Gainford Care Homes Limited

Lindisfarne Ouston

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 4, 5 and 10 August 2015 and was unannounced. This meant the provider and the registered manager did not know when we planned to carry out the inspection.

We carried out our last inspection in June 2014. During the inspection we found breaches of the regulations relating to people's care records. The provider submitted an action plan to us telling us how they were going to improve. We found not all of the improvements had been made within the timescales identified by the provider.

Lindisfarne Ouston is registered with the Care Quality Commission (CQC) to provide residential and nursing care for up to 49 people. During our inspection we found there were 36 people in the home, although this varied slightly due to people being admitted and discharged on a respite basis. Each person had their own room with ensuite facilities. The home had a sensory room and outside space including a garden and a veranda. At the time of our inspection no-one was deemed to require nursing care and there were no nurses employed by the service.

Summary of findings

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

The service 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.

Improvements were needed in many areas where the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had a registered manager in post.

We found the home did not follow the provider's guidelines when administering people's topical medicines.

The registered manager showed us using a dependency tool they provided more staffing hours than was required. However we raised concerns about the numbers of staff employed on a night time and recommended the provider review their staffing levels.

We found people's weight measurements were listed in different files and there was consistent method used to record people's weights. Some people had lost weight and the provider had not taken appropriate action.

People's fluid intake was not being robustly monitored. Staff repeatedly wrote in people's daily records, 'Good food and fluid intake' when there was no prescribed amount of daily fluid in place for any person. Variations in people's fluid intake did not trigger any action or changes in care planning.

We found people in the home whose dignity was not preserved.

We observed staff regardless of their role responding to people and offering help to get them where they wanted to go.

Not all staff had met with their line manager for a supervision meeting to discuss their progress, their training needs and any concerns they may have in line with the provider's supervision policy. We also found a number of staff who had not received an annual appraisal.

We found the procedures outlined by the provider had not been used by the registered manager to investigate complaints. The system used by the manager was incomplete. We were not assured people's complaints had been appropriately managed.

We found people's care plans were out of date, contained conflicting information and when reviewed found changes in people's care needs were not reflected in their care plans. The registered manager told us this was an area for improvement.

Activities provided by the home were not person centred and activity care plans were not aligned with other social activities plans in people's care files. We found people had stated their preferred activities but these were not always carried out by staff.

People's needs to evacuate the building in an emergency had been assessed and their support needs were documented on one sheet in the downstairs nursing station which was accessible to emergency services.

We found regular checks were carried out including fire, water and emergency lighting to ensure the safety of the building.

The provider's recruitment processes were robust and appropriate checks had been carried out on staff to ensure they were able to work with vulnerable people

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

We found regular checks were carried out to ensure the safety of the building.

We found there was a lack of staff accountability in the way people's topical medicines were administrated and the home did not follow the provider's policy.

The provider's recruitment processes was robust and appropriate checks had been carried out on staff to ensure they were able to work with vulnerable people.

Is the service effective?

Inadequate 

The service was not effective.

People had lost weight and the home had failed to take appropriate actions.

People's fluid intake was not being robustly monitored. Staff repeatedly wrote in in people's daily records, 'Good food and fluid intake' when there was no prescribed amount of daily fluid in place for any person. Variations in people's fluid intake did not trigger any action or changes in care planning.

Not all staff had received supervision and an annual appraisal in line with the provider's policy.

Is the service caring?

Requires Improvement 

The service was not always caring.

We found staff did not always support people's dignity.

We observed staff regardless of their role responded to people and offered help to get them where they wanted to go. Domestic and maintenance staff offered support to people in the home.

We observed staff treated people with care and provided them with an explanation when for example they were using a hoist to enable people to access the dining room.

Is the service responsive?

Inadequate 

The service was not responsive.

We found the procedures outlined by the provider had not been used by the registered manager to investigate complaints.

We found people's care plans were out of date, contained conflicting information and when reviews identified changes their care plans had not been altered.

Summary of findings

Activities provided by the home were not person centred and activity care plans were not aligned with other social activities plans in people's care files.

Is the service well-led?

Inadequate

The service was not well led.

We had received no death notifications from the home since October 2010. We found other notifications concerning injuries to people and DoLS had not been submitted to the CQC.

