Care Quality Commission

Princess Lodge Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Princess Lodge Limited is registered to provide accommodation for 32 people who require nursing or personal care. People who live there have health issues related to old age. At the time of our inspection 26 people were using the service.

Our inspection was unannounced and took place on the 4 & 5 August 2015. At our last inspection in October 2014 the provider was not meeting the regulations which related to safeguarding people from being unnecessarily deprived of their liberty. Evidence that we gathered during this, our most recent inspection, showed that the improvements required had not been made.

The manager was registered with us as is required by law. 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.

Feedback was received from the local authority's Contracts Team following a monitoring visit on 27 July 2015. They told us that the providers response to issues they had identified as a result of their last meeting was disappointing and that more had not been done to address the issues raised.

Summary of findings

People and/or their relatives told us they felt the service provided to them was safe and protected them from harm. Staff we spoke with were clear about the how they would protect people from abuse and how to report any concerns they received or witnessed.

We found that when people's health needs changed staff were not always proactive in accessing professional advice and/or support in a timely manner. Systems for completing care records were effective.

Medicines were not consistently administered as prescribed. We found that storage and the application of analgesic patches was in line with good practice.

The registered manager used a dependency tool to calculate the amount of staff necessary to support people and complete care safely; however, from our observations and feedback we received the care provided was often task led and not person centred due to the availability of staff, particularly during the busy morning period.

People's ability to make important decisions were considered in line with the requirements of the Mental Capacity Act 2005. However, we found that the provider had not made the necessary improvements to meet the regulations in relation to protecting people using the service by failing to make applications, when restrictions were identified, for consideration of a Deprivations of Liberty Safeguards (DoLS) authorisation.

People were not always supported appropriately to take food and drinks in sufficient quantities to prevent malnutrition and dehydration. We observed that the lunchtime experience was overall relaxed and the food was nutritionally balanced.

Staff interacted with people mostly in a positive manner and maintained people's privacy and dignity when providing support.

People and their relatives were involved in the planning of care. Some staff told us they were too busy to look at care plans and risk assessments, although they had been encouraged to do so by management. Staff we spoke had a good but basic understanding of people's needs.

Information and updates about the service was made available to people and their relatives, in meetings and with the use of notice boards. The complaints procedure was displayed and people and their relatives knew how to and who to raise a complaint with.

People, relatives and staff gave us variable feedback about leadership skills of the registered manager. Structures for regular supervision and appraisal to provide staff with feedback about their performance and to discuss their training needs were lacking.

Quality assurance audits were undertaken regularly by the registered manager. These systems were not always robust enough to identify some of the issues we found during our inspection.

The registered manager had failed to meet the requirements of their registration with the Commission as we found a number of incidents that had occurred within the service had not been reported as required.

The history of this service is that the provider has not been meeting the requirements of the law fully over the last two years; within this time the Commission has undertaken this and five other unannounced inspections. On this our most recent inspection, we found the requirements of the regulations were not being adequately met.

The overall rating for this service is 'Inadequate' and the service is therefore 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

Summary of findings

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.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff had received training about the various forms of abuse that people may experience and how they should protect them.

People's changing needs in terms of risk were not assessed and reviewed in a timely manner.

Medicines were not always administered safely; checks were not regular enough to ensure people received them as prescribed.

Inadequate

Is the service effective?
The service was not always effective

The registered manager had failed to submit applications for consideration by appropriately qualified persons for a Deprivation of Liberty Safeguards (DoLS).

Overall people who were able, their relatives and staff confirmed that health needs were identified and met appropriately.

Peoples nutritional and hydration needs were not always met in a timely manner.

Requires improvement

Is the service caring?
The service was not always caring.

People and relatives spoke positively about the caring nature of the staff working at the service.

People told us that staff were rushed at times and not able to spend time talking to them or acknowledging their needs in a positive way, particularly during the morning period.

Some staff had never had the opportunity to read people's care plans.

Requires improvement

Is the service responsive?
The service was not always responsive.

People were not actively supported to access the outdoors or the local community.

People and their relatives knew how to raise concerns and complaints and to who.

Feedback was sought from people in a variety of ways.

Requires improvement

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

Staff were not provided with formal supervision or appraisal in order to receive support and feedback about their performance.

The registered manager had failed to notify the commission and other external agencies of incidents that had occurred within the service.

Staff, relatives and people using the service gave mixed feedback about the leadership skills of the registered manager.

