Four Seasons Homes No.4 Limited

Marquis Court (Tudor House) 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Marquis Court (Tudor House) provides accommodation for up to 52 people who require nursing or personal care, divided into a nursing and a residential unit over two floors. Some people have complex medical conditions and some people are living with dementia. On the day of our inspection visit, 28 people were living at the home. We had previously inspected the home in September 2016 and rated the home as Requires Improvement overall with specific concerns about the management of risks associated with people's care and medicines and that people were not always treated with dignity.

We received an action plan from the provider in October 2016 which said the improvements would be made by January 2017. At this inspection, we found some improvements had been made but further action was still needed to ensure the legal requirements were being met. We also found improvements were needed to ensure there were sufficient, suitably qualified staff available to meet people's needs and the effectiveness of the provider's quality assurance systems.

There was a registered manager who had started working at the service in October 2016 and had registered with us in February 2017. 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 improvements were still needed to ensure risks associated with people's care were always managed safely. The registered manager had made improvements to ensure medicines were administered, stored and recorded safely. However, there were insufficient, suitably qualified staff and people's medicines were sometimes delayed and people's care needs were not always met in a timely fashion. Staff were busy which meant interactions with people were limited and at times, staff did not always treat people with dignity and respect. People were not always supported to have an enjoyable mealtime experience and some people's individual needs were not met. The activities co-ordinator had been absent from the service for some time and people were not always offered opportunities to join in social activities and follow their hobbies and interests

People and their relatives had told the provider on a number of occasions that there were insufficient staff to meet their needs. However, the provider had failed to act on their feedback and had not effectively assessed, monitored and mitigated risks to ensure there were sufficient suitably qualified staff to meet people's needs at all times. Quality assurance checks were not always effective in identifying shortfalls and driving improvements in the service.

Improvements were needed to ensure staff received effective training and support to meet the needs of people they cared for. The provider followed procedures to ensure staff were suitable to work in a caring environment.

People felt safe living at the home and staff understood their responsibilities to protect people from the risk of abuse. People accessed the support of other health professionals when needed and were encouraged to keep in contact with family and friends. Visitors were able to visit without restriction. Relatives felt involved in people's care and were kept informed of any changes.

The registered manager and staff understood their responsibilities to support people to make their own decisions as much as possible. Where people lacked the capacity to make decisions for themselves, decisions were made in people's best interests which followed legal guidance. Where people were being restricted of their liberty in their best interests, the registered manager had applied for the required legal approval.

People felt confident raising concerns and complaints. The provider was open and transparent and kept people informed about things that were happening in the service.

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

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 consistently safe.

The provider had not made the required improvements to ensure risks associated with people's care were always managed safely. There were insufficient, suitably trained staff to meet people's needs at all times; people's medicines were sometimes delayed and people's care needs were not always met in a timely way. Staff understood their responsibilities to keep people safe from the risk of abuse. The provider followed procedures to ensure staff were suitable to work in a caring environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were still required to ensure people were supported to have an enjoyable mealtime experience and have their needs met. Improvements were needed to ensure staff received effective training and support to meet the needs of people they cared for. The registered manager and staff followed the Mental Capacity Act 2005 where people lacked the capacity to make decisions for themselves. People were supported to access other health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring in their approach but at times they did not always treat people with dignity and respect. People were encouraged to maintain important relationships and visitors were made welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were happy with the way staff cared for them. However, when staff were busy with care tasks they did not always respond in good time to ensure people's individual needs were met. People told us they were frequently bored and the long-term

absence of the activities co-ordinator meant that they were not offered opportunities to join in social activities or encouraged to follow their hobbies and interests. People felt confident raising concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had failed to act on feedback received and had not effectively assessed, monitored and mitigated risks to ensure there were sufficient suitably qualified staff to meet people's needs. Quality assurance checks were not always effective in identifying shortfalls and driving improvements in the service. People and their relatives found the new registered manager to be approachable and visible at the service. Staff were positive about the improvements being made by the registered manager.

Marquis Court (Tudor House) Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 February 2017 and was unannounced. The inspection was carried out by two inspectors, a member of the CQC medicines team 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.

