Buckland Care Limited

Kingland House Nursing & Residential Home

Inspection report

Kingland House
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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

Kingland House Nursing Home is registered to provide nursing care for up to 44 people. At the time of this inspection 39 people lived at the home.

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

This inspection was unannounced and took place on 26 and 28 October and the 2 November 2016. At the last inspection in February 2016 the service was not meeting the requirements of the regulations and CQC took enforcement action.

At this inspection we identified serious shortfalls and both on-going and new breaches of the regulations. You can see some of the action we have asked the provider to take at the end of this report.

We identified that risk management and administration of medicines was not consistently safe. In addition, people were not protected from the risk of abuse because the systems in place did not safeguard them. The environment posed some risks to people and we made a recommendation that staffing levels were reviewed to ensure people's needs were met in a person centred way.

Staff told us they were informally supported but records showed some staff had not received adequate training or supervisory support to ensure they were safe and competent in their role.

Some people told us staff were caring. Other people felt they had not received a caring service. We observed that people experienced care differently depending on the skills of the care worker supporting them.

People's needs had been assessed, and care plans reflected people's needs in an individualised way.

The governance systems in place were not effective, as they did not assess and monitor the quality of the service, and did not fully assess or mitigate the risks to people.

We have imposed conditions of registration for the breaches of regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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 safe.

People were not safeguarded from the risk of abuse because the systems in place had not led staff to alert the local authority safeguarding team when required.

Risks were not fully mitigated and incidents were not always reported or recorded.

Medicines were not fully managed in a safe way.

The environment and staff infection control practices posed a risk to people.

Is the service effective?

Requires Improvement

The service required improvement to become effective.

Staff told us they were supported but records did not evidence staff had received the training or supervision they required to deliver safe and effective care.

People had mixed experiences during meal times.

People received support from healthcare professionals when they were unwell.

Is the service caring?

Requires Improvement

The service required improvement to become caring.

Some people told us staff were caring, but other people described poor experiences of the care and concern shown to them by staff.

People's dignity was not upheld.

Is the service responsive?

Requires Improvement

The service was responsive.

People's needs were assessed and care was planned for.

There was evidence that some people were supported to engage in activities.

The service had a complaint process.

Is the service well-led?

Inadequate

The service was not well-led.

The culture at the home was reactive rather than proactive.

There were ineffective governance systems in place to assess and monitor the quality of service.

Kingland House Nursing & Residential Home

Detailed findings

Background to this inspection

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

The inspection took place over three days. One inspector was supported by a specialist advisor in nursing care on the first day of the inspection. On the second and third days of the inspection, two inspectors visited the service.

As part of the inspection we chatted with 25 people to learn about their experiences of living at Kingland House Nursing Home. Because a number of the people were living with dementia we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed four people's care plans in full and checked aspects of a further 11 people's care and support records to establish the quality of care they received.

We spoke with the registered manager, a senior manager and the deputy manager. We also spoke with 11 other members of staff, four family members, a visitor and a community professional.

We looked at records relating to how the service was managed. These included four staff recruitment records, staff rotas, training records, audits and quality assurance records as well as a range of the provider's policies and procedures.

Before our inspection, we reviewed the information we held about the service. We also looked at information about incidents the provider had notified us of, and requested information from the local authority.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in February 2016 we took enforcement action because there were specific aspects of care delivery that posed a risk for people living at the home. At this inspection we found that thickened fluids were safely stored. People who required their drinks to be thickened were easily identified by a notice on their bedroom door and there were no instances where we found un-thickened fluids in these people's bedrooms. People who were at risk of dehydration had their fluid consumption monitored so that staff were aware and could take action if the individual needed additional support. People who were at risk of weight loss were weighed in accordance with their care plan to identify when further action might be required. Pressure mattress settings were recorded in people's plans and checked by staff to make sure they were operating effectively.

At this inspection people told us they felt safe living at the home; however we identified a number of areas where people were at risk of harm.

