Bupa Care Homes (CFChomes) Limited

Tadworth Grove Care 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**

Summary of findings

Overall summary

This unannounced inspection was carried out on 7 July 2016. Tadworth Grove Residential and Nursing Home provides residential and nursing care. The service is currently registered to accommodate up to 71 people however due to the recent closure of their dementia unit this is due to decrease. On the day of our inspection 30 people lived in the service.

There was no registered manager on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were assisted during the inspection by the interim manager and the service recovery team.

On the 29 January 2016 we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service was rated as 'Inadequate'. We carried out this inspection to establish whether the requirements were being met. On this inspection sufficient improvements had been made to meet the Regulations and therefore the service is no longer in 'Special measures.' We found on this inspection that whilst some improvements had been made the provider was still in breach of regulations around care planning, staffing and quality assurance.

There were not always enough staff deployed around the service to ensure that people's needs were being met.

People's rights were not always met under the Mental Capacity Act 2005 (MCA). Assessments had not always been completed specific to the decision that needed to be made. DoLS applications had been submitted to the local authority but these were not always supported by the appropriate mental capacity assessments.

People were not always receiving care from staff who had received appropriate training or supervisions. Appraisals for staff had not been undertaken.

People were not always involved in the planning of their care although this was being addressed at the time of the inspection. People did not always have access to meaningful and person centred activities.

However we did find that people were treated with dignity and respect and staff were caring. Staff were attentive to people and anticipated their needs.

There were not effective systems in place to assess and monitor the quality of the service. Audits and surveys had been undertaken with people but had not always been used to improve the quality of care for people.

Incidents and accidents were recorded however there was not always evidence of any learning from these in order to reduce the risk of falls and incidents in the service.

Risk assessment guidance for people was detailed and being followed by staff. Staff had knowledge of safeguarding adults procedures and what to do in the event of abuse occurring. Appropriate checks were undertaken on staff before they started work. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

There were clear policies in place to guide staff should they have any concerns. Medicines were stored appropriately and audits of all medicines took place. Medicines Administrations Records (MARs) charts for people were signed for appropriately and all medicine was administered, stored and disposed of safely by staff who were trained to do so.

People said that they enjoyed the food at the service. People at risk of dehydration and malnutrition had their needs met and people were supported to remain healthy.

There was a complaints procedure and complaints were recorded appropriately with information around how there were responded to.

People's records were kept securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of all significant events.

People and staff said that the management of the service had not been stable but they did feel listened to.

During the inspection we found several continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Staff were not deployed appropriately at the service to meet people's needs.

Other aspects to the service were safe. Risks of harm were being managed.

People told us they felt safe and staff understood their responsibilities in relation to abuse and reporting this to the safeguarding authority.

People were receiving their medicines in a safe way and medicines were stored safely.

Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005.

Staff did not always have the most appropriate training to be able to meet people's needs. Staff's competencies were not assessed.

People were provided with a choice of nutritious food and drink and people's weight and nutrition was always monitored.

People were able access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was caring however people were not always involved in their care planning.

People's dignity was respected and staff were kind and considerate to people.

People's rooms were personalised to them.

Visitors were made welcome in the service.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

There was not always the most up to date information available to staff about people's care needs.

There were not enough activities that suited everybody's individual needs.

Complaints were recorded and there was evidence that complaints had been responded to.

Is the service well-led?

Requires Improvement

The service was not well-led

There were not appropriate systems in place to monitor the safety and quality of the service. However records were kept securely.

Where people's views were gained these were not used to improve the quality of the service.

People and staff said that the management of the service was not stable and there was not a registered manager in post.

Notifications of significant events in the service had been made appropriately to CQC.

Tadworth Grove 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 was an unannounced inspection which took place on the 7 July 2016.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Because of the concerns we identified at our previous inspection, the provider was sending in weekly action plans to inform us of the improvements that they were making.

We looked through notifications that had been sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. This included safeguarding concerns, accidents and incidents and notifications about important events that had occurred.

The inspection team consisted of three inspectors (one of whom had a background in nursing care) and one specialist nurse. During our inspection we spoke with the interim manager, the clinical lead, two members of the recovery team, 11 members of staff, two people who used the service, two relatives and one volunteer.

