Healthcare Homes (LSC) Limited

Blandford Grange Care Home

Inspection report

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Date of inspection visit:
21 February 2018
23 February 2018

Date of publication:
13 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blandford Grange Care Home is purpose built to accommodate up to 63 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation is spread over three floors. At the time of our inspection there were 54 people living at the home.

This inspection took place on 21 and 23 February 2018 and was unannounced.

There was a registered manager in post. 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.

This was the first inspection of this service since it was registered with Healthcare Homes (LSC) Limited.

Risks associated with some people's behaviour were not effectively managed. Care plans lacked detail to support staff to meet people's needs.

There were not enough staff to support people that presented a risk to themselves and others. There were not enough staff to provide meaningful activities for people and to be supported to pursue individual interests. We have made a recommendation about the review of staffing levels in the home.

Staff knew how to identify and respond to abuse. Concerns had been shared with the local authority by the registered manager.

Medicines were administered safely but improvements were required to how 'as and when' (PRN) medicines were monitored for their effectiveness.

Improvements were required to improve the cleanliness the home.

Staff's employment history and suitability were checked before they started working at the home.

Premises and equipment were managed to keep people safe.

Staff required more training and support to meet the needs of people living with dementia including supporting people with behaviours that may challenge others.

People received support from staff to eat and drink where required.

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards at this service. Care homes must follow the Deprivation of Liberty Safeguards otherwise this is unlawful.

Relatives and people gave us mixed feedback about how the home had ensured that staff got to know people and treat people with compassion and as individuals.

Staff did not always communicate with people in accessible ways that took into account any sensory impairment which affected their communication.

People did not always receive care that was responsive to their needs and improvements were required to the home's approach to person centred care.

People's preferences and choices for their end of life care were discussed with them and recorded in their care plans.

The service did not have a clear strategy for how it supported people living with dementia.

There were systems in place to track incidents and accidents in the service but this was not always effective to identify action required and review care provided.

Arrangements for oversight of the service required improvement to identify and respond to concerns and risks.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read at the back of the full report what action we have told the provider to take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks associated with some people's behaviour were not effectively managed.

Medicines were administered safely but improvements were required to how 'as and when' (PRN) medicines were monitored.

There were not enough staff to provide meaningful activities for people and to manage risks.

There were arrangements in place to check staff employment history and suitability before they started work.

Is the service effective?

Requires Improvement

The service was not always effective.

Care and support provided did not reflect current evidence-based guidance and best practice on meeting the needs of people with dementia.

Staff required more training and support to meet the needs of people living with dementia.

Staff told us there was a formal supervision system in place and they felt supported by their supervisors.

People received this assistance to eat and drink in line with their assessed needs.

The home did not follow conditions attached to Deprivation of Liberty Safeguard authorisations.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not ensure that staff got to know people and

provide person centred care.

We observed the majority of staff talking to people in a friendly way and people looked relaxed in their company.

Improvements were required to support staff to communicate with people in accessible ways that took into account any sensory impairment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was responsive to their needs.

People's care plans lacked information about people's individual needs.

The provider had arrangements in place to respond to complaints and a complaints procedure.

People's preferences and choices for their end of life care were discussed with them and recorded in their care plans.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements were required to how the service was monitored and systems reviewed.

People told us they felt the service was well managed.

The provider had been proactive at identifying additional resources to support the improvements required and this was on-going.

Blandford Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

Blandford Grange Care Home accommodates up to 63 people in one purpose built building.

This inspection took place on 21 and 23 February 2018 and was unannounced. The inspection was completed by two adult social care inspectors and one specialist advisor who was a registered nurse.

Before the inspection we reviewed other information we had received about the home, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We gathered this information during the inspection. We obtained the views of the service from the local safeguarding team prior to our inspection.

During the inspection we spoke with five people and six relatives about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia, and were unable to communicate their thoughts. We therefore 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 spoke with the registered manager, deputy manager, regional director, regional manager and 10

members of staff. We also spoke with three health professionals.

We looked at care documentation relating to seven people, six people's fluid monitoring records, three people's authorised Deprivation of Liberty Safeguards, medicine administration records, five staff personnel files, staff training records and records relating to the management of the service including quality audits.

Requires Improvement

Is the service safe?