Systems were not in place to ensure that breaches of the Health and Social

Care Act 2008 (Regulated Activities) Regulations had been addressed.

Princess Lodge Limited

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 on 3 & 4 August 2015 and was unannounced. The inspection was carried out by two inspectors, a pharmacy inspector and an Expert by Experience of older people's care services. The Expert by Experience had personal experience of caring for a user of older peoples services.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We also liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with six people who used the service, three relatives, four staff members, the chef, the activities coordinator, the deputy manager and the registered manager. Not all the people using the service were able to communicate with us so we used the Short Observational Framework for Inspection (SOFI) during the afternoon in the lounge area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included looking closely at the care provided to four people by reviewing their care records. We reviewed three staff recruitment records, the staff training matrix, 20 medication records and records used for the management of the service; including staff duty rotas and records used for auditing the quality of the service.

Inadequate

Is the service safe?

Our findings

We observed one person being transferred by two staff using an inappropriate moving and handling technique. Records showed that staff had received training and regular updates in how to protect people from such abuse or harm. We spoke with the registered manager who told us both members of staff were up to date with moving and handling training, but that they would be provided with retraining; in addition to this our observations prompted the registered manager to review the persons abilities to assist staff in relation to transfers. We also reviewed the services accident records and saw that for one person on two occasions staff had failed to ensure their alarm sensor mat was working effectively and they had fallen out of bed. This meant that equipment in place to alert staff to people movements and therefore minimise the risk of injury were not utilised effectively in order to protect people.

People who were able to or their relatives had been involved in establishing and assessing any risks to them and have their say in how they were managed. Assessments had been completed in respect of any potential risks to people's health and support needs. We reviewed people's care records and found that although events that had occurred were detailed, such as falls and significant weight loss; we found preventative action was lacking. For example, we saw that for one person who had had several falls over a two week period, no specific action had been taken in relation to how the person could be protected from further falls. We saw that the person's GP had been contacted by phone to discuss an increase in their level of agitation and their medication had been increased; however records showed the nurse had failed to mention the person's recent falls history. In addition, records showed one person had lost a large amount of weight over the previous six weeks; their care plan stated the person needed to be "encouraged and prompted with meals". Despite the loss of weight there had been no liaison with a healthcare professional, no increase in frequency of weighing the person or review of their care plan until four weeks after the weight loss was initially noted. This meant that identified risks to people who use the service were recorded but not always effectively managed in order to minimise further risks. Staff told us that changes to practice following incidents were cascaded to them at shift handovers and they were able to demonstrate to us they had a good understanding of the risks in relation to people they cared for.

People who were able to and relatives we spoke with told us they were happy with how the service managed medicines. One person said, "They [nurses] tell you what they are for". Another said, "We get our medicines regularly". Although people expressed satisfaction with medication management we found some issues of concern which meant that medication management was not always safe and put people at risk of not always receiving their prescribed medication as they should.

We looked at the Medicine Administration Records (MAR) for 20 people. We found two people had been prescribed a medicine that needed to be given once a week however they had not been provided with this. We identified a third person had their MAR for the administration of a medicine signed but the medicine was still in their medication supply. We informed the nurse about the error and they immediately gave the person their prescribed medicine. Supporting information was available for staff to refer to when people were prescribed a medicine to be given 'when necessary or when required'. However we noted that the information was not specific to individual people. In particular when people were prescribed a medicine for agitation it was not possible to know under what specific circumstances the medicine could be given. This meant that administration of as required medicines could be inconsistent. We further identified one person had been prescribed a medicine to be given when required for chest pain. However, the MAR chart was signed for the administration every morning. On informing the management team they agreed that this was not correct and would investigate.

We found that sufficient quantities of people's medicines were available to ensure that their healthcare needs were being met. All medicines were stored securely including special storage arrangements for controlled drugs. It was evident that good practice was being observed in relation to the application and administration of pain relief medicine patches. The registered manager was undertaking regular checks on people's medicine administration records to identify any problems and to ensure staff followed safe medicine procedures. We saw that action was taken to remedy any errors or omissions

Inadequate

Is the service safe?

identified; the MARs we reviewed had not yet been audited for that month by the registered manager. However, the provider's audits and checks had failed to identify the issues we found.