We reviewed the information we held about the service which included statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. The provider had submitted 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. Following our last inspection in September 2016, we had been liaising closely with the local authority safeguarding team who were carrying out an investigation of the home. The local authority had placed an embargo on the provider to prevent admissions as they had ongoing concerns about the quality of care being provided and were working with the provider in relation to these to bring about improvements. We reviewed the information shared with us as part of their investigation and used this information to help us plan the inspection visit.

We spoke with nine people, three relatives, five care staff, the nurse, the cook, the deputy manager, the registered manager and the regional manager. We did this to gain views about the care and to ensure that the required standards were being met. We spent time observing care in the communal areas to see how the staff interacted with the people who used the service. Some of the people living in the home were unable to

speak with us in any detail about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

We looked at the care records for six people to see if they accurately reflected the way people were cared for. We also looked at records relating to the management of the service, including staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, the provider was in breach of Regulation 12 of the Health and Social Care Regulations (Regulated Activities) Regulations 2014. This was because risks associated with people's care were not always well managed. Staff were not always clear on how frequently people should be repositioned to prevent pressure damage to their skin and staff did not always have guidance in the correct use of pressure relieving equipment to ensure people received the correct therapeutic support. In addition, we found that people's medicines were not always available when needed and medicines including topical creams were not always recorded in accordance with good practice or stored securely.

At this inspection, we found the required improvements had not been made and people's risk management plans were not always followed which meant people were at risk of not receiving their care as planned. On the residential unit, we saw that one person had been referred to the district nurse for advice to manage an area of sore skin and their records noted to 'continue with pressure relief on a two hourly basis'. We spent time observing care in the communal lounge and saw that for large parts of the morning, there were no staff to support people as they were busy supporting people in their bedrooms. We saw that when staff passed through the lounge they occasionally spoke to the person and although it was evident they were in some discomfort because we saw them wincing and crying out, staff did not seem to notice this. As a result, the person remained seated in the same position in their armchair for more than four hours. We alerted the senior member of staff to our concerns and the person was supported to their bedroom. Staff were aware of the person's needs and the need to reposition them on a two hourly basis. One member of staff said, "We are trying to get to [Name of person] but we have been busy". This meant that at times the person did not receive the care or support they needed which put them at increased risk.

We also found that staff were unsure about how to support people who were at risk of choking. One person's care plan stated that they should have a fork mashable diet and their drinks should have two scoops of thickener added. It also stated that the person should be sat upright and supervised whilst drinking. We saw that the person was served an unthickened drink and staff did not supervise them to drink it. At lunchtime we saw the person was served a meal of egg and chips which was cut up into small pieces but the chips were too hard to be mashed. We saw that the person was unsupervised whilst eating and drinking and was not sat upright which put them at increased risk of choking. Discussions with staff and checks on the care plan of another person confirmed that staff were not clear on the correct consistency of people's drinks. We saw that staff on the nursing unit had a list of people's specialist dietary needs but this was not available on the residential unit.

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

At this inspection, we found that some improvements had been made to the management of medicines. We saw that people's medicines were available when they needed them and medicines were stored securely and appropriately recorded. However, some people were prescribed medicines on a when required basis.

We found that protocols to describe the use of these medicines were not always in place as required by the provider's medicine policy. We saw that the registered manager had identified this and was taking steps to ensure sufficient information was available to guide care staff on when the medicine was needed. This would ensure people received their medicines in a consistent way. Records were kept for people that had medicines given via a skin patch to ensure staff were able to correctly rotate the sites of application. The home used separate administration charts for people who were receiving medicines via a cream or ointment and records of application were being kept. On the residential unit these included body maps which guided staff on where these must be applied. These maps were not in use on the nursing unit; however, standardising the use of these charts had been identified as a priority by the registered manager.

