South Yorkshire Care Limited

Cathedral Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 2 July 2015 and was unannounced.

Cathedral Nursing Home provides accommodation for 38 older people or people living with a dementia. The home provides both residential and nursing care. There were 34 people living at the home on the day of our inspection.

There was a registered manager at the service. However, they were not registered to manage all of the regulated activities the service provided. Following our inspection they submitted applications to become a registered manager for all the required regulated activities. 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.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the administration of medicine was always safe and systems to monitor and improve the quality of care people received were not effective. We

Summary of findings

also found a breach of the Health and Social Care Act 2008 (Registration) Regulated Activities 2009. The provider had not told us about certain incidents. You can see what action we told the provider to take at the back of the full version of this report.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. People who were at risk of having their liberty deprived had their rights protected by a senior staff team who had received appropriate training and understood how to protect people's rights.

There were systems in place to ensure that when it was needed medicine was always available to people. However, the administration of medicines was not always timely and the systems did not support staff to reduce the risk of medicine errors. There were systems in place to protect people from risks which included appropriate infection control processes.

Parts of the home were tired and in need of decoration and maintenance was not always completed in a timely manner. The provider had a maintenance plan in place, but it was not robust, did not identify furniture which needed replacing or how the provider could improve the environment to support people's independence. There was an unpleasant odour in areas of the home and it was not nice to spend time in these areas.

The registered manager had identified appropriate staffing levels and staffed the home accordingly. Where agency staff were used, there was guidance available to them to ensure they could meet people's needs. However, staff did not receive clear direction and this impacted on their ability to meet people's care needs. Staff were supported with training and supervision. However, we saw that training was not embedded in every day care and people's dignity and privacy were not always maintained.

People were offered a choice of food and people told us the food was good. However, staff did not ensure people enjoyed a pleasant dining experience. Support for people who needed help to eat was not always available.

Staff members were polite and friendly to people. However we saw that they were task orientated and did not put people at the centre of the care provided. Care records did not support staff to build relationships with people by knowing what was important to them.

Care records for people who required nursing care did not always accurately record their needs and monthly assessments did not always accurately identify changes in people's needs. Support to people was not always delivered in a way to meet their needs.

People told us they knew how to make a complaint. However, the registered manager had not always responded to complaints in a timely fashion.

The registered manager had developed systems to monitor the quality of the service provided, however they were not effective as they were not embedded into the everyday running of the home. Staff were not given clear instructions of what they were expected to do and this meant some people received poor care. At times the registered manager put the needs of staff above the needs of people living at the home and this resulted in poor standards of care being provided.

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?

Requires Improvement

The service was not consistently safe.

There were systems in place to identify risks to people's health and safety and care was planned to reduce these risks.

Appropriate staffing levels were identified; however, staff were not deployed in a way which ensured people received good care.

Systems ensured medicines were available for people. However, medicines were not always administered in a timely fashion.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed regular training. However this training was not embedded in the care people received.

People's rights were protected as senior staff were aware of their responsibilities under the Mental Capacity Act 2005.

People were offered a choice of food. However, where people needed support to eat this was not always provided.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were friendly and polite to people. However, staff were focused on completing tasks and did not consider how this impacted on the care people received.

Staff did not always respect people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Reviews for people who needed nursing care did not always correctly identify changes in people's care needs. Staff were not always responsive to people's needs.

Activities were available to people. However, they were not used to identify people's interests or to design care to support people in a more person centred way.

People knew how to complain. However, the registered manager did not always respond in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Summary of findings

Staff received a lack of direction from the registered manager and care was disorganised.

Systems were in place to monitor the quality of service; however, they were ineffective as they were not embedded into every day care.

The registered manager had not always told us about notifiable events.

Cathedral Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 July 2015 and was unannounced. The inspection team consisted of an inspector, a specialist advisor and an expert-by-experience. The specialist advisor was a qualified nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commissioned care for some people living at the home.

