Midland Healthcare Limited

Nightingale Care Home

Inspection report

Fourth Avenue
Edwinstowe
Mansfield
Nottinghamshire
NG21 9PA

Tel: 01623824480

Date of inspection visit:
02 August 2017
16 August 2017

Date of publication:
14 February 2018

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**

Summary of findings

Overall summary

We inspected the service on 2 and 16 August 2017. The inspection was unannounced. Nightingale Care Home provides residential and nursing care, support and treatment for up to 49 people, some of whom are living with dementia. During our inspection 20 people were using the service.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
At our last inspection on 17 January 2017, we asked the provider to take action to make improvements to the governance and quality assurance processes. The provider sent us an action plan detailing the action they would take and told us actions had been completed in May 2017. We found that the provider had not effectively implemented and monitored the actions identified.

People could not be assured that risks to their safety were always assessed, kept under review and that these were reduced as much as possible. In addition, people could not be assured that staff were recruited safely, that staff had received training in safeguarding adults and that incidents of abuse or possible abuse were referred to the local authority when required.

People were supported by sufficient amounts of staff and received their medicines as required, although improvements were needed to systems which recorded medicines administration.

People were not always supported by staff who had received sufficient supervision, appraisal and training. People were supported to eat; however, improvements were required to ensure that people were drinking sufficient amounts of fluid when needed.

People were asked for their consent before care and support was provided however, decisions which had been made in people's best interests had not been clearly recorded.

People were supported to see external healthcare professionals when required and were not deprived of their liberty without an application being made or authorised.

People were supported by staff who were caring; however people could not always be assured that sufficient care was taken to maintain their dignity.

People told us they were given choices about some aspects of their care but not others, and it was not always clear how people were involved in planning and reviewing their care. People had access to independent advocacy services.

People's care records did not always contain an accurate and up to date account of their needs and how

these were being met. Staff displayed knowledge of people's needs but systems to ensure they were aware of any changes required improvement.

People were provided with activities but had limited opportunities to access the outside or local amenities. People knew how to raise concerns but these had not always been reported due to a lack of confidence that changes would occur. When they had been recorded, it was not always clear what action had been taken.

Systems to monitor the quality and safety of the service were not effective and people were at risk of avoidable harm as a result. There was a lack of effective oversight by the provider and we had not received information about certain events which had occurred to enable us to monitor the service.

You can see what action we told the provider to take at the back of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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 of 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?

Inadequate

The service was not safe.

People could not be assured that risks to their safety were always assessed, kept under review and that these were reduced as much as possible.

People could not be assured that staff were recruited safely, that staff had received training in safeguarding adults and that incidents of abuse or possible abuse were referred to the local authority when required.

People were supported by sufficient amounts of staff and received their medicines as required, although improvements were needed to systems which recorded medicines administration.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had received sufficient supervision, appraisal and training.

People received support to eat, however records did not always show that people were drinking sufficient amounts of fluid when needed.

People were asked for their consent before care and support were provided, however, when decisions had been made in people's best interests these were not clearly documented. People were not deprived of their liberty unlawfully.

People were supported to see external healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who were caring; however people could not always be assured that sufficient care was

taken to maintain their dignity.

People told us they were given choices about some aspects of care but not others, and it was not always clear how people were involved in planning and reviewing their care.

People had access to independent advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain an accurate and up to date account of people's individual needs and how these were being met.

People were provided with activities but had limited opportunities to access the outside or local amenities.

People knew how to raise concerns but these had not always been reported due to a lack of confidence that changes would occur. When they had been reported the action taken had not always been clearly recorded.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality and safety of the service were not effective and people were at risk of avoidable harm as a result.

There was a lack of effective oversight by the provider to ensure that improvements were identified and acted upon.

We had not always received information about certain events which had occurred at the service to enable us to monitor this.

Nightingale Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 2 and 16 August 2017 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor, who was a nurse.

Prior to our inspection we reviewed information we had received from and about the service. This included previous inspection reports, action plans produced by the provider, reports from commissioners and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with five people who were living at the service and four visiting relatives. We spoke with two care workers, the activities co-ordinator, the registered manager and two visiting healthcare professionals. We observed staff providing support in communal areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We also looked at all or parts of the care records of eight people who lived at the service and other records relating to the running of the service such as the recruitment files of three staff and accident and incident forms.

Inadequate

Is the service safe?