Risks to people were assessed but not always mitigated. Two people told us they were concerned about the potential risk posed by another person living with dementia. They told us about the strategies they had decided to use to protect themselves if they needed to. Within this person's care plan we found that some of the risks they posed to others had been assessed there was not a comprehensive management plan in place. Records showed a request for specialist support stating, 'informed about [the person] being more agitated and physically hurting other residents'. There was no other information recorded about this. The person had also required staff to physically move them from a communal area of the home, but there was not a safe handling care plan in place that provided staff with adequate guidance and less than half of the staff team involved in care had been trained in safe handling techniques. The person and others were at risk because staff had not all received the correct guidance and training to fully support this person.

For some people who required equipment to maintain their safety, this was in place. Moving and handling equipment such as hoists had been serviced and people's hoist slings were clean and in working order, however other people did not always have the equipment they needed in place to maintain their safety. For example, three people had pressure mats in place to alert staff when they got out of bed. These mats were either not positioned in a way that meant staff would have been alerted, and for one person the pressure mat was not plugged in although the person was sat in their chair.

There were systems in place to record and analyse accidents and incidents, however we identified two incidents which were not recorded. This meant staff could not assess what had occurred and put strategies in place to minimise the risk of reoccurrence.

Medicines were not fully managed safely to ensure people received their medicines as prescribed. We observed a medicines round. The staff member wore a red tabard to indicate they should not be disturbed and locked the trolley when they administered medicines. In general, people were not rushed and the staff member made sure they were happy to take their medicines. Medicine Administration Records (MARs) were well maintained. There was an ordering system in place, including for unexpected medicines such as

antibiotics and staff told us it was effective. Some people required specialist medicines that needed to be carefully monitored. We checked these and found that the records had been accurately maintained. Where people had PRN (as required) medicines there were PRN plans in place. The staff member showed us how they checked the handover records to see if one person might need a particular medicine. This reduced the risks that people received medicines when they did not need them.

We talked to the staff member who was a qualified nurse about the medicines they were administering. For one medicine they were aware of the reason it had been prescribed and any potential side effects. However, they were not aware of the purpose of another medicine. One person required a liquid medicine. The guidance stated, 'shake well before use'. The medicine was administered without shaking the bottle.

The fridge temperature was recorded on a daily basis to ensure it was operating at a safe temperature. The daily records showed that at some point the fridge temperature had reached an unsafe temperature. There was no policy in place to make sure staff knew what action to take when medicines may have been affected by an increase in temperature. In addition the ground floor medicines room was very warm. There was no thermometer in the room to alert staff to the temperature. We asked staff to locate a thermometer and found that the room was 26 degrees. There were medicines kept in the room that needed to be stored at below 26 degrees. We asked the registered manager to take action to ensure the fridge and ground floor medicine room were operating at a safe temperature, which they did.

On the last day of the inspection we checked one person's medicine administration records. We found that one of their medicines had been out of stock for ten days. This had not been identified by any of the staff administering this person's medicines. This meant the person had not received their medicines as prescribed.

Infection control was not effectively managed. There was an infection control lead who was knowledgeable but had not yet completed their training. Their role was in a domestic and cleaning capacity. The infection control audit carried out in April 2016 stated that a training programme for infection control was in place. However, training records showed that none of the other employed domestic staff and less than half of the care staff had received training in infection control. We talked to a member of staff about how they cleaned people's commodes. They told us the sluice was not used because it was on the first floor. They told us that once a week commode pans were soaked in a communal bath using bleach. On a daily basis commodes were cleaned in people's en-suite sinks. The water temperature is capped at a temperature that is not hot enough to kill bacteria. In addition people used their sinks for washing and cleaning their teeth.

One of the bedrooms had a linoleum floor. This was raised in a number of areas and was ripped in two places. The threshold between the bedroom and the ensuite bathroom was covered by industrial tape. This meant the flooring could not be effectively cleaned. We drew the registered manager's attention to the risks posed by this person's flooring. They told us that the health and safety audit completed had not included this room.

The home environment was not fully safe for the people who lived there. The window opening had not been restricted on two windows. Window openings on the first floor and above are restricted to prevent the risk of people falling from open windows. The registered manager confirmed that checking windows opening did not form part of their health and safety audit. We asked the registered manager to take immediate action to rectify this, which they did.

