

Pribreak Limited

Mount Pleasant Residential Home

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?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Inadequate



Overall summary

This inspection was carried out on the 2 December 2015 and was unannounced.

Mount Pleasant residential home is a privately owned residential care service located close to the rural village of Norley. The service is based over two floors and is registered to provide accommodation for up to 24 people

who may require nursing or personal care. Local amenities are a short distance away from the service in the village. At the time of our inspection there were 21 people living at the service.

At the last inspection on 3 June 2015 we found that there were a number of improvements needed in relation to: management of medicines, staff support and training and notification of changes and significant incidents. We

Summary of findings

asked the registered provider to take action to make a number of improvements. After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified. They informed us they would meet all the relevant legal requirements by the 12 October 2015. However, whilst the registered provider has made some improvements, they had not fully met their own action plan. We found a number of breaches and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. We also identified some additional concerns. You can see the action we have told the provider to take at the end of the report.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since our last visit the service now has a nominated individual.

The service has a manager in place who has recently applied for the registered manager's position. We were informed during our visit that the manager had been unavailable at the service for a period of eight weeks. The registered provider had failed to ensure that sufficient measures had been implemented to ensure that important information was reviewed and actioned in the event of the manager being absent from the service.

People felt safe at the service and told us that staff were quick to respond to them if they needed help and support. Relatives informed us that staff kept them up to date with any concerns and they felt happy with the care people received. Prior to our inspection we had been informed of a safeguarding incident that occurred at the service since our last visit. The registered provider had failed to notify us of this concern.

The care plans, including risk assessments, did not always record people's needs accurately. Records were not personalised to reflect people's individual preferences about how they would like their care and support to be provided. Supplementary records including food and fluid charts were not always completed in detail

to reflect what people had consumed on a daily basis. This meant that the registered provider was not able to safely protect people from the risks of dehydration and inadequate nutrition.

During our visit we found that sufficient checks were not made on pressure relieving equipment. Three people used pressure relieving mattresses and the appropriate assessments to establish the correct pressure levels required had not been completed. The manager informed us that checks on this equipment were not completed at the service.

Risks to people health and safety were not always identified by the service. Accidents and incidents were not monitored effectively. The registered provider did not undertake regular reviews to identify risks, patterns or changes to care needs. There were no actions identified to keep people safe from harm.

Water temperatures had not been monitored since July 2015 by the registered provider and thermometers were not in place in the bathrooms. The manager informed us that staff used their elbow to test the temperature of the water prior to people having a bath. We asked the registered provider to take immediate action to address this concern.

Pull cords for the call alarm systems were not in place in the bathrooms and a number of bedrooms at the service. Therefore, people were unable to raise an alarm in the event of an emergency to gain the attention of staff on duty.

People did not always receive their medication as prescribed. People's medication administration records (MAR) had been appropriately signed when medication was given. Medication was stored in a safe and secure way. However, care plans for PRN (as required) medication were not in place for staff guidance. This meant that people could be administered more medication than required. The manager informed us that this would be reviewed immediately.

The registered provider had not undertaken supervision, appraisal or appropriate training with staff to ensure that they had the skills and knowledge required to support people. The lack of support and training available to staff could put people at risk from receiving unsafe care and support.

Summary of findings

Staff showed a basic understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered provider did not have a policy and procedure in place with regards to the MCA. Staff practice showed that consent was sought from people prior to care and support being provided. Care plans did not reflect how people's consent; ability to make specific decisions and decisions made in their best interests was considered.

The quality assurance system at the service was not effective and had not been completed since July 2015. Issues we found as part of our inspection had not been identified by the registered provider. Audits that had been completed prior to July 2015 did not identify any actions for improvement or timescales for completion. Quality assurance systems did not protect people from harm or unsafe care. Policies and procedures contained out of date information and did not reflect current practice, law and legislation. We saw that the manager had started to review these documents.

The mealtime experience promoted a positive experience for people. The dining room atmosphere was calm and relaxed and meals served were nutritious and well presented. Resident's committee meetings had been introduced on a monthly basis to listen to the views of people regarding meals, activities and general feedback about the service.

Staff treated people with dignity and promoted choice and independence at all times. Staff knew people well and had a good knowledge of how people would prefer to be supported. Staff were kind, caring, patient and respectful of people's privacy.