Procedures for the administration of medicines to people who lacked capacity to make an informed decision were not always followed. We were told that one person was being given their medicines concealed in food or drink. This is called the covert administration of medicines; where medicines are given to people without their consent or knowledge. We found that best interest procedures had not been followed. Detailed instructions were not available in relation to providing medicines in food or drink to enable nursing staff to know how to give people these medicines safely. No advice about the suitability of crushing medicines and administering them in food had been sought by staff with a pharmacist which meant people were exposed to any potential avoidable risks. We spoke with the deputy and registered manager who both told us that no consent for covert medication to be administered was in place; they advised us that a GP review of the person's medication would be requested immediately.

The above constitute a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

People who were able and relatives told us that they felt the service was safe. One person told us," I feel very safe, particularly at night". Another told us, "I do feel safe when being hoisted from wheelchair to armchair or anywhere else". A relative said, "I have no concerns, "I think my relative is safe".

Staff we spoke with knew their responsibilities for protecting people from the risk of abuse and what action they would take if they suspected someone was at risk. They were able to describe the procedures for reporting if they witnessed or received allegations of abuse; they were knowledgeable about the types of potential abuse, discrimination and avoidable harm that people may be exposed to. A staff member told us, "If I saw anything untoward I would report it straight away". Two other staff we spoke with told us they would immediately challenge any poor practice to protect a person and then refer their concerns to the registered manager.

We saw that the registered manager used a dependency tool to determine how staffing levels were determined in line with people's changing needs. People we spoke with felt that there were not enough staff to meet their needs in a timely manner. A person said, "Staff sometimes leave us in the lounge for long periods of time; there are not enough staff to look after us properly". Another person told us," I have been here a few years now and it was ok when I first came, but now it seems like there is not enough staff". Staff told us that the management were responsive to covering sickness, even when only short notice was provided. One staff member said, "They are responsive to staffing issues and will ring agency in; they are good like that". We reviewed staff rotas and the numbers of staff on duty were in line with the numbers recommended in the dependency tool being utilised. During our visit we spent time in the communal areas and saw that people that needed support were responded to as quickly as possible by staff. However some people required more attention than other people and due to a lack of availability of staff particularly during the morning period some people were left without any contact from anyone for long periods of time. Throughout the morning period and over lunchtime staff were rushed when assisting people and there was little time to spend with them chatting or supporting them to undertake meaningful activity. A staff member told us, "I think we just about get away with it; it is so busy in the mornings". Another told us, "There's not enough staff in the morning as someone has to stay in the lounge; sometimes there is no one in the lounge; so it's not always safe".

We reviewed the provider's recruitment processes. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. A staff member told us, "I had to provide references and complete forms for other checks before I started work". This included up to date criminal record checks, fitness to work questionnaires, proof of identity and references from appropriate sources, such as current or most recent employers. Staff had filled out application forms with any gaps in their employment history explained.

Requires improvement

Is the service effective?

Our findings

On our previous inspection in October 2014 we identified that the provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty. During this our most recent inspection we found that the provider had failed to appropriately refer people using the service, for consideration by the supervisory body, in this case the local authority for authorisation of DoLS. Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) is the legislation that protects the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals.

At the time of our inspection no applications had been submitted for consideration by the supervisory body and no one using the service had a DoLS authorisation in place. We spoke with the registered manager who told us she was considering submitting an application for consideration for one person using the service. We observed this person, spoke with staff about their needs and reviewed their care records. Staff told us that the person had been restricted since they came to service some months before and were able to provide examples of how they were restricted. Records along with our own observations demonstrated that this person was and had been for some considerable period potentially deprived of their liberty; which required consideration for a DoLS by an appropriately qualified professional. We noted that in May 2015 a visiting professional had also recommended the person should be referred for consideration of a DoLS; but this had not been acted upon. We spoke to the registered manager and they agreed that there was a need to submit an application; on the second day of our inspection we were informed by the registered manager that they had submitted an urgent application to the local authority. The person was not having their requests to return home met and this refusal was causing them to become distressed; clearly staff were acting in the persons best interests and were keeping them safe by not meeting their request, however a DoLS needed to be considered in order that staff actions were lawful. This meant that the registered manager had not been proactive when this issue was identified and had failed to respond to this through referral to the relevant authorities.

