Anchor Trust

Annesley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Annesley Lodge Care Home was inspected on the 26 and 27 October 2017. The inspection was unannounced. Annesley Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked during this inspection. The service is registered for 48 people and 41 people were using the service on the day of inspection.

Following this inspection the service was rated as Requires Improvement as we found concerns which led to two breaches of the Health and Social Care Act 2008 Regulations (2014) and one breach of the Care Quality Commission (Registration) Regulations (2009). You can see what action we told the provider to take at the back of the full version of the report.

The service had registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from the risk of abuse as staff did not always recognise when abuse had occurred. The registered manager did not always share information with the local authority when needed and act on concerns when they were raised to them.

Risks to people's safety were not always properly assessed to give staff the information required to provide suitable care to keep people safe.

People were not always supported by adequate numbers of staff; however the management team continued to address this. People were not always supported to receive their medicines safely. Although the majority of staff received their mandatory training to enable them to complete their role there was a need for further training for staff to support them to understand people's different health needs

The principles of the Mental Capacity Act (MCA) were not always followed and best interest decisions were not always clearly documented. However some people had been assessed as lacking the capacity to make their own decisions.

The majority of people received a varied and nutritious diet and were supported with any special requirements to ensure they received a suitable diet in a safe way. However, there was evidence to show one person dietary needs had not been assessed to meet their individual needs

People's health needs were not always managed in a timely way and health professionals' advice was not always followed.

People were supported by a group of caring and kind staff who understood and accommodated their needs and preferences. Staff supported people to be independent and they worked to ensure people's privacy and dignity was maintained.

People told us they received individualised care, however the information in people's care plans was variable and as a result staff did not have clear information to enable them to provide consistent and individualised care for people.

People were supported to undertake social activities of their choice and staff worked hard to prevent people from becoming isolated. People felt able to raise concerns and felt they would be listened to.

People felt the registered manager was approachable and visible but the service lacked robust quality assurance processes to ensure standards of care were maintained.

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.

People were not always protected from abuse as staff did not always recognise when abuse had occurred.

The risks to people's safety was not always well managed as risk assessments lacked consistent information for staff.

Staffing levels did not always meet the needs of people.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective

Whilst the majority of staff received mandatory training there was a lack of training for staff to support them to understand people's different health needs.

The principles of the Mental Capacity Act were not always followed, to support people who lacked the capacity to make their own decisions.

The majority of people were supported with their nutritional needs but there were times when appropriate referrals to health professionals were not made.

People were not always supported to gain access to health professionals in a timely way and instructions from health professionals were not always followed.

Is the service caring?

Good

The service was caring

People were supported by staff who knew their needs and were kind and caring towards them.

People's choices and preferences were supported.

People's privacy and dignity was supported and staff were aware of the importance of promoting people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not always have consistent information to support staff to meet people's individual needs.

People were supported to follow activities of their choice and prevent them from becoming socially isolated.

People felt able to raise concerns and complaints and felt they would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led

People felt the management team were approachable and their opinions were taken into consideration. However, some staff felt they did not always receive support from the senior team.

There was a lack quality assurance audits in place and those in place were not completed regularly and actions identified were not carried out to improve care standards.

Annesley Lodge 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 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 unannounced inspection took place on the 26 and 27 October 2017. The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.
Prior to our inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) and asked them for their views.

During the inspection we spoke with 10 people who were living at the service and three people who were visiting their relations. We also 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 to us. We spoke with five members of care staff, the activities co-ordinator and the chef. We also spoke with the registered manager and Head of Care.

We looked at the care records of five people who used the service, four staff files, as well as a range of records relating to the running of the service, which included audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

People and the relatives we spoke with told us they felt safe at the service. One person said, "I have never seen any abusive behaviour by staff, even with 'provocative' residents." The person went on to say that the service was secure as the doors were locked and when they went out they needed to let the staff know. Another person echoed this and told us they felt the service was safe as the staff were careful; the security was good as no one could get in or out of the home without staff knowing. A relative we spoke with told us, "I have never had any concerns (about safety) and would talk to the manager or team leaders if I did."

Staff we spoke with were aware of the different types of abuse people could be exposed to, and discussed what things they would look for to identify any issues of concern. Staff told us they would speak to the deputy manager or registered manager if they had concerns. One staff member said if they weren't being listened to, they could ring the local authority safeguarding team as the telephone number was displayed in the team leader's office.

