Mr & Mrs R M Parkhouse

Garston Manor Nursing Home

Inspection report

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Ratings

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

Overall summary

Garston Manor Nursing Home is registered to provide nursing care and support to 26 people who have dementia, mental health needs, and /or a physical disability. The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available in the home on the day of our visit. We contacted them after the inspection to gather further information.

At the last inspection carried out on 28 July 2014 we found the provider was not meeting the regulations in relation to people's care and welfare, safeguarding people, managing medicines safely, having sufficient numbers of staff and monitoring quality and safety. We

Summary of findings

served two enforcement warning notices relating to safeguarding and medicines. These warned the provider that we would take enforcement action if they did not make changes to ensure people were safe.

Following that inspection the provider sent us an action plan telling us about the improvements they were going to make. They told us they would make these improvements by 7 October 2014. During our inspection on 22 October 2014 we found that the provider had taken action to address some of these issues. However, we found the warning notice in relation to medicines had not been met. Although the warning notice in relation to safeguarding had been met, we found additional concerns relating to safeguarding at this inspection.

People did not always receive their medicines at the times they needed them and in a safe way. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from abuse. There was a lack of evidence of action taken following incidents to keep people safe. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care needs were not always assessed and people did not receive care in line with the requirements set out in their care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not always treat people with dignity and respect or respect their privacy. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people lacked capacity to make decisions about their care, decisions were not always made in their best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.Quality assurance processes were inadequate; the issues we found had not been identified by the provider's own monitoring and audit processes. Risks to people's health, safety and welfare were not appropriately assessed and managed. This was a breach of Regulation 10, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

We found appropriate checks had been undertaken to ensure staff were suitable to work with people who lived in the home.

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.

The systems in place for the management of medicines were unsafe and did not protect people who used the service.

People were not protected from abuse. When incidents took place the provider did not always contact the local authority safeguarding team.

The provider's safeguarding policy did not contain a clear procedure to ensure staff reported abuse without delay.

Inadequate

Is the service effective?
The service was not effective.

Staff were not consistently following the care plans to ensure people's individual dementia care needs were met. Whilst staff had up-to-date training, it was not always put into practice.

People enjoyed the food at the home. The cook had a good knowledge of people's individual dietary needs and knew people's preferences.

Inadequate

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

Some staff demonstrated warmth and respect towards the people they were caring for. Some staff supported people well, engaged with them, and made good eye contact.

People were not always treated with dignity and respect. Some staff did not engage, talk with or offer assurance to people when they provided support.

Requires Improvement

Is the service responsive?
The service was not responsive.

Staff were not consistently responsive to the needs of people. We saw instances where staff did not respond to people's individual needs and they did not get support at the time they needed it.

There was no evidence that activities had been designed to engage people with dementia. The service had recently employed an activities co-ordinator and planned to develop more person centred activities.

Care plans contained information about people's likes, dislikes and preferences. Staff had information that helped them to provide care in line with people's wishes.

Requires Improvement

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

We found a number of issues during our visit which had not been identified by the provider. Systems were not in place to ensure people received adequate quality care.

The provider had not addressed a breach of the regulation relating to the management of medicines found during our last inspection. People were placed at continued risk of unsafe administration of medicines.

Garston Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 22 October 2014 and was unannounced.

Three inspectors and an expert-by-experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care for older people.

Before the inspection we reviewed the information we held about the service and contacted the local authority to ask for their feedback about this service.

On the day of our visit there were 26 people living in the home. We used a range of different methods to help us understand people's experience. We spoke with six people who lived in the home and three relatives. We spoke with eight staff including the registered manager's personal assistant who was the person in charge on the day of the inspection. We also spoke with a continuing healthcare assessor.

We spent time observing care and used the Short Observational Framework for Inspection (SOFI). This gives us a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care plans, medication records, the staff rota, two staff files, audits, policies and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our inspection on 28 July 2014 we were concerned about the management of medicines in the home. We served a warning notice telling the provider they needed to take action to ensure there was a system for the safe management of medicines in use in the home by 30 September 2014. During this inspection we found significant problems with the way medicines were managed in the home. Therefore people were not protected against the risks associated with the unsafe management of medicines.

We met with the provider on 17 September 2014 and they told us they would make the safe management of medicines a priority. At this inspection, we found the required improvements had not been made. The Medication Administration Record (MAR) charts were not always completed correctly. For example, we looked at the charts in the morning and saw one person's lunch time medicines had been signed as having been given. However, the medicine was still within the monitored dosage system 'blister' pack. Entries on the MAR sheet which had been hand written were not always signed by two people to ensure the correct information had been recorded.