Our findings

People were not always able to tell us about their experience of living at Blandford Grange Care Home. We observed that the risk associated with some people's behaviour were not effectively managed. Staff were not always present in communal areas as they were providing care to other people. This meant there was a risk that people would not receive adequate support to keep them safe. The majority of staff told us they felt the home required more staff. The majority of relatives and one person told us they felt people were safe. However one relative told us they did not think there was enough staff at times to keep people safe. Staff told us they felt confident that the registered manager would respond to any individual concerns.

Risks associated with some people's behaviour were not effectively managed by the home. We looked at three people's care plans that presented risks to others due to their dementia care needs. All three care plans lacked sufficient detail to advise staff how to support people safely. Three healthcare professionals told us that there was not a consistent approach by staff and advice given was not always followed. For example, for one person the community mental health team (CMHT) advised the home this person should be supported to go outside to reduce incidents of challenging behaviour, and any incidents of challenging behaviour needed to be recorded to monitor the person's care needs. This information had not been handed over to a member of staff responsible for reviewing the person's care plans. The person had not been supported to go outside and records lacked details.

People who presented risks to themselves and others were not adequately supervised. The registered manager told us some people had behaviour that challenged others, and staff had to intervene at times to keep people safe. This had resulted in incidents of staff being hit by people and staff intervening to keep people safe. Staff were not able to supervise people at times as they were providing care. People that presented risks to others and themselves spent time in the communal areas at times without any member of staff close by. One relative told us, "At times there are not enough staff to keep people safe".

For another person who presented risks to themselves and others, not all staff felt confident about how to manage these risks. One member of staff told us they were not aware of the care plan for how these risks should be managed. The person's care plan lacked detail how staff should mitigate any risks and how to support the person. The registered manager told us staff had to move the person away from other people at times as they presented risks to themselves and other people that lived there. One healthcare professional gave us positive feedback about how one member of staff supported this person but they told us this was not consistent across the team.

The provider had systems in place to learn from safety incidents and concerns but further improvements were required to implement required actions. For example, assessments of incidents in the home had resulted in some changes to manage risks. Following an incident in the home a television had been secured to the wall to prevent harm. One member of staff told us, "the new TV had now been secured to the wall, we try to keep a member of staff in the lounge and everyone is on safety observation which is recorded hourly to ensure everyone is safe". However incidents of staff being hit or incidents between people were not adequately reviewed to identify how risks should be managed and how staff should be deployed.

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

Healthcare professionals that we spoke with raised concerns about staffing levels in the home. The majority of staff that we spoke with told us there were not enough staff to meet people's needs. One member of staff told us "There is not enough staff to supervise people" and "If staff had more one to one time with people, residents would be happier". Another member of staff told us staffing levels had been raised in meetings and, "An additional staff member would assist the shift during the day".
There were not enough staff to provide meaningful activities and support to allow people to pursue their interests or be supported to go outside. One healthcare professional told us, "More staff are needed as patients don't get the input they need". One person's relative told us their relative was bored and needed "better stimulation" to support their dementia care needs and "had never been taken out". Opportunities in the home for person centred one to one activity were limited due to staffing levels. Activities provided were not based on people's interests or with reference to good practice for supporting people living with dementia. One member of staff told us they were not able to support people to go outside because of staffing levels. People were not supported to go out of the home to activities to support their wellbeing.

We recommend that the provider reviews staffing levels to ensure people's needs are met.

Where people were at risk of skin damage pressure relieving equipment was in place and being used correctly. However we received information following our inspection of the an outcome of a safeguarding investigation that concluded that the home had failed to maintain one person's skin integrity as recording and communication to staff of the person's needs were not satisfactory. Referrals were made to healthcare professionals for advice on how the registered nurses were managing pressure sores, ulcers and wounds. This advice was followed and any wounds were monitored and treatment provided as required. Other risk management plans, such as people at risk of choking that required thickened fluids or modified diets were in place. Staff were aware of these risks and how they should be managed. Systems were in place to check air mattresses, bed rails and oxygen in the home on a daily basis.

Staff told us they knew how to contact the local authority safeguarding team if they witnessed any abuse and that people were safe. The registered manager had shared safeguarding concerns with us and the local authority prior to and after our inspection. These concerns were being investigated at the time of the inspection. This information of concern had also been shared with the families of people that it affected.

The registered manager told us the home used temporary clinical staff in response to vacancies and this had an impact at times on the continuity of care. One relative told us their main concern was "About a lack of continuity" as the home was having to use a lot of agency nurses. Other comments from relatives included, "The agency staff do not have the experience of supporting people with dementia" and "There is lots of agency staff. They do not know the residents". The registered manager told us recruitment was being undertaken to recruit permanent nursing staff. The provider wrote to us following our inspection and told us the home told us they were developing a more robust handover sheet to improve information handed over to staff.