However, during our inspection we saw there had been an incident in relation to the care of one person with an ongoing health condition and there was a lack of clear monitoring of the person's condition. The person had been admitted to hospital as their condition had become unstable as a result of staff not monitoring them. Whilst the registered manager had worked with the district nursing team following the event to rectify the issue and improve the way the person was monitored they had not recognised this as a safeguarding issue and an act of neglect. They had not informed the safeguarding team or ourselves at the Care Quality Commission of the incident or undertaken a formal investigation of events. We discussed this with the registered manager who recognised they should have informed the safeguarding team and completed a statutory notification to ourselves so the incident could have been properly investigated and lessons learned to improve the standard of care and prevent reoccurrence.

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

People were not always supported to receive their medicines safely. People told us they were happy with the way they received their medicines and received them on time. However, one person told us that before a staff member had gone off duty they had left a tablet in the person's bedroom for them to take later. We checked and saw the tablet had been left in the person's bedroom. The bedroom door was unlocked and the staff member did not monitor the person taking the tablet. This unsafe practice meant there was a risk of another person going into the room and taking a medicine that was not prescribed for them. We also found one person's medicines in an unlabelled cup in the medicines trolley after the medicines round had been completed. A member of staff said this had been given to them by a person using the service and was from the previous evening when they had been unaware they had been left in their bedroom by staff. However, on checking the medicine administration record (MAR) we saw the medicines had been signed as being 'given'.

One person's records we viewed noted they were receiving their medicines covertly. This is medicine which

is hidden, usually in food. The GP had been consulted and had agreed to covert administration of the person's medicines but the staff had not consulted their pharmacist to ensure the method of administration for each medicine given had been assessed as safe.

One person was taking responsibility for their own medicines administration and a risk assessment had been completed to ensure they were safe to do this. However, their care plan did not provide an up to date description of the process. There were no checks recorded on the MAR and staff told us they did not check the person took their medicines on a daily basis. This meant if the person's condition altered staff were not undertaking adequate monitoring processes to alert them to this. This placed the person at risk of not receiving important prescribed medicines when they needed them.

Whilst protocols were in place for medicines which were prescribed to be given only on an 'as required' basis, the information was minimal. For example, two people were prescribed a sedative medicine and the entry in the protocol stated it was prescribed 'To prevent agitation.' There was no information about the symptoms a person may display or the circumstances which indicated they might become agitated. This lack of information meant there was a risk of people not receiving their required medicines on a consistent basis.

The storage of medicines was not safe; we found the medicines refrigerator unlocked. There was a record of room and refrigerator temperature checks in the room where medicines were stored; however these were not always fully completed on a daily basis. This meant staff could not be sure the medicines had been kept at the recommended temperatures consistently.

This lack of safe practice in relation to medicine management is a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they had aids to assist them keep safe. For example one person told us there were rails along the corridors to assist people when they were walking and they also had a walking frame to assist them with their mobility. However, we found that risks to people's safety were not always fully identified, monitored and managed.

During the inspection we observed a person had considerable bruising to one side of their face. Staff told us the person had previously fallen out of bed onto the floor. We reviewed the care of the person and we saw the person had fallen frequently in the past and their personal profile stated they had a history of a fractured bone. Whilst we saw there were some measures in place to monitor the person, the measures in place would not have reduced injuries to the person should they fall again. For example, the person wore a pendant alarm which they could use if they fell and there was a sensor mat in front of their bed. However, the person's bed was a relatively high divan bed and the bedroom had wooden flooring. There had been no consideration of the use of a profiling bed which could be lowered, or the use of a mattress/soft mat by the bed to reduce the risk of injury if the person fell from their bed again. The person's care record did not contain evidence of a recent referral to the falls team, occupational therapist or physiotherapist and staff we spoke with were unaware of any referral undertaken. The lack of appropriate measures in place put the person at risk of sustaining further serious injuries should they fall again.

We discussed the care of another person with a visiting health professional who told us the person's GP had stopped a particular medicine related to a health condition and following this the staff had not robustly monitored the person's condition and this had led to the person's health condition becoming unstable for a period of time. The health professional felt this this could have been prevented with robust monitoring and appropriate reporting to relevant health professionals who would have provided the person with support.