Staff told us the majority of people living at the home had their medicines crushed or removed from capsules before they were given to them. The care plans we reviewed recorded the person's GP and their representatives had signed documents saying they agreed with the person's medicines being crushed. However, some medicines are not suitable to be crushed or to be removed from their capsule. When tablets are crushed or capsules are opened this may affect the way that the medicines work. Some of these medicines could be given as liquids. However, information we requested from the registered manager showed a pharmacist had not been consulted on whether it was appropriate to crush the medicine or remove it from capsules. The liquid form of the medicines had not been requested or considered.

The home's 'medication protocol' stated staff should give out all medicines that had been prescribed to be given 'when required' (PRN) only at specified times. This showed staff may be overriding the prescribing instructions given by the GP.

Controlled drugs were kept securely and records were completed. However, other medicines were not secured safely at all times. Medicines were distributed from a medicines trolley that held medicines securely. We saw that when medicines were given to people in the lounge, the trolley remained outside the lounge. When one person fell in the lounge, the staff giving out the medicines needed to assist this person but had nowhere to securely store the medicine they were holding. On this occasion, they had to hand it to the inspector to hold, as there was no other staff member available and the medication trolley was outside the room where the incident took place.

The service had a homely remedies policy and list, detailing over the counter medicines that could be given to people without a prescription. This included mild indigestion remedies, simple linctus and paracetamol. As staff were administering these medicines a record should have been kept when they are given to people. However, one member of staff did not know where to record when homely remedies had been given. The administration of these medicines was not being recorded consistently. This placed people at risk of receiving too many medicines.

The registered manager had previously told us only people who had received medicine training would administer medicines. However, one member of care staff who had not completed the training told us they had been given medicines by another member of staff to administer to people living at the home. People were placed at risk of being given the wrong medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who lived in the home and their relatives told us they felt safe. We talked with staff about how they would raise concerns about abuse and poor practice. Some staff were aware of the whistleblowing procedure and said they would not hesitate to report any concerns they had about care practices. They told us they had also received training to recognise harm or abuse and felt the registered manager would listen to their concerns. Other staff were not aware they could contact external agencies and report concerns outside of the home. We looked at the provider's policy. This said "Where an incident of serious concern is alleged the person making the allegation must report this directly to the Proprietor". The provider is sometimes absent from the home, therefore this policy meant there could be a delay in acting upon concerns about people.

Inadequate

Is the service safe?

People were not safe because the provider had not always taken advice to protect them from some people's behaviour that was challenging to the service or might cause harm. For example, where one person's behaviour challenged the service, we found the provider had sought advice from the person's mental health consultant and their medicines had been reviewed. The person had been involved in further incidents after this review. For example, there had been an interaction between two people where staff had to intervene. On another occasion staff were hurt by a person who had become distressed. The staff had recorded these incidents on behaviour charts and the behaviour management plan had been updated. However, the service had not sought further advice, or made a referral to the mental health team. A healthcare professional told us they had contacted the service to find out about this person. The staff had told them the person had been verbally aggressive but was settling. They did not tell them about the incidents of physical aggression, which had occurred prior to this contact. We found these safeguarding incidents had not been reported to the local authority safeguarding unit. If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required. This placed people at risk of further harm.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to individuals were not managed. One person's care plan had a behaviour management plan for incidents of significant aggression. This included information on triggers that could result in aggressive behaviours. The care plan said skilled intervention was required. There was no information about the interventions that would be appropriate to support the person in a distressed or agitated state. The plan suggested the person might benefit from being in a quiet room to calm down. However there was no information about how the person should be supported to move to a quieter environment. There is evidence that staff had to intervene in incidents. There was no guidance for staff to ensure they were able to carry out these interventions in a safe and supportive way. The service had failed to carry out risk assessments to ensure care was delivered in line with people's individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although staff were very busy on the day of our inspection, they attended to people's needs. People received care and support in a timely manner. The staff rota informed us there was one nurse, four care staff, one activities worker, a cook, and a domestic on duty each day. Staff told us they felt there were enough staff on duty to meet people's needs.

There were personal emergency evacuation plans in place. These gave information on how people were to be evacuated in the case of an emergency such as fire.

Safe recruitment processes were in place. We looked at the files for two staff who had recently started work in the home. We found that appropriate checks had been undertaken to ensure staff were suitable to work with people who lived in the home.

Inadequate

Is the service effective?

Our findings

People's healthcare needs were not being met effectively. For example, three people had diabetes. Care plans contained information related to this condition. However, there was no clear guidance in place for the management of high or low blood sugar levels. It was not clear when people's blood sugar levels needed to be tested. We saw one person who had diabetes repeatedly sought out sweet things to eat, this included taking these foods from others or from the drinks trolley when staff were distracted. This was significant for people with dementia who may not be able to manage their own condition.

