T Fusco and Mrs A Heathcote

Birch Holt Retirement Home

Inspection report

Marlpits Lane
Ninfield
Battle
East Sussex
TN33 9LD

Tel: 01424892352

Date of inspection visit:
27 March 2017
28 March 2017

Date of publication:
26 May 2017

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?	**Inadequate**

Summary of findings

Overall summary

This was an unannounced inspection. Birch Holt provides accommodation, care and support for up to 26 people. On the day of our inspection 13 older people were living at the home. The service provided care and support to people living with dementia, risk of falls and long term healthcare needs such as diabetes.

We carried out an unannounced comprehensive inspection at Birch Holt Retirement Home on 10 and 12 October 2016. Breaches of Regulation were found and the service continued to remain in special measures following a previous rating of Inadequate in November 2015. As a result we undertook this inspection on 27 and 28 March 2017 to follow up on whether the required actions had been taken to address the previous breaches identified. We found some improvements however risks still remained.

A manager was in post, however due to ongoing Registration applications neither the provider nor manager was registered with the Care Quality Commission (CQC) and this is currently an unregistered service. The CQC are taking action to address this matter. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The ratio of care staff to people on each shift had improved since our last inspection. However there were examples of where the poor management of short notice unavailability of staff and their deployment impacted on responsiveness and the smooth running of the service.

The provider had not undertaken all appropriate checks on staff to ensure their suitability for employment.

We saw examples of poor staff practice in regard to infection control whist they undertook routine care tasks around the home.

Risks related to people's safety had not always been mitigated effectively. For example with regards to specialist care equipment.

The provider had not taken steps to ensure they were fulling their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

The systems the provider used to track staff training requirements had improved however we found examples where some staff had not completed training in a timely manner. Staff supervision and probationary meetings provided limited feedback that was designed to develop staff's performance and capability.

We found examples within the service where the culture and staff approach did not consistently promote people's dignity.

The provider had not made adequate provision to ensure people with the highest care support needs had their social needs met.

Although with support from an external consultant the provider's quality assurance systems had improved these had not been effectively used by senior staff to provide them with clear oversight of the service.

Despite the concerns we identified during our inspection people wanted to communicate with inspectors that they enjoyed living at Birch Holt Retirement Home and had many positive comments about the service provided.

The management of medicines had improved and people were receiving safe and appropriate support with their medicines. Senior staff had worked collaboratively with the pharmacy service the provider used to establish safe effective systems.

People told us staff were kind and we observed positive interactions between people and staff. We observed various meals, people told us they enjoyed the food and looked forward to coming to the dining room to spend time with others.

At the last comprehensive inspection this provider was placed into special measures by CQC. At this inspection there was not enough improvement to take the provider out of special measures. There were a number of breaches of the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after all legal requirements have been fulfilled.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found occasions when there were not sufficient numbers of staff to enable timely support for people.

We found some staff did not demonstrate good practice in regard to infection control principles. Some risks related to people's care had not been adequately managed and recorded.

The provider had not completed all appropriate checks to assure themselves staff were suitable to work within a care setting.

Medicines were managed safely and people supported to receive their medicines appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not ensured they were fulfilling their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff supervision did not provide feedback that was designed to support or develop staff's performance and capability.

The provider's staffing rota impacted on the effectiveness of staff communication.

People enjoy their meals and mealtimes and were supported to make decisions about what they ate and drank.

Is the service caring?

Requires Improvement

The service was not always seen to be caring.

Although we saw positive interaction between people and staff we found people's dignity was not consistently promoted.

Relatives and friends told us they were unrestricted as to when they able to visit people.

Peoples care records were held securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found the provider had not made adequate provision to ensure people's social needs were met.

We found examples where people's care plans did not always capture information which would be relevant for staff whilst providing care.

The provider did not have effective systems to act on feedback from people.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to consistently use their quality assurance systems to drive improvement.

The provider had failed to take timely corrective action to the areas of concerns which had been previously identified.

