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Tordarrach Nursing 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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8 June 2017 and was unannounced.

At the previous inspection on our comprehensive inspection in April 2016 we identified breach of regulations relating to depriving people of their liberty, good governance and staff training. We rated the service 'Requires Improvement' in two of the key questions we asked of services, 'Is the service effective?' and 'Is the service well-led?'. Therefore the service was rated overall as 'Requires improvement'. We carried out a focused inspection on 12 October 2016 and we found the provider was meeting the breaches of regulations we had identified previously. We however did not change our rating of the service as we needed to see sustained and maintained improvement.

Tordarrach Nursing Home provides nursing care for up to 20 older people, some of whom were living with dementia. There were 13 people using the service at the time of our inspection.

There was a registered manager in post. 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.

The provider did not have appropriate arrangements to ensure risks to people were always managed appropriately with suitable risk management plans put in place, including managing risks relating to falls from height and entrapment and falls relating to bed rails. Some aspects of the premises were not safe. For example checks of a fire door alarm system were not in place and so the provider had not identified the alarm was not working during our inspection. This meant people who required staff supervision in the community to stay safe were at risk of leaving the service and coming to harm without staff being aware.

Medicines management was generally safe and our stock checks indicated people had received their medicines as prescribed. However, staff did not always administer medicines safely to a person and had not assessed the particular risks relating to this sufficiently as part of keeping them safe. In addition protocols for staff to follow when administering 'as required' medicines were not always in place which meant staff could not be sure the signs to observe to indicate people required these medicines.

People were not adequately protected against the risks associated with the management of records because the provider did not have appropriate systems in place. Quality assurance procedures were ineffective in assessing, monitoring and improving the service as they had not identified the issues we found during our inspection.

The registered manager did not always submit statutory notifications to CQC about the outcomes and applications made to relevant authorities for authorisations to deprive a person of their liberty as required by law. This meant CQC was not able to monitor the volume and nature of these applications at the service.

The provider did not provide people with a suitable range of regular activities they were interested in to occupy them and we observed people had little to do for much of the day of our inspection.

People knew who to complain to and had confidence any complaints they made would be dealt with appropriately.

Staff received regular support with a suitable programme of induction, training, supervision and appraisal to help them understand and meet people's needs. Staff felt well supported by the registered manager.

Staff understood how to use the Mental Capacity Act (2005) properly in assessing people's capacity and in making decisions for them when they lacked capacity. In addition the registered manager applied for authorisations to deprive people of their liberty appropriately as part of keeping them safe.

Systems were in place to safeguard people from abuse and staff understood the signs people may be being abuse and how to report concerns.

There were enough staff deployed to meet people's needs. Recruitment was safe because the provider carried the required checks before staff worked with people who use the service to ensure they were suitable.

People enjoyed the food they were provided with, and received a choice of food that met their needs. People received the right support in relation to eating and drinking. People received access to the healthcare professionals they required, such as GP, tissue viability nurses and physiotherapists as and when necessary.

Although staff knew the people they supported, they provided care in a task-based way with minimal conversation. People provided mixed feedback regarding how kind and caring staff were. People were not cared for in a person centred way. For example people told us they could not always choose the time they got up in the morning.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach relating to Care Quality Commission (Registration) Regulations 2009 during our inspection. We served a warning notice to the provider for breaches of the regulations in relation to good governance and safe care and treatment. In relation to the breaches of regulations in regard to person-centred care and notification of incidents you can see the action we took at the back of the full length version of this 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 always safe. The provider did not have robust risk assessment processes in place to mitigate risks to people. Some aspects of the premises were not managed safely. Medicines management was generally safe, although improvement was required in some areas to keep people safe.

Staff understood the signs people may be being abused and generally understood how to respond to these to keep people safe.

The provider checked staff were suitable to work with people prior to offering them employment and there were enough staff deployed to care and support people.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were supported through a programme of induction, supervision, appraisal and on-going training.

Staff followed the Mental Capacity Act 2005 in assessing whether people had capacity to make particular decisions and the provider was meeting the Deprivation of Liberty Safeguards (DoLS) Code of Practice.

People received and enjoyed a choice of food and were supported to access healthcare professionals appropriately.

Is the service caring?