Our findings

Risks to people's health and safety were not always assessed in a timely manner. For example, staff had not completed any initial risk assessments to identify risks to the health and safety of a person until 15 days after their admission to the service. The registered manager told us they had carried out a pre admission assessment and end of life care plan; however the person's nutritional risk or risk of developing a pressure ulcer had not been assessed by the service. This presented a risk that all of the actions and measures required to reduce the risk may not have been identified and acted upon. On the second day of our inspection, care plans and risk assessments had been completed.

Records showed that people who lived at the service had risk assessments in relation to different areas of their care such as nutritional risk, risk of falls and risk of developing a pressure ulcer. These records had not always been regularly reviewed or updated when changes had occurred. For example, one person's risk assessment stated they had not had any falls in the last 12 months but an accident form stated they had experienced one fall. The person's risk assessment had not been updated for two months. We also found the measures required to reduce risk were not always clearly documented. For example, we found that the action taken to reduce the risk of falls for another person was not clearly recorded, however when we checked measures were in place. This meant that we could not be assured that risks to people were being regularly monitored or that staff had clear documented guidance about the measures required to keep people safe.

People had access to equipment they required to reduce risks to their health and safety, such as pressure relieving mattresses and mobility equipment. However, when we checked pressure relieving mattresses we found these were not always set correctly which meant they may not be fully effective. We also found that some people required regular observations to ensure their safety. On the first day of our inspection we found these had not always been completed within the required timeframes. On the second day of our inspection we found that checks on people and of pressure relieving equipment were being carried out as required.

The failure to assess the risks to health and safety of people and mitigate risks as much as possible constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that checks of equipment and fire safety systems were being carried out and that people had individual personal evacuation plans which documented the support they would require to evacuate the building in the event of a fire.

People told us they felt safe living at the service. One person told us, "I feel very safe" and told us they would speak to staff if they had concerns about their safety. People's relatives expressed mixed views on whether their relation was always kept safe. One relative explained this was because an incident had occurred during which their relative's safety was compromised. The registered manager was aware of the incident and told us that action had been taken following this.

People could not be assured that all staff had received training in safeguarding adults. The staff we spoke with told us they had received training and were aware of the possible signs of abuse and the action they should take if they were concerned about possible abuse. We looked at training records which showed that staff were required to undertake safeguarding adults training on an annual basis. Records showed that over half of the staff were due or overdue this training. Some of the staff had been employed within the last few months, however were working with vulnerable people without training which the provider had identified as mandatory. The registered manager told us that recent safeguarding training had been cancelled and they were in the process of rearranging this. This meant that some staff had not received training which the provider had identified as being mandatory to keep people safe.

People could not be assured that referrals were always made to the local authority safeguarding team when required. For example, records did not confirm that one incident of a person who lived at the service being physically aggressive towards another person had been referred as required. We also became aware of another incident following our visit which should have been referred to the local authority safeguarding team and had not been. Referrals would have enabled the local authority safeguarding team to determine whether any further action was required to keep people safe. We found that some measures were in place to help ensure people were safe but the system to ensure safeguarding referrals were made when required was not robust. This presented a risk of harm to people as safeguarding procedures had not been adhered to.

People could not be assured that recruitment processes were effective in identifying and responding to risk. Records showed that one staff member had started work at the service prior to a DBS check being carried out. This was confirmed by a member of staff who told us the staff member had started work without a DBS check being completed but had not worked unsupervised. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. Records showed that prior to a check being carried out and when a positive DBS check was returned, no risk assessment had been carried out to consider what measures were required to ensure people's safety. The registered manager sent us information following our inspection to say they had discussed the DBS result with the staff member and did not feel people were at risk. Whilst this may be the case, risks from recruitment checks had not been identified or assessed prior to our visit.

The failure to ensure that recruitment processes were established and operated effectively constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff to meet their needs and they did not normally have to wait long for support. One person told us, "They (staff) come quickly if I press my buzzer. There are enough staff," whilst another person commented, "Sometimes they (staff) are very prompt, other times I have to wait but it isn't normally very long." People told us that staff were also available to attend hospital appointments with them. One person's relative commented, "The staff do their best. Staffing levels have improved."

During the two days of our inspection we observed sufficient amounts of staff were available to respond to people's needs in a timely manner and that people's call bells were responded to swiftly.

The staff we spoke with told us that staffing levels at the service were improving and records we saw confirmed this to be the case. A visiting healthcare professional told us they had observed more stability among the staff team which meant staff were more knowledgeable about the people they supported. We saw there was a nurse on duty 24 hours a day and that staffing levels had recently been increased and were being maintained.