The registered provider had implemented safe systems for recruitment since our last visit. Appropriate checks had been completed with the Disclosure and Barring Service (DBS).

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

The service was not safe.

Call bell systems in bathrooms and bedrooms did not always have pull cords in place or were not in reach for people to use in the event of an emergency.

Where risks to people's health and safety had been identified the registered provider had not implemented a risk management plan to identify what support was required.

Appropriate water checks were not completed at the service to ensure that people were protected from the risks of legionella and exposure to high temperature water.

Accidents and incidents were not reviewed on a regular basis at the service. This meant the registered provider was not taking appropriate actions to minimise risk.

Inadequate



Is the service effective?

The service was not always effective.

Staff had not received appropriate support, training or professional development to enable them to understand their role and responsibilities.

Records and procedures did not always demonstrate that people's rights had been fully considered when implementing the Mental Capacity Act 2005.

Applications had been made under Deprivation of Liberty Safeguards (DoLS) by the provider to ensure that any restrictions placed upon people were assessed.

Mealtimes were a positive experience and people were offered a choice of meals. Staff were respectful of people's preferences on where they would like to sit and with whom.

Requires improvement



Is the service caring?

The service was caring.

People's dignity was always maintained.

People were treated with kindness and respect and staff encouraged people with their independence.

Staff promoted choice with people at all times and were respectful of people's decisions.

Good



Is the service responsive?

The service was not always responsive.

Requires improvement



Summary of findings

Care plans were not personalised and did not reflect the care and support that people required.

Supplementary charts recorded little detail as to what people ate and drank.

Changes to health needs were not always identified in a timely manner and appropriate support sourced from health professionals.

Is the service well-led?

The service was not well led

The registered provider had failed to notify CQC of the management arrangements for the period of the manager's absence. The manager was not registered with CQC.

The registered provider had failed to notify CQC of key incidents that had occurred at the service.

The registered provider had an ineffective quality assurance system in place at the service. Audits had not been completed since July 2015.

Inadequate



Mount Pleasant Residential 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 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.’

The inspection took place on the 1 December 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, we reviewed the information that the provider had given us following our last inspection. They had provided us with an action plan that gave details of how they were going to make improvements. They had indicated that all of the improvements were to be

completed by the time of this inspection. We looked at information provided by the local authority, safeguarding teams and infection and prevention control. We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of the inspection we spoke with six of the people living in the service, four relatives, visiting professionals, four staff, and the deputy manager and manager. We observed staff supporting people and reviewed documents; we looked at five care plans, medication records, four staff files, training information and policies and procedures in relation to the running of the service.

We spent time observing the support and interactions people received whilst in communal areas.

Is the service safe?

Our findings

People told us they felt safe at the service. One person said “I feel much safer here than I did when I lived at home” another person told us “Staff always come quickly if you need them for anything”. Relatives informed us that they knew their family members were kept safe from harm and that they were kept informed of any concerns that arise.

People’s basic needs were assessed and where risks were identified there was not always a risk management plan in place. Assessments included risks associated with pressure care, skin integrity, nutrition and hydration and falls. Three people’s care plans identified that they were at risk of pressure damage due to poor mobility and health needs. People had the required equipment in place and were supported on pressure relieving mattresses and observations confirmed that people were being repositioned. However, we found no documentation in place to indicate to staff the correct pressure settings that were required on the mattresses. We saw no supporting evidence to identify that mattresses were checked to ensure that they were working properly. The manager confirmed that these checks were not in place at the service. This meant that people were at further risk of developing skin problems if the settings were incorrect or faults were not identified and corrected quickly.

The registered provider had a policy and procedure in place to review and monitor accidents and incidents at the service. Records of incidents for both people and staff were kept through the use of an accident book. However, there was no evidence to support a detailed review of incidents and accidents taking place in order to identify themes and trends or actions that could be taken to prevent further risks occurring. Care plans identified a number of people were at risk of falling at the service but there were no management plans in place to determine what changes had been identified or taken to minimise these risks. This meant that the manager was not monitoring accidents and incidents effectively.

This was in breach of Regulation 12 and 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014 as the provider did not have effective systems in place to identify and assess risks to the health and safety of people using the service.

