and other health and social care professionals when they needed to. Comments from people included, "I ask the carer and tell her what's wrong if I want to see a doctor. They will decide if I need to see one" and, "The staff will phone the dentist and optician for you". Care records showed and a visiting healthcare professional told us that people's health needs were monitored as requested by them. They said, "They monitor people's weights and pressure areas" and, "They follow our advice".

Care records showed that advice and support was requested from health and social care professionals. However, this was not always completed in a timely manner. For example, a number of referrals to professionals were made in response to our feedback at inspection which meant the staff had not proactively identified the need for these referrals themselves. This meant that people were not always supported to access health and social care professionals in a timely manner to promote their health, safety and wellbeing.

People who could tell us about their care told us their consent was sought before staff offered assistance. Comments from people included; "Staff always ask, 'do you want me to help you' or they say, 'do you mind' when they wash my back" and, "They ask if they can help you". We saw that this was the case as staff asked people if it was okay to support them before they provided any support. For example, we saw staff ask people if they agreed to be supported to access the toilet before they provided this support.

Some people who used the service were unable to make certain decisions about their care. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff demonstrated they understood the principles of the MCA by telling us about how the Act applied to the people who used the service. Care records showed that the requirements of the Act were followed when people were unable to make important decisions about their care. For example, care records showed that people's ability to make the decision to live at Maple Tree Court had been assessed and their families and health and social care professionals had been involved in making this decision in people's best interests if this was appropriate.

Requires Improvement

Is the service caring?

Our findings

Some people told us and we saw that their right to privacy was not always promoted. One person said, "They don't always knock (on their bedroom door)". Another person who was talking to our expert by experience in their room was interrupted by a staff member who proceeded to complete a non-urgent care task. The staff member asked the expert by experience to leave the room to maintain the person's dignity. However, the staff member's actions did not promote their person's right to hold a private conversation in their bedroom as the care task could have waited until the conversation had ended. The person told us that the staff member's actions frustrated them. They said, "I want to be the boss of my own room".

People mostly told us they were treated with dignity and respect. However, we observed some undignified care at times. For example, one person's clothing lifted up, exposing their midriff during two transfers. Other people who used the service were present on both of these occasions which meant the person's dignity had not been promoted or maintained. We also saw that two people were repeatedly ignored by staff when they called for help. This meant these people were not treated with the respect they deserved when their requests for help were made.

People who could tell us about their care told us they could make choices about how they received their care. Comments from people included; "I can choose which food to eat and how to spend my day" and, "I go to bed at 6.00pm and get up when I want to. It's my choice. I choose what clothes to wear. I am very independent and staff encourage me to do things myself". However, people who found making choices difficult were not always enabled to be involved in this process. For example, we saw one staff member serve a person sandwiches for their lunch. They were not shown the choices on offer like other people were. We asked staff why they had not offered this person a choice. They said, "Some people are incapable of making choices, but I know their likes and dislikes". This meant that although the staff member felt they were acting in this person's best interests when making choices for them, they had not promoted or enabled the person to be involved in making even the most basic care decisions. This was not an empowering and dignified approach to care.

The above evidence shows that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people about the qualities and attitudes of the staff who worked at the service. Positive feedback included; "The staff are very pleasant, helpful and caring" and, "Well I reckon they got people who are caring. I think they can do no wrong". Negative feedback from people included; "Some staff do care and some don't" and another comment we received suggested staff were caring, but their care was limited due to the home being, "Understaffed".

We saw that staff were sometimes task focussed which on occasion, may have resulted in them appearing 'uncaring'. For example, we saw one staff member washing dishes after lunch with their back towards the people in the lounge. During this time, we saw and heard one person repeatedly shout out that they wanted to go home. The staff member did not respond to the person's shouts whilst they were washing up. Some

staff confirmed that they did not always have the time they needed to provide people with the care and reassurance needed. For example, we saw one person become agitated on a number of occasions during our inspection. For the majority of these occasions, staff did not approach the person to reassure them. One staff member confirmed this by saying, "[Person who used the service] needs reassurance, I've not really had much time to do that today". This meant that although the staff member knew how to meet this person's needs, they did not always have the time they needed to do this.

Requires Improvement

Is the service responsive?

Our findings

People's care records showed they or their relatives had been involved in the initial planning of their care needs. This was evident because most care records contained information about people's individual preferences, such as; the food people liked and disliked and people's activity preferences. However, we saw that people's individual care preferences were not always met. For example, one person's care records stated that their preference was to receive personal care from female staff. We saw that this person was assisted to use the toilet by a male member of staff, despite female staff being present at the service. When we asked staff about this they told us they didn't think that assisting someone to use the toilet was classed as personal care. This meant this person's individual care preferences were not always met.

People's care records were not always reviewed or updated in response to changes in people's needs. For example, one person repeatedly asked to go home. We saw and staffed told us that they managed this person's requests to go home differently. For example, we saw some staff ignored the person's requests, one staff member responded by saying, "Stay here with us" and another staff member said, "Would you like a drink, you can go home later". No guidance was contained in this person's care plan to help staff manage this behaviour. This meant the person received inconsistent care that did not meet their individual needs.