During the inspection we spoke with seven people who lived at the home, six visitors to the home and spent time observing care. We spoke with the nurse, a senior carer, a care worker, the activities coordinator, two domestic staff, the administrator and the registered manager. We also spoke with three healthcare professionals who visited the service.

We looked at seven care plans and other records which recorded the care people received. We also looked at management records including how the quality of the service provided was monitored.

Requires Improvement

Is the service safe?

Our findings

There were systems to order, monitor and return medicines safely which ensured that there was always medicines available to give to people. However, medicine was not always stored and administered in way which ensured people received their medicine safely and in a timely manner. Most medicine was stored safely, however, the medicine which needed two people to administer was jumbled up in the secure cupboard and we saw the nurse got very confused trying to identify the correct medicine to give. We saw they looked at some boxes two or three times to identify the correct medicine. They finally identified and administered the medicine. While this person received the appropriate medicine there was a risk that a medicine error could have occurred as the systems did not support good management of medicine.

People's medicine was not always administered in a safe and timely fashion. Staff dispensed the medicine in the senior carer and nurse's rooms and carried them out to people. This meant there was no immediate storage available if the member of staff needed to deal with an emergency and it increased the time it took to complete the medicine round. The morning medication round was not completed until 11.30am. When we discussed this with staff they said that this was a normal occurrence. This meant people may not have received important medicine like pain killers at the time they were due.

Staff completing the medicine rounds were continually interrupted by other staff. This increased the risk of medication errors and interrupted people's routines. For example, one person was left waiting for 25 minutes after initially speaking to the nurse before being given their medicine.

People were not always fully supported or encouraged to take their medicine. One person had been prescribed supplement drink as they were at risk of not maintaining a healthy weight. The person did not touch this and care staff moved him away from the table, ignoring the food supplement. When the nurse appeared, she picked up the bottle to check if he had drank it and then asked where he was, there was no further approach made to get him to take this medicine.

Care plans did not contain information on when it was appropriate to administer medicines prescribed to be taken as required and there was no recording of why medicine had been given. For example, we saw one person was prescribed a tablet which would calm them when they displayed behaviour others may find challenging. There was no record to say when it would be appropriate to offer the person this medicine or who should be involved in the decision. We saw this medicine had been administered once on the medicine administration record. However, there was no recording of why it had been given.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that they felt safe living at the home. Two people mentioned that sometimes people may wander into their rooms during the day. Although they said this did not overly worry them, they had mentioned it to staff. One person who had spoken to staff told us "They didn't seem bothered."

Where people had been put at risk of harm, records showed the registered manager had completed good investigations into the incidents and had taken appropriate disciplinary action against staff when needed. All the incidents had been reported to the local authority safeguarding team.

Staff were able to tell us about the different types of harm and what signs may indicate that people at risk of harm. Staff were clear on how to raise concerns internally with the registered manager. However not all staff knew how to raise concerns with external agencies.

The home was secure and the front door was kept locked and visitors had to ring and speak to staff for access. However, we saw that the keys to the safe where people's money was kept were left in the safe door in the office. The office door was unlocked and not always occupied.

All the care plans we looked had had basic risk assessments in place and people received the care needed to minimise the risk of harm. For example, we saw moving and handling information was available to staff and included information on how many care workers needed to support people and what equipment was needed. Where people needed increased levels of monitoring appropriate charts were in place and completed. For example, some people had food fluid and reposition charts in place.

Requires Improvement

Is the service safe?

Accidents and incidents were analysed to see if there were any similarities and actions taken to resolve issues.

People said that there was usually enough staff on duty to meet their needs, but that sometimes they had to wait for care. One person said, "I need toilet help sometimes and occasionally have to wait, but not too long." Another person said, "When I ring my bell, I sometimes have a wait for the toilet."

The registered manager told us they used the local authority tool to determine their minimum staffing levels. However, they said they would increase staffing levels if people needs increased. For example, if a person was at the end of their life and needed more care. One person needed one to one care for 12 hours a day. We saw this was available and allocated separately on the rota. As well as the care staff and registered nurse there were also supporting staff available including kitchen staff, domestics an administrator and the handyman.