The health professional told us this had been discussed with the registered manager who was working to improve the issues raised.

People's opinions on the staffing levels at the service were mixed. One or two people we spoke with felt there were enough staff to meet their needs however other people felt there was not enough staff. One person told us the service could be short staffed in the mornings, they explained they needed help to get dressed and sometimes had to wait for the help they needed. Another person told us the service had been short staffed, "Quite often."

Staff we spoke with told us they did not feel there was enough staff on duty to provide the care everyone required. One member of staff said, "People have to wait and we are slow to answer buzzers sometimes." They went on to say they felt the people they cared for sometimes felt rushed. Some staff we spoke with told us the staff levels were often worse at a weekend. One member of staff said, "At weekends it's like a ghost town." The feedback from staff about how the management team managed the staffing levels was mixed. One member of staff told us the managers were not always responsive if they rang and reported the lack of staff. But other staff members told us the managers did try to cover short notice sickness and did come into the service to support them if this was required.

The registered manager told us they used their company's dependency tool to help them establish staffing levels and on the days of our inspection we saw there were enough staff to meet the needs of people in the service. However, we viewed the staff rosters for previous months and saw the numbers of staff required were not always on duty. The registered manager told us they did always try to get staff to cover short notice sickness and both they and the deputy manager worked with care staff when required. They told us there was an on-going recruitment plan in place to ensure the staff numbers met the needs of the service.

People could be assured the management team followed safe practice when recruiting staff. We viewed staff records and saw there were references in place from previous employers and the provider had used the Disclosure and Barring Service (DBS) to carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. The checks are used to assist employers in making safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

The majority of the people we spoke with felt staff had the right training to support them in their roles. One person said, "I do feel the staff are well trained, yes, they are all very good." Another person told us staff were good at lifting and handling them when they needed support to move from one place to another. A relative we spoke with told they were happy with the staff's knowledge, they said staff were, "Pretty well up on things," in relation to their family member's care.

Staff we spoke with told us they received regular mandatory training for their roles and the majority of this was completed via e-learning. New members of staff had received classroom based training for moving and handling. Team leaders we spoke with also told us they had achieved a nationally recognised qualification in care.

We spoke with some members of staff about particular health care areas such as diabetes and found there was a mixed level of knowledge about the subject amongst staff. One member of staff felt they required more training and support in this area. They told us they had asked the manager if further training was available but they did not know if they would receive any additional training. We addressed this with the registered manager who explained they were in the process of arranging extra training sessions for staff in areas such as tissue viability (management of skin care), management of urinary tract infections and dementia. They had also asked the district nurses for diabetes training and end of life training for their staff and was confident this would be provided for staff.

We saw the training matrix showed that 82% of staff had completed their on-going mandatory training and the registered manager had a plan in place to ensure the remainder of staff received up to date training.

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

The service did not always work within the principles of the Mental Capacity Act 2005. Whilst we saw there were some mental capacity assessments undertaken for different aspects of people's care these were not always supported by best interests decisions to ensure any interventions made on behalf of the person was made in the least restrictive way and in their best interests.

We saw some aspects of people's care had not always used the most up to date information to assist in making safe decisions in people's best interests. For example, one person's care record contained a mental capacity assessment showing the person was at high risk of choking when eating and drinking, and lacked the mental capacity to understand they required support with their nutritional requirements. The mental capacity assessment had been completed in 2017. However we also found that information and guidance from a health professional given a number of years ago was continuing to be used to support a decision to allow the person to choose their own meals. The person had a degenerative dementia related condition and

their mental capacity and physical condition had diminished since this guidance had been given. But there had been no re-evaluation of the advice given in the person's mental capacity assessment. Nor had there been any on going dicussions with relatives or relevant health professionals to establish whether it was in the person's best interests to up hold this decision.

This also meant staff caring for the person had conflicting information on how best to support the person in this area of their care. We discussed this with the registered manager who told us they had been reviewing the mental capacity assessments and had yet to arrange best interest meetings with the relevant people. They also told us they felt they required further training in this area and this had now been arranged.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The records we viewed showed the provider was working within the recommendations of the authorisations.