We looked at 10 care plans, three staff recruitment files, medicine administration records, staff supervision records, mental capacity assessments and deprivation of liberty applications for people who used the service. We looked at records that related to the management of the service. This included minutes of resident and staff meetings and audits of the service. We observed care being provided throughout the day including during a meal time.

We last inspected Tadworth Grove on the 29 January 2016 where several breaches were identified.

Requires Improvement

Is the service safe?

Our findings

We asked people and relatives whether they thought there were enough staff. One person told us, "There are always staff around" whilst one relative said, "I'm happy enough with the amount of staff, although sometimes on a Sunday it can be short on the ground floor." They said that on occasions at the weekend there were no staff in the lounge areas to support people as staff were busy elsewhere.

On the previous inspection in January 2016 there was not enough staff to meet the needs of people. We found on this inspection that although the correct numbers of staff were on duty (according to staff levels needed as assessed by the provider) improvements were still needed around how staff were deployed around the service.

People's needs were not always met because staff were not deployed effectively around the service. On the day of the inspection people were still waiting for their morning personal care at 12.00. There were times where we could not see where staff were. On one occasion one person was calling out for a member of staff for five minutes however staff were busy supporting other people. On another occasion the only person supporting people in the lounge for more than 30 minutes was a volunteer. We reviewed the call bells records over a period of four weeks and found that on occasions people were waiting more than 10 minutes before their call bell was answered and on some occasions 20 minutes. One member of staff said that at times they would turn the call bell off and tell the person that they would return to provide their care when they could. This meant the call bells records did not always accurately reflect how soon people received their care.

Staff told us that there were people who required two members of staff to support them with personal care. They said that whilst they were providing care to people in the morning other people were having to wait for long periods of time for their assistance. One member of staff said, "We are really struggling with personal care in the morning, residents think we are ignoring them." When asked how this impacted on people the member of staff said, "Sometimes residents wet themselves, this upsets the resident, and it's stressful for us too." Another member of staff said, "People need feeding or a double up (two members of staff to support them), one person calls out a lot but we are busy."

The interim manager told us that nine care staff and three nurses were required to assist with care for 30 people and that the needs of people had been assessed using the service dependency tool. According to the rotas there were always staffing numbers in line with what we had been told however the interim manager told us that more work needed to be undertaken around how staff were deployed to ensure that people were not kept waiting for care.

There were not always enough staff deployed around the service to ensure that people's care and treatment needs were being met. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the previous inspection in January 2016 we identified that risks to people had not been addressed by

staff in the correct way. On this inspection we found sufficient improvements had been made.

People's safety was assured because identified risks of harm were appropriately managed. During this inspection care plans contained risk assessments to identify any risks to people and measures to reduce these. Risks to people around falls, pressure ulcers and inadequate nutrition or hydration had been assessed and actions taken to reduce these risks. Risk assessments had been reviewed each month to take account of any changes in need. Where people required repositioning in their beds to prevent or reduce the risk of pressure sores this was being done. One person needed to wear comfortable shoes whilst walking with a frame and we saw that this was happening. Bed rail risk assessments were taking place and these were updated regularly. One member of staff said, "We need to keep people safe as they could harm themselves." Accidents and incidents were recorded and we could see what action was going to be taken to reduce further occurrence however we did raise with the interim manager that this had not been updated to show the care that had been provided.

Appropriate checks were carried out on staff to ensure that they were suitable to work at the service. We reviewed the records of staff that had started working at the service since the last inspection and found that recruitment files contained a check list of documents that had been obtained before each person started work. Documents included records of any cautions or convictions, evidence of their conduct in their previous employment, evidence of the person's identity, evidence of nurse's professional registration and full employment history. Staff confirmed that before they started work all the appropriate checks were undertaken.

On the previous inspection in January 2016 people's medicines were not being administered safely and there was a risk that people were not receiving medicines when they needed them. Medicines were not always been stored in a safe way. On this inspection we found sufficient improvements had been made.

People's medicines were managed safely. We spoke with the nurse in charge who advised they were responsible for medicines management. The nurse told us that all staff responsible for administering medicines received training in this area and had their competency assessed before being authorised to do so. We confirmed this from the records. Weekly audits of medicine took place to ensure that systems were working effectively and regular medicine training was provided to staff to reduce the risks of any errors. One person had their medicines given to them through a percutaneous endoscopic gastrostomy (PEG); we found that staff were knowledgeable about the management of this.