Requires Improvement

The service was not always caring. Staff worked in a 'task-based way' and spent little time engaging with people. We received mixed feedback in relation to how kind and caring staff were towards people.

Staff knew the people they were supporting including their

preferences, health needs and backgrounds.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not have enough activities they were interested in to keep them occupied. People did not always receive care that took into account their individual preferences and wishes.

The registered manager investigated and responded to complaints appropriately.

Is the service well-led?

Inadequate

The service was not well-led. Our findings indicated the registered manager and staff were not fully aware of their role and responsibilities in making sure people received a safe and quality service.

The audits in place to assess, monitor and improve the quality of the service were ineffective and the provider had been unable to maintain at sustain improvements at the service. People were not protected against the risks that can arise from poor record keeping.

The provider did not always send statutory notifications to the CQC as required by law, such as those relating to the outcomes of applications for authorisations to deprive people of their liberty under DoLS.

Tordarrach Nursing 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 inspection took place 8 June 2017 and was unannounced. The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service.

During the inspection we spoke with seven people, two relatives, three care workers, one nurse, the chef and the registered manager. We also spoke with a non-clinical continence reviewing officer and a physiotherapist. We reviewed five people's care records, three staff records and records relating to the management of the service. We looked at medicines management processes. Throughout the day we undertook general observations and used the short observation framework for inspection (SOFI) in the main lounge. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we received feedback from representatives from the local authority and the CCG.

Requires Improvement

Is the service safe?

Our findings

We found a number of areas that suggested risks relating to the health and safety of people were not always being well managed appropriately. Although the provider had found a risk of people falling from windows they had not identified suitable control measures to minimise that risk. The provider had installed window restrictors so windows did not fully open to reduce the risks of a person falling from a height. However, we found that these restrictors could easily be unlatched completely, which meant that the windows could be fully opened. The Health and Safety Executive (HSE) in its Guidance 'Falls from windows and balconies in health and social care' on pg. 2 states 'Window restrictors should ….be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements (such as cutlery) and require a special tool or key.' When we informed the registered manager of our concerns they immediately instructed their maintenance person to replace all the window restrictors as soon as possible.

The provider had not ensured a risk assessment by a competent person was in place with sufficient controls to reduce the risks of Legionella developing in the water system as per guidance from the HSE. In addition the provider was unable to confirm the system was regularly checked by a competent person that it remained clean with no stagnation of water and with temperature checks and controls in line with HSE guidance (HSE: Health and Safety in Care Homes 9.1 – 9.12). Although the provider had contracted specialists annually to test the water for Legionella, Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. Annual testing is unable to prevent this from happening. This meant that people may have been at risk of the spread of Legionella infections, as a proper risk assessment and risk management plan were not in place to address this risk.

The provider had not carried out risk assessments and put management plans in place relating to bed rails including regular checks. We identified a bedrail 'bumper' (a cover over the bedrail which helps prevent entrapment) was not in place on the bedrail of a person who spent much of their time in bed. This meant the person could have at risk of entrapment in the bedrails. In addition we learnt form accident and incident reports that in November 2016 a person's foot became trapped in their bed rails and this resulted in skin damage. The registered manager told us on this occasion in November 2016, although a bed rail bumper was in place but this proved unsecure as the person dislodged it. The registered manager replaced beds and rail bumpers as a consequence of this incident. However, people remained exposed to risks relating to bed rails due to the lack of risk assessments and management plans.

Although the provider had a risk assessment in place to address risks relating to the premises this had not identified people were at risk of burns from a portable heater in the communal lounge. The heater had no restrictor to prevent people making contact with the radiator. Staff told us the radiator was used through the winter and was still in use on cold evenings to provide additional heat. When we raised our concerns with the registered manager they told us they would look into this immediately to protect people.

We found risk management plans to keep the premises safe were not always appropriate. We identified the alarm to alert staff of the fire doors being opened was not working, by walking out of the fire door on the first floor and round to the front of the house, and staff were unaware the alarm was not working. As many

service users were disorientated to time and place and required constant supervision to remain safe, there was a risk that service users could leave the home via this door and come to harm. The registered manager was unable to evidence checks were in place to ensure the alarm was working and told us they would address this immediately.