People we spoke with told us they were happy with the food on offer at the service. One person told us, "I enjoy the food here and for most of the meals you get a choice." Another person told us there was always plenty to eat and drink and that families were able to sit and have a meal with them if they wanted to. One or two people felt there could have been more dessert choices for those people who had diabetes. We raised this with the registered manager and chef who told us they would address this.

The staff we spoke with were knowledgeable about people's nutritional needs and the chef told us they or a member of their team went out each day to talk to people about their choices. They told us they had a daily dietary sheet that had everyone's needs and preferences on it. The chef said, "I know everyone's dietary needs." They also told us they worked to stimulate people's appetites and tried to present the meals in an appetising way. For example those people who required a fork mashable diet would be shown the meal before it was mashed up and if people required a pureed diet the chef would separate items to make it as palatable as possible.

However, whilst people were encouraged to follow a healthy diet and had their weight monitored, one person with a health condition that meant they required a special diet had gained a significant amount of weight within the period of a month. We discussed this with staff who told us the person had the capacity to make their own choices and they always offered healthy choices at meal times. However the person's health condition had been unstable and we could not see a referral to a health professional to advise the person on their diet. This meant people were not always supported in the way they should be to maintain a healthy diet.

People told us they had access to health professionals when they needed them. One person told us the G.P came in once a week to see people, and if they required a G.P urgently then this was arranged. People had access to an optician, dentist and chiropodist on a regular basis. As there were a number of people who required the service of a district nurse they visited on a daily basis.

However, staff we spoke with told us that senior care staff weren't always as responsive as they could be if they reported health concerns to them. One member of staff said, "Sometimes we can ask a senior three or four times to come and look at someone before they get a doctor." Health professionals we spoke to told us that, "communication could sometimes be an issue." One health professional said, "Instructions are given but loosely followed." They gave an example of written instructions given and put in people's care plans not always being adhered to, or instructions not being passed on to staff. We discussed this with the registered manager who told us they would address the issue with relevant staff.

Good

Is the service caring?

Our findings

People who lived at the service and their relatives were very positive about the caring attitude of the staff who supported them. One person said, "The staff make this place. You know you can always go to them." Another person told us, "They (the staff) know me and I know them. I like the staff, I think they are good." People told us they liked the fact the staff knew their names, were affectionate towards them and had good relationships with them. Relatives felt welcome when they visited their loved ones and felt staff were caring and their relatives were well cared for. One relative said, "I can visit whenever I want to. I'm always made to feel very welcome. They're (the staff) a genuine bunch."

Staff we spoke with felt there was a caring culture at the service, one member of staff said, "Yes my colleagues are caring, we have built up good relationships with people and their relatives."
Our observations supported these comments. We saw staff's interactions with people showed their knowledge of their needs and preferences. Staff knew where people enjoyed sitting, their food and drink preferences and their routines. For example a member of staff explained how some people enjoyed breakfast in their rooms before coming to join other people in the different communal areas.

Throughout the inspection we saw that people's choices and preferences were highly considered by staff and people spoke positively about how they were able to choose how they spent their days. One person said, "I go to town on my own." Throughout the visit we saw people were able to move freely around the service and there were two lounge areas for them to use throughout the day. The meal time experience was pleasant and people who were sat together were served together making the meal time experience a sociable event.

People we spoke with told us staff provided their care in the way they wanted it and listened to their views on how they should receive their care. People and their relatives told us they had been involved of different aspects of their care plans. One person we spoke with told us, "We (themselves and their relative) had a meeting with staff recently and talked about general arrangements for my care." Another person told us they had a care plan and that one of the team leaders discussed it with them to ensure they were happy with the way their care was provided. One relative also told us they had been involved with their relation's care planning. They told us staff had been going into their relation's room at night to check on them but this disturbed their relation's sleep pattern. They said, "(Relation) asked them not to so, now they have stopped."

The manager told us no one living at the service had any diverse cultural needs but where people wanted to attend their chosen place of worship they were supported to do so.

People we spoke with told us staff treated them with respect and maintained their privacy and dignity when providing care for them. One person said, "Staff don't barge in when I am in my room. My room is private. Staff help me because I have asked them to." Other people we spoke with told us staff were very careful to maintain their privacy when offering personal care. They told us doors are closed and staff spoke discreetly about aspects of personal care.