The provider had not taken steps to ensure there was effective day to day leadership within the service.

Birch Holt Retirement 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.

We inspected the service on the 27 and 28 March 2017. This was an unannounced inspection. The inspection team consisted of two inspectors. At the time of our inspection the provider had submitted an application to the CQC to alter their registration status from a partnership to a single provider.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. We looked at care documentation and records which related to the running of the service. We looked at six care plans and four staff files, all staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Birch Holt. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked at areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with nine people who live at Birch Holt, two relatives, seven staff, the provider and manager.

Before our inspection we reviewed the information we held about the home. We had not received an action plan from the provider following our previous inspection in October 2016. We did not request a provider information return (PIR) as this inspection was undertaken at short notice. We considered information which had been shared with us by the local authority and members of the public. We spoke with a representative from the Local Authority's contracts and monitoring team. We reviewed notifications of incidents and

safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2016, the provider was in breach of Regulations 18, 12, 15 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's safety in relation to staffing levels, medicine management, cleanliness and recruitment checks.

At this inspection we found some improvements in areas and the previous breaches in Regulations 18, 12, and 15 had been met; however the improvements were not fully embedded in practice and there remained areas that required improvement. The provider remained in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found three staff whose Disclosure and Barring Service (DBS) returns indicated there had been prior convictions. The provider could not evidence what steps they had taken to assure themselves these staff were suitable to work within a care setting. It is good practice to record either at interview or via supervision that these historic issues had been discussed with the employee to assure the provider they are suitable to work within a care setting. At this inspection we found no action had been taken in response to the breach in Regulation and there was no evidence within staff files that these issues had been discussed in their supervision. The manager confirmed this had not been completed. This is a continued breach in Regulation 19 HSCA (RA) Regulations 2014.

At our last inspection staff told us there were not sufficient numbers of staff on shift to keep people safe and respond to their care needs in a timely manner. At this inspection staffing levels on shifts had remained the same however there were now 13 people living at the service compared to 20 people in October 2016. Staff told us that they were able to respond to people's needs more quickly and felt that there were sufficient numbers of staff to keep people safe. However on the first day of our inspection two care staff were unavailable for work at short notice; and in the afternoon there was a period of time where there were two care staff working and we saw examples of people waiting extended periods of time for support and care. Due to the shortage of staff during this period the provider was required to support staff in the kitchen to assist with washing up and taking people's prepared meals to their rooms. On the second day of our inspection three care staff were on duty between 8am and 6pm; however we found an occasion where the deployment of staff was not effective. For example, all three care staff were seen taking their break at the same time; this meant during this time there were no carers in communal areas. The areas related to staffing levels and deployment requires improvement.

At our last inspection we found shortfalls in risk assessments. At this inspection risk assessments for people's care needs had improved. For example risk assessments for mobility detailed the equipment and the number of staff required. However we found the provider had not adequately assessed risk in relation to a person who was using bed side rails. Bed side rails are a 'medical device' and their use can present a range of hazards which the provider was unable to show they had assessed before their installation. The manager committed to undertake a risk assessment to ensure they could be assured of this person's safety.

At our last inspection we found concerns with the management of medicines. These included discrepancies

between actual medicines in the service and medicines administration records (MAR). This had meant the provider could not be assured people had been supported appropriately with their medicines. At this inspection there had been improvements with many aspects of medicine management including people's PRN 'as required' medicines. PRN are medicines which may only be required occasionally such as for the relief of pain. However we found staff were not consistently recording the reason why they had given people PRN. This is good practice so patterns can be tracked and the effectiveness of PRN medicines monitored.

All other aspects of medicine management were safe and met people's needs. Medicines in current use were stored in line with regulations in a secure area. We looked at a sample of MAR charts and found them competently completed. Medicines were ordered correctly and in a timely manner that ensured medicines were given as prescribed. Medicines which were out of date or no longer needed were disposed of appropriately. One senior staff member told us, "Since the recent support from our pharmacist I feel much more on top of everything to do medication."