The registered manager had failed to be accountable to the regional manager and had not completed a weekly risk report for people's weight loss in the home.

We found the records in the home did not demonstrate the regulatory requirements.

Lindisfarne Ouston

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 4, 5 and 10 August 2015 and was unannounced.

The membership of the inspection team consisted of a one lead adult social care inspector and three other adult social care inspectors who visited the home, one on each of the inspection days.

Prior to the inspection we reviewed information available to us, this included provider statutory notifications. No concerns had been raised with us by local commissioners or safeguarding team about the service.

During the inspection we spoke with the registered manager, the regional manager, the provider and thirteen staff including care and support staff. We also spoke with six people who used the service and five relatives. We reviewed eleven people's care records and looked at four staff recruitment records.

Before the inspection, we did not ask 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. During the inspection we asked the registered manager and staff members what they did well and the plans they had to continuously improve the service.

Requires Improvement

Is the service safe?

Our findings

Relatives told us their family members were safe. One family told us they had looked at a number of homes and found Lindisfarne Ouston to be the best one. One person who lived in the home said, "It's a nice area. I definitely do like living here. I am here all the time."

We looked at the accidents and incidents which were recorded in the home and found some people's falls had resulted in them receiving injuries and being admitted to hospital. The registered manager had oversight of the accidents and incidents and had directed staff to take actions to avoid a reoccurrence.

The registered manager showed us the level of staffing provided in the home and told us there was a senior staff member and two other staff members on each floor during the day and at night this was reduced to a senior staff member and one other staff member on each floor. The registered manager also showed us the results of using a dependency audit tool and told us they usually provided more hours than needed. We visited the home at 8.30pm on the first day of our inspection and found nearly everyone was dressed for bed. The staff told us about their nightly duties and said they managed with the staffing levels. However they told us if someone needed to go to hospital and a member of staff needed to go with them they struggled for time to care for people. We noted in one accident report it required staff to be in close proximity to a person's room if they went to bed. This meant there was only one member of staff available to care for the remaining people. We could not be reassured there was sufficient staff on duty to care for people.

We recommend the provider reviews the level of staffing deployed over the 24 hour period.

We looked at the safety of the building and found regular checks were carried. We saw there were weekly checks on emergency lighting, window restrictors and fire alarm tests. Fire extinguisher checks and water temperatures checks were also carried out. The home had in place a monthly health and safety audit and carried out actions to prevent an outbreak of Legionnaires disease in the home. This meant the provider had in place arrangements to ensure people living in the building were safe.

The provider's recruitment processes was robust and appropriate checks had been carried out on staff to ensure they were able to work with vulnerable people. We found staff completed an application form outlining their qualifications, knowledge and skills. The provider had sought two references for each person and a Disclosure and Barring Services (DBS) check prior to the staff member starting their employment. Where the provider had recruited staff from abroad we found there were additional appropriate checks in place. Although the home is registered with the CQC to provide nursing care there was no one during our inspection working as a nurse. The provider told us this was because those staff who were qualified to work as nurses in other countries required additional training to work as nurses in this country.

We found people's needs had been assessed in relation to the support they required to evacuate the building in an emergency. Their needs had been aggregated onto one sheet which was on the notice board in the nurse's station downstairs. This meant emergency service could have access to readily available information.

We checked to see if people's medicines were safely administered. We observed a medicines round and found the staff member who administered people's medicines did so competently and followed correct procedures. The provider had in place competency assessments for senior carers who handled medicines. We saw one person had controlled drugs; these are drugs where there are additional risks. The provider had the controlled drugs stored in a locked cabinet in a locked cupboard; we found the records of controlled drugs matched the amount of stock.

We saw there were no gaps in people's Medication Administration Records (MAR). People in the home had PRN (as and when required medicines). We found there were care plans in place to guide staff as to when a person might need their PRN medicines.