However, staff were not well organised. For example, at one stage there were three members of staff looking for the handyman. Staff asked and were allowed to go to lunch while people who lived at the service were waiting for their lunch. This meant it took longer for lunch to be served and we saw people in the dining room waited over half an hour for their dessert. During lunch there was a ten minute period where there was no staff in the dining room supporting people.

The provider used agency staff to cover for registered nurses at times. Before allowing an agency nurse to work the registered manager checked their registration and current training with the agency. There was a folder developed for agency staff which included information on people's care needs and medicines so that agency staff had all the information needed to care for people.

The provider had systems in place to ensure people employed had the appropriate skills and qualifications to care for people who lived at the home. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

People living at the home and their relatives told us the home was clean. One person said, "I think my room is clean, its quite nice." Another person said, "I'm happy here. Its very clean." There were appropriate cleaning schedules in place and domestic staff told us and records shows that cleaning was competed in line with the schedule. However, while the home was clean there was an unpleasant odour in parts of the home.

Systems to reduce the risk of infection were in place. For example, one person had infection and appropriate infection control measures were in place. Staff told us and records showed they had received training in infection control and they could tell us how they would reduce the risk of infection while providing care. However, when observing staff it was not always clear if they had understood correct infection control processes. For example, gloves were not changed when they should be changed which meant there was a risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

People made compliments about the food provided at the home. A relative said, "[My relative] has actually put on weight since being here." A person living at the home told us, "I look forward to my meals. I like good food." People indicated they were offered a choice of food at meal times. One person said, "Most of its very good. I can ask for something different." People were supported to take their meals where they felt comfortable. One person said, "I manage by myself in my room for meals and I get to choose lunch".

People had been assessed by visiting health care professionals to ensure they could eat and drink safely. Where concerns were identified people's care plans recorded how staff should keep them safe. For example, some people were on soft diets and had their drinks thickened so that they could swallow them better. Care plans also contained information about if people were able to maintain a healthy weight.

Where people were at risk of malnutrition records showed they staff monitored them to see how much was needed and when necessary referred them to the GP for advice and support. Food and fluid monitoring charts did not record how much people needed to eat and drink to keep them healthy and there was daily total or check to see if the person had reached the required level of nutrition or hydration.

During the meal staff did not always support people to eat enough food. For example, we saw one person who was losing their independence was unable to eat their meal. When the care worker had given it to them they had said to the person to see how they got on and they would come back and help if needed. They sat without eating for 10 minutes and then attempted to use their fork with little success. Staff never came back to see if they needed help. We also saw one person who had finished both of their courses, then proceeded to eat from the remains from another person's plate. Staff did not notice this and did not offer the person second helpings.

Staff told us they had received a comprehensive induction which ensured they had the skills needed care for people safely. This included a full week shadowing an experienced colleague and studying in line with government recommended learning. During their induction staff received weekly supervision with the registered manager so they could discuss their ongoing learning and support needs.

Staff told us they received regular update training and records showed there were systems in place to check that staff had undertook the required training. Staff were also supported to work towards nationally recognised qualifications in care. Staff received regular supervisions and annual appraisals. Staff told us these were supportive and they were always asked if they required any further training.

However, we saw the activities coordinator had not had any training in caring for people living with dementia or how to provide meaningful activities for people.

The senior staff had completed training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These are laws which ensure people's human rights are respected when they do not have the ability to make choices for themselves about where they live and the care they need. The registered manager had assessed people at the home to see if they were at risk of having their liberty deprived. The registered manager submitted appropriate referrals to the local authority when people may need their rights protecting.

People's choices about their end of life care had been discussed with them and appropriate records were in place to ensure their wishes were known, respected and communicated to other healthcare professionals who treated them. .

People's abilities to make decisions were recorded in their care plan. Appropriate mental capacity assessments had been completed to identify if people could make decisions with appropriate support in place. Where people were not able to make decisions systems were in place to make decisions in their best interest. For example, one person was refusing to take their medicines and an assessment showed they did not have the capacity to make this decision as they could not understand the consequence of not taking their medicine. The registered manager was in the process of arranging a best interest meeting with the family and healthcare professionals to discuss the options.