Risk management plans to ensure water temperatures were maintained at or below 44 degrees Celsius to minimise the risk of scalding were inadequate. We saw records which showed the provider tested the hot water of one outlet each week. However, records showed the provider did not record which outlet was being tested so there was no audit trail to confirm all outlets across the home were being tested with sufficient regularity. This meant the registered manager could not be sure that the water temperature at hot water outlets to which people had access to was within a safe range and that they were being protected from the risk of scalding.

Risk management plans to ensure fire safety across the home were not always appropriate. We observed several fire doors were wedged open, this meant in a fire they would not operate as intended to protect service users. These were not addressed in the fire risk assessment for the home and there were no mitigating plan in place. We noted this had been reported in the registered manager's overall internal inspection of the service of 9 April 2017, so insufficient action had been taken even though the registered manager was aware it was an issue previously.

A person told us, "They give me my medicines so I don't have to worry about them." Staff did not always administer medicines to at least one person safely. We observed staff left medicines for the person on their table in their room and did not stay to observe them take the medicine. The registered manager told us the person often refused their medicines and leaving them out for the person was a solution to these issues. However, this meant staff could not be sure the person swallowed the medicine and staff were not able to ensure an adequate gap before their next dose as they did not know the time the person took the medicine. The registered manager was unable to evidence they had risk assessed issues relating to medicines for this person and there were no recorded risk management plans in place.

Some people had medicines prescribed to be taken when required (PRN) including a person who received pain relief medicine and who was not able to verbalise when they required this. The registered manager told us they did not administer the PRN pain relief to this person because they received pain relief from two other types of strong pain relief and they believed this was sufficient for the person. However, there were no pain assessment to assess if the person was in pain and no protocols in place to inform staff as to when to give PRN medicines, such as additional pain relief, and at what dose. The registered manager said they would develop PRN protocols to guide staff clearly on when to administer these medicines.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above concerns, the provider had a range of checks in place carried out by external contractors and staff relating to the fire systems, central heating, electrical and lifting equipment. In addition we found other aspects of medicines management were safe, including ordering, storage, and disposal. We carried out stock checks of medicines and our findings indicated people were administered medicines as prescribed.

One person told us, "Knowing the nurses makes me feel safe and I know what happens during the day". A relative told us, "He is so much safer here and they are good about staying in touch." Our discussions with staff showed while staff understood the signs people may be being abused they may not always respond

appropriately. One member of staff told us if a person told them a member of staff was abusing a person they would confront the member of staff about this, instead of reporting the matter to their manager or the local authority. The registered manager told us they would provide further support to staff to understand their responsibilities in relation to this. provided staff with annual safeguarding training and refreshed their knowledge of safeguarding during supervision and team meetings.

At our inspection in April 2016 we found the provider had not taken reasonable measures to ensure the safety of people living at Tordarrach Nursing Home. This was because the provider had not ensured staff's criminal records checks were renewed every three years in line with their own policy. This meant the provider could not assure themselves of the suitability of staff they employed. At this inspection we found the provider had improved and was checking staff criminal records every three years. In addition the provider continued to check applicants' qualifications and training, identification, right to work in the UK, health conditions and employment history, including references, from previous employers. For nurses the registered manager carried out additional checks including checking with the Nursing and Midwifery Council (NMC) if they were appropriately registered to work as nurses.

A relative told us, "There is always someone around so I'm comfortable to leave her." A person told us, "There are enough staff… [there are] no problems at night. If I call, someone comes quite quickly." People, relatives and staff told us there were sufficient staff deployed to meet people's needs. Our observations were in line with this and we saw staff responded to people who required their assistance, including responding to call bells, promptly. Earlier in the year the local authority put an embargo on admissions, partly due to concerns about staffing levels. This embargo was lifted as the local authority considered sufficient improvements had been made.

Requires Improvement

Is the service effective?

Our findings

The provider had no ensured that the premises were maintained, adapted and decorated to take into account the needs of the people living with dementia. They had not considered using contrasting colours to enable people who were disorientated to place to navigate more easily around the home, for example to more easily identify toilets and bathrooms. Most bedroom doors did not have any prompts for people to recognise their bedrooms, such as a memory box, photograph of themselves or something that would remind the person that it was their room.