Additionally, on the first floor of the building a linen cupboard contained a boiler. A notice on the door stated 'please keep locked' and there was a bolt in place. However, the bolt was not working so the door

could not be properly secured. The boiler had a number of lagged pipes and one pipe not lagged that was very hot. This meant there was a risk of scalding for people.

On the ground floor there was a stair gate blocking access to a fire exit. We discussed this with the registered manager who confirmed that use of this stairgate had not been risk assessed. We asked the registered manager to complete a risk assessment by the end of the inspection. We also asked them to consider any risks the communal stairs posed to people. We checked with the registered manager at the end of the inspection six days later about both these risk areas and they told us risk assessments had not been completed.

After the inspection we wrote to the registered manager and asked them to tell us what risk assessments they had completed to safeguard people. They sent us risk assessments for the communal stairs and for the stair gate blocking the fire exit. However, this document did not explore any fire risks to people posed by blocking the fire exit.

Staff at the home had not identified the health and safety issues we found. Less than half of the care and support staff had received training in this area. This included the registered manager who had no record of receiving training in health and safety but had completed the September 2016 health and safety audit.

The shortfalls in providing care and treatment in a safe way were an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully safeguarded from the risk of experiencing abuse or improper treatment whilst living at the home. Only half of the staff team had received training in safeguarding adults. The registered manager told us that they had undertaken training in safeguarding adults and the training record corroborated this. We identified two incidents that should have been reported to the local authority safeguarding team, but had not been reported. We also needed to prompt the registered manager to raise a safeguarding alert during the inspection because we identified one person who had not been safeguarded against the risk of neglect. People were not protected because the service did not have effective systems in place, or the right skills and knowledge to safeguard people.

The shortfalls in safeguarding adults were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures had been followed and all the required checks had been carried out. Records contained a photograph of the staff member concerned, proof of their identity, references and a health declaration. There was an employment history for people although this only covered the years of their work history rather than the month and year as required. A check had also been made with the Disclosure and Barring Service to make sure people were suitable to work with people in a care setting.

Observations throughout the inspection showed that call bells did not ring for long periods of time and some people felt staff responded as quickly as they could with one person saying the staff response was, "Pretty good". However, other people reported that the care they received was not always person centred because staff were too busy. One person talked about the problems they experienced at the home commenting, "Lack of staff that's the chief thing", another individual said, "They are so rushed off their feet" and a third person told us, "I don't see enough of them because there are not enough of them". The registered manager told us there were sufficient staff on duty to meet people's needs. Staff also commented on the increased stability of the staff team reducing the need to use agency staff. We reviewed the call bell audits carried out monthly for the last quarter. These showed that whilst the average response time to a call

bell was between 1-3 minutes, there were occasions on each audit where people had been trying to summon assistance for over 24 minutes.

We recommend a review of the staffing levels based on people reported experiences.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in February 2016 staff had not been supported to receive the training they required to meet the needs of the people they cared for and supported. We gave a requirement notice for this regulation. The registered manager wrote to us in June 2016 and told us, 'The training issues highlighted in the report have now been carried out'.

At this inspection the registered manager told us staff had received a range of both on-line and face to face training. They said on-line training covered areas such as first aid, fire, manual handling and safeguarding adults. The registered manager told us staff had also received face to face training in areas including record keeping and nutrition and hydration.

Some staff had received induction training, but this had not been provided for all newly appointed staff.

Most staff had received training in manual handling, fire, first aid, nutrition and record keeping. However there were significant gaps in training that staff required to ensure the care and support they provided was safe, effective and caring. For example, some people at the home were living with dementia but less than half of the staff team had undertaken training to enable them to effectively support people living with dementia in a person centred and caring way. Some staff had not received training in areas where we identified breaches of the regulation. These included the safe handling of people, safeguarding adults, dignity and respect, health and safety and infection control.

When staff had been trained this did not always result in the delivery of safe effective care. For example, a member of staff was supporting one person to move from their wheelchair to an arm chair. They did not engage the wheelchair brakes although they were instructing the person to stand up. Whilst moving the person's mobility aid they caught this against another person's leg. We drew this to the attention of a nurse and asked them to check the person had not been injured.