Staff we spoke with showed a good understanding of their roles in maintaining people's privacy and dignity. One member of staff said, "We would cover people up (when giving personal care). Give people the option of managing their own needs if they wish and give people private space when they need it." We saw staff talked discreetly with people about their care and when they provided aspects of care they did so in a way which was respectful.

Staff encouraged people's independence and people were appreciative of this. One person told us "I try to be independent. I like to go out in the garden. I shave myself." Another person told us when they wanted to go out they just signed themselves out when they wanted to go out of the home. They said, "I can do as I please" and they told us they valued this independence.

Requires Improvement

Is the service responsive?

Our findings

Whilst people told us they were treated as individuals and supported in the way they wanted to be, their care plans did not always reflect this. The information in people's care plans was variable. Whilst the care plans had been developed for people's care and support needs, some lacked sufficient and consistent information to assist staff to give the individualised care people required. For example in one care plan there was several references to changes in the care of one person's health condition. The information showed in one part of the care plan that the person was receiving a particular medicine for their condition but another part of the plan stated this had been stopped. This was confusing for staff as there were no dates to show which was the most up to date information related to the treatment of the person's condition and posed a risk they would not be treated correctly.

A further example in another care plan we viewed there was reference to a person having a crash mat, sensor mat and bed rails in place to prevent them falling out of bed. However, when we checked there was only bed rails in use for the person. Whilst staff we spoke with thought that the person only required bed rails there was a lack of clear assessment on how this decision had been reached, so staff did not have clear information to provide consistent care for this person.

Information in people's care plans was not always followed by staff. We saw in one person's file they wished to have a shower 'a few times a week'. The person also required regular checks on the condition of their skin as they were at risk of skin problems . The care plan stressed the importance of these checks due to the person having an underlying health condition that could affect their skin integrity. The daily records we viewed showed the person had not received a shower for almost a month and had been washing themselves each day. There was no record of the person's skin being checked in their care records. Staff we spoke with confirmed that as the person had been managing their own personal care these checks had not been undertaken on a regular basis. This put the person at risk of any skin issues being overlooked. We discussed these issues with the registered manger and the head of care for the provider who told us they were formulating a plan to address these issues and ensure staff used the information in the care plans to assist them. They told us they were also improving the information in the care plans so staff had the necessary information to ensure people received individualised care.

People were supported to follow their interests and hobbies at the service. People told us the staff at the service did everything they could to arrange different activities to suit people's needs and support them with their hobbies. One person told us they were able to go out and meet friends at a local pub. Other people enjoyed a weekly quiz, board games, singers and puzzles. A further person said, "Yes I do feel supported to do what I want to do. I enjoy the activities. We have made a Christmas cake and we are going to decorate it soon." The service had regular themed days and often linked the food that was served with the different themes and decorated the service to reflect this.

Staff we spoke with felt there were different activities for people. One member of staff said. "There's loads of things for people to do." They went on to say eight people went to a local fair in the service's mini bus the previous week and people went to the local market each week. They told us there were arrangements to

take people to the upcoming Christmas market in the town. On the day of the inspection we saw the quiz taking place and it was clear a large number of people enjoyed it. We saw other people were encouraged to take part in craft work.

People and their relatives told us they knew who to complain to if they had any issues. People were aware there was a complaints procedure and one relative told us they had seen it on the notice board in the service. People told us they went to see staff if they had any problems. One person said, "I'm comfortable making complaints – they (staff) usually do something about it." Another person said "I have no complaints. There's always someone to talk to if I am worried." People felt the registered manager and staff would deal with any complaint or concerns they had. One relative told us they had queried something with the registered manager recently about their relatives care. They told us they were happy with the explanation given and response from staff.

Staff we spoke with told us they were aware of how to deal with concerns or complaints. One person told us they would sort out anything they could themselves and record this. If they couldn't deal with it they would make sure the person in charge was aware of the complaint and again record the issue.

The registered manager was able to show us information on how they had dealt with complaints raised to them and there was a complaints policy up in the home.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post. They had been registered with the CQC since August 2017, prior to this they had worked at the service as a deputy manager for a number of years and people we spoke with knew who the registered manager was. They spoke about her by name and felt they could talk to her. One person said, "The manageress is (name). She comes and says hello at meal times, yes she is definitely approachable." Another person told us they felt the registered manager did listen to them.