At our last inspection in October 2016 we found areas of the home were not clean. At this inspection there had been improvements in the general cleanliness of the service. However we saw occasions where staff were not following good practice in regards to infection control principles. For example we saw a staff member carrying soiled laundry without wearing gloves or apron; another staff member had placed a person's clean bed linen on the floor in a busy corridor. Another senior member of staff's finger nails were an inappropriate length for supporting people with personal care; and not in line with the National Institute for Health and Care Excellence (NICE) for Healthcare-associated infections: prevention and control guidance. The provider did not have policies to guide staff on hand hygiene or dress code in line with The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance.

Environmental risks such as those related to fire continued to be managed safely. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Maintenance and servicing of equipment such as fire alarm, portable appliance testing (PAT) and boiler were seen to have been undertaken. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "The handyman is here a few days a week and is good."

Care staff were able to identify their responsibilities to keep people safe from harm or abuse. They had an understanding of the different types of abuse. Care staff told us they had confidence senior staff would take action if they raised concerns relating to potential abuse. Care staff told us if they were not satisfied with the response from senior staff they would contact the local authority or the CQC.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the provider did not have clear understanding of their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005. Care documentation contained limited information or reference to people's mental capacity. Although at this is inspection there had been improvements in multiple areas of care planning these did not provide information or clarification on people's mental capacity. The Care Quality Commission (CQC) is required by law to monitor how providers operate in accordance with the Mental Capacity Act (MCA) 2005. The MCA requires that assessment of capacity must be decision specific and must also record how the decision of capacity was reached. There were people living at the service who were living with dementia type illness; however the provider was unable to show how decisions made on these peoples' behalves for daily living needs, such as personal care and medicines, had been reached. For example staff had recorded that a person was frequently declining baths; however no assessment had been completed to determine whether this person had the capacity to accept or decline this specific care need.

At our last inspection we identified shortfalls in the providers understanding of advocacy. The issue had related to tow people sharing a bedroom; and no evidence as to who had agreed and advocated the decision in line with legislation. At this inspection we found that a person's relative was being consulted to advocate on decisions for a person without the provider being clear on the relative's legal status to make these decisions. Following our inspection in October 2016 the then deputy manager had written to the family to seek clarification however no response had been forthcoming.

The identified shortfalls related to the providers understanding and implementation of MCA Legislation are a continued breach of Regulation 11 HSCA (RA) Regulations 2014.

At our last inspection we found the provider had not sought timely health care intervention for people. At this inspection there were examples where staff had taken appropriate prompt action in response to health care concerns. People continued to tell us they felt supported to maintain their health, however we found an example where staff had not been proactive in following up on a health care matter. A person had been referred for additional tests by their GP following a series of falls; however staff had failed to follow up, until prompted by the inspector, with the person's GP to determine the outcome of these tests. The tests had taken place over a month before our inspection.

At our previous two inspections in November 2015 and October 2016 we found staff supervision was unplanned, brief and provided limited feedback that was designed to develop staffs' performance and capability. At this inspection we found the manager had implemented a structured plan of when staff would undergo supervision; however we found no improvement in the detail or quality of supervision provided. A staff member who had completed their induction in December 2016 had undergone one supervision since they had started their employment. Their supervision form stated only, 'discussed the importance of completing mandatory training.' However at the time of our inspection this staff member had only completed safeguarding and moving and handling training. This staff member's records identified they had scored 66% (grade D) in a Care Certificate module titled, 'Understanding their Role'. However there was no

evidence the staff member had been further questioned on their knowledge or supported by senior staff to better understand their role.

At our last inspection we found inaccuracies in the recording tool used by senior staff to track when staff had completed training and required refresher and updates. At this inspection we found the tracking of staffing training was more accurate and more accessible for senior staff. Despite these improvements we again saw examples of staff demonstrating poor practice regarding infection control. The providers response to this was, "We are always reminding them and telling them." However there was no evidence that staff supervision was being used as a tool to improve and manage practice. The provider who supported staff in the kitchen on day one of our inspection had not completed food hygiene training; they were in bare feet in the kitchen and were seen taking people their meals in their rooms in bare feet.