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had undertaken training and were able to discuss with us the relevance of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We observed that people's consent was sought by staff before assisting or supporting them. Records showed that people's mental capacity and best interests had been considered as part of people's initial and on-going assessment. The Mental Capacity Act 2005 (MCA) sets out what must be done if restrictions on people's freedom and liberty are identified, these need to be assessed by an appropriately trained professional; this relies upon the provider submitting applications for consideration to the supervisory body .

We observed breakfast and lunch being provided for people. People told us, "The food is ok and we have a choice" and, "We have a choice of food at lunchtime". We saw that a choice of two meals and a choice of deserts were on offer; menus were displayed in the dining room for people to see. During the morning period we saw that people in the lounge area did not have a drink freely available to them within their reach. As most of the people using the service were unable to consistently communicate their needs, some people were left waiting for the drinks trolley to come around at 11.15am. We observed one person being provided with their breakfast at 11am which they finished at 11.30; staff then assisted them to a more comfortable chair in the lounge area. However, we then saw this person being seated again in the dining room by staff at 12.30 to have their lunch.

We also observed how people who were cared for in bed received their meals and found that people did not always receive the assistance they needed to take adequate diet and fluids. We found one person at 2.30pm had a cold untouched main meal and dessert in front of them. We spoke with staff about this person and they were able to tell us that they were at risk of malnutrition and needed a level of prompting as they were reluctant to eat and drinks in sufficient quantities.

We saw that a list was available for staff to refer to when providing drinks and meals to people that identified the consistency required by the individual based on any risks identified, for soft diet or thickened fluids. We spoke with the chef and asked them about people's preferences and any special diets they required, for example vegetarian or

Requires improvement

Is the service effective?

diabetic. They told us that any specific dietary needs or changes to people's nutritional needs were communicated to them by nursing staff as necessary. The chef was able to tell us who these people were but was unable to provide us with any documented information regarding their specific needs. This meant that people may be at risk of receiving a meal that did not meet their dietary requirements in the absence of regular kitchen staff. The chef told us they intended to put their knowledge into documentation that would be available in their absence for other kitchen staff to refer to. We found that people or their relatives were not involved in planning or deciding what was included on the menus.

A picture and written menu was displayed in the dining area about the choice of meals on offer to assist people to make a decision about what they preferred to eat. Staff also bought plated up meals to people to show them and enable people less able to communicate their needs to see and smell the food on offer. We saw that people had a number of food choices on offer to them at both meals; the food was presented well and smelt appetising. Staff we spoke with knew which people were nutritionally at risk.

We spoke with staff about how they were supported to develop their skills to meet people's needs effectively. A relative told us, "I am not sure if staff are trained to meet people's needs; when my relative has problems, they sometimes call me and they always seem to know what to do". Staff told us they were provided with training which they felt had equipped them to perform their role effectively. A staff member said, "We do get regular training and updates". One newly recruited member of staff told us, "The training was good, and yes I feel equipped to do the job well". The registered manager said that all staff were going to receive dementia training in the coming weeks which they had managed to source.

Overall people who were able, their relatives and staff confirmed that health needs were identified and met appropriately. People we spoke with told us if they needed the doctor they could request this and they did not have to wait long for this. Relatives we spoke with felt staff supported their relatives appropriately to access healthcare. We observed staff responding to someone in an emergency; they provided them with health checks initially and then moved them to their room to maintain their privacy and continue to monitor them whilst they waited for emergency help to arrive. Records showed most people were supported to access a range of visits from healthcare professionals including more urgent reviews by a doctor in response to their changing health needs.

Requires improvement

Is the service caring?

Our findings

People we were able to speak to and their relatives described staff as "caring" and "kind". One person told us, "I am well cared for; I would tell them if I wasn't". Another person said, "The staff are friendly and approachable". We observed staff interactions with people and saw they interacted with them in an open and friendly manner.

People voiced their concerns that staffing levels affected the ability of staff to spend quality time with them and not be rushed in the care they delivered. One person told us, "Staff sometimes leave us in the lounge for long periods of time; there are not enough staff to care for us properly". Another person stated, "There is nothing to do, we are so bored; they just leave us here in the lounge to watch television". We observed one person being asked how they were feeling by a staff member; the person responded negatively but the staff member did not respond to this as they did not wait for the person to respond before having to attend to another person's needs. We observed another person was left with their meal and drinks on a bed table that was too high and they had therefore not eaten or drank at lunchtime; staff had not took the time and care to reposition them in bed to ensure they were comfortable and able to eat and drink independently.