In people's bedrooms we saw there were prescribed topical medicines. The provider had in place procedures for such medicines. In one person's room we found a plastic container of Diprobase which had been prescribed in 2013. We also found three tubes of the same topical medicine opened in one person's bedroom, one appeared to be empty; none of the topical medicines had the date they were opened. We spoke with one staff member who said they marked on the MAR chart when people had received their topical medicines as they were told by other care staff. This meant one member of staff was signing to state

Requires Improvement

Is the service safe?

another member of staff had told them people's topical medicines had been administered. We found there were no body maps in place in people's bedrooms. This meant staff were not guided as to where to apply people's topical medicines. We found the home was not acting with the provider's guidance. We spoke with the provider, the regional manager and the registered manager about this issue. They agreed to seek a resolution which made staff accountable.

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

The provider had in place a policy on abuse. Staff we spoke with confirmed they had received safeguarding training and were aware of how to report any concerns. We saw in the staff handbook staff were given guidelines on the awareness of bad practice and were advised to report such incidents to their manager. The staff handbook information was in line with the provider's 'Whistleblowing Policy'.

People's care files contained risk assessments. We saw following each care plan there was a risk assessment, however the assessments did not reflect the contents of the care plan and did not extract from the plan the potential risks to people alongside actions to be taken to mitigate the identified risks. This meant risks had not been analysed and guidance to staff to reduce potential risks was not in place.

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

We saw there were cleaning schedules in place and domestic staff explained their work to us. For example one person checked and cleaned people's mattresses each day. We saw records which matched this activity. We spoke with the domestic supervisor who showed us the cleaning routines of the home and found these to be thorough. This meant staff were familiar with their work and understood what they were expected to do to maintain cleanliness and reduce cross infection in the home.

Inadequate

Is the service effective?

Our findings

People told us they enjoyed the food and relatives thought their family members were well fed. One relative told us they had positioned their family member in a different seat in the dining room because they were getting confused by the staff accessing the kitchen and being distracted from eating. We looked at people's nutrition in the home and found members of care staff submitted notifications to the kitchen staff giving them information about people's requirements. The kitchen staff showed us the notifications they held. We saw some notifications had been ticked to demonstrate a person required a high protein diet. We asked the kitchen staff what this meant and they were unable to tell us. The kitchen staff were aware of the numbers of pureed diets required on each floor. In one person's file we saw they required their food to be fortified with cream, their care plan had been amended but no new notification had been forwarded to advise the kitchen staff of their requirements. On our last inspection day we asked to see the new notification and it had yet to be completed. We spoke with the registered manager in the presence of the provider and the deputy manager about the meaning of a high protein diet. We were told this was where people's food was fortified with for example cream to increase the person's food intake. We found people were at risk of receiving insufficient nutrition to meet their needs.

We saw the provider had in place food and fluid balance charts to monitor people's intake. People's fluid charts were incomplete and people had varying amounts of fluid intake each day. We found gaps in people receiving fluids for up to seven hours. We found the intake amounts of fluid were not totalled and measured against a recommended defined amount for each person. This meant the provider was not monitoring people's fluids, and the differing fluid intake amounts did not trigger any action on the daily recording sheet or changes in the overall care plan. In addition we found staff had regularly written in people's daily records, 'Good fluid and food intake' irrespective of the fluid amount consumed each day. This meant people were at risk of being dehydrated.

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

We looked to see if people had been regularly weighed and found a number of people were losing weight. However due to the different records where weight monitoring was kept there was not a consistent level of oversight of weight monitoring. We also found where people had lost weight the provider had failed to take any action. This meant people were at risk of malnutrition. We spoke with the registered manager, the regional manager and the provider in a feedback meeting. The regional manager queried with the registered manager where people were weighed and if the scales had been properly calibrated. The registered manager said the scales were taken to people in the home and they were unsure if the scales had been calibrated. This meant that although the provider was weighing people their weights may not have been accurate.

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

Staff told us they had an induction period and were required to shadow staff to learn and become familiar with people's needs. The registered manager told us they were responsible for training in the home. We saw the registered manager had held training sessions on DoLS, mental capacity, care planning and continence promotion and health and safety. Staff confirmed to us they had received training and one member of staff told us "Wednesday is training day".

We asked the registered manager about staff supervision and asked how often staff had supervision meetings with their line manager. They told us they thought it was every three months. We asked the regional manager for the staff supervision policy and found staff were meant to have supervision with their manager every two months. This was confirmed by the provider. We found out of the 41 staff employed 11 had not had supervision since 2014 and early 2015. The supervision sessions did not have a time recorded; we were therefore unable to check if the home was working within the provider's supervision policy of staff having supervision for one hour.