We found the provider had not ensured there were sufficient appropriately trained staff to administer medicines, which sometimes had an impact on the timeliness of people's medicines. One person told us, "I mostly get my medicines when I need them but sometimes a situation arises when the staff can't give them, like if the emergency alarm goes". On the morning of the inspection we observed people receiving medicines that should be given before food, being administered with their breakfast. This would result in these medicines being less effective than intended. Staff told us this was due to the medicine round starting late following an overnight emergency. Further discussion with the member of staff and registered manager demonstrated that people's medicines had been delayed on other occasions and at weekends, the nurse administered medicines for both units because there was no other trained member of staff available. The nurse told us this meant them doing six medicines rounds each day which resulted in medicines being given later than intended. In addition, the night staff on the residential unit were not trained to administer medicines so could not support the giving of medicines early in the morning. This meant people could be put at risk of not receiving their medicines as prescribed. when needed.

The registered manager told us staffing levels were based on people's needs and calculated using a dependency tool. Staff rosters confirmed that staffing numbers were being maintained in accordance with this. However, it was clear that in addition to a lack of staff trained to administer medicines, there were insufficient staff to provide people's care as planned. People told us they frequently had to wait for support and at times their care was rushed. One person said, "When staff are helping with the shower, it's a quick in and out – there's no luxury". Another person said, "If staff are washing somebody else you sometimes have to wait quite a while when you call for assistance". We saw that staff weren't always able to assist people in a timely way when they asked for support. On the nursing unit there were three care staff and most people required the assistance of two staff, which meant people had to wait when staff were supporting another person. At times, we saw that people had to wait up to 15 minutes for support. A relative told us, "[Name of person] needs two staff to assist them and often has to wait for assistance". We saw that call bells in people's bedrooms were not always answered promptly and at times they rang for up to 10 minutes before being answered. Staff told us they regularly struggled to meet people's needs. One said, "Three staff and a nurse just isn't enough, we need a fourth carer. We can't always get people up; sometimes it's 2pm or 3pm before everyone is washed and dressed. The buzzers ring but we can't always go to people straight away". At lunchtime, three people were left alone in the dining room to eat their meals. One person was at risk of choking and their care plan stated that they needed close supervision and encouragement but for the majority of the mealtime there were no staff available to do this. This meant the person was at increased risk of choking.

On the residential unit, we saw there were frequent occasions when there were no staff available to support people in the communal areas because staff were supporting people in their bedrooms. We observed one period of just over 20 minutes when staff only passed through the communal lounge on their way to the kitchen or dining room and did not stop to check on people. One person was walking around the room using their frame but then left the frame and began using the arms of chairs to mobilise, which increased

their risk of falling. Staff told us they felt under pressure with the number of staff the provider allocated to each shift. One said, "On paper the staffing numbers are right, but the staff are under strain. We're not getting people up, and showering and bathing is delayed". Staff told us and we saw that they were still supporting people to get washed and dressed at mid-day. One person told us, "I had a shower at 5am this morning; the night staff have to help us as the day staff haven't got time".

The above issues demonstrate a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who were able to give us their views told us they felt safe and liked living at the home. One person told us," I feel very safe here, I think it's the company". Another said "I'm happy in my home, it's a nice atmosphere". Relatives we spoke with felt their relations were happy and were satisfied with their care. One relative told us, "I think [Name of person] is content". Staff could tell us about the different types of abuse and what action they would take if they suspected someone was at risk of being abused. One member of staff told us, "If I saw something wrong I would go straight to the nurse or the manager". All the staff we spoke with were confident that any concerns they raised were acted on but told us they had the information they needed to escalate their concerns if necessary. One member of staff said, "I haven't had to go the manager yet but I think they'd take it seriously". Our records confirmed the registered manager reported any concerns to the local safeguarding team and ourselves. This showed the registered manager and staff understood their responsibilities to keep people safe from harm.

Staff told us and records confirmed that the provider carried out recruitment checks which included requesting and checking references and carrying out checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. We saw that checks were carried out to ensure that nurses were registered with the Nursing and Midwifery Council. This meant the provider followed procedures to ensure staff were suitable to work in a caring environment.

Requires Improvement

Is the service effective?