Bathroom and toilet facilities at the service did not always have pull cords attached to call bells which meant that people could not summons help when they required assistance. On the day of our inspection, a person who used the service fell in the toilet and staff did not hear their calls for help. The inspector had to go to get their attention and ask staff for help. We observed that bedrooms at the service did not always have a pull cord for the call bell in place. Care plans or risk assessments we viewed did not contain information as to why they were not in place. Staff had relocated one person’s bed in their room and their call bell was now at the opposite end of the room and not accessible in an emergency. The manager advised that the bed would be returned to the original position in the room to enable access to the call bell.

We were informed that Legionella checks were completed at the service. However there was no documentation to confirm that these checks were carried out and the outcome of any checks recorded. During discussions with the manager it was evidenced that water temperature checks were not completed on a regular basis at the service. We were advised that both the taps and the boiler had temperature regulators fitted to ensure that people were not at risk of scalding. On review by the inspectors the water was very hot to the touch. The main boiler did have a thermostat in place and this was set at maximum temperature. The manager advised the inspectors that there were no thermometers in place to test the temperature of water prior to people having a bath and this was tested by staff dipping their elbow in the water. We asked the manager to ensure that they took immediate action to ensure that water temperatures were checked. Since our inspection the registered provider has confirmed that appropriate thermometers have been purchased for the bathrooms and that the water temperature was monitored on a weekly basis.

At our inspection in June 2015 we told the registered provider to take action to ensure that the care provided was safe and that improvements were made in the systems for management of medication and recruitment procedures. We asked the registered provider to send us an action plan telling what action they had taken.

When we inspected the home in June 2015, we identified concerns that medication was not stored or administered properly and there was not enough information to guide staff in these procedures. This breach was identified as a

Is the service safe?

safety risk to people. This was a breach of Regulation 12 of the Health and Social Care Act (RA) Regulations 2014 safe care and treatment. We issued a requirement notice to the provider.

During this inspection we saw that the registered provider had made improvements in the safe management of medication.

Medication was managed and administered by the senior care staff. Records showed a list of staff that had completed relevant training and been assessed as competent to administer medication. Medication administration record sheets (MARs) were properly completed and staff had used signatures and appropriate codes when completing them. A recent photograph of the person was in place which helped staff identify the person prior to administering medication. We observed staff practised a person centred approach to administering medication. People were offered a choice of where and when they would like to have their medication and staff supported people at their pace. Staff gave clear explanations of what was being given to people and answered any questions clearly that they raised. Important information about people's medication, including what the medication was for and any possible side effects was kept within the medication records. Some people received 'as and when required' medication (PRN). However, guidelines for staff on the safe use of 'PRN medication were not in place this meant people were at risk of receiving more medication than needed. We raised this with the manager who advised they would review this immediately and take the appropriate action required.

Medication was stored safely in a locked cupboard which had been built since our last visit. Each person's medication was clearly labelled in an individual named basket for ease of identification. We raised concerns with

the manager regarding the temperature within the medication store cupboard as this reached 29.2 degrees during our visit. High temperatures in storage areas can impact on the effect of medication. The manager advised that she would move the medication to a different part of the cupboard which was cooler in temperature. Medication that was required to be kept in the fridge was safely stored. Procedures were in place for the use of controlled drugs and appropriate records were kept of these medicines.

Previously we had concerns about safe recruitment procedures not being followed at the service. Following our visit in June 2015, we issued a warning notice to the registered provider to ensure that they implemented safe and robust recruitment processes. On this inspection, we found that improvements had been made and the registered provider had implemented safe procedures for recruiting staff. We viewed the recruitment records for five staff including one new team member and saw that appropriate checks had now been completed including the Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. This ensured staff were suitable to work with vulnerable people.

Staff told us they had completed safeguarding adults training and records confirmed this. Staff knew what abuse meant; they described the different types of abuse and knew how to report concerns they had about people's safety. They were not aware of the local authority policy but knew that they would need to report concerns to the manager, deputy manager or registered proprietor.

We saw certificates to show that there had been routine servicing and inspections carried out on items such as hoists, electrical and gas installation.

Is the service effective?

Our findings

People were complimentary about the meals at the service. One person told us “The food is excellent here; there is a very good cook in the kitchen”. Kitchen staff told us that they cater for a variety of needs and always try to meet special requests from people.