Requires Improvement

Is the service effective?

Records showed that where needed people had been seen by an independent advocate. This is an independent person who can speak for the person when they are not able to speak for themselves and may not have family.

We saw people were supported to access health care when needed. For example, one person told us the optician had been to see them and care plans recorded that GP's visited when needed. Visiting healthcare professionals told us that the home contacted them appropriately if they had any concerns and that the staff were approachable. However, two of the healthcare professionals said that they sometimes struggled to find care workers to accompany them when they visited people. They said this was important as the care staff knew people better than they did and could input into the consultation. They said that they sometimes struggled to hand over information about people's treatments as care staff were always busy. They felt this sometimes impacted on the care people received. For example, creams not being applied as requested.

The environment was tired in some places and in need of maintenance and decoration. One person, said their toilet was still broken and they used a commode, due to a leak coming up through the floor. Other relatives told us that they were waiting for maintenance to be completed including a toilet which did not flush properly and meant the person could not flush the toilet. Furniture was not maintained to an acceptable standard. For example, we saw chest of drawers with edge strips missing and a footstool in conservatory area was badly stained and not attractive.

One relative commented on how the front approach to the home was full of cobwebs and dust. They said this was the first impression people had of the home.

The signage around the home was not dementia friendly and did not support people to be more independent. For example, there were no signs with pictures to help when people were struggling to understand words.

There was a maintenance in place for the home and we saw that some ongoing maintenance had been completed, For example, the television lounge had been redecorated. However, the maintenance plan in place did not highlight how to make the home more dementia friendly or what furniture needed replacing.

Requires Improvement

Is the service caring?

Our findings

There were pictures in the hallway of all the staff to help people identity who was caring for them. However, this was in the front hall way and some people did not go into this part of the home on a regular basis. In addition staff did not wear name badges and people living at the home were unable to call the person providing care for them by their name.

Staff members were polite and friendly to people they cared for. However, most of the interactions we saw were when care was being given. Comments made by the people living at the home and their relatives were favourable about the staff and their attitude. One person told us, "The staff are friendly and helpful". While another person said, "I like the older staff. The young ones are not so bad really." However we saw staff were very focused on completing tasks and did not always consider how they impacted on the people living in the home.

Lunch time was not a pleasant experience for people and staff were disorganised. We saw people were supported to sit at the table half an hour before lunch was ready. There was also a long gap between the main meal and dessert at lunch time. One person asked how long the dessert would be but gave up waiting and left the table before it was brought out. There was no background music or stimulation whilst people were dining. Staff did not respect that people would like a quiet period in which to enjoy their meal had instead continued to use the dining room to get to some of the bedrooms. We saw a cleaner's trolley, a linen trolley and a hoist crossing the room during lunch. The activity person was reviewing the contents of their cupboard and had stacked games and puzzles at a table where a person was eating their lunch.

We saw the care worker assigned to support a person one to one was poor at interacting with the person. For example, during lunch we saw that the care worker was standing with her back to the person they were meant to be supporting and watching what was going on in the dining room. Later we saw the care worker sat at the side of the person completing a crossword. The person they were supporting was not interested in the crossword and sat staring off into space. The person was not receiving stimulation or support from their one to one hours.

We saw people were offered a choice of what they would like to do and where they wanted to spend time. For example, we saw a care worker chatting to several people in the lounges and later joining in a quiz activity. Staff were able to describe how they offered people choices for example by offering them a choice of clothes to wear and options about where they wanted to spend the day.

However people told us they had not been involved in developing their care plans. One relative told us they had been kept up to date about changes to medicine but were not involved in care planning. They said, "The home just gets on with it. But I keep a notebook of how she is and her mood every day when I visit."

Staff had received training in helping people to maintain their dignity and the home had appointed dignity champions. However, this did not ensure staff remembered people's dignity at all times. We saw staff were task focused and sometimes forgot about the need to maintain people's privacy and dignity when completing tasks. For example, staff did not always ensure conversations about people's care were private.