The service had a garden but we observed that the potential of the garden was not fully used in the care for people with dementia. There were few flowers or sensory areas for people to smell and touch different plants. We saw no evidence that people were encouraged to use the outdoor areas, for example to do any gardening tasks as this was not on the activity schedule. The registered manager told us they would put plans in place in response to our feedback. We recommend the provider follow guidance from a reputable source on improving the environment for people with dementia.

At our last comprehensive inspection in April 2016 we found people were at risk of receiving care from staff who were not appropriately trained or aware of best practice. This is because staff did not receive all the training they needed to ensure they were appropriately prepared to fulfil their roles and responsibilities. At our focused inspection in October 2016 we found the provider had made the necessary improvements, providing training in areas including moving and handling, end of life care and dementia awareness. At this inspection we saw training records which confirmed the training programme continued, with nurses receiving comprehensive training and assessment in wound management. However, staff had not received training in risk management and bed rail safety which meant they lacked understanding of how to keep people safe in relation to some risks including those relating to bed rails.

The registered manager had completed a personal development plan for each staff member detailing the training the required and when this would be delivered and they told us ongoing training was booked throughout the year. In addition, records showed staff received supervision from their line manager every three months with an annual appraisal. Staff told us they felt well supported and supervision was an opportunity to receive feedback on their performance and to review their practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Our discussions with staff showed they understood their responsibilities in relation to the MCA code of practice. Staff ensured people who had capacity, or fluctuating capacity, to make certain decisions received the right support in making their own decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). At our inspection in April 2016 we found a breach in relation to DoLS as not all staff understood what a deprivation of liberty was and how to prevent depriving people of their liberty unlawfully. At our focused inspection in October 2016 we found staff had been retrained in MCA and DoLS and understood how to care for people in accordance with this legislation. At this inspection our discussion with staff showed they continued to have a good understanding of MCA and DoLS. The registered manager continued to apply to the local authority for authorisations to deprive people of their liberty appropriately as part of keeping them safe.

A person told us, "I fancied a fry up and they did that for me. I loved it." Another person said, "'I look forward to the food – not restaurant standard but OK". A third person said, "I am a vegetarian and they always make things I can have." The chef understood people's requirements in relation to their meals in line with advice from speech and language professionals, to reduce their risk of choking. If there were concerns a person was losing or gaining weight and required food prepared in a particular way staff informed the chef who made the necessary arrangements. People received a choice of food or drink as staff asked people their preferences each morning. If people changed their minds at meal times the chef provided an alternative meal of the person's choice. Staff monitored people's food and fluid intake where there were concerns to check people received the right amount to eat and drink. Where people were losing or gaining weight the provider identified this and was taking appropriate action, such as referring them to a dietician.

People were supported by staff with their health needs and records confirmed people regularly saw the healthcare professionals they needed such as GPs, tissue viability nurses and speech and language therapists. A physiotherapist visited the home regularly to work with people who required their support to improve their mobility. A professional told us staff understood and followed their instructions for meeting people's particular healthcare needs.

Requires Improvement

Is the service caring?

Our findings

A relative told us, "There's little interaction from the staff that just sit in the lounge. They are always busy writing notes". Another relative told us, "There aren't many staff that have anything to do with the residents unless they have to. They sit and watch the television when they're in here". Our observations were in line with this. Throughout our inspection we observed staff sitting writing notes and seldom engaging with people in communal areas. Staff generally provided care in a task-based way with minimal conversation. When we raised this with the registered manager they told us they did not believe this was the case. We asked them if they monitored the way staff interacted with people and they told us they noted this as part of their spot checks. However, we were unable to evidence this from the spot checks records they provided after the inspection.

The registered manager told us people's birthdays were sometimes celebrated and for a forthcoming birthday they had booked a professional entertainer to sing to people. However, people did not always get choice in how they celebrated events. For example, one relative told us, "The Christmas party was combined with other homes with people with [learning disabilities] and their behaviour frightened my [family member]. It made me very uncomfortable and…quite a few residents here were obviously unhappy." When we fed this back to the registered manager they told us this would not happen again because of changes to their circumstances.

People and relatives generally told us staff treated people with dignity and respect. However one person told us, "One or two carers bring their mood in and they can be rude. Nothing physical but it doesn't make you feel good." We observed staff took care to close doors when providing personal care. People looked well-groomed and staff took care to support people to dress in clean, matching outfits which were appropriate for the weather. A hairdresser visited most weeks to provide people with their preferred hair-care.