Medicines were administered safely but improvements were required to how 'as and when' (PRN) medicines were monitored for their effectiveness and reasons for them being given. Protocols for people prescribed PRN medicines for symptoms of anxiety and agitation lacked detail to guide staff. For example, two people's PRN protocols did not detail other approaches to try first before medicine administered and administration records lacked detail of care to evaluate their effectiveness. For example, for one person on four out of ten occasions the medicine administered was recorded as not effective. PRN administration records should

detail the reasons for administration, its effect and other care interventions tried by staff.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine administration records (MAR) were accurately completed and had a current photograph of the person. Staff were trained and assessed to make sure they were competent to administer people's medicines. Staff told us that they had received training in the administration of medicines and their competency had been checked. Action had been taken when a medicine error had been found and advice sought from people's GPS. A medicine error by a temporary registered nurse not administering medicine to 15 people on one occasion was identified at the next time medicine was to be administered and advice sought from the GP's of the people affected and this information shared with relatives.

Improvements were required in regards to how the home was cleaned and maintained to maintain cleanliness standards and infection control. The home was unclean in places, with dirty marks in areas such as on walls near key pads, some chairs had ripped fabrics, stained sinks in the kitchenette and an empty room with an unclean mattress and chair. Three relatives told us they had to raise concerns about the cleanliness of the toilet in their relative's room and two relatives told us they had raised concerns about the cleanliness of bedrooms. One relative raised concern with a member of staff during our inspection. All relatives told us any concerns about dirty toilets were responded to. One member of staff told us that domestic staff cleaned resident's en-suites, including toilets each morning but after that care staff were responsible. They told us there had been several complaints about the cleanliness of toilets from visitors. We raised our concerns about the three chairs with ripped fabric in one of the lounges with the registered manager. Chairs with ripped fabrics cannot be cleaned effectively and therefore compromise infection control procedures. The provider told us they would arrange for the chairs to be removed.

Staff understood what infection control procedures they should follow but some improvements were required to display hand washing advice for staff and visitors to the home. The home had been closed in December 2017 and January 2018 as some residents had experienced diarrhoea and vomiting and flu. The registered manager wrote to us in January 2018 and told us what actions they had taken to manage these risks. Staff understood their responsibilities around protocols to follow when a resident had a contagious virus. A member of staff told us that individual people's rooms were deep cleaned after the norovirus but they were not aware of how the virus spreads. Staff were aware of infection control procedures including the use of appropriate coloured bags for laundry and the use of aprons and gloves when providing care. All communal toilets had soap and paper towel units but not every basin had a chart showing the safe stages of hand washing. Good hand hygiene is important to stop the spread of viruses such as norovirus.

Premises and equipment were managed to keep people safe. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment and lift maintenance. Fire checks were carried out weekly in accordance with fire regulations.

Requires Improvement

Is the service effective?

Our findings

Care and support provided did not reflect current evidence-based guidance and best practice on meeting the needs of people with dementia, including NICE guidance. People's physical, mental health and social needs were not adequately assessed together to deliver person centred care that achieved good daily outcomes for people.

Care plans did not have sufficient detail to ensure care provided was consistent in approach. Improvements were required to update care plans and risk assessments to ensure the plan of care was based on advice from healthcare professionals and best practice. For example, one person's care plan stated the person is anxious and needs support. There was no guidance for staff how to provide the support. For another person, two members of staff told us not all staff understood how to meet their needs. One member of staff told us it was important to keep their voice quiet when supporting one person. However they told us, "Some staff speak loud when approaching them and this triggers some of their behaviours". One member of staff told us handover was not consistently good to ensure they were aware of changes to people's needs.

All staff told us they required more training and support to meet the needs of people living with dementia including supporting people with behaviours that may challenge others. One member of staff told us the provider had not provided training to them on how to "calm dementia patients" and "feels this should be provided". Another member of staff told us, "I do not feel confident about dealing with challenging behaviour". The provider wrote to us following our inspection and told us that all staff would receive two days dementia care training by the end of March 2018 and this training would include person centred care, deprivation of liberty safeguards and distressed behaviour. Healthcare professionals told us they felt staff required more training and support on meeting people's needs living with dementia.