We also saw that staff did not respect people's right to privacy. For example, we saw the nurse and a relative sat at a table in the dining room discussing key aspects of care for an individual. The relative had made an appointment to come in at that time specifically to meet the nurse and discuss the issues. We also saw discussions with other healthcare professionals took place in communal areas.

Requires Improvement

Is the service responsive?

Our findings

Care records for people who needed residential care were well structured and contained information needed to provide safe care for people. However, the care records for people who needed nursing care were not always up to date or clear about the care people needed. For example, in one care plan we saw information recorded on pressure ulcers saying they had got better by March 2015, but then in another part of the record identified that there were two further pressure ulcers in March 2015. Each plan had a section for review and evaluation and this had been regularly completed. However, the content of the review was limited and did not always link changes particularly around pressure area care, weight and diet and nutrition.

Staff were not always responsive to people's needs. For example, we saw the activity person told one care worker that a person had indicated they felt sick while eating their lunch. We saw this member of staff did not take any action to either help the person or report the concerns to either the senior care worker or the nurse. The person sat at the lunch table for another 15 minutes before the senior carer entered the room and saw them sitting with their hand up and went to help them.

We saw one person living with dementia had been identified as needing extra support. However, this was not in place until midday and there was no plan of care on how to help this person spend a settled morning. Three times between 10.30am and 11.30am they opened an external fire door in the dining room to go outside, which triggered the alarm. Each time three or four staff then rushed to bring them in and silence the alarm interrupting the support they were giving to other people.

We saw an extra care worker was available from 12pm onwards to support this person. However, there was no information recorded in the care plan to help care staff provide the support she needed. The support varied dependant on the care worker allocated. The care worker supporting this person recorded hourly what the person had been doing, but nothing happened with the information. There was no baseline of key areas of risk and no firm plan which would give ideas of things the person liked to do.

There was an activities coordinator in place who worked four days a week. We saw they had started to complete people's life histories with them. However, they had not used the information they had gathered to help plan the care people needed. A weekly schedule was prepared with a daily group activity and there was range of games, jigsaws, activities, accessories and crafts available for people to access. Formal entertainment was also arranged, for example, a clothes party had been arranged and this supported people who were unable to go to the shops. The activities coordinator also visited people individually in their rooms if they did not like to spend time in communal areas.

However, people had mixed views about the activities on offer and felt that they did not always meet their needs. One person told us, "I'm not bothered about doing them and as I'm in my room a lot, no-one comes to ask me anyway." Another person said, "I'm not interested, not in games. I'd like to try cross-stitch again though as I used to be really good at it." A relative said, "[My relative] will join in with a bit of prompting, but she likes singing better and is better if occupied, like helping clear up after meals or drinks."

We saw there was a leaflet in people's bedrooms informing them how to make a complaint and a suggestion box in the hallway where people could raise concerns anonymously. People told us they knew who the registered manager was and would be happy to approach her with any concerns or problems. However, a relative whose family member was new to the home had not been introduced to the registered manager and so did not know who to speak with to raise any concerns. One relative told us they had raised a concern with the registered manager as the bed was too low for their relative and this reduced their independence as they struggled to get up. They told us no action had yet been taken. We also spoke with another relative who told us they had raised a complaint. However, the registered manager told us they had not received any complaints since our last inspection. This showed the registered manager had not always responded appropriately to concerns raised.

Requires Improvement

Is the service well-led?

Our findings

We found the registered provider did not have adequate systems in place to ensure people received a service which met their needs.

The registered manager had developed a system of checks and audits which should have helped them provide a quality service to people. However, the systems were not effective as staff did not embed them in every day practice For example, maintenance was not completed in a timely fashion and the use of protective equipment did not fully reduce the risk of cross infection. The registered manager had not provided clear direction to staff about their roles and responsibilities and systems they needed to maintain. The registered manager had not identified that the systems were not effective which resulted in people receiving some poor care.