Whilst the people and their relatives were positive about the management team and felt they were visible and approachable we received mixed feedback from staff about the management team. Some staff we spoke with did not feel supported and felt there was a lack of confidentiality when issues were raised. One member of staff said, "There is poor morale and because things aren't dealt with people lose their motivation." These concerns were echoed by some people we spoke with who had highlighted that at times staff were heard complaining about aspects of their jobs. However other members of staff felt the registered manager and deputy manager were new to the role and were beginning to make some improvements.

We discussed this with the registered manager and the head of care for the provider. The management team recognised that there had been a lack of support for the registered manager who had not been in their role very long. The head of care manager was now working with the registered manager to support them further in their role.

Whilst we saw there were a number of required improvements highlighted during the inspection that the registered manager and head of care needed to address such as training on specialist areas for staff, care plans and mental capacity assessments. We also saw the registered manager had introduced initiatives to improve care for people including changes to staff working practices to improve management of mealtimes to ensure people who required support were given this support.

Whilst staff told us they were aware of and were confident to raise safeguarding concerns at the service. We also found there was a lack of recognition of what the management team should be reporting to the CQC and the local safeguarding teams. For example, prior to our inspection a person had suffered a serious injury which resulted in them being hospitalised for a number of days and we had not been informed of this incident. An ambulance crew had also raised concerns to the service about the management of the person's care. Whilst we saw there had been some work undertaken between the district nurses and the registered manager there had been no formal investigation into the issues. The registered manager had not completed a statutory notification to the CQC or made a referral to the local safeguarding team as required.

It is a legal requirement of the registered manager to submit this information to the CQC and as a result of this omission there has been a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

Staff we spoke with told us they had received some supervision from the management team however it was not undertaken on a regular basis and the feedback from staff on how useful it had been was varied. Some

staff told us there was a printed sheet with issues the registered manager wanted to discuss and they signed to confirm they were aware of the issues. However they told us there was no opportunity to raise their own concerns or discuss their future development. The comments were supported by the supervision matrix which showed a number of gaps in the supervision programme and also showed that sometimes up to 12 staff had received supervision in one day. The registered manager told us they did try to undertake group supervision however when we looked at the evidence provided we found staff had simply attended a staff meeting where different topics were raised. There was no evidence that staff had been able to have a meaningful discussion around the topics raised. The registered manager told us they working to ensure a more comprehensive supervision and appraisal programme was in place for staff. This would ensure the deputy manager and team leaders were trained to undertake staff supervisions.

There was a lack of robust quality audits in taking place at the service and this had led to some issues around people's care not being addressed. For example, we saw a gap in the medicine administration record for one person for a medicine prescribed for 8am on one day and gaps for all the medicines for another person on the same day and time. We also noted a person had not had one medicine which was prescribed to be given at 8am for 17 days as the person was asleep. This issue had not been addressed through auditing and we found the medicines audits were not completed regularly and when they had been completed issues such as this example had not been addressed. We further noted that an audit completed in August 2017 had identified that three member of staff required some medicine training. This had not been actioned and had been noted on the audit completed in October 2017. This example meant whilst the auditor had identified some issues they had not completed the actions necessary to ensure safe practice was maintained.

There was a lack of care plan audits and this lack of audits had meant that there was no oversight of the information contained in people's care plans. This had resulted in the information in some care plans relating to people's underlying health needs giving conflicting information for staff on how the risks related to their health condition should be managed. For example one person whose condition had been unstable over a period of time had conflicting information on how often they should have a particular monitoring test undertaken. The records we viewed were inconsistent and the staff we spoke with gave conflicting information on how often they had been monitoring the person.

A further person's care plan showed they had been assessed as being at high risk of developing pressure sores. The care plan noted that daily checks of the person's skin integrity be undertaken by staff on a daily basis. On viewing the person's records we could not see that these checks had been taking place. We raised this with the head of care for the provider who told they had also undertaken an audit which had highlighted the same issues we had found. They told us they were putting in a plan to address these issues.

The lack of monitoring of the above issues 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 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 12 HSCA RA Regulations 2014 Safe care and treatment Administration of medicines at the service were not always managed safely. The risks to people's safety was not always assessed and managed in a way to prevent avoidable harm

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 safeguarding incidents were not always recognised, investigated and reported to ourselves and local authority

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust audits in place to effectively monitor the quality of the service provided for people