We saw that staff engaged people in leisure based activities at the service. However, they were not always tailored to meet people's individual needs. For example, we saw a group of people were supported to paint. The equipment provided met some people's needs, but not others, which caused one person to become agitated. We also saw that staff were not always available to support people to participate in enjoyable leisure and social based activities. For example, we saw a staff member facilitate a sensory based reminiscence session where people were guided to recall experiences from being outdoors. Outdoor sounds and smells were used to help people recall previous memories and experiences. However, the session was interrupted on multiple occasions as the staff member had to answer the phone and look for other staff to send to another part of the service. The sounds CD was also left on after the session had finished which meant people were listening to a loud thunder storm. This caused some people to become confused as it was a sunny day. We observed people saying, "Where's that coming from? It sounds like the roof is caving in" and, "It can't be the TV, there's no pictures on". This CD was turned off by the cook who entered the room and identified that it was inappropriate. One person responded to this by saying, "Thank goodness for that". This meant the sensory reminiscence session was not facilitated in a manner that promoted people's enjoyment and participation.

There was a complaints policy in place and we saw that formal complaints had been investigated in accordance with this policy. We received mixed feedback from people and their relatives about the complaints process at the service. Some people told us they felt able to raise complaints and were happy with how these were responded to. Comments to support this included; "I complained about care staff working in the kitchen. Now care staff don't work in the kitchen" and, I complained about staff sleeping at night to the area manager. I complained verbally, my complaint was sorted". However, some people told us they were reluctant to make complaints as they lacked confidence in the management team. Comments from these people included; "I have little confidence in the manager" and, "We can approach the manager,

but things are not always changed". This meant some people did not have confidence in the complaints procedures at the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we told the provider that improvements were needed to the way the service was managed. At this inspection, we found the required improvements had not been made.

Some people and their relatives told us they did not have confidence in the management team. For example, a number of people and staff told us they had raised concerns about staffing levels at the service, but they told us that no action had been taken to address these concerns. We found that effective systems were not in place to ensure safe staffing levels were maintained. The provider's minimum safe staffing levels had not been maintained for a significant period of time and the registered manager could not demonstrate that they had taken action to address this.

The service used an electronic call bell system. Therefore we asked the registered manager for a copy of the call bell response times so that we could review how long people had to wait for assistance when they requested it. The registered manager told us they had been unable to access this information for a significant period of time, which meant they had not been monitoring call bell response times to assess if people had received their care in a prompt manner to promote their safety and meet their needs.

People told us that they attended meetings where they discussed their thoughts on the activities and food at the home. However, their feedback about their care was not always acted upon. For example, minutes of these meetings showed that people had requested to go on day trips and participate in activities outside of the service. People told us their feedback had not been acted upon. Comments from people included; "We haven't had an outing to a restaurant and there have been no walks .There's not enough staff" and, "It would be nice to go to the shops". The registered manager confirmed that there had been no day trips because of, "Staffing levels". This meant that people's feedback had not been used to improve the quality of their care.

Effective systems were not in place to ensure safety incidents were appropriately reported. For example, four people's unexplained bruising had not been reported by staff to the management team as staff did not think unexplained bruising was a reportable incident. We also found that safety incidents were not always investigated or managed effectively to prevent further incidents from occurring. For example, at the time of our inspection, no action had been taken in response to a person's risk of falling from their bed, despite falling and injuring themselves on at least four recent occasions. This showed that lessons were not always learned from incidents to improve people's safety and wellbeing.

The information contained in people's care records was not being effectively monitored or analysed by the registered manager or provider to ensure people's needs were being managed effectively. For example, the registered manager and provider had not identified that plans were not always in place to help staff manage people's behaviours that challenged. They had also not identified that one person's prescribed diet had not been incorporated into their care plan. This resulted in the person receiving potentially unsafe care as it was not in accordance with professional advice.

Effective systems were not in place to ensure equipment was being used safely. For example, we viewed two

staff members using a hoist to support a person to move in an unsafe manner. Other staff were present in the room during the transfer, but none of the staff had recognised that the transfer was unsafe. This resulted in that person being exposed to a significant risk of harm.

Effective and timely action was not taken in response to concerns identified through provider audits. For example, a provider audit completed the month before our inspection had identified the medicines issues we found. However, no action had been taken by the registered manager to address these issues. This meant people had continued to be exposed to the risks associated with medicines as action had not been taken to mitigate these risks.

Staff told us they felt supported by the management team and they had regular meetings with senior staff to review their development needs. However, we found that significant gaps in the staffs' knowledge and skills were not being addressed promptly to ensure people's needs could be met in a safe and effective manner. This meant some people's needs were not met in a consistent and suitable manner as staff did not always have the skills required to do this. For example, some staff had not been trained in dementia care and we saw that people's dementia care needs were not always met in line with best practice.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following our inspection, we shared our findings and concerns with the provider. They sent us a detailed action plan that showed how the immediate safety concerns had been addressed and how they planned to make improvements to the quality of care at the service. This showed the provider was responsive to our feedback and committed to make the improvements required. We will check these improvements have been made at our next inspection.

The registered manager and provider notified us of reportable incidents that occurred at the service as required.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people consistently received their care in a safe manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems were not in place to ensure people were consistently protected from the risk of abuse. The legal requirements of a person's DoLS were not being met as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective systems were not in place to ensure adequate numbers of staff were consistently available to keep people safe and meet people's care needs in a timely manner. Staff were not always suitably skilled to meet people's care needs in a safe and effective manner.

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 Effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing.

The enforcement action we took:

We told the registered manager and provider to make the required improvements by 25 September 2017.