People and relatives told us staff knew them well. One person said, "I really appreciate the company of [one particular staff member] as he can relate to me, age and culture, and it helps to have a man help with personal things". A relative said, "I feel that most staff know Mum." A professional also told us staff knew people's needs. Our discussions with staff showed they knew people's daily care needs such as their food preferences and the people who visited them regularly. This information about people was recorded in their care plans for staff to refer to in supporting people.

Relatives told us they could visit anytime and we observed the service encouraged visitors to maintain people's relationships with those who were important to them.

Requires Improvement

Is the service responsive?

Our findings

Relatives and people consistently told us there were not enough meaningful activities to occupy people and our observations were in line with this. The registered manager told us they were developing two staff to focus on activities within their role as care workers. We spoke with one staff member and they were unable to tell us about people's personal interests or how activities were developed to take into account people's interests and abilities. An activity programme was in place but there were few meaningful activities listed for example on Wednesday and Saturday the activity was 'old time music – staff encourage singing and clapping' and on Sunday the activity was 'a number of relatives visit – general discussions.' The activity programme was not followed on the day of the inspection as the planned quiz did not take place. Instead in the morning staff told us there would be a sing along. They put on a music CD but no staff member led the session, leaving people to sing along of their own accord if they knew the words.

We also found few one to one activities were organised for people who spent most of their time in bed. One person told us, "The only one I see [who spends time with me] is [another person using the service]." This meant there was a risk people who spent time in their room could feel socially isolated.

Although staff told us they were careful to provide people with choices when providing care, such as offering a choice of clothes for the day we found that care was not always provided in a way that took into account people's preferences and wishes. For example two people told us that they were woken up early. One person said, "They come and get me up about 7:30am and then I'm ready for when they do breakfast." Another person said, "Mornings are early for me but they have a lot to do". A third person said the time they got up "depends on when they wake me up." When we raised this with the registered manager they told us this should not be the case as people should be free to choose the time they got up themselves and they would ensure this was the case in the service. In contrast, people consistently told us they could choose the time they went to bed.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager generally met with people to assess their needs before they were admitted to the service. They completed a form detailing the person's needs and preferences and used this information, as well as any professional assessments, to form care plans and risk assessment. People or their relatives were also invited to view the home. A relative told us, "We are involved in her care plan, well we were at the beginning [during the assessment process]."

Records showed the provider reviewed people's care plans each month, recording any changes although it was not clear how people and their relatives were involved in reviewing people's care to ensure it met their needs and preferences.

People's care plans contained some information about people's backgrounds, preferences, preferred methods of communication and healthcare needs to help staff understand the people they supported

better. People's care plans also contained information for staff to support people in the best ways for them and staff had signed paperwork to indicate they read people's care plans. There was a keyworker system in place, but it was not clear how this system was used to ensure people received care in their preferred ways and there was no evidence keyworkers met with individuals to gather their views on their care. A keyworker is a member of staff who works closely with a person to check they are happy with their care.

People all told us they would be confident to tell staff if they were not happy about something. One person said, "I would talk to the one who gives out the medicines". Another person told us, "I would go to the manager and I'd be confident that she would take it seriously." A complaints procedure was on display in the reception area for relatives to refer to and people were provided a copy in the literature about the home when they were admitted. We viewed records relating to four complaints made in the last 12 months and found all detailing the complaint clearly as well as the action taken in response to help resolve the complaint.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection in April 2016 we rated the provider 'requires improvement' in the key question 'Is the service well-led?' This was because the providers' governance arrangements to regularly assess and monitor the quality of the service had not identified shortfalls we found during our inspection in relation to staff criminal records checks and a lack of certain safety checks on the premises. At our focused inspection in October 2016 to check on action taken in respect of breaches found in the April 2016 inspection we found the provider had taken sufficient action to improve their governance of the service. However, we did not change the rating for 'well-led' from 'requires improvement' because we needed to see consistent improvements over time.