Staff we spoke with knew people's care needs. Two members of staff who had worked at the service for a number of weeks told us they had learnt from other staff about people's needs and had some limited knowledge of people's preferences and life histories. We saw that records were available to staff which contained a good level of information about their care needs, related risks, likes and dislikes, personal history etc. Staff members told us they had not looked at peoples care plans or files as they had not had time since they had taken up post. They confirmed they had been advised to look at these records but both told us they had simply been "too busy" when on shift to take time to do this. This meant that staff were not utilising all the information available to them in order to ensure all aspects of peoples life were considered when supporting them.

We saw that people who were able were consulted about their care and relatives were spoken and met with regularly to give their views in regard the care being provided. A relative told us, "I am asked to contribute information on behalf of my relative". Information about the service and other local services were displayed on notice boards that were accessible in communal areas. Staff we spoke with were aware of how to access advocacy support for people.

We observed practical action was taken by staff to relieve people's distress and discomfort; for example we saw staff comforting one person who was anxious by using specific distraction techniques that the person clearly responded to whilst ensuring their dignity was maintained. During the afternoon we observed a staff member who had just come on duty speaking to each individual in turn, kneeling down to their level, listening and offering comfort by holding people's hands as they spoke; people clearly responded to this small gesture and individual attention.

People's dignity and privacy was respected when staff were assisting people for example, we observed staff adjusting peoples clothing to maintain their dignity or providing a blanket to cover or shield them if they refused assistance. One person told us, "Staff look after me very well and when administering care it is done privately with respect and my dignity is respected". A relative said, "I have no concerns, my relative always looks well and well looked after; she is always clean and dressed nicely". Staff told us, "I look after these people as if they were my own family", "I always treat people how I would want to be treated" and, "I help people to look their best and get them to choose their own clothes if they can". Language used by staff when discussing people and their needs with us demonstrated a fondness and genuine caring for people using the service.

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us that staff asked for their views about how they would like their care to be delivered. One person said, "Some staff talk you through things but others don't". A relative told us, "They [staff] do consult with us". Records showed assessments to identify support needs involved contributions by people or their relatives including information about their life history, wishes, likes and dislikes; however staff we spoke with told us they did not refer to care plans. As many of the people using the service were unable to communicate their needs and preferences this meant that care delivered may not be in line with their wishes.

Care plans we reviewed included important instructions for staff relating to each individual, for example, one person preferred to receive care from females only, the person told us that efforts were made to ensure this happened. Records we looked at were reviewed and the staff we spoke with had a good understanding of people's current needs.

People's views about how readily staff attended to them was mixed. One person told us," After breakfast we have to wait sometimes over an hour to be moved from wheelchair to armchair". Another person said, "They don't always come when I want them". Our observations were that staff were not always able to provide the care people needed in a person centred way; for example we saw that one person who preferred to have female carers was being supported with personal care by a male member of staff as other female staff were involved in other activities. We observed that one person who received care in their room did not have their call bell within their reach. We raised this with the registered manager on day one of the inspection; but found that on day two the same person had again been left without their call bell. On both occasions the person asked us for assistance. This meant they were not able to summon assistance in order to receive the care they needed at the time they needed it.

Visiting times were open and flexible and visitors we spoke with said they were able to visit the home without undue restrictions. People told us they rarely went outdoors. One person told us, "I haven't been outside or in the garden for months". Another person told us," I am happy to sit here with the television on I don't want to do anything else; they do let me keep contact with my family by phone". A relative told us," I am able to contact my relative by phone if I wish to do so". We spoke with the activities coordinator who had recently taken up post and prior to this had previously been a staff member providing care at the service. They confirmed to us that people were not supported to access the outdoors or the local community, although they were keen to address this. The activities coordinator demonstrated to us how they were in the process of meeting with people and their relatives to ascertain what activities they may like to take part in both individually and in groups. We saw that they were reading psalms to one person in their room which had been a past love of theirs. We saw that people's rooms had been personalised with items of sentimental value or of interest to them.

People and their relatives had been asked about any cultural and spiritual needs they may wish to pursue as part of their assessment. Records showed aspects of peoples lifestyle choices had been explored with them or their relatives. For example, people were being supported to maintain their beliefs in relation to nutrition.