The nurse was not always available to staff and staff had to spend time looking for them. The nurse did not support care workers when they were busy and were clear they were there to carry out nursing tasks like dressings, medicine and assessments. The lack of availability of the nurse impacted on the care people received. For example, the senior care worker spent a lot of time looking for the nurse when they needed support to administer a medicine. This reduced the number of staff available to care for people.

There were no clear defined roles or tasks for care workers and this meant at times the care provided to people was disorganised. For example, over the lunch period we saw no one was tasked to stay in the dining room and monitor that people were safe. We saw this lack of organisation also meant that staff were allowed to take their lunch breaks at busy times. This meant people received less support when they needed it most and lunch was not a pleasant experience for people.

We discussed with the registered manager that a care worker who was supporting a person one to one had not interacted positively with the person to stimulate them. The registered manager was aware of the situation and said that other care workers supported the person better but that they had to offer the opportunity to all staff. This showed the registered manager did not use their resources to ensure people received the best support available and placed the needs of the staff over the needs of people living at the home.

There were signs around the home reminding staff about safe working practices, For example using protective equipment. However, the signs were not always dementia friendly. For example, one sign on the wall in the corridor had a pair of eyes telling staff that they were being watched and needed to ensure the followed good infection control processes. This sign may upset people living with dementia as they may think people were watching them from the walls. It showed staff and the registered manager did not always consider the impact of their action on the people who lived at the home.

Care plans did not always accurately reflect the nursing care people needed. In addition, nursing records were not completed to maintain a clear audit trail of the care people received. For example, we saw correction fluid had been used in one set of notes and adjustments made were not signed or dated. Care plans had been re-written with no corresponding evidence in the review as to the change from the previous to the current care plan. In two people's care records we saw they had experienced a decline in their health and moved from residential to nursing care. The care record had not been reviewed to take account of this change in need.

People living at the home and their relatives told us that they were not invited to meetings to discuss the care they needed, and to identify where improvements were needed. Relatives also told us that at times the staff did not always keep them updated on the care their relative received. For example, two separate family members commented that although they had requested a chiropodist visit for their relative, they had not been made aware of whether an appointment had been made or carried out. One relative said, "I leave the money for Mum's feet but aren't told if they've been or not."

The provider had also surveyed people living at the home to find out their views on the service received. The registered manager sent us a copy of the action plan which showed they had identified specific areas of concern. However they had not used this as an opportunity to look at the people needs and how the service could be developed.

Requires Improvement

Is the service well-led?

These issues were a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always notified us correctly about incidents. The provider was required by law to notify us of these incidents. There was some confusion from the registered manager about what incidents they should notify us about and they had not told us about everything they needed to. However, they had taken other appropriate action such as involving the local safeguarding team to ensure people were safe. This meant we could not accurately identify if people at this service were at risk. The registered manager had also not told us when people living had the home had a Deprivation of Liberty Safeguards application authorised.

This was a breach of Regulation 18(2)(e) and 18(4B) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There was a registered manager in post at the time of our inspection. However, they were not registered for the regulated activities which enabled the provider to provide nursing care. We discussed this with the registered manager and were happy that they had systems in place to adequately manage the nursing care. Immediately following our inspection the registered manager submitted an application to register for all the regulated activities provided at the home.

The registered manager spent time in the communal areas of the home and knew the people who lived at the home and their care needs. We also saw that the senior care worker was available to colleagues and people living at the home all the time during our inspection. Staff told us they would be happy to raise concerns with the registered manager if they needed to. However despite the registered manager telling us it was covered in the induction, staff were not aware of their ability to raise concerns as a whistle blower. Raising concerns as a whistle blower legally protects people from workplace reprisal for raising a genuine concern.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Systems did not always support the safe administration of medicine.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents This was a breach of Regulation 18(2)(e) and 18(4B) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider had not notified us of safeguarding incidents and when Deprivation of Liberty Safeguard applications had been authorised.

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 This was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Systems to assess, monitor and improve the quality and safety of the service were not effective.