There was no assessment tool in place to help staff recognise whether people were in pain. Some people had behaviour that challenged the service. Staff had no effective way of determining whether people were in pain which may cause changes in their behaviour, such as becoming anxious and/or distressed. The National Institute for Health and Care Excellence (NICE) guidance states "if a person with dementia has unexplained changes in behaviour and/or shows signs of distress, health and social care professionals should assess whether the person is in pain, using an observational pain assessment tool". The service did not use specialist pain assessment tools for people with dementia and impaired verbal communication or dementia anxiety rating tools.

We had concerns about the ways in which people were supported to transfer and move. We saw two people being moved in wheelchairs without the footrests being in place. This put people at risk of injury. We also saw two people being transferred from their chairs to wheelchairs in an unsafe manner by staff. For example, staff moved a person by lifting them under their arms which puts the person at risk of harm. We looked at the care plan and the moving and handling plan for one of these people. It stated two members of staff were to transfer the person into a wheelchair using a hoist. This meant staff had not followed the person's care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people from the premises were not effectively managed. We saw the top of one of the dining room tables was no longer attached to the base. We saw people trying to use the dining room tables to support themselves to get up from their chairs. If people had leaned on the broken table to support themselves to get up the top could have slid off. This was unsafe and was discussed with the person in charge at the time of the inspection. They told us they would ensure the table was repaired.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so that they get the care and treatment they need, where there is no less restrictive way of achieving this.

At our inspection on 28 July 2014 we were concerned that people were being deprived of their liberty without the protection of a legal authorisation to do so. We served a warning notice telling the provider they needed to take action by 30 September 2014. At this inspection, we found the provider had made the appropriate Deprivation of Liberty Safeguards (DoLS) applications. The local authority confirmed they had received the applications.

The Mental Capacity Act (2005) (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Some people did have mental capacity assessments in their care plans. We found that some staff did not demonstrate an understanding of the MCA and how this applied to their practice. For example, staff were making some decisions on people's behalf without doing this in line with the Mental Capacity Act. There was a widespread practice that people's medicines were crushed and hidden in food without their knowledge. Care plans recorded the person's GP and their representatives had signed documents saying they agreed with this. However, there was no evidence that each person's capacity to make a decision for themselves in relation to their medicines had been assessed on an individual basis. There was no information about how the decision was made, or how the decision to give medicines in this way was in each person's best interests.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us, and records confirmed, they had completed training in areas such as fire safety, infection control, safeguarding, medicines management, moving and

Inadequate

Is the service effective?

handling and food hygiene. However, action was not taken by the person in charge when they saw that training in relation to moving people was not being followed. Staff were doing this in a way that was not safe. Some of the staff who worked in the home did not have English as their first language. They found it difficult to understand what the inspector was saying and were unclear about some of the home's policies. Although staff completed an online test as part of their training, there was no procedure in place to ensure staff understood their training and responsibilities.

The environment was not suitably adapted for people with dementia. For example, we saw the dining room tables and chairs were transparent and the floor below had a complex geometric pattern. This could be difficult for people with visual and perception problems associated with dementia to understand. There were recent photographs on people's bedroom doors of the person that used the bedroom. People with dementia may not recognise themselves as they are now. We contacted the provider after the inspection and they told us an independent occupational therapist had assessed the environment. However, the environment did not take into account the NICE guidance for supporting people with dementia which states "environments are enabling and aid orientation".

People and their relatives told us their health needs were met. Records showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs. A GP visited nine people at the home during the inspection. All visitors confirmed they had been fully consulted about their relatives care and treatment and would receive a telephone call when there was a concern.

We saw records that showed staff had received regular supervision. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues. Staff confirmed they had received supervision.

Everyone was satisfied with the quantity of food they received and one person added they sometimes had "seconds". A visitor commented their relative had put on a welcomed amount of weight since moving to Garston Manor. Comments from people included "Food is lovely", "Food is good", and "Food is alright".

We spent time with the home's cook looking at the food provided, people's diets and food monitoring. The cook had a clear understanding of people's likes and dislikes and a balanced approach to the management of diabetic diets. Information for staff about people's preferences and special diets was kept attached to the drinks trolley for quick reference. For example, this showed who needed sweeteners or thickened fluids. People who required a soft diet had this individually pureed. Aids for eating such as high contrast coloured plates and mats were used to help people eat independently. If people wanted an alternative meal, these were always available. For example, we saw one person did not want to eat their lunch, so they were given scrambled eggs and tomatoes, which they ate and enjoyed. We observed people being asked if they wanted more food to eat. The cook had pre-prepared sandwiches for the evening or night in case people were hungry.