Previously we had concerns regarding training, supervision and appraisal that staff received to ensure they had the appropriate knowledge and skills for their roles. The registered provider advised following our last inspection that they would begin formal assessments and appraisals with staff in September 2015. This had not been implemented at the time of our inspection. The manager showed how she had started development files for staff which had been set up in line with the Care Certificate qualification. We were advised that due to the manager being away from the service for a period of eight weeks that these had not progressed further. We saw no written records to evidence that formal supervision and development had taken place with staff. The manager advised that supervisions had been informal and discussions had been held with staff when they were on shift as needed. Staff told us “I have seen lots of improvements since you were last here, but we have not received a lot of training this year”. Other staff confirmed that they had not received supervisions with the manager. We saw certificates that confirmed staff had attending training in Person Centred care, Fire awareness and Continence promotion since our last visit. However the manager was unable to provide any other information regarding what staff required or had completed for development.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations as the registered provider had not ensured that staff received appropriate and ongoing support, training and professional development

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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 are called the Deprivation of Liberty Safeguards.

The manager had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They described that their responsibilities were for ensuring that the rights of people who were not able to make or to communicate their own decisions were protected. It was clear through practice we observed that staff asked people for their consent before carrying out any activities and knew that they needed to assist people to make choices where possible. However, staff knowledge of the MCA and DoLS principles was limited and records showed that training had not been completed in this area. Staff were unable to confirm if anyone who lived at the service were subject to DoLS.

Records showed that consent had been sought from relatives for the use of restrictive practices such as the use of bedrails without an appropriate assessment of the persons own capacity to make that decision. Staff were not able to tell us if there were circumstances in which family or relevant others held Lasting power of Attorney and could make a decision on someone's behalf. People's care planning documents did not demonstrate people's consent; ability to make specific decisions and decisions made in their best interests when required. Therefore, there was a risk that decisions and care was being delivered without a person's consent.

The manager demonstrated that applications had been made to the local authority on behalf of people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations.

The mealtime experience promoted a positive experience for people. The atmosphere in the dining room was calm and relaxed and people were offered a choice of where they preferred to sit and with whom. Tables were well presented with a choice of condiments available for people to use independently. The manager had implemented two different times for meal times to be served to cater for those people who went out on a regular basis or for people who required more support to eat their meal. Meals served looked appetising and well-presented and there was alternative choices available for people. Relatives told us “There is always something lovely and home cooked to eat

Is the service effective?

here, my [relative] never goes hungry” another told us, “There is always a choice of food available if my [relative] doesn’t like what’s on offer, they will even go out of their way to buy them something special if they make a request”.

Staff were knowledgeable about the care and support people needed. Staff explained their role and responsibilities and how they would report any concerns they had about a person’s health or wellbeing. Appropriate referrals for people were made to other health and social care services. Staff identified people who required specialist input from external health care services, such as

GP’s and District nurses. Discussions with people and the staff who supported them confirmed that routine healthcare appointments had been attended to keep them healthy. A visitor told us that they found that staff were always willing to help and raised concerns to the relevant people were appropriate.

We recommend that the provider improves the procedures, documentation and recording systems in place to ensure that the Mental Capacity Act 2005 is fully implemented.

Is the service caring?

Our findings

People told us that the staff were respectful and polite in their approach. Comments shared with us included “Its lovely here, it surpasses all the others I have been too. The staff are patient and kind and they don’t rush me at all” and “It’s like being part of a lovely family”. Relatives and visitors told us that the service was homely and welcoming. One person said “The care staff have been here for years so there is great continuity of care for my [relative]”.

Staff had a good knowledge and understanding of how people wanted their care to be provided. We saw that staff engaged with people in a patient and caring way and that people were treated with dignity and respect. Staff told us “We always make sure people are supported to make choices for themselves in all aspects of their care”. Practice we observed showed that people were encouraged by staff to be as independent as possible and staff were always respectful of people’s decisions. Consent was sought where possible before people’s care needs were attended to. An example of this was when a person was offered a choice of where they wanted to spend their time. The person chose to sit in their room and staff regularly visited them to ensure that they were safe and had everything that they required throughout the day.