Our findings

At this inspection, we found that improvements had not been made to ensure mealtimes were a sociable experience for people on the nursing unit. This meant the provider had not achieved the improvements stated in their action plan. We observed the lunchtime meal and saw that staff were not available to support people eating in the dining room. We saw that staff offered people a choice of main course, served the meal and then left the room to assist people in their bedrooms. We saw that people sat in silence for around 45 minutes as there was no member of staff to stimulate any conversation or encourage them to have sufficient to eat and drink. We saw that people ate only a small amount of their meal and when staff returned to the dining room, they offered some encouragement but it was clear that people's meals had gone cold and were no longer appetising. A member of staff asked people if they would like a pudding but there was no encouragement and when asked, staff did not seem to know what it was and whether it should be served hot or cold.

People we spoke with told us they were happy with the meals on offer and that they had a choice. They told us they were able to have alternatives if they didn't like the meal on offer. We saw that people had snacks in between meals, for example a biscuit or a yoghurt. Although we have identified concerns that one person's dietary needs were not being met, we saw that people's weights were monitored and staff sought advice from professionals including the dietician and speech and language therapist in response to any concerns. This ensured people had sufficient to eat and drink to maintain good health.

At the last inspection, we asked the provided to make improvements to ensure all staff received training in the areas they deemed mandatory. At this inspection, we found improvements were still needed. The provider told us that they had recently identified concerns with mandatory training provided via eLearning and the decision had been taken for all staff to repeat the training to ensure their skills and knowledge were up to date. At a national level, the provider had also advised us that they were addressing problems with eLearning compliance in relation to other areas of training whereby staff had not been prompted to complete their annual re-fresher training. The regional manager advised that the provider was moving towards a greater emphasis on face to face training. They told and the provider's resident experience team would be visiting the home to provide this training.
Staff were aware of these planned eLearning updates and told us they also received annual face to face training for moving and handling and were assessed by an accredited in-house trainer to check that they were competent.

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 people 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 under the DoLS. We saw that people's mental capacity had been assessed to reflect their ability to make decisions for themselves and where decisions were being

made in people's best interests, these were documented. For example, best interest decisions were in place where it had been recommended that a sensor mat be put in place to alert staff when the person got out of bed, because they were at risk of falls. Staff recognised their responsibilities to support people to make decisions where they were able. One member of staff told us, "If people can't communicate easily we look for their facial expressions and body language. For example, if I'm helping someone with a drink I hold the beaker up and see if they open their mouth". We observed staff asking people for their consent before they provided care, for example, we heard a member of staff discretely asking a person if it was OK to take them to the bathroom for personal care. One person told us, "The staff ask before they do anything – they say, is it alright if I look at your hands and trim your nails". This showed the staff understood the importance of gaining consent.

We saw that the registered manager made applications for people who were being restricted of their liberty in their best interests and we saw they ensured any conditions were followed. Our records confirmed that approvals had been notified to us as required. This showed the registered manager and staff were working within the principles of the legislation.

People told us they accessed the support of other health professionals when needed. One told us, "I see the district nurse now and again and the chiropodist comes in". Another person told us they had appointments arranged with the chiropodist and the optician, "The staff are helpful and put you in touch with the relevant person". Relatives told us the staff were proactive and kept them informed when their relation's needs changed. One said, "The moment [Name of person] is unwell, the staff phone me and keep me informed". We saw that visits from professionals were recorded and people's care plans were updated when specific advice was received, for example changes to people's medicines. This showed people were supported to maintain their day to day health needs.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, the provider was in breach of Regulation 10 of the Health and Social Care Regulations (Regulated Activities) Regulations 2014. This was because staff did not always treat people with respect and promote their dignity. The provider's action plan stated that dignity training was provided for staff and staff conduct would be monitored by their resident experience team during quality assurance visits. However, we found improvements were still needed to demonstrate that people were consistently treated in a dignified and respectful manner.

People and their relatives told us the staff were kind and caring but they were frequently too busy to chat with them. A relative said, "To an extent they seem caring but they don't stop and chat, they haven't got time. Our observations showed that staff were caring in their approach but interactions with people were brief and focussed on the support task being provided.". Staff did not consistently address people in a respectful manner that showed they valued them. For example, one person appeared to be anxious and in some discomfort. We heard a member of staff say to the person, "What's up? You don't know do you, you're at that funny age". The member of staff did not wait for their response and did not take the time to sit with them to find out what was the matter.