The shortfalls in supporting staff by effective training and supervision are a continued breach in Regulation 18 HSCA (RA) Regulations 2014.

We identified anomalies in staffs' shift rotas which impacted on effective communication. Between the hours of 8am and 10pm there could be up to five separate staff shifts. For example 8am to 6pm and 1pm to 6pm and 4pm – 8pm. Staff told us this meant that handovers between staff were either very brief or did not happen. A senior member of staff told about a recent communication difficulty between staffing shifts, they said, "The night staff could not find their night recording book, I had moved it but I had told day staff to pass the message on but the message had not got through." They went on, "There is no central place to leave messages that you can be sure all staff will see." This area related to effective communication between staff required improvement.

People continued to speak positively about mealtimes at the service. The majority of people came to the dining room for their lunch and afternoon meals. One person told us, "I always like to sit with others when I eat, much more sociable." Three people ate in one of the home's lounges using a tray table and others chose to eat in their rooms. On the first day of our inspection we saw a staff member taking meals to people's rooms; however they did not used plate covers which protect the food and keep it warm. There were drinks and condiments available. People told us there was always a choice on offer and that the cook and staff were flexible at meal times if a different request was made. One person said, "I thoroughly enjoy my food here, probably a bit too much at times, always lovely and I am grateful."

Requires Improvement

Is the service caring?

Our findings

At our last inspection in October 2016 we found the service was not consistently caring and identified areas that required improvement. At this inspection although we identified some improvements there remained examples where the service provided was not always caring and continued to require improvement.

Despite people telling us staff were caring and kind we found examples where the staff approach was not always caring. For example, in one person's bedroom the wardrobe had a large sign up which was used to remind staff to complete routine care tasks. This did not promote this persons dignity.

On the second day of our inspection three people took part in a motivation class in the upstairs lounge, they all told us they had enjoyed it. However whilst this activity took place three people were in the down stairs lounge. These three people all required support with their mobility, two of whom required mechanical lifting equipment each time they wished to move. Staff were unable to confirm as to whether these three people had been asked if they would like to attend the class. One staff member said they were 'not sure' and another said, "I don't think they wanted to go." These three people's care documentation did not identify they would not wish to be extended an invite to this type of activity.

Although we observed many kind and warm interactions between people and staff, not all staff were familiar with people's backgrounds and interests. One staff member, when asked, could not provide any information on a person's background or life history. The staff member said, "It would be nice to get more chance to sit down and chat with residents but it's not really possible."

However people spoke positively about the service and the caring attitude of staff. One person said about the service, "Nothing is too much, I am very happy living here and with the support I get from the carers." They continued, "The carers don't behave like carers but like friends." One person's relative told us staff were, "very approachable" and "get the balance right between being efficient and homely." We saw staff knocking on closed doors before entering and spoke to people in a polite and courteous manner. One person told us they would often have a 'laugh and a joke' with staff, they said, "I can be a bit cheeky and have a bit of fun with most of the staff." Ancillary staff such as the cook, cleaners and the maintenance person were all seen interacting with people in a friendly manner as they undertook their tasks within the service. One staff member said about people, "I've know most of the residents years and I enjoy having a chat and a laugh with them." People were seen to enjoy these interactions and light hearted exchanges were observed throughout the inspection.

People told us they enjoyed meals times. One person said, "It's a nice bright room and the food is nice and we sit and have a natter." People sat within friendship groups and enjoyed chatting. Music was playing and staff interacted with people in a friendly manner.

Visitors were welcomed during our visit. People's relatives and visitors commented that the service was friendly and caring. One relative said, "There is a new deputy manager who is very positive and is making a difference, having her has been excellent."

People's documentation related to their care was stored securely within the service. Care staff were aware of the importance of protecting people's confidential information. Staff were seen to return records to the home's office or care records cupboard once they had completed using them.