Staff told us they were able to talk with the registered manager to gain advice or guidance. However, we found a number of issues within the supervision system that placed people at risk of unsafe or inappropriate care. Shortfalls had been identified in two staff member's performance however they had not received appropriate supervision to ensure that they could support people safely.

The supervision matrix showed that other staff had not received supervision in accordance with the home's supervision policy. For example, two members of staff had only received one supervision in 2016.

The shortfalls in the training and support staff received were an on-going breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were happy with the meals provided and told us, "it's good", "Quite good", "Not too bad" and, "Food is very simple but tasty". Other people did not always enjoy the food at the home. One person said, "If you are like me and need building up the food is poor", and another individual told us, "Sometimes it's quite

awful, it's like school meals. You get the impression it's being done on the cheap".

We observed that people had mixed experiences of care and support during the lunch time. We saw some people were happy and engaged prior to the meal. People were chatting with each other and some staff as they helped people to sit at the tables. One person was laying tables and folding aprons. They placed a pile of folded aprons on each table and then offered the people sat at the table an apron. They helped people to put on an apron when they were not able to do this themselves. They visibly enjoyed their role and had their own tabard with their name embroidered on it. Another person was given a soft toy dog to hold and they clearly liked this and stroked it throughout their meal.

Some staff sat with people to assist them to eat their meal and chatted with them throughout the meal. However, three of the six staff stood up for some of the time they were assisting people to eat, they did not all speak with people and explain what they were eating. This did not acknowledge people as individuals and was not respectful or dignified.

One staff member did not speak to the person they were supporting to eat their meal. They repeatedly got up and walked away from the person without explaining where they were going. When they returned they carried on spooning food into the person's mouth without any explanation. This person had their drinks thickened and the staff did not explain when they were changing from giving them pureed food to the thickened drink. This meant this person who was living with dementia did not have any explanation of what was happening throughout their meal. The person did not smile or engage with the staff member at all throughout their meal. However, another staff member came and spoke gently with the person and they responded and gave the staff eye contact and smiled.

Another staff member used a tea towel to wipe the food off one person's face. This was not dignified. Other staff used serviettes to gently wipe any loose food away from people's lips and faces.

The shortfalls in treating people with dignity and respect were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA. Most people we spoke with felt that staff listened to the choices they made. One person said, "I'm the boss". Records showed that where possible people had consented to specific aspects of their care. Where people lacked capacity to make a specific decision, decision's had been made in their best interests. For example, two people received some of their medicines covertly. This decision had been made in their best interests and involved health professionals such as their GP and the pharmacist.

One professional told us that for one person staff had not assessed their capacity accurately. This meant they were making decisions on the person's behalf where the individual had capacity and could make these decisions independently.

We recommend people's mental capacity assessments and any consequent best interests decisions are reviewed to ensure the original assessments of capacity are accurate.

Some people had representatives who had lasting power of attorneys for welfare or finance. The registered manager was aware of these and had also recently discussed this area with relatives at a meeting.

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. Applications had been made where there was a risk people were being deprived of their liberty. Some people had conditions attached to their DoLS authorisation. One person had a condition that had not been met. We drew this to the manager's attention during the inspection.

People told us they saw healthcare professionals when they needed to and records confirmed people had seen their GP or a nurse when they were unwell. People were also supported to see other healthcare professionals such as a chiropodist, optician or their medical consultant when this was required. Staff had received training in emergency first aid. However the one member of qualified staff was unclear about the action they should take in a specific medical emergency and staff were unable to locate one piece of emergency equipment they told us they had.

Requires Improvement

Is the service caring?

Our findings

People reported mixed experiences of the care and concern for their welfare from staff.

Some people spoke positively about the staff that cared for them. We received a range of comments that included, "They are very nice some of them", "Very good" and, "I am being looked after here". However, other people reported poor experiences of the care and support they received. We received a range of comments which included, "They vary. Some of them don't want you, they are fed up with you, they are not pleasant, but others are pleasant" and, "Sometimes they sigh as if to say, not again" and, "it's a question of attitudes".

There was a mixed view from family members. Some were happy with the care and support their relative received. One told us staff were, "All very helpful". Other family members were not satisfied with how their family member was cared for or supported. One told us about a particular staff member who they described as, "Outstanding, second to none", but said they felt another staff member was, "Abrupt, no care". They also told us that, "At certain times there seems to be a lack of care".