We also checked to see if staff had received an annual appraisal and found 14 staff who continued to work in the home had not received an appraisal since 2013, and two staff had not had an appraisal since 2012. We asked to see the minutes of the last staff meeting and saw this had been held in April 2015, another staff meeting was held during our inspection. This meant staff were not being appropriately supported.

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

Inadequate

Is the service effective?

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager told us they trained the staff in the Mental Capacity Act 2005 and the DoLS. We saw staff had signed training attendance records and staff confirmed to us they had carried out the training. We looked at the mental capacity assessments carried out on people and found these did not follow the legislative requirements or good practice. For example we saw one person had three mental capacity decisions to be made; these were recorded on one assessment document and the document did not demonstrate decisions had been made in the best interests of the person. Instead the document stated decisions were to be taken in the person's best interests. This meant the principles of the Mental Capacity Act and best interest decisions were not been appropriately applied in the home.

We found the registered manager had made applications to the relevant authority to deprive people of their liberty. One application had been approved and others were waiting approval. We spoke with the registered manager about one application as the rationale for the application did not appertain to deprivation of liberty. The registered manager was unable to give us an explanation.

The provider had in place a handover communication tool. This was used to pass information on to the next shift about each person. We saw these were completed between day and night shifts and information was passed between staff if they had any concerns about people.

The registered manager told us there was one volunteer in the home. We asked the registered manager if appropriate checks had been carried out on the volunteer. The registered manager could not remember if checks had been carried out. This meant we could not be assured if any volunteers in the home were safe to work with vulnerable people.

We looked at the premises to see if they had been adapted to support people living with dementia. The regional manager told us work had commenced in the home; new signs had been put on bathroom and toilet doors and rails around the corridors were painted in contrasting colours. The regional manager told us further work was needed to develop the premises but they had made a start.

Requires Improvement

Is the service caring?

Our findings

One person described the staff as. "Very helpful." Family members told us staff were "Approachable." Another relative did not have confidence in the staff and felt they could do better in their work. One relative was upset when they spoke with us about the lack of care their relative had received. A person who lived in the home told us the staff were very good and did not take long to help.

We asked staff about what was good about the home. On staff member told us, "The residents, that's what it's all about giving the care they need." Another staff member told us, "What's good, the staff team and residents." We found staff were motivated to care for people

During our inspection we saw the home's rabbit was brought in daily and people who lived in the home stroked the rabbit and talked about it. This engaged people in conversation and helped to promote their well-being.

Staff throughout our inspection gave us information about people, their likes and dislikes and how they liked to be treated. This meant staff were knowledgeable about people's needs and able to respond to them. However one person told us there was a large turnover of staff which meant there was a lack of continuity of care for people. We observed staff treating people with kindness and answering their questions.

We observed staff treated people with care and provided them with an explanation when for example they were using a hoist to enable people to access the dining room. Staff spoke with us about people whose behaviour challenged the service and explained to us about the person's condition fuelling the behaviours rather than it being the person at fault. For example one staff member explained that due to a person's dementia type condition they could become anxious and in need of reassurance. We saw staff respond warmly to people and provide reassurance.

We observed one person walking around the home where the markings on their clothing of her initials and room number could be clearly seen through the white stripes on their top. We spoke with the management of the home about another person who appeared unkempt, required a shave and a haircut. They agreed to look at the person's needs. On a late evening visit to the home we saw a person who was wearing a nightdress lying on a special chair with their legs exposed. There was a sheet next to them which was not being used to cover their legs and there was a visitor to the home in the room. We found not everyone had their dignity considered and respected.

The registered manager told us which people had an advocate allocated to them. The registered manager named one person and thought there might be two other people. We asked if the advocacy service was on display for people's information. The registered manager said she had difficulty getting posters from the service. The regional manager suggested the home make their own and display the information for people.