On some occasions we saw staff did not ensure they promoted people's dignity when supporting them to move using equipment. For example, we saw that a member of staff did not cover a person's legs when they supported them to transfer to their armchair. The person became embarrassed as their bare legs were on show and there were other people in the room with them. They said, "I don't like people looking at me". We also observed that staff sometimes struggled to remove the sling used to help move the person; they did not always do this in a dignified manner and people's legs and underclothes were sometimes visible. We saw that one person's dignity was compromised because staff had not ensured they had their false teeth in place before bringing them into the communal lounge. The staff member said to them, "Oops, I think we are missing something" and took them back to their room.

Staff did not always ensure people were supported to make choices about their daily routine. For example, staff asked people for their meal choice at lunchtime but they did not clearly explain what was on offer and encourage people to make a choice for themselves. We also observed a member of staff adding a large amount of salt to one person's meal at lunch-time but they did not ask them if they wanted it or not.

This was a continued breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We did see examples of positive interactions between staff and people. Staff were patient with people and encouraged them to retain their independence when moving around the home. For example, we saw a member of staff spent time with a person encouraging them to walk using their frame. We also saw staff spent time explaining to people what they were doing, for example when they were supporting them to move using equipment. We saw they ensured they were comfortably seated in their armchairs before

leaving them.

People told us the staff respected their privacy. One person said, "If I go to my bedroom, the staff always knock on the door and ask if they can come in". Another said, "Staff only come into my bedroom to see what I want and before they come in they knock on the door". People were encouraged to maintain relationships that mattered to them. One person said, "Visitors can come anytime. My daughter has a laugh and joke with everybody when she comes. My family can come and take me out on a wheelchair any time".

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, we asked the provider to make improvements to ensure people's concerns and complaints were responded to and resolved. At this inspection, people told us they would have no hesitation in speaking to a member of staff or the manager if they had any concerns. One person said, "I have complained and the manager has done something about it. If they didn't, I wouldn't think twice about going to someone higher up". A relative told us, "I've had no cause to complain but if I did, I would go to the office". The provider's complaints procedure and contact details for the provider's senior management were on display in the foyer of the home. People were encouraged to raise any concerns and complaints and the registered manager met with people and their relatives to reach a resolution. Complaints were logged and monitored by the provider to ensure they were responded to in line with their policy and procedure.

People told us the staff understood their needs and they were happy with the way staff cared for them. However, we saw that because staff were busy with care tasks they did not always respond in good time to ensure people's individual needs were met. For example, one person cut their hand and asked staff for a dressing to cover it. We saw that it took more than 20 minutes for a member of staff to arrange for this. Another person asked for a blanket because they were cold and it was 10 minutes for this was brought for them and the window next to them was closed.

People told us the activities co-ordinator had been absent for some time and opportunities to join in social activities and be supported to follow their hobbies and interests were limited. Comments included, There's no activities, the activities lady has not been here for weeks", and "We don't do things very often". People told us a member of the care staff had supported them to make cards recently, "We enjoyed making valentines cards with one of the carers but we want to get ready for Easter and we need some help". Some people told us they were happy to amuse themselves with puzzle books and colouring, or watching their television, but other people said they were bored. One person said, "I do get bored on some days, especially as I've been an active person". Another said, "I think everyone here gets bored". We saw that people who were cared for in their bedrooms were offered no social stimulation as interaction with staff was limited to care tasks. One person told us, "Nobody seems to have the time to do any kind of activities with us now". A member of staff told us, "We know people are bored but we don't have the time to spend with them". The provider was aware that people were not happy with the lack of activities and had been looking for ways to improve things whilst the activities co-ordinator was absent but they had not yet found a solution.