We saw records were kept of the food and drinks each person ate and drank each day. This helped to ensure the nurses were aware of each person's daily intake. People's weights were recorded regularly. Where people were at risk of losing weight, the cook prepared enriched foods, which included fruit smoothies, and adding cream and butter to mashed potatoes.

Requires Improvement

Is the service caring?

Our findings

We observed staff supporting people throughout the day in communal areas. The quality of the interactions and support people received was variable.

We saw one person being transferred using the hoist. Staff who supported the person did not talk to or engage with them whilst they were being transferred. We saw the person had significant confusion. The staff involved did not reassure or support the person whilst they delivered the care they needed. We also saw a member of staff stand over a person, supported them to eat a mouthful and then moving on to another person to help them. This did not give people a positive experience of being supported to eat.

We heard staff talk over people or talk about people between themselves. For example, we heard one member of staff say to another "She's wet as well" within the person's, and other people's earshot.

One person did not want to eat their lunch in the dining room. A member of staff helped them to sit in an easy chair with their lunch. However, they did not provide a table and the plate slid from their lap onto the chair. A member of staff saw this when they walked past. They scooped the food, which was very soft in consistency, from the person's clothing and the chair with their hand and put it back on the plate. The person did not eat their meal and it was removed. The person was not offered any opportunity to clean their hands or clothes. We did not see other people were offered opportunities to wipe their hands after eating.

The provider failed to ensure people's privacy, dignity and independence were respected. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw some good exchanges between staff and people who lived in the home. For example, one person spoke with a member of staff about another person who had upset them. The staff member touched them gently and asked them "What can we do to put this right for you?" This helped the person feel listened to and was supportive. We saw some staff demonstrating warmth and respect towards the people they cared for. Some staff worked with people at their own pace, for example when walking with them. Relatives commented; "The staff are very caring", "The staff are very good at distraction techniques" and "The staff have a caring attitude". One staff member told us "Staff have a good way with people."

When the GP visited the home, staff took them to see people in their individual bedrooms. Three of the bedrooms in the home were used for two people. Curtains were in place and could be closed when personal care was carried out. This respected people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and care plans developed but these did not always give clear information to ensure people's needs were met. Staff did not always respond to people's needs.

Care plans did not give information about how each person's dementia impacted on their day to day life or how to care for people with more complex needs in an individual way. Care plans did not contain detailed information in relation to each person's communication needs.

We saw some positive examples of care and support. However, we also saw instances where staff did not respond to people's individual needs and they did not get support at the time they needed it. For example, one person was agitated and restless throughout the mealtime we observed. This resulted in them moving away from the table and leaving their meal regularly. The person's care plan recorded they had not been eating enough recently and therefore "requires a quiet environment to avoid anxiety in order to complete (their) meals". The lounge and dining areas did not give the person a quiet environment, and they had not had access to a quiet area throughout the time we were at the home. We also saw the person looked anxious at times.

Care plans did contain information about each person's needs, history, and how they liked to be supported. This included people's likes, dislikes and preferences. Where people lacked the capacity to make a decision for themselves the provider had involved the family and other professionals in writing and reviewing the care plan. Relatives said they were satisfied with the care. One relative told us they had been involved in the care planning and felt the service listened to their opinion about what they thought the person would like.

There was no evidence that activities or engagement had been designed to address issues such as preventing isolation, helping to maintain the person's identity, and helping the person to feel valued, helpful and involved. We recommend the provider takes into account the College of Occupational Therapists guidance in relation to engaging people with dementia. The service had recently employed an activities co-ordinator. The service also arranged a visiting art group once a week. A list of each person's interests had been written and the service planned to develop more person centred activities. In the meantime the activities co-ordinator told us they provided activities on a one to one basis or to small groups. We saw this staff member worked hard to engage people. The activities co-ordinator spent time speaking with people on a one to one basis and played the guitar to a group of people. However, most of the time we observed people were either wandering around the lounge with no apparent purpose, sat watching a muted television or other people, or sleeping and dozing.

The service had not received any complaints since our previous inspection in July 2014. All the relatives spoken with were aware of procedure should they wish to make a complaint but none had done so as yet. People who lived in the home said if they had a concern or complaint they would see the registered manager or person in charge.

Inadequate

Is the service well-led?

Our findings

We served the provider of this service with two warning notices on 9 September 2014. These related to safeguarding people and the management of people's medicines. These warned the provider we would take further enforcement action if they did not make changes to ensure people's care needs were met safely. We met with the provider on 17 September 2014, to discuss our concerns. The provider told us they had taken action to make improvements and had introduced a new quality assurance system.