During our inspection we noted people's bedroom doors were locked, this meant people could not seek the privacy of their own rooms. Staff told us there was a person in the home on respite who entered people's rooms and they locked the doors to keep people's personal possessions safe. Staff also told us if people wanted access to their room they would open the door for them. We observed staff knock on people's doors before entering. We spoke with domestic staff who explained to us how they clean people's rooms whilst respecting their privacy. They told us they have to work around people's wishes but also described approaches they used to engage people with diagnosed conditions in conversations whereby they could access people's bedrooms to ensure they were clean.

Throughout our visit we found the interaction between staff and people who used the service to be supportive. We observed staff regardless of their role to respond to people and offered help to get them where they wanted to go. The staff used humour to engage people. One relative told us, "When you come here you get a good laugh."

We asked the registered manager if there was anyone on end of life care. They told us there was no one in the home who was on such care, however we noted some staff had received training in end of life care.

Staff understood confidentiality and worked with us throughout the inspection to ensure rooms containing confidential information were secure. We noted on the medicines round the staff member covered up the person's details whilst they were giving people their medicines.

Inadequate

Is the service responsive?

Our findings

The registered manager told us people's care plans was an area of the service which required improvement and they had begun to work on this area and review people's care files. Prior to living in Lindisfarne Ouston staff undertook a pre-assessment visit and gathered information about the person. We found one person on whom a pre assessment had been completed and they were admitted to the home, there were no further care plans available. Their relative told us they were concerned about the lack of appropriate care they had received. This meant without care plans in place staff did not have the guidance to care for the person which had resulted in the person receiving inappropriate care.

We looked at people's care files and found each person had a number of care plans including mobility, nutrition and continence. Each plan outlined the person's care needs, however we found significant gaps. We found people's care files contained plans which were out of date. For example we found plans which were dated 2010. Care plans had been reviewed and where people's care needs had changed their plans had not been updated. For example one person in 2010 did not have a pull cord in their room because they were thought to be at suicide risk; their needs had not been reviewed. We found some care plans to be confusing, for example in one person's file it stated the person could verbally indicate their wishes, in another part of the file the same person was said to have problems with their communication skills. We observed the person and found they could not verbally communicate with us. In another person's file we read they had a podiatrist visiting. We pointed out to the manager we could not find any records of a podiatrist visiting. They gave us a copy of the person's financial information which showed the person paid privately for a chiropodist. We found people diagnosed with diabetes lacked care planning and associated health risks for foot and eye care.

There were separate bathing records for people. People had expressed the frequency they wished to have a bath or shower. We found the records did not match people's preferences. For example one person was to be offered a shower every three days; we found 12 days had elapsed and no bathing had been offered to the person.

We looked at the activity records file for people living in the home. Each person had an activity care plan and for most people the objective was the same – 'To provide stimulation and maintain levels of mood, to encourage [person] to participate in activities'. The activity records provided by the home documented visits by people's families and visits by the hairdresser to the home. In one person's file it documented they liked world affairs and having a daily newspaper. We found arrangements for the latter were not put in place. In another person's care plan we read they liked the sensory room, however on checking their activity records they had not visited the sensory room between mid-February 2015 and mid-July 2015. In people's care files there were other care plans for social activities which provided different information about what people liked to do. For example in one person's file we read, 'Home to take [person] to the library for large print books'. We found there were not cohesive plans about people's individual activity preferences and people's individual preferences had not been carried out.

We found the care delivered to people was not always person centred.

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

A relative told us the staff put their family member in a chair on a morning and do nothing with them. The manager told us the activity coordinator was not at work and if the situation continued they would have to put something in place. On the last day of our inspection we saw staff got out games for people to play. We observed staff engage people to throw bean bags through a hoop and keep score. Other staff tried to engage people in a game of bowling. We observed people were enjoying the activities.

We spoke with one person who told us due to most people in the home living with dementia they were unable to have a conversation with people. Staff told us the person used to go out and now spends more time in their room. The staff did not associate this increased withdrawal with a potential deterioration in the person's mental well-being. The provider and the regional manager agreed this person needed to be re-assessed.

On the wall in the reception area we saw information on how to complain about the service. Relatives we spoke with during our inspection told us they would speak to the registered manager but had not yet needed to make a complaint. We looked at the complaints records in the

Inadequate

Is the service responsive?

home and found the registered manager had used a notebook. The last complaint recorded was in 2014. During our feedback meeting the regional manager and the provider advised the registered manager they had not been following company procedures in managing complaints. Following the inspection the regional manager sent us the provider's complaint's procedures. We saw the registered manager had not followed the procedure.