Staff were respectful of people’s privacy and knocked on bedroom doors and waited for a response before entering. If the person was not in their room, permission was sought by staff if they needed to enter a room without the person

being present. People told us “I feel very comfortable discussing issues with the staff if I need too”. Family members told us that they felt that the service respected their confidentiality when they needed to discuss anything with them.

Discussions staff held with people demonstrated that staff knew people well. Staff knew what interested people to help engage in conversation which created opportunity for social interactions. During our visit we saw a group of people sitting with staff and having a chat about Christmas with a cup of tea and some cake. People were relaxed, happy and cheerful throughout our visit and there was good staff interaction.

Visitors told us they were always made welcome at any time of the day. One visiting relative said, “I can visit my relative whenever I want, there are no restrictions places on us popping in to see them”. Other visitors told us that they were always made to feel welcome whenever they visited.

We saw that each person had their own bedroom which they had personalised with items such as family photographs, ornaments and their own furniture. One person told us “Having my own bits and pieces around me makes me feel at home”.

There was no information readily available for people on how to access local advocacy services. However we noted that staff knew how to access advocacy support for people when required.

Is the service responsive?

Our findings

People told us they received the care and support they needed that met their individual needs and preferences. “They always help me when I ask” and “I don’t trouble them for anything, but when I do need anything they are there to help”. We saw staff spent time chatting with people and responding to people’s needs and requests for assistance to use the bathroom and for refreshments. A visitor told us that staff were attentive to people’s needs and that they knew people’s habits and routines.

Previously we had concerns regarding the lack of accurate and complete records in respect of people who used the service. Following our visit in June 2015 we issued a warning notice to the provider to ensure that records were reviewed and updated to meet the needs of people supported.

Through discussions we found that staff had an understanding and awareness of the support required for people. We saw that the registered provider had started to review care plans at the service, however written records were not accurate or fully completed. Information recorded did not always reflect the care a person required. For example, we found that four care plans did not contain personalised details about how a person may need to be supported. Comments such as “requires two staff for assistance with personal care” and “[person] is at risk of falls and staff are to offer assistance” were written in care plans with no further guidance for staff to understand what support the person may require.

Care records highlighted that there was inconsistent practice in place for the monitoring of weight loss. We noted that the registered provider had not given due consideration and action when people had lost weight within the service. One person’s records showed a weight loss of one stone over a period of three months. The service had completed basic dietary assessments; however there were no MUST assessments, risk assessments or management plans to identify what actions were required to be taken. We saw that supplementary charts used to record food and fluid intake for people did not clearly identify the amount of food and fluid that people had eaten or drunk. Comments such as ‘half a glass’ or ‘full glasses were regularly written on the fluid intake diary and ‘soup’ or ‘cauliflower cheese’ in the food intake section

asking for ‘type/details’. Records did not evidence any review of care and support needs. This meant that people were not safely protected from risks of dehydration and inadequate nutrition.

Assessments had not been completed to assess the risk of pressure ulcers. We saw that three people who used the service had a pressure relieving mattress in place. However, there were no records to indicate what pressure the mattresses should be set at or if they were reviewed or checked regularly. The service had not considered how a person’s weight would need to be monitored to ensure that the correct pressure setting was in place on the mattress. This meant that people using the service were at risk of harm. We asked the registered manager to ensure that immediate action was taken to ensure staff were aware of the correct settings.

We found that there had been delay in the service recognising deteriorating health issues for a number of people such as elimination and refusal of medication. Records showed that staff were recording information about bowel movements on a regular basis but did not identify significant patterns that emerged. Staff had not looked at the possible causes and impact on people’s health. We noted that one person had not taken their medication for a period of twelve days and this had not been reviewed or discussed with the GP. Staff informed us that this was a pattern of behaviour followed by the person; however there was no medication care plan in place to identify what actions should be taken if this occurred. We raised this with the manager and deputy manager who advised that the GP would be visiting the day after our visit and they would review this immediately.

This was a breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that people received care and treatment that was appropriate and met their needs and accurate records were not held in respect of each person.

During our visit we saw some activities taking place such as a coffee morning and making Christmas decorations whilst listening to Christmas carols. People told us “We have music sessions here and play bingo and games together. I like to play dominoes”. Relatives told us “There isn’t a lot of activities, but when they do something it is really good”.