Staff told us, "We have a good team and try our hardest" and, "The staff are fantastic, we help each other out".

We observed that some staff were extremely caring. For example, we heard staff checking people's comfort and that they had the things they needed. We saw an individual being support to move using a hoist. The staff were very caring protecting the person's head and knees and explaining throughout what they were doing whilst checking the person was ok.

However, other observations showed people were not supported in a caring or dignified way. One person said hello to a care worker stood beside them. The care worker ignored them and continued to talk above them to another member of staff. One person also commented on staff ignoring them telling us, "You can ask a question and they walk right past you, it's infuriating".

When we observed people's mealtime experience we found that for some people support was not provided in a caring way. One person was alone in their bedroom with their lunch out of reach. A care worker arrived to support them and was stood over the individual helping them eat their lunch. We asked the care worker whether the lunch was still warm, they replied, "Well it should be it's not been out for long". We asked the care worker to check the temperature of the food, they did and told us, "It is stone cold".

During an observation in the dining room the radio was on a pop station with the volume quite loud. One person said, "I'm not too keen on the music are you?" to a person they were sat with. Staff were present. Staff did not respond or acknowledge this or turn down or change the station.

Some staff were quick to reassure people if they were unsettled or calling out. They smiled at people gave them eye contact and spoke gently to them. However, other staff did not smile at people or reassure them

when they were unsettled.

13 of the 37 care workers and nurses identified on the home's staff training matrix had received training in equality and diversity. Only one member of staff was recorded as having received training in dignity and respect. On the first and second days of the inspection we drew our concerns to the attention of the registered manager. On the third day of the inspection they told us they had provided staff with training handbooks on dignity and respect. They told us that staff could also seek further guidance from senior staff.

The shortfalls in treating people with dignity and respect were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified one person who was mainly cared for in their room. They had little stimulation such as music, pictures or being able to look out of their window. At this inspection we found their room had sensory lights and soft music. Their bed was facing the window. In addition most people's rooms were personalised and most people told us their beds were comfortable. One person was too tall for their bed. They had to sleep at an angle. They told us they had told staff about this but nothing had happened. When we drew this to the attention of the manager they had not been aware of this person's discomfort. They told us they would take action.

There was information about people that supported the delivery of person centred care. One person had a 'this is me' record which told staff about their interests, previous occupation and how they liked to spend their time. Staff were also guided by a care plan explaining how the person communicated. Observations showed that staff took an interest in and interacted with this individual, asking how they were or what they were doing regularly throughout the day.

Requires Improvement

Is the service responsive?

Our findings

Some people were happy with how staff responded to their needs. One person told us, "I appreciate the things they do".

Staff undertook an assessment of need before people came to live at the home. This helped staff to understand what help the person wanted or needed to ensure they felt able to meet their needs.

From the assessments care plans were drawn up to help staff understand what assistance an individual required with different aspects of their care and support. Care plans had improved since the last inspection in February 2016 and were more person centred. They had been reviewed and amended when people's needs changed. Care plans covered a range of areas including manual handling, sleep and rest, skin integrity and communication.

We asked staff about one person's method of communication. They were able to tell us about how they needed to support the person and what they told us was reflected in the individual's care plan.

We received both positive and negative feedback from people and their relatives about how people spent their time. Some people were complimentary telling us that there was enough do and they didn't get bored. We saw lots activities taking place in the main lounge and dining room. On one occasion people were actively engaged in a quiz and there was lots of laughter. The activities co-ordinator involved as many people as possible and checked with people who were quiet whether they were ok and gave them the opportunity to answer questions. However, people who were less able or who did not wish to participate in group activities reported they were bored and isolated. We received a range of comments including, "It's boring, that's the worst of it" and, "I can't make friends easily, people don't chat. You sit like a lemon, no conversation" and, "There is not a lot to do, I just wish they came to see me a bit more. They are all very good to me but they haven't got time to come and see me".