Staff told us they received regular training to give them the skills to understand other aspects of their role, including infection control, equality and diversity and supporting people to move. New staff were supported to understand their role by working with experienced staff until they were assessed as being competent. For example, one member of staff told us the home had an in house trainer on moving and handling who provided training and support to staff. Another member of staff told us they were being supported to gain qualifications to progress in their role. The registered manager had a record of all training staff had completed and when refresher training was due, which was used to plan the training programme. Care staff were supported to complete formal national qualifications in health and social care. Qualified nurses employed as permanent staff were supported to keep their skills up to date and maintain a record of their continuous professional development.

Staff told us there was a formal supervision system in place and they felt supported by their supervisors. One member of staff told us they received regular supervision and appraisal by the nurse in charge or registered manager. Another member of staff told us they could approach their unit manager for advice and support.

People were referred to healthcare professionals when necessary, such as their GP, specialist nurses or hospital clinics. One person's relative told us staff were supporting their relative to manage their physical

health condition. People's care records described the support they needed to manage physical health needs, such as diabetes and ulcers. There was information in care plans about monitoring for signs of deterioration in people's conditions, details of support needed and health staff to be contacted. The registered manager told us the Community Mental Health Service were concerned about how the home was supporting some people and was going to write to them to make recommendations. Health care professionals raised concerns with us that staff do not consistently follow their advice and information from the home is not supported by good recording of deterioration in people's conditions or changes in behaviour. The registered manager told us the home was working with a GP service to improve how information was shared with GPs following concerns.

People received support from staff to eat and drink. People received this assistance in line with their assessed needs. We observed staff supporting people to drink and had access to drinks throughout our inspection. Staff provided support by sitting alongside people and allowing them time to eat and swallow. Lunchtime was calm and some people chatted to one another. People were offered choices of what they wanted to eat from a menu but people were not supported to make choices using pictorial images or larger print. People's likes and dislikes in terms of food and drink were known by the kitchen staff, along with any known allergies. One person's relative told us, "Food is excellent" and "always fresh vegetables". The registered manager told us the home was purchasing one pictorial menu board for the first floor only.

People's relatives told us they were involved in decisions about their care. We observed staff checking with people before providing any care or support. However two relatives told us they were not involved in decisions around how staff support their relative with behaviours that may challenge others. 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 legally authorised under the MCA. Staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity.

People's care files recorded best interest decisions made on behalf of people who lacked capacity. Improvements were required to record where relatives or those with power of attorney had been involved in the decision making. Those seen related to personal hygiene, supporting people to eat and drink and administering medication. Documents were completed by staff that worked in the home and recorded whether people had representatives who could be consulted, such as relatives or those with power of attorney. The majority of relatives we spoke with confirmed they had been involved in decision making.

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards at this service. There were conditions attached to the DoLS authorisations for three people. Care homes must follow the Deprivation of Liberty Safeguards otherwise this is unlawful. These conditions were not followed. Those seen related to accessing the community, confirmation to the authorising authority of the person was settled living in the home and staff completing records of any behaviour that may challenge others. The provider wrote to us following our inspection and told us they would take immediate action to ensure these conditions were adhered to.

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

Arrangements were in place to handover information to staff. However improvements were required to ensure that all relevant information was handed over to staff in an effective way. Some staff told us that

information about people's needs or changes were not consistently handed over to them. One member of staff told us, "Communication is lacking between night and day staff" and "don't speak to night staff as they leave when we come on duty as not involved in handover". Another member of staff told us information about a person's review of care with healthcare professionals had not been handed over to them. The registered manager highlighted that on occasions a temporary registered nurse will handover to another temporary nurse because of permanent vacancies. They told us they were taking actions to ensure permanent care staff attend these handovers to ensure all relevant information was shared. The provider wrote to us after the inspection to tell us that a more robust handover document was being developed to improve communication.

Improvements were required to the environment to support people with dementia. Gardens and outside space were not accessible to everyone and people were not supported to access them. There were some visual prompts outside people's rooms to support people living with dementia. However additional improvements were required, including signage in the home to improve people's quality of life and to support their independence. The provider told us during the course of our inspection they had commissioned someone to carry out an audit of the environment to identify improvements to support the needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Relatives and people gave us mixed feedback about how the home had ensured that staff got to know people and provide person centred care. Some relatives told us, "very pleased generally, staff are kind and responsive" and another relative described staff as "lovely". However one relative told us, "There are lots of agency staff, they don't know the residents". One person told us, "Some staff talk, some don't". We observed the majority of staff talking to people in a friendly way and people looked relaxed in their company. However staff were not able to spend time to talk with people for a meaningful length of time before moving onto another care task or arranging group activities for people. One member of staff told us they felt some staff did not explain what they are doing when assisting someone and told us some staff can be "abrupt". We asked one member of staff why someone was crying out. They told us, "I don't know, her habit I think". People did not always receive care to support their wellbeing and emotional needs.