Medicines were stored securely and in an appropriate environment. Medicines were stored in a locked room and dispensed from a drugs trolley. There were appropriate arrangements for the ordering and disposal of medicines. We checked medicines administration records and found that these were clear and accurate. Each person had an individual medicines profile that contained information about the medicines they took, any medicines to which they were allergic and personalised guidelines about how they received their medicines. There were individual protocols in place for the administration of as required (PRN) medicines. We observed that staff waited until the person has taken the medicine before they signed the medicine chart.

People told us that they felt safe. One person said, "I feel safe, I'm not sure why, I have just never thought I wasn't." Systems and processes were in place to protect people from the risk of abuse. Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. Staff said that they would refer any concerns they had to the manager or to the local authority if needed. One member of staff said, "Safeguarding is making sure you protect people from harm or abuse. (If I saw anything) I would report it to the nurse." There was a Safeguarding Adults policy and staff had received training regarding this. There

were flowcharts in the offices on each floor to guide staff and people about what they needed to do if they suspected abuse. Staff were aware of the whistleblowing policy and all of them said they would use this if they needed to report any concerns they had.

People would be safe in the event of an emergency because appropriate plans were in place. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe. There were personal evacuation plans for each person that were updated regularly and a copy was kept in the reception area so that it was easily accessible. Staff were aware of where to access people's information in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

On our inspection in January 2016 we found that the staff had not had appropriate training, support or supervisions. On this inspection we found there had been some improvements around this but there were still further improvements needed.

People were not always cared by staff whose competency was assessed in relation to the work that they carried out. There was also a risk that staff were not provided with the most up to date guidance in relation to their role. Despite a new clinical lead being recruited nurses had still not received any clinical supervision to assess their competencies. Care staff had not undertaken any one to one supervision with their manager and none of the staff had undergone an appraisal to discuss their performance or any additional training needs they may have. In addition there were large gaps in the service mandatory (clinical and non-clinical) training for staff. There were gaps around moving and handling, food hygiene, infection control, dignity and respect and end of life care.

Staff were not suitably supported in their role and training was not always up to date. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this we found on the day that the care that staff provided was effective and in line with best practice. Clinical staff had knowledge around the identified needs of people that included wound care, catheter care, diabetes care and care for people with Parkinsons. The interim manager told us that they used some agency nurses and ensured that before they came to the service that they were skilled and were appropriately qualified to provide care to people. We saw care staff move people with hoists in a way that was safe and according to best practice.

Before staff started work they underwent a full induction. One member of staff said, "I had worked at another home before but I still spent time with the staff before working on my own." Other staff we spoke with were complimentary about the training that they had received. One said, "There is quite a lot of training here" whilst another said, "I'm newish but I've done a lot of training already."

At our inspection in January 2016 we found that there were a lack mental capacity assessments and staff did not have an understanding of the Mental Capacity Act 2005 (MCA) regulations. At this inspection we found that staff knowledge had improved and but not all of the MCA assessments were completed appropriately.

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.

The risk to people having decisions made for them without their consent had reduced on this inspection as appropriate assessments of their mental capacity had been completed. The assessments were more detailed and were more specific to the particular decision that needed to be made. There were people who

received their medicines covertly (medicines administered in a disguised format, for example in food or drink, without the knowledge or consent of the person receiving them). Other people had bed rails. We found there were MCA assessments specific to both of these and evidence of best interest meetings to support giving medicine covertly. However there were some MCA assessments that needed to be completed or updated in relation to the locked front door. The interim manager told us that they were aware that these needed to be done and provided us with an action plan of when these were going to be undertaken.

Staff were able to describe the principles of the MCA to us. One said, "We need to act in the people's best interests if they can't make a decision for themselves." Another told us, "Even people with dementia have a choice; we have to think about things that are in their best interest (if they do not have the capacity)."

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. Five applications had been appropriately submitted to the local authority. These were around the locked front door, covert medicines and the use of bed rails.

On our inspection in January 2016 people's nutritional and hydrations needs were not always met. We found on