One person told us, "If you complain of a pain they respond straight away." Relatives we spoke with told us the service was quick to get a doctor if someone needed medical attention and the home got a better response that they had personally experienced.

Inadequate

Is the service well-led?

Our findings

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. We found Lindisfarne Ouston had a registered manager in post.

Staff members told us they felt the registered manager was supportive and helpful. They told us they only had to ask for something to support people who used the service and they would get it. One person told us they thought the registered manager was a, "Great manager."

We found the lack of supervision by the manager and the absence of staff meetings did not give staff the forums to voice their concerns and suggest improvements. This meant the culture of the home lacked openness.

Prior to the inspection we checked to see if we had received any notifications about deaths in the home. We found no death notifications had been submitted by the home since October 2010. On the first day of the inspection we asked the registered manager about the notifications and they stated they might not have kept all of them. The registered manager later showed us the death notifications they stated they had sent to the CQC since the last inspection, none of which had been received by the CQC

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. Following the inspection further contact has been made with the provider to discuss this breach.

We also found the registered manager had not notified us about serious injuries to people and where a DoLS application had been approved. This meant the registered manager had not met their registration requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following the inspection further contact has been made with the provider to discuss this breach.

The registered manager was expected to complete a weekly risk report to be sent to the regional manager for checking. The weekly risk reports included where people had lost weight and what actions had been taken. We compared the weeks when people had lost weight with the weekly risk report and found the registered manager had not been accountable to the provider for people who had lost weight. This meant the registered manager had not been accountable for people in the home and mitigating risks to people's health.

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

We saw the registered manager had in place a number of audits to manage the service. These included kitchen audits. The provider had also introduced a nutrition audit and mental capacity act audit, We saw these had been completed once and asked the manager how often were they being carried out. The registered manager told us, 'Every six months'. Six months had yet to elapse before the next audit was due.

We found the registered manager was not following policies and procedures as set out by the provider. For example they had not followed the complaints process and used appropriate documentation to ensure complaints were satisfactorily drawn to a conclusion. We also saw the registered manager had not followed policies and procedures in relation to staff supervision and appraisal and medicines. This meant the management of the home did not follow the requirements of the provider.

The provider had in place a record keeping policy which listed the standards for record keeping. The records we found in the home did not meet the regulatory requirements. We saw similar information was stored in different areas for example people's weights were stored in a weights file, on their care records and some were found on notice boards. We spoke with the registered manager about this in the presence of the regional manager and the provider, the registered manager did not respond. The regional manager described the process the provider had in place to monitor and mitigate risks when people lose weight. This was not being used in the home.

We checked to see if the notes held were contemporaneous and found people's care records were out of date; some of the care records on the files were up to five years old. Care plans had not been updated when people's needs had changed. A person living in the home for a respite period did not have any plans in place.

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

Inadequate

Is the service well-led?

One person told us they were 'Not impressed' by the level of care people received. We asked the registered manager for the feedback from service users and their relatives to inform improvements to the service. The registered manager gave us 17 feedback sheets and we found people's feedback to be largely positive. There was no date on the feedback but the registered manager said they carried out surveys' every six month. One relative commented on how their family member looked unkempt and needed their teeth cleaning. Another relative commented on the activities and said, 'Very little is done activities' and suggested more bus trips out. We found the undated results had not been collated and there were no actions taken to improve the service, therefore we could not be assured the provider responded to the feedback.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff had not received appropriate support through supervision and appraisal as described in the provider's procedures.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had failed to do everything reasonable practicable to ensure people received person centred are which reflected their need and personal preferences.

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment of people was not provided in a safe way. Regulation 12(1) Risk assessments did not give staff clear guidance on how to ensure risks were mitigated. Regulation 12(2)(b) People's topical medicines were not being managed in a safe way. Regulation 12(2)(g)

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes required by the provider had not been implemented by the manager. Regulation 17(1) The manager had failed to assess, monitor and mitigate risks to people. Regulation 17(2)(b) Records were not accurate, complete or were contemporaneously kept. Regulation 17(2)(c)

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.