People who were able to and their relatives told us they were consulted and involved in their relative's care. We saw that reviews of people's care had taken place with them and/or their relatives including an opportunity for any concerns to be raised with the management. Meetings were organised regularly which both people and their relatives were encouraged to attend. The relatives we spoke with told us that they were aware of these meetings but they had not been able to attend as they were not held at times which were convenient for them to attend, for example outside normal working hours.

The service had a complaints procedure. Information about how to make a complaint about the service was in an accessible area. People we spoke with knew how to complain. One person told us, "I can and would raise any concerns I may have with the carers". Relatives we spoke with told us that if they raised any issues in general they were dealt with to their satisfaction. A relative told us, "I complained regarding mum's buzzer been taken from her and it was dealt with satisfactorily". We saw that complaints were analysed to determine any patterns and trends. Complaints we reviewed had been resolved in a timely manner. Staff we spoke with were clear how to direct people should they have any concerns or complaints.

Inadequate

Is the service well-led?

Our findings

The provider had failed to notify us and other external agencies of incidents that had occurred and affected people who used the service. We reviewed the notifications received from the service and we found that a number of incidents, including injuries people had sustained had not been reported. As the incidents related to allegations of abuse and injury in relation to people who used the service, the registered manager had a legal responsibility to report these in accordance with their registration with the Commission. We spoke with the registered manager about why these incidents had not been reported but they were unable to provide us with any reason for this; no documentary evidence that the registered manager or their representative had liaised with the relevant agencies to discuss these incidents was provided. We spoke again to the registered manager a week after our inspection and they told us they planned to submit the notifications retrospectively but had not done so as yet; they also asked for further clarification as to which incidents were notifiable. This meant the registered manager was not fully aware of her responsibilities with regard to consistently notifying external agencies of such events occurring within the service.

This is a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009.

At our last inspection in October 2014 we rated the service as Requires Improvement. The provider was required to display this most recent assessment of their overall performance in relation to the regulated activities undertaken at the premises. These should be both on any website operated by the provider in relation to the service and also at least one sign should be displayed conspicuously in a place which is accessible to people who live at the home. We were unable to see the rating displayed at the home or on the provider's website: the registered manager confirmed to us that this had not been completed as they were unaware of their need to do so.

This is a breach of Regulation 20A HSCA 2008 (Regulated Activities) Regulations 2014.

New employees were provided with an induction which included basic training, familiarising themselves with the provider's policies and procedures and shadowing a more senior member of staff before undertaking their role. One staff member told us, "I shadowed a senior for the first three shifts". Staff we spoke with said they felt the induction provided was adequate. The registered manager confirmed us that the majority of staff were not receiving regular supervision and appraisal. Staff we spoke with confirmed this, including three members of staff who had not received any supervision during their induction or since commencing work some months ago. A staff member told us, "I had no meetings or supervision with the managers or seniors during my induction period". Another told us, "I don't get feedback about how I am doing; I need encouragement". Staff told us they did not receive any formal feedback about their performance or have the opportunity to discuss any additional training needs they had. Staff we spoke with felt they would benefit from some structured feedback about their performance; the importance of supervision for some of the staff we spoke was clear as this was their first job in a caring environment and therefore any unidentified training needs could impact upon the care that people received.

This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

The history of this service is that the provider has not been meeting the requirements of the law fully over the last two years; within this time the Commission has undertaken this and five other unannounced inspections. The Commission has issued compliance actions and warning notices; however any improvements made are not sustained.

Feedback we received form people, staff and their relatives about the leadership of the service was varied. One person told us, "I think that the problem here is staffing, it's due to the owners, not the staff; staff are frustrated. I think the manager is really good". Another person said, "I know who the manager is but she does not come and speak to us". A third told us, "If we have concerns we would speak to the deputy manager, not the manager". The registered manager was not able to demonstrate to us that they had a clear knowledge of people who used the service and their current support needs. Relatives we spoke with knew who the manager was. A relative said, "The manager is always friendly". Another relative told us, "I have not signed a contract since my relative has been here, which has been two years now".

Staff we spoke with understood the leadership structure and lines of accountability within the service. However they all told us they had little contact with the registered

manager. A staff member told us, "We need more management support". Another staff member told us, "The manager does come to handovers sometimes but I haven't had a proper meeting with her; I know her to say hello to in passing". The registered manager told us the provider was approachable in relation to any ideas they had about how to develop the service.