People were supported to take their medicines. Processes were in place for the timely ordering and supply

of medicines and we observed that staff supported people to take their medicines. We did observe one occasion where the medicine trolley was left closed but unlocked in a communal area of the home. Although a staff member was nearby, this presented a small risk of unauthorised access by people, some of whom were living with dementia.

People's medicines administration records (MARs) contained information necessary to ensure the safe administration of medicines such as a photograph of the person. The service was using an electronic medicines administration system. We found a number of gaps in the administration records indicating either medicines had not been given or they had been given and records had not been signed. We discussed our findings with a staff member who had identified the gaps during a recent medicines audit. They told us they had checked with the staff responsible for administering medicines who told them the medicines had been given. They told us there were problems with the internet connection, which we observed to be the case during our visit, and the gaps in the electronic system were caused by this. Whilst this explanation is accepted, it is important to ensure there is a reliable system in place for recording medicines administration. The registered manager told us they would be returning to paper records to resolve this issue.

People's medicines were stored securely within locked trolleys, refrigerators or cupboards within a locked room. The temperature of the storage areas were recorded daily and were within acceptable limits. Records confirmed that staff administering medicines had received training and had their competency assessed.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff were competent in meeting their needs. One person told us, "I feel safe if staff are using the hoist, they seem to know how to use it. They seem trained." Another person confirmed this view and told us, "They (staff) know what they are doing." However, two people's relatives told us that staff did not always appear confident in responding to people with dementia and behaviours which could challenge. One of the relatives said that some staff appeared to "lack confidence" in supporting people with dementia.

We were provided with records of staff training. These showed a number of gaps in the training which the provider had identified as mandatory. For example, only seven out of 30 staff had completed training in basic life support and 16 out of 30 staff had completed training in dementia awareness. A large number of people who lived at the service had dementia and could communicate through their behaviour. This presented a risk that staff may not respond in the most appropriate way to people living with dementia which may present a risk to people and staff. Following our visit we received confirmation that training in dementia awareness had been booked for October 2017.

The staff we spoke with felt supported by the registered manager and told us they received supervision. However, the registered manager told us that not all staff had received recent supervision and records showed this to be the case. For example, one member of staff had not received a formal supervision for seven months at the time of our inspection. In addition, training needs identified during supervision were not always acted upon by the provider. Records showed that a member of staff had identified a training need in 2015 which had not been acted upon. The member of staff told us the required training had recently been arranged following concerns raised about staff competency by an external agency. This meant the providers systems to ensure that staff were provided with training required to carry out their roles effectively and safely were not robust.

The failure to ensure that staff were received appropriate supervision, appraisal and training to enable them to perform their role constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received an induction and training when they commenced working at the service. We observed staff following correct procedures when providing care and support, for example when administering medicines and using equipment. Whilst staff were mostly aware of people's needs they told us they did not read people's care plans and relied on senior staff to update them of any changes.

Prior to our visit we received information of concern in relation to the amount of nurses available at the service and their clinical skills. The need to recruit more nurses and develop the clinical skills of the nurses already employed was accepted by the registered manager. During our inspection agency nurses were being used to ensure people's clinical needs could be met. We were provided with a training programme which had been implemented to ensure nurses had the correct training to provide effective nursing care. We were also told by the provider they were in the process of recruiting more nurses. This meant that following

concerns raised by an external agency action was being taken to ensure staff had the necessary skills to provide nursing care.

People told us they were able to make decisions about how they spent their day and were asked their consent before care was provided. One person told us that staff, "very often asked first" before providing care and support. We observed staff interacting with people and saw that the majority of time, staff used effective communication methods and offered explanations to improve people's understanding.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff were able to describe the basic principles of the MCA and who they would involve to make a decision if the person was deemed to lack capacity. Records showed that staff had received training in the MCA.

Records showed that people's capacity to make decisions about the care and support they received had been assessed when appropriate in relation to decisions around medicines, resuscitation and the use of equipment such as sensor mats. We found that although people's capacity had been assessed, the outcome of a best interest decision was not always clearly documented. The registered manager told us that they would ensure that best interest decisions were clearly documented.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that a number of applications had been made to the local authority if people were identified as potentially being deprived of their liberty. We checked three authorisations which had been granted to ensure that any conditions of authorisation were being complied with and found that they were.