At this inspection we found the provider had not sustained improvements in their oversight of the service and we found a repeated breach of the regulation relating to 'good governance'. We also found new breaches of regulations relating to safe care and treatment, person-centred care and notification of incidents.
The provider did not have effective systems to review all aspects of service delivery and ensure a focus on continuous improvement. Audits were undertaken on medicines administration and regular checks of some aspects of health and safety were carried out by staff and external contractors. The registered manager also carried out spot checks and observations to review the quality of service. However, the audits and checks in place were insufficient as they had not identified the concerns we found during our inspection relating to safe care and treatment and the safety of the premises. In addition we were unable to evidence how the provider assessed the quality of interactions between staff and people, as well as the quality of the activities programme in place and whether this met people's needs.

The provider reviewed falls in the service as they were required to send this data to the local authority each month. However systems were not in place to review other key data such as accidents and incidents and complaints to identify any trends and patterns so plans could be put in place to help prevent similar incidents from happening again.

People were not adequately protected against the risks associated with the management of records because the provider did not have appropriate systems in place to ensure records kept within the service were comprehensive and contemporaneous. The provider could not easily identify when training had been completed and when it needed to be refreshed as it was not always recorded appropriately. We identified this concern at our focused inspection in October 2016 so this meant the provider had not improved these particular records despite our previous concerns. The registered manager told us they had not been able to do this because their administrator had been off work for a considerable time but they would focus on it as soon as possible. There was also no central record to show when staff received their last supervision and when their next was due to enable the provider to monitor staff supervision. The registered manager told us they were in the process of putting this in place. In addition, although staff recorded the development of pressure ulcers, they did not always record when they treated people's wounds. This meant the information to check whether progress was being made to wound healing and to evaluate if the wound treatment plan was successful was lacking.

In addition we experienced difficulty reading some people's hand written care plans. We asked the registered manager to read some particularly unclear sections of the care plans to us and found they were not always able to do so. We asked staff for their feedback on the legibility of the care plans and they told us sometimes they were difficult to read, depending on who had written them. This meant people were at risk from receiving inappropriate care because staff did not always maintain clear and appropriate records about the care planned for people and the care they received.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not always submit statutory notifications to the CQC about the outcomes of applications for authorisations to deprive people of their liberty under DoLS as required by law. This meant CQC was not able to monitor the volume and nature of these applications to deprive people of their liberty.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and relatives knew who the registered manager was but their feedback was not always positive in that the service was not well-led by the registered manager. One person told us, "[The registered manager] is in charge but she's not here very often. The staff nurse is the main person." Another person said, "I know her but it's the medicines lady who tries to 'mother' me and really cares about me. She goes out of her way to help." The registered manager was also the owner of the service and managed the service. Our inspection findings indicated that, while the registered manager was aware of some areas of their role and responsibilities, our findings in this report show that they did not always ensure that the service provided to people was safe and appropriate. One commissioning authority lacked confidence in the provider's ability to care for a person with high needs appropriately and had made arrangements to commission additional staff to care for this person.

The provider had a number of ways to get feedback from people, but these were not as comprehensive as they could have been. The registered manager recently sent out questionnaires to relatives and people using the service to gather their feedback. A relative said, "I have filled in a feedback form but I don't say much as I want it all to be OK for Mum." The registered manager told us they met with relatives who raised concerns individually to talk through the issues and seek resolution. When we asked relatives and people using the service, they were not aware of any recent meetings to update them on service developments and gather their views, feedback and ideas for improving the service. The registered manager told us these meetings had not taken place for some time but would be restarted in the future as part of improving the service.

The registered manager held regular staff meetings which staff told us were useful as they were able discuss issues which were important to their role, and staff told us they felt well supported. Staff told us they worked well as a team and shifts were well organised and led by the nurse in charge. Staff were assigned responsibilities each shift which were agreed at handover and this was recorded. In addition staff found the registered manager approachable.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission in a timely manner of applications to deprive people of their liberty. Regulation 18(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate and did not always meet their needs and preferences. Care and treatment was not always designed with a view to achieving people's preferences and ensuring their needs were met. Regulation 9(1)(2)(3)(b).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not provided to people in a safe way through the proper and safe management of medicines, assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b)(d)(e)(g).

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operating effectively to assess, monitor and improve the quality and safety of the services provided, to assess monitor and mitigate the risks relating to the health, safety and welfare of people and to maintain securely an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person. Regulation 17(1)(2)(a)(b)(c).

The enforcement action we took:

We issued a warning notice