At this inspection, we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. Management systems at Garston Manor Nursing Home were not sufficient to improve the quality of care and support provided to people. We identified failings in relation to dignity and respect, care and welfare, safeguarding, and management of medicines.

The registered manager had carried out their own quality assurance self-assessment. This self- assessment had identified the actions required to bring about improvements in the service delivered. However, this was a list rather than a plan of how the improvements were to be made. For example, the self-assessment identified that care plans needed reviewing and needed to be appropriate. The action plan said that care plans should be reviewed on a weekly basis or sooner if necessary. It did not provide a plan or guidance on what an appropriate care plan would include. The action plan recorded that this action had been completed in September 2014. When we looked at care plans, this review had not identified that care plans did not contain enough information to ensure that people's needs were met. The self-assessment identified that there was an inadequate quality assurance system in place that did not show quality or safety issues in a timely manner. The action required was that the system needed to be adapted to be suitable and simpler. The action plan recorded that this action had been completed in August 2014. However, we found that the system had not identified quality and safety issues.

At the inspection carried out in July 2014, we served a warning notice requiring that improvements were made in relation to the management of medicines. The self-assessment undertaken by the registered manager in relation to medicines showed this was an area for improvement and an action plan was recorded. This action plan identified that all nurses required on-going training and that appropriate checks should be in place to pick up any mistakes. The action plan did not identify what those appropriate checks would be. There was no evidence that the nurses had received any further training and the checks designed to pick up any mistakes had not identified the errors we found during this inspection. The action plan also identified that medication records needed to improve. The action identified to achieve this was to warn staff they would be dismissed if records did not improve.

Quality assurance processes were not effective in ensuring that action was taken when issues of quality or safety were identified. For example, during our inspection, we saw inappropriate and unsafe moving and transferring practice. The person in charge told us they had also seen this. They had not intervened to ensure people's safety.

This home provided support for people with dementia. Guidance is available for care home providers on how to make their care home suitable for people with dementia. The décor and furnishings chosen at this home did not reflect the current guidance. Quality assurance processes had not identified this as a possible area for improvement.

Without effective quality assurance processes, this provider has relied upon inspections by the CQC to identify areas for improvement. The provider has taken some actions in relation to these inspections and the identified breaches of regulations. However, they have been unable to sustain the improvements and have demonstrated that they cannot identify the improvements needed for themselves.

The above shows this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The quality assurance action plan told us a deputy manager had been appointed to act in the absence of the manager. However, we found the decision making remained with the manager during occasional absences of up to three weeks at a time. The registered manager was away at the time of this inspection and during the last inspection.

Staff told us the registered manager was responsible for decision making at all levels. The person in charge told us they maintained regular contact with the registered manager during their absence. Staff told us the registered manager managed the home at a distance whilst they were

Inadequate

Is the service well-led?

absent. For example, staff told us they had to ask the registered manager's permission before they contacted a GP. These management arrangements could delay people receiving the support they need.

Most staff told us they felt supported by the management team**.** They told us they felt listened to and were able to suggest improvements. However, we saw minutes of team meetings that showed a style of leadership which did not promote a positive culture. These minutes recorded that staff had been told they had let the home down at the previous inspection. The minutes listed staff's shortfalls. At the same meeting, staff were asked for their suggestions and comments. They responded they wanted to work as a team, without pressure to do things quickly. One member of staff said they did not trust other staff. The minutes of the meeting did not record how the issues and suggestions raised by staff would be addressed. There was no evidence in the action plans that action had been taken to address them issues. Staff told us there was a high turnover of staff because of the culture within the home.

Relatives told us they found the registered manager to be approachable. For example, one relative told us their parent did not like sleeping alone in a single room. The registered manager suggested they moved into a larger shared bedroom and everyone involved agreed to this solution.

Since this inspection, the provider has told us they have employed a consultancy firm to support them in bringing about the required improvements. In addition, the local authority quality monitoring team are supporting the provider to make improvements to quality and safety for people living at Garston Manor Nursing Home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe. Regulation 9 (1)(a)(b)(i)(ii)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 10 (1)(a)(b)(2)b(v)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not have suitable arrangements in place to ensure that people were safeguarded against the risk of abuse. Regulation 11 (1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not have suitable arrangements in place to ensure that people's dignity and independence were maintained as far as practicable. People were not always treated with consideration and respect. Regulation 17 (1) (a)(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining consent or acting in people's best interests. Regulation 18 (1)(a)(b)(2).

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.