Care planning and staff deployment did not ensure people received support in their preferred way. People's relatives told us they were kept informed but some relatives told us the home did not do enough to support people as individuals. For example, one relative told us their relative was not supported to go outside and this was important to them. Another relative told us staff did not do enough to support their relative to reduce the amount of time they spent in their room. Not all staff demonstrated a good understanding of what was important to people and how they liked their support to be provided. For example, two staff we spoke with did not know any information about people's history and what was important to them.

Staff did not always communicate with people in accessible ways that took into account any sensory impairment which affected their communication. Staff were aware of people's hearing and sight loss but there were no visual aids available for staff to use to assist communication. Some people were not always able to speak. One member of staff told us the home had used communication cards to support individual people but they did not know where they were. Care plans contained some information about how people with sensory impairments expressed their needs but these plans required more detail.

The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The registered manager told us they had plans to introduce other resources, such as communication cards for other residents and larger print to improve how the home supports people to understand information. Handover information given to staff did not detail people's communication needs.

Staff respected people's privacy but improvements were required to how people's dignity and independence were respected and promoted. One person who required support with washing and dressing were observed with their clothes unbuttoned that did not support their dignity. Another person did not look like they had received support with their personal hygiene and were not well presented. A member of staff assisted this person later that day to have personal care.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. Three healthcare professional told us they felt improvements were required to the home's approach to person centred care. One healthcare professional told us one person needed, "more meaningful person centred care". Another healthcare professional told us the home did not support people to follow their interests in order to meet their needs and did not follow their recommendations. Relatives told us staff responded quickly when people needed assistance. Two healthcare professionals were positive about an individual care worker's approach but told us this was not consistent across the staff team. Three staff gave us different answers on how staff support one person who had behaviours that challenge others.

We observed that some people were supported by staff to attend music performances in the home. The people that attended looked like they enjoyed it and some people were joined by their relatives. One person's relative confirmed their relative had enjoyed the music sessions. Staff spent some time with people talking to them and painting their nails but the time was limited and interrupted by other tasks. Some people spent time on their own without activity. One person told us they just closed their eyes and pretended to sleep and they did not know anyone in the home. One relative told us their relative needed more person centred input from staff. One member of staff told us one person asked them to support them to go out but they could not do this because of staffing levels. Care plans lacked information on how to support people to maintain their independence.

People's care plans lacked information about people's individual needs. For example, one person's care plan said they were anxious and required support. It did not detail how staff should provide this support. For another person, their care plan said the person can present behaviours that challenge. The care plan records that the person has been referred to other healthcare professionals but it did not record how staff should support the person. There were a number of incidents recorded of the person becoming distressed and hitting staff. Records of care from staff recorded that a member of staff had tried to reassure the person but that this did not work so "they walked away" in order to leave the person to calm down. The registered manager told us staff had to use a soft hold technique for one person to keep other people safe at times when they became very distressed. This approach was not recorded in the person's care plan. Staff told us they left another person to calm down when they become distressed and took action to make sure other people were safe. One heath care professional told us some staff did not always respond in the right way when the person presented behaviours that challenge and this "made the situation worse".

People's preferences and choices for their end of life care were discussed with them and recorded in their care plans. For two people, there was an end of life care plan in place that recorded their wishes, including their spiritual needs and who they wanted to be with them. Where people lacked capacity to communicate all of their end of life wishes, families and people with power of attorney had been involved in developing this plan. However for another person, their care plan said the person was unable to participate in discussions in their end of life wishes "due to cognitive impairment". The person had an appointed person with power of attorney for health and welfare. The care plan said the care staff should follow the instructions from the person's appointed power of attorney at the time.