The registered manager showed us their monthly analysis of accidents, for example falls. The details recorded in the accident book by staff were minimal and did not reflect the level of impact for people involved in the incident. We saw that one person had experienced several falls in a two week period, including one incident where they had sustained a head injury requiring hospital treatment but no action had been taken to prevent further falls. We spoke to the registered manager about this and they were unaware of the amount of accidents the person had recently experienced. We asked why they did not know about the accidents and they told us "I haven't completed the analysis for that month yet". This meant that the registered manager was reliant upon minimal information contained in accident reports and was not able to demonstrate an up to date working knowledge of the people using the service and the risks in relation to their well-being.

The registered manager undertook a number of quality assurance audits of the service. However the provider's quality assurance systems and checks had failed to effectively identify the issues we found during our inspection for example, those found in relation to the lack reporting of incidents to external agencies.

The provider sought feedback from people and their relatives through a variety of methods including an annual satisfaction survey and meetings. People and their relatives we spoke with told us they were aware they could attend meetings to be more involved in the development of the service and give their opinions. Staff we met with could not recall any meetings this year taking place for them to participate in, but told us a meeting had just been scheduled for the following week. They all told us they did not feel they were fully involved in developing or understanding the values of the service.

Staff were able to give a good account of what they would do if they learnt of or witnessed bad practice. The provider had a whistle blowing policy which staff received a copy of on induction and a copy was also available in the office. A staff member said, "I know how to report concerns; either to the manager or higher if necessary". Staff we spoke with knew the emergency procedures to follow and knew who to contact in a variety of potential situations. We saw that people's abilities to mobilise in relation to how they would need support to evacuate the building in an emergency had been assessed. However the information was not readily available to be provided to, for example the fire service in the event of a fire, as it was kept amongst the persons care records. The registered manager remedied this during our inspection.

The registered manager advised us that senior care staff were responsible for conducting regular 'walk abouts' around the units to assess the quality and safety of the service being delivered. They had developed specific documentation to formalise this process since our last inspection. However we reviewed the records in relation to this and found this was not consistently completed by staff. The registered manager said the completion of this 'walk about' was checked and that if it was not completed staff had been reminded of the importance of doing so. However due to a lack of formalised supervision this system would be limited in its effectiveness as staff may not be see the true value of its completion and their role in ensuring a quality service is being provided. Systems were in place to ensure the safety of equipment and premises. The registered manager advised us that the provider made regular visits to the home and conducted checks on their completion of quality audits of the service and also supported their assessment of required staffing levels.

At our inspection in October 2014, the provider was in breach of the law in relation to their failure to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty or to minimise the risk of harm. We were concerned that the registered person was not protecting people against the risks of inappropriate or unsafe care and treatment. We asked the provider to submit an action plan to demonstrate what action they had or would be taking to meet the regulations including the timeframe for the completion of the proposed actions; however they failed to submit this. The registered manager confirmed to us that an action plan had not been sent and that this was an oversight. An action plan was offered to us on the day of our inspection and later submitted to us by email following our inspection. On this our most recent inspection we saw that the improvements in relations to Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 which relates to the

Inadequate

Is the service well-led?

safeguarding of people who use services from abuse had not been met. Since April 2015 the regulations have been added to and updated, so the new regulation which outlines the responsibilities of providers to safeguard people is now Regulation 13. This meant that the provider and registered manager had failed to respond to requests for information to be sent to the Commission.

During our inspection we found a number of omissions to act on people's behalf that we discussed with the registered manager; they responded to these issues straight away. We had to direct the registered manager in relation to the lack of application to the supervisory body for DoLS consideration, the need for reporting to and liaison with other health professionals and reassessment of some people's support needs including preventative measures needed to protect them. Although the registered manager acted on our findings, this meant that a delay had occurred in people's needs being fully met and considered. The registered manager did not have a clear oversight of the current needs of people using the service and they had failed to be proactive in identifying and dealing effectively with risks as they arose.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to consistently prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The providers failed to notify CQC of specific incidents that affected the health, safety and welfare of people who use the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had failed to provide regular professional development to staff through supervision and appraisal that are necessary for them to carry out their role and responsibilities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider had failed to display their rating received as part of their CQC performance assessment for their regulated activities.**

This section is primarily information for the provider

Enforcement actions

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

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 The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.

The enforcement action we took:
Issued a warning notice on 1 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The providers had ineffective governance, including assurance and auditing systems or processes.

The enforcement action we took:
Issued a warning notice 1 September 2015