People expressed mixed opinions on the food available at the service. One person commented, "Sometimes it's good, sometimes it's not. It's mostly chips." Another person said, "I used to choose (meals), not now. I don't mind. I like chips." However, we observed that people were provided with a choice of meal during a mealtime and when we asked people if they were enjoying their meal they told us they were. We observed that most people ate well and were provided with support if this was required.

Risks relating to people's nutritional needs had been considered although were not always clearly documented. Prior to our inspection an external agency had identified that the electronic system used at the service did not correctly calculate a nutritional risk score. Staff showed us a copy of the new risk tool they would be using in future. This meant that action was being taken to ensure people's risk in relation to their nutrition was correctly assessed. We also spoke to a visiting healthcare professional who told us staff had taken appropriate action when they were concerned about changes in a person's weight.

Some people who lived at their service had been identified as being at risk of not eating and drinking enough. We found that these people had food and fluid monitoring charts in place. However, these had not always been completed to show that people were drinking a sufficient amount each day. For example, there

was no record of one person having anything to drink on one day in between our visits to the service. Another person required a specific amount to drink each day due to a medical condition. Whilst records showed on most days they were drinking sufficient amounts, at weekends this had not been recorded. We spoke to the registered manager about our findings who told us they were confident people were receiving enough to drink but acknowledged records should evidence this.

People told us that staff responded to their healthcare needs. One person told us, "There are nurses here and they will get a doctor if needed." The person also commented that staff supported them to attend hospital appointments. Another person told us that staff supported them with their medical condition appropriately.

Care plans indicated that support from a range of professionals had been sought when this was required. For example, we saw evidence of the involvement of a community psychiatric nurse, chiropodist, GP, occupational therapist and the dementia outreach team. We spoke with one visiting healthcare professional who told us that staff were "on the ball" and they were contacted appropriately to review people.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring. One person told us, "They (staff) look after me very well, they are lovely" and they gave the staff a thumbs up. They told us that staff came and checked whether they wanted anything and were always cheerful. Another person told us, "Staff are caring." One person's relative told us, "The staff work well as a team, they are very good. I am absolutely satisfied."

We observed staff had good relationships with people and interacted with them in a warm and considerate manner. We observed a person approach a member of staff about their hearing aid, the member of staff said they would help them sort this out and asked them if they wanted them to walk back to their bedroom with them. Staff noticed if people required support, for example with their meal or to keep warm, and provided assistance in a compassionate and timely manner.

Some people did not have useful information about their earlier life included in their care plans to help staff know about them, their background and their likes and interests. When we spoke to staff we found them to be knowledgeable about the people they were supporting, but the lack of information in care plans may mean that new or temporary staff would not be provided with important information about the person. In addition, when information was recorded in care plans, staff told us they did not always read care plans. One staff member told us they got to know people's history and story by "spending time talking to them. I think the information is in care plans. I've not read many of them."

People told us they felt involved in decisions about their care such as when to get up and go to bed and one person gave us an example of being involved in decisions about the equipment they required to keep them safe. The person told us, "They (staff) do check out if I am happy". Some of the people we spoke with told us they were not always asked their opinions on the food they would like to eat or how they would like their drink. The registered manager told us that staff knew people well, however acknowledged that some people's care plans lacked information about people's likes and dislikes.

People had access to independent advocacy to help them express their views. The service manager told us about one person at the service who used an advocate. Advocates are trained professionals who support, enable and empower people to speak up. Information was on display within the service which informed people about local advocacy services available to them.

We received mixed views regarding whether people's privacy and dignity were respected. One person told us about how staff supported them with their personal care discreetly and ensured that doors and curtains were closed whilst providing support to preserve their dignity. However, another person's relative expressed concern about how their relation was supported to keep clean and maintain their dignity. They told us they had reported their concerns to the registered manager and they did see improvements on their next visit. However, felt they required further information and reassurance about the support provided to their relative.

The staff we spoke demonstrated a clear understanding of how they respected people's privacy and dignity and were able to provide examples of how they supported people in this way. We observed that staff were

discreet when asking a person if they needed support with their personal care and ensured that people were able to meet with health professionals and visitors in private.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff did not always respect their preferences. One person told us about their preference of how they like their tea, they told us, "They (staff) know it but very often I don't get it." However, the person told us they were happy with staff and thought staff knew their needs. Another person told us they would like the opportunity to spend some time outside and when asked if they were provided with the opportunity told us, "They (staff) wouldn't take you out."
The people we spoke with were not aware of being involved in the planning and review of their care, however one visiting relative told us, "I was involved in a care plan review following the last inspection."