Most people thought that staff would listen to them if they were not happy or wanted to make a complaint although one person said, "You hope they take it on-board, sometimes they do, sometimes they don't". A family member felt that they would be listened to if there was an issue but commented, "We haven't got a problem at all". However, another relative said that felt that their comments were not acted upon, stating that the registered manager, "Didn't listen to my point of view…very, very defensive". The home had a complaints policy and procedure that was publicised in a communal area of the home. We reviewed the complaints they had received in 2016 and found these had been responded to. We also looked at compliments staff had received. One family member had written to the home and said, 'Thank you for the care and consideration shown to our dad'.

Inadequate

Is the service well-led?

Our findings

At the last inspection in February 2016 we set a requirement because the governance systems in place were ineffective. Following the inspection the registered manager wrote to us and told us they would meet this regulation by the end of June 2016. However, at this inspection we identified on-going shortfalls in governance including assurance and auditing systems.

The viewpoint of people and their relatives was sought however their comments or concerns were not always acted upon. Questionnaires had been sent to 17 people in April 2016. The home received five responses which had been analysed but did not lead to a development or action plan. Family members had completed quality assurance questionnaires in April 2016. There were a number of positive comments. However, one relative had commented, 'Not always sure they change resident's pads often. Sometimes they are sat in wet pants and clothes'. There was a system in place to elicit people's views through quality assurance questionnaires; however this was not fully effective.

There had been a relatives meeting in August 2016, but there had not been a meeting for people who lived at the home since May 2015.

The registered manager told us that they had realised that the lack of any action or development plans were impacting on their ability to ensure people were received safe, effective and responsive care. They said they had asked their manager to support them to develop an annual plan and hoped this would be completed in the near future.

Quality assurance systems were not fully effective. Weight and nutrition audits were effective, however audits such as infection control and health and safety had not identified the issues we found during the inspection. Care plans were audited on a random basis. The lack of a systematic approach to this meant that one person who we had identified as at risk had not had their care plan and other records audited to check they were accurate and continued to meet the individual's needs. Monthly audits completed by the provider covered areas such as the environment, hazards, complaints, recruitment, supervision and infection control. However these checks had failed to identify the issues we found during the inspection.

Accidents and incidents were monitored; however this did not safeguard people because not all incidents were recorded. In addition staff had not recognised incidents that may have constituted abuse and had not made alerts to the local authority to safeguard people.

Staff told us they felt able to talk with the manager. One commented, "[the manager] is a brilliant manager". A senior manager told us the, "home is improving all the time, a lot better atmosphere. [The manager] has brought stability". However we identified a number of serious issues that meant effective governance systems were not in place. Staff training was not effective and where it had taken place this had not impacted upon how some staff undertook care delivery. Supervisions for staff had not been carried out in accordance with the services supervision policy. Where aspects of staff competence may have posed a risk to people, this had not been recognised and effective support or monitoring had not been put in place.

The registered manager told us about some of the improvements they had made since the last inspection in February 2016. These included a pressure ulcer audit they had developed and about changes they had made following the enforcement action taken by CQC to reduce the risks to the safe delivery of care.

The registered manager also told us about changes they had made to people's records to make sure these were accurate and up to date. The records we reviewed had improved in terms of regular reviews and reflecting people's individualised needs including how they preferred to be cared for or supported. However, there were significant gaps in record keeping. One person had sustained an injury. This had been recorded on a body map. The body map had not been reviewed to check the person had recovered. We asked the registered manager to check this person's injury had healed, which they confirmed was the case. There were room checks in place however these had not been completed regularly by staff. For example, one person's record had not been completed since April 2016. Another person had significant gaps in an observation chart staff had been asked to complete by a healthcare professional. This person also had a daily care chart with no entries for three days in October 2016.

The shortfalls in governance and auditing were an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection the February 2016 inspection rating had not been displayed visibly in accordance with the regulation. We drew this to the attention of the registered manager. On the last day of the inspection the rating had been visibly displayed in the entrance of the home.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected against the risk of abuse.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and risks to people were not robustly managed.

The enforcement action we took:

We have imposed conditions of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not robust and did not enable the provider to assess, monitor and improve the quality of safety of the services provided.

The enforcement action we took:

We have imposed conditions of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to ensure people were cared for safely and in a caring and compassionate way.

The enforcement action we took:

We have imposed conditions of registration.