Requires Improvement

Is the service responsive?

Our findings

At our previous two inspections in November 2015 and October 2016 we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On each occasion the provider had not ensured there were regular and meaningful activities and in October 2016 we identified concerns with people's care plans.

At this inspection there had been improvements in care planning however the provider had not ensured care was consistently responsive to people's physical or social care needs. The provider therefore remained in breach of Regulation 9 of the Health and Social Care Act 2008 (RA) Regulations 2014.

In the afternoon on the first day of our inspection the number of staff working impacted on their ability to respond to people in a timely manner. Two people who were unable to walk and required mechanical equipment for all manoeuvres waited an extended period before receiving the personal care they required, in line with their care plan. We spoke to a member of care staff regarding this and they acknowledged this was not usual but had occurred as a result of the reduced number of staff available to support people on that shift. One person, after repeated requests to go to the toilet, did receive the support they required; the other person who was unable to verbally communicate did not receive support for an extended period. This left them in an uncomfortable position.

At our last inspection we found people's care plans were in the process of being transferred on to an electronic software package. At this inspection all care plans were now on the electronic care planning system. The software provided clear headings and prompts for staff to populate; staff told us it made it easier to access information. Despite this improvement we found examples where care plans did not always capture information which would be relevant for staff to deliver appropriate care. For example, a recent care plan audit undertaken by an external consultant identified a care plan was missing a section related to skin care. This person had been assessed as at high risk of skin breakdown. This meant the provider could not be assured staff would support this person in a consistent manner. We also found an example where a care plan contained conflicting information. The care plan summary stated the person should be, 'encouraged to wear their glasses', however within the more detailed care plan it stated, 'I don't wear glasses'.

At our two previous inspections we identified shortfalls in the opportunities available for people to engage in meaningful activities. The manager told us they had recruited an activities coordinator to address these shortfalls. This staff member had been employed for approximately one month; however due to some negative feedback from people and staff they were informed their services were no longer required. This occurred on the first day of our inspection. The provider had not made alternative short term plans to cover this vacancy whilst a replacement was sought. This meant people with higher dependency needs were left for extended periods without meaningful engagement as care staff were occupied with their routine care tasks.

The most recent satisfaction survey had been completed in January 2017; four people had responded. There was no rationale identified as to why the response rate was low. One person had identified on the survey

that activities were 'poor'. There was no evidence this person had been responded to and additional information or suggestions sought from them. Although it was apparent activities were discussed at a 'resident meeting' in March 2017 this person had not attended.

The continuing lack of person centred care which reflected people's preferences; shortfalls in care planning and enabling and responding to people's comments on the service was a breach in Regulation 9 HSCA (RA) Regulations 2014.

During our inspection people were keen to communicate that they enjoyed living at Birch Holt and had many positive comments relating to the homely feel of the service and the caring nature of staff. People who were more independent were able to freely move around the service and long standing friendship groups had been established. We saw people playing cards and sitting chatting whilst waiting for their lunch time meal. One person said, "I like living here, it's more personal and more family like." People told us they were supported to attend a luncheon club in a nearby village and the manager accompanied two people to the local public house for lunch on a routine basis.

The home's complaints log showed there had been no recent complaints recorded. We saw historic complaints had been appropriately responded to. We spoke to people about how they would raise concerns if they had any. People told us they would speak to the staff or the manager if they wanted to discuss an issue. A visiting relative said that they had always, "Found staff will find time to listen to anything I want to chat about in terms of care."

Inadequate

Is the service well-led?

Our findings

At our last two inspections in November 2015 and October 2016 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to establish effective quality assurance processes. At our inspection in October 2016 we also identified additional failures in the leadership of the service to address concerns related to areas such as staffing and care planning.

Since our last inspection the provider and manager had remained unchanged however the previous deputy manager had left the service and another member of care staff had been appointed 'acting deputy manager'.