Most of the staff we spoke with had an understanding of people's individual care needs and gave examples of the support they provided to people. However, staff told us they did not always read people's care plans and relied on senior members of staff to keep them updated. This presented a risk that not all members of staff may be aware of any changes in people's needs.

Prior to our inspection, we received concerns that records kept by the service to show how people were supported with their needs were not sufficient. During our inspection, we found that people's care plans were not always followed to ensure they received the care and support they needed, for example in relation to monitoring people's fluid intake on a daily basis or recording details of a seizure when this had occurred.

People's care plans were stored on an electronic system and supplemented by paper charts to document daily care provided such as repositioning (moving a person cared for in bed) and food and fluid intake. During our inspection the service was in the process of transferring care documentation back to paper format due to problems with the electronic system. Most people whose care we reviewed had a range of care plans in place to provide information to staff about the care and support they required. We found these to be variable in relation to the quality and quantity of information they provided about the person's needs. For example, one person's care plan stated they needed to be re-positioned at specific intervals during the day and night but staff told us this was not needed as they repositioned themselves. Another person's care plan stated they required assistance from staff and the use of equipment to change their position but did not specify what type or size of equipment should be used. In addition, not all the care plans we viewed had been regularly reviewed and updated when incidents had occurred at the service. Due to the contradictory and limited information contained within care plans we could not be assured they contained an accurate picture of people's care needs or that they would be cared for correctly.

People could not be assured they were provided with a personalised plan of care. Several of the care plans contained a lack of personalised information about how staff should best support the person in line with their wishes. This would help ensure that people's care met their needs and reflected their preferences.

People were complimentary of the activities provided in the service by the activities co-ordinator. One person told us about the activities provided at the service and that they enjoyed these. During our visits we observed the activities co-ordinator engaging people in group activities in communal areas of the service. We also witnessed them talking to a person who spent their time in their bedroom and arranging a game of

dominoes.

We asked people if they were supported to spend time outside or access local amenities. Some people who lived at the service and some relatives expressed frustration at the lack of opportunity to spend time outside. Following our inspection, the registered manager told us of the action being taken to repair an outside wall which would give people more privacy should they wish to spend time outside.

We received mixed views as to whether concerns and complaints about the service were responded to. One person told us they had raised an issue with the registered manager and were happy with the result of this. However, on another occasion their issue was unresolved. Another person told us, "There was one time a carer did not talk respectfully but I didn't raise this with the manager as I never see her." People's relatives also expressed mixed views. One person's relative told us they were satisfied with the way their complaint had been handled whilst another relative told us they, "lacked confidence" that a complaint would be responded to by the provider.

Staff told us of the action they would take if a complaint was raised with them which included reporting any concerns to the registered manager. We saw that a copy of the complaints procedure was on display in the service along with comment forms.

We reviewed records of six concerns which had been received by the provider since our last inspection. Whilst the nature of the concern was recorded there was not always a record of the action which had been taken in response, whether the concern had been resolved and the complainant responded to. After further review of two of these concerns we found evidence that action had been taken to resolve the issue but this had not been recorded.

Inadequate

Is the service well-led?

Our findings

At our inspection in January 2017 we found that systems were not operated effectively to assess, monitor and improve the quality and safety of the service. These included processes for ensuring risks to people were reduced. The provider sent us an action plan outlining the improvements they would make. During this inspection we found that sufficient improvements had not been made.

Systems to ensure the safety and quality of the service were not always effective in reducing risks to people despite previous assurances from the provider. The provider told us in their action plan that staff files had been audited and no employee would commence duties prior to recruitment checks being completed. We found that an audit had been completed of staff files in June 2017 which highlighted some gaps in recruitment checks. When we checked staff recruitment files, records showed that a member of staff had commenced employment approximately one month prior to some of the required recruitment checks being completed. The risks in relation to this had not been assessed and there was no record of the action taken to reduce the risks to people. This showed that the system was not effective in assessing and monitoring the safety of recruitment processes which meant people were at risk of unnecessary harm.

People could not be assured that the monitoring of accidents and incidents which occurred at the service was robust. We reviewed accidents and incidents which had occurred since our last inspection. The details of incidents had been collated but the information was not always accurate and there was minimal evidence that regular analysis was carried out to identify themes or trends. This meant there was a risk that actions required to reduce risk may not be noticed or acted upon in a timely manner. In addition, people's care records and risk assessments did not always show accurate information and the action taken in response to accidents and incidents was not clearly documented.