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

The provider had arrangements in place to respond to complaints and a complaints procedure. The home had received over ten complaints in the last six months about individual registered nurses employed by the home on a temporary basis, cleanliness and standard of care. Complaints received had been responded to and actions taken to share concerns with the safeguarding authority where necessary. However there was a lack of oversight over complaints to identify any emerging trends and whether further actions were required.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a clear strategy for how it supported people living with dementia. The governance and leadership of the home did not always support the delivery of person centred care and was not clear. The provider's approach to supporting people whose behaviour many challenge others was inconsistent. The registered manager and a healthcare professional told us 'soft hold techniques' were used in the home. A senior manager told us the provider did not support this approach.

Staff were not supported to understand how to meet people's needs, or deployed to ensure continuity of care and effective care review. For example, temporary registered nurses were asked to carry out care reviews without knowing all information about people. Healthcare professionals raised concerns with us about "a lack of senior management support for nurses", concerns about how information was shared and the home's approach to person centred care.

There were systems in place to track incidents and accidents in the service but this was not always effective to identifying action required and review care provided. We looked at some incidents and accidents over the last three months along with behaviour incidents recorded in care records. Not all incidents recorded in care records were included in these audits. The outcomes of these audits recorded actions such as referrals made to the safeguarding authority, risk assessment to be updated and referral to healthcare professional. The risk assessments reviewed following incidents lacked detail of control measures to prevent future incidents and guidance for staff. This meant that people were at risk of receiving unsafe or inappropriate care. Provider visit audits did not review risk assessments for individual people or incidents of harm.

The home had a number of audits in place that included care plan audits, tissue viability, fire safety, and weight and falls tracker. The registered manager had also used a home development plan to identify improvements. However this was very long and they told us they no longer used it to record improvements for the home. We found at this inspection that the provider's approach to governance did not effectively identify the concerns we found at this inspection. This included DoLs conditions not being adhered to, staff not supported to carry out their roles, cleanliness of the home and people's needs not being met.

Arrangements for oversight of the service included feedback from people, relatives and staff. Feedback received was not always effectively responded to, in order to monitor and improve the service. Concerns raised in a relative's meeting in January 2017 included concerns about some staff's ability to communicate effectively where English was a second language and some resident's behaviour upsetting other residents. These issues were still present during our inspection and had not been effectively responded to. At another resident's meeting in February 2018, residents fed back that they wanted to go out on trips from the home. The minutes recorded that the last outing planned for in June 2017 was cancelled due to the "hot weather" and "lack of staff". There was no timescale recorded in the resident's meeting of when this would be organised by. The timescale recorded was "ongoing".

Staff raised concerns in a staff meeting in November 2017 about communication between staff within the home, including between day and night staff. One member of staff told us that, "Communication was

lacking between night and day staff" as night staff were not involved with handover meetings.

Care plans and records had not all been updated and lacked information in places. The registered manager told us the home was undertaking a transfer of people's care information onto new care planning documentation. Daily records such as fluid monitoring had also not been fully completed. Record forms of any activities offered to people, recorded observations such as person "walking around the corridor" rather than support offered by staff. Records of any behaviour that challenge were not completed fully. One healthcare professional told us this had an impact on how the home was able to communicate any changes in someone's symptoms and the plan of care. The provider had deployed additional staff from other services to support the home with regard to the care planning process.

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

The majority of relatives and all staff told us they felt the registered manager would respond to any concerns they had. All staff told us they felt supported by the registered manager and could always approach the registered manager. Some staff told us they felt the registered manager could not always make changes, like increasing staffing as the provider would not always support these changes. Three relatives told us they were concerned about the continuity of care provided and cleanliness in the home. One relative told us they had raised their concerns recently about continuity of care with the registered manager.

Personal confidential information was securely stored in locked offices and cabinets. Staff were aware of the need to ensure information remained secure. We observed staff closing doors where records were stored to ensure confidential information was not left unsecured.

The registered manager understood their legal responsibilities and ensured that the local authority's safeguarding team and the CQC were notified of incidents that had to be reported and maintained records of these for monitoring purposes.

The registered manager and provider responded to the concerns and shortfalls identified and provided an action plan following feedback at the end of the inspection to address the improvements 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 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured care was assessed and planned in ways that met people's individual needs and preferences. Regulation 9 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not taken effective action to assess risks to people using the service and to mitigate those risks. Regulation 12(2) (a) (b)

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 The registered person did not ensure that people deprived of their liberty were treated in accordance with conditions from the supervisory body. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not taken effective action to assess, monitor and improve the quality of the service provided. Accurate, complete and contemporaneous records were

not being kept in respect of each service user. Regulation 17 (2) (a) (c)