People's needs were assessed prior to moving into the home and their care was regularly reviewed to ensure it continued to meet their needs. Relatives told us they were kept informed of any changes. Staff told us and records confirmed that they recorded the care people received on a daily basis and any concerns that other staff should be aware of. This was discussed during the shift handover which ensured incoming staff were kept up to date about people's needs. We saw there was a written record of the handover meeting which staff were required to read, for example after an absence from work, to ensure they were aware of any changes in people's needs.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, there was no registered manager at the service and systems to ensure the safety and quality of the service were not up to date. At this inspection, a new manager had started working at the service and had recently registered with us. The registered manager had brought the quality assurance systems up to date and improvements had been made in the management of medicines. However, improvements were needed to the systems used to monitor and allocate staff. People told us they had repeatedly raised concerns that there were not enough staff to meet their needs. One person told us, We keep saying that they need more staff but they don't listen to us". The provider was confident that their dependency tool ensured there were sufficient staff available to meet people's needs. However, people's experiences and our observations showed that this was not always the case. This demonstrated the provider had failed to act on feedback received to ensure they effectively assessed, monitored and mitigated risks to ensure there were sufficient suitably qualified staff to meet people's needs at all times.

The registered manager carried out other audits, including checks of care records. We saw they identified areas of concern such as falls, weight loss and skin integrity and monitored these using a vulnerable residents list and noted any action taken, for example referrals to the falls team and dietician. However, the registered manager had not identified the concerns we found whereby staff were not following risk management plans to ensure people were protected from the risk of skin damage and choking. Checks to assess the competence of staff in the use of thickeners, to minimise the risks of choking, were not always effective as we found that some staff were unsure about people's individual needs. This showed that improvements were needed to ensure staff received effective supervision to ensure they were competent in their role. In addition, the provider's action plan had stated that staff received training and supervision to ensure people were treated with dignity and respect but our observations showed that this had not been effective.

We saw that the new registered manager was taking action to bring about improvements at the service. However, repeated breaches of regulations demonstrate a lack of consistency and need for improvement in how the home is managed and led.

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

Accidents and incidents were recorded and monitored for any trends to ensure appropriate action was taken to minimise the risk of reoccurrence. We saw that the registered manager had introduced a falls protocol to ensure staff were clear on the action they should take and the records were reviewed after each fall to ensure action was taken to prevent reoccurrence. Care plans were monitored on a monthly basis to ensure they were accurate and reflected people's current needs and an action plan was put in place to make any required improvements.

Although we found the provider did not always act on people's concerns, systems were in place to ensure

people could give their views on the service. There was a tablet in the foyer of the home where people could leave comments at any time. Resident and relative meetings were held to and the provider was open and transparent with people about the ongoing local authority safeguarding investigation at the service. Notes of a meeting held in February 2017 showed that the provider had acted on concerns about security at the home and installed new coded keypads as an interim measure whilst they evaluated other options. The provider told us they reported people's feedback through a 'you said, we did' system that was displayed on the noticeboard in the foyer.

People knew who the registered manager was but most felt it was too early to say if they were making improvements at the service. Comments included, "The new manager seems alright but you've got to wait and see." and "She's only been here a few weeks but I think she's slowly making some progress". And "She's only been here a bit but she listens to us". At the last inspection, staff told us morale was low and there were concerns about inconsistent management support. At this inspection, staff told us things were beginning to improve. They told us the registered manager was making changes and at first this had been difficult but they now felt able to give their views and were confident the manager listened to them. One member of staff told us, "The manager is trying to make things better". Staff were aware of the whistleblowing policy at the home and felt confident reporting any concerns about poor practice to the registered manager. One member of staff said, "If there are any concerns at all, big or small, the manager always acts".

The provider and registered manager understood the responsibilities of registration with us. We received notifications of important events that had occurred in the service, which meant we could check that appropriate action had been taken. The provider had published the service's performance rating on their website and a copy of the last inspection report was on display in the foyer of the home. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to act on feedback received and had not effectively assessed, monitored and mitigated risks to ensure there were sufficient suitably qualified staff to meet people's needs. Quality assurance checks were not always effective in identifying shortfalls and driving improvements in the service. Regulation 17(2)(a)(b)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient, suitably trained staff to meet people's needs at all times. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with their care and treatment. The provider was not doing all that is reasonably practicable to mitigate any such risks. Regulation 12(1)(2)(b)(c)

The enforcement action we took:

We have issued a Warning Notice.