We looked at concerns and complaints which had been received since our last inspection and found these were not always completed to evidence what action had been taken to ensure people were safe and issues responded to. There was no evidence that complaints had been analysed for any themes to help drive improvement at the service. This meant that the provider was not robustly monitoring the safety and quality of the service which could result in poor outcomes for people.

People could not be assured that systems to ensure staff had the correct skills and training to meet people's needs safely were effective. We were informed by an external agency prior to our inspection they had concerns about the competency of staff employed at the service to meet people's needs in relation to specific health conditions. For example some people had health conditions that required monitoring and clinical intervention and we could not be assured the staff had training to manage these conditions. This presented a risk to people's health and safety. Whilst the provider had taken action in response to these concerns, their internal governance systems had not identified and acted on this risk prior to feedback from external agencies. In addition the registered manager told us there was not a system in place to regularly check nursing registrations to check they were registered and have no restrictions on their practice. Although when we checked there were no restrictions on nurse's practice, the lack of regular checks presented a risk. An annual check was introduced following our visit.

The provider had not taken sufficient action in relation to feedback from external agencies such as the CQC and commissioners. Concerns regarding safeguarding referrals, recruitment and governance systems had previously been identified. Despite the provider submitting an action plan to us detailing the improvements they would make, further improvements were still required during this inspection. Therefore we were not assured that the provider would robustly monitor the progress of their action plan to ensure improvements were made. In addition, timely action was not taken when issues were identified. For example, records showed an agreement was made to move to paper care plans at the end of June 2017. At the time of inspection, electronic care plans and medicines administration records were still being used despite identified issues with these systems. This meant that people's current care and support needs were not always clearly documented. This presented a risk due to the regular use of agency staff at the service.

People could not be assured that the provider had effective oversight of the service. We asked for records or minutes of visits carried out by representatives of the provider and received some evidence that a representative had regularly met with the registered manager and staff and discussed issues. A representative of the provider told us they or the provider, had visited the service a minimum of twice a week since our last inspection to provide support and guidance to the registered manager. Despite evidence of some of these visits, sufficient improvements had not been maintained which presented risks to people's safety.

The failure to effectively monitor and assess the quality of the service in order to make necessary improvements constituted an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2017 we found we had not received notifications of certain events which had taken place at the service. The provider submitted an action plan detailing the improvements they would make. During this inspection we found that sufficient improvements had not been made and the provider remained in breach of regulation.

The provider is legally required to notify us without delay of certain events that take place whilst a service is being provided. We found during this inspection there had been some events that took place which should have been reported to us that had not been, for example in relation to 10 potential safeguarding incidents at the service. This meant we were restricted in how we monitored the service due to a lack of information received.

The failure to notify us of certain events which had taken place within the service was an ongoing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We previously identified during our last inspection that people were provided with limited opportunities to contribute to the development of the service. The registered manager told us that people were invited to complete questionnaires and showed us a notice informing people about weekly meetings which people who lived at the service and their families could attend. They told us that people and their relatives chose not to attend the meetings. The people and relatives we spoke with were not aware of any meetings they could attend about the running of the service and told us they were not regularly asked their views. This meant that the systems in place to capture people's views about the running and development of the service to enable the provider to respond to areas requiring improvement may not be fully effective.

People told us they would approach the registered manager or another member of staff if they had concerns. However, some people's relatives told us they did not get a quick response to concerns or issues they raised or were not confident their concerns were fully addressed. The records we saw did not always

confirm that people had received a response to concerns they raised.

The service had a registered manager in post. The relatives we spoke with were aware of who the registered manager was but expressed mixed views on whether the registered manager was visible and responsive. The staff we spoke with told us they felt the staff team worked well together and they had a good relationship with the registered manager and another senior member of staff. One staff member told us, "[Registered Manager] is brilliant, friendly and on the floor a lot." Staff told us they recognised improvements were needed at the service and they were supported in their role by the registered manager and held regular staff meetings to discuss improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to the health and safety of people were not always assessed and the risks to people were not always mitigated as much as was reasonably practicable.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not established and operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate supervision, appraisal and training to enable them to perform their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents We had not been notified of certain events which had taken place within the service as required.

The enforcement action we took:

We issued a fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. This included the process for ensuring that risks to service users were mitigated.

The enforcement action we took:

We have issued notices of proposal to impose conditions on the providers registration.