Since our last inspection the provider had used the services of an external consultant to provide support and guidance. Care staff spoke highly of the support they had received from the consultant, one senior staff member said, "They have been really helpful and given lots of clear advice." The consultant had worked with the provider to formulate a 'quality improvement plan' in response to the October 2016 inspection. There was evidence senior staff had been working through the plan and noting when an action was completed. An inspector spoke with the consultant on the first day of the inspection and they told us since spending time at Birch Holt they did not believe management had clear oversight of the service. They said, "We have fed this back to the provider." A senior member of staff said, "The manager has been off for three weeks holiday and it has been so calm without them here." During our inspection we also found examples where the manager was unable to demonstrate they were providing effective leadership at the service. For example the manager was unable to locate key documents such as the most recent East Sussex Fire and Rescue service inspection report. In addition a copy of the most recent external health and safety report was not available and the manager had to send an email to the consultant to retrieve another copy. This report contained actionable points and would serve as a helpful reference document.

As a result of the input from the external care consultant there had been some improvements in the way information had been collected to inform routine audits. For example more detail was now available on the 'actions taken' in response to accidents and incidents; however the most recent audit stated there had been six accidents, yet we identified there had been seven. We found a health and safety concern which had not been identified by the provider's health and safety audit. There was an exit door leading from the dining room out to the garden which was not locked, and unable to be locked. On the other side was, an approximate, two foot drop to a garden path. The inspector identified this risk to the maintenance person who secured the door. The external consultant had undertaken several audits of people's care plans in November 2016 however we found some of the actions from these had not been completed.

Since the departure of the provider's previous deputy manager, the manager was now the only person who had received training on the electronic care planning system. Staff told us any care plan updates required in their absence needed to be hand written on printed out copies. During the inspection the manager told us they were still learning about the electronic care planning software and its capabilities; however the provider had purchased the system six months previous to this inspection. An example of the manager's

lack of understanding of the software was highlighted during the inspection. The manager, after prompting by the inspector, located a mental capacity assessment tool within the electronic care planning software which they were previously unaware of. The manager said, "We only had one days training on the software."

During our inspection we found the shortfalls in effective leadership impacted on many areas of the service along with the culture. We found examples where senior staff had failed to take action in response to previous concerns from the October 2016 inspection; for example failure to act on the shortfalls in the recruitment process. In addition the staff supervision process continued to have limited effect at supporting staff or addressing some of the performance issues such as poor infection control practice. We discussed this issue with the provider and their response was, "We keep telling them and telling them, what more can we do?" At our two previous inspections we identified the requirement to ensure the staff room door was not wedged opened however at this inspection we saw staff continued to keep the door open using a wedge. This is not safe practice and in keeping with fire regulations.

The provider had failed to establish appropriate staffing mechanism and processes in regard to rotas. Staff told us that there were occasions when staff absences, particularly those with short term notification, impacted on the smooth running of the service. A senior staff member told us they could recall shifts where they had to work with less staff that were planned in these instances. On the first day of our inspection we saw the impact when two staff made themselves unavailable to work at short notice. The provider told us they did not use agency care staff to cover staff shortages. The external consultant told us they had also identified to the provider and manager the impact of the complex staffing rota; however no action had been taken to rationalise and simplify these.

The lack of effective leadership and quality assurance are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's use of the services of external consultants for care and health and safety had provided the service with clear and up-to-date advice and guidance in these areas. In addition senior staff's closer liaison with the provider's new pharmacist had improved the management of medicines.

Since our last inspection the Local Authority's quality and monitoring staff had become much more involved with the service. All staff told us that this involvement had been of benefit and having social care professionals more readily available for advice and guidance had been helpful and beneficial.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure peoples care was meeting reflecting their preferences. Regulation 9(1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not taken appropriate steps to ensure people where people lacked capacity were supported in line with the Mental Capacity Act (MCA) 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	The registered provider had not established effective recruitment procedures which ensured persons employed were of good character. Regulation 19(1)(a)2
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured staff received appropriate support and supervision. Regulation 18 (2)(a)