Is the service responsive?

Through a review of care plans we saw no information relating to meeting people's activity and social needs or an activity log within their care plans. The manager had introduced a residents committee meeting in November 2015 which highlighted that a review of activities is currently being undertaken. People were asked for ideas

and suggestion of activities that could be implemented at the service in the future. We saw that a number of activities had been arranged to take place over the Christmas period such as a Christmas pantomime, raffle and a local singing group to visit.

Is the service well-led?

Our findings

The service is not currently managed by a person registered with CQC. There was a manager at the service who has recently applied to become the registered manager. Relatives told us “I know I can always raise concerns if I have them and the service will do their best to resolve them”. Another relative told us “I spoke to the manager as I had concerns about my [relative] and relationships with staff and they looked into my concerns and got back to me very quickly”.

When we inspected the home in June 2015, we identified concerns that the registered provider had not notified CQC of the absence of a registered manager and of notifiable incidents that affect the health, safety and welfare of the service.

Prior to the inspection we reviewed notifications that the registered provider had submitted to CQC. We saw that a notification relating to the death of service users had been completed; however we had not received a notification relating to a safeguarding incident that had occurred at the service. During discussions with the manager we were informed that she had been unavailable at the service for a period of eight weeks and the incident had occurred during this time. The registered provider had not ensured that sufficient measures had been implemented to ensure that important information was reviewed and actioned in the event of the manager being absent from the service.

Previously we had concerns that the registered provider did not have effective systems and processes in place to monitor and improve the quality and safety of the service. We issued a warning notice to the registered provider.

During this inspection we found that quality assurance systems in place at the service were not effective. The manager was responsible for completing an internal inspection and audit schedule followed by the completion of an overview report of their findings for the provider. The audit consisted of checks across a number of different areas throughout the year such as safeguarding, staff training, fire safety and water safety. The manager informed us that these checks had not been completed since July 2015 due to her absence from the service. Records confirmed this. The registered provider had not maintained oversight of the service in the absence of the manager. Audits that had been completed prior to July 2015 did not

identify actions required for improvements or timescales for completion. Issues we raised during our inspection had not been highlighted by the registered providers audit system. Quality assurance systems did not ensure that people were protected from the risks of unsafe care or support.

We reviewed the service policy and procedures manual. Policies did not reflect current law and legislation. Information included in documents was out of date and inaccurate. An example of this was the missing resident’s policy which indicated that the National Care Standards Commission which is an organisation that no longer existed should be informed. There was no policy and procedure in place to support the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). The manager acknowledged that policies and procedures required replacing and records showed that this process had been started at the service. We saw updated copies of the complaints, safeguarding and recruitment policies during our visit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider did not have effective systems in place to assess, monitor and improve the quality and safety of care.

Staff told us that they felt morale was low at the service at present. We were informed that staff had not been provided feedback about our last visit to the service and that they had been “left guessing” about what had happened. We were told “There is a lack of communication with us at the moment. We have seen lots of changes happening, but don’t always know why” and “We are lacking guidance on shift at times, I think we need clearer information about what we need to do”. Other staff told us that there had been a review of staffing levels at the weekend and an improvement had been seen. The manager had booked a team meeting in December 2015 to update staff on information that was important to the service.

The provider had systems in place to record complaints and compliments. Records showed the service had not received any complaints since our last inspection. We saw records of three compliments that were received from relatives thanking the service for the care and support they had provided to their family members.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered provider failed to assess risks to people supported and take appropriate action to mitigate such risks. They also failed to ensure that pull cords were accessible to people in the event of an emergency. 12(1)(2)(a)(b)(e)

The enforcement action we took:

We issued a warning notice and told the registered provider to be compliant by the 8 April 2016.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered provider failed to assess, monitor and improve the quality and safety of the service. They also failed to ensure that there was people were protected from risk as there was not accurate or complete records held for each person. 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

We issued a warning notice and told the registered provider to be compliant by 6 May 2016.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered provider failed to ensure that staff were provided with appropriate support, training and professional development to enable them to carry out the duties they are employed to perform. 18(2)(a)

The enforcement action we took:

We issued a warning notice and told the registered provider to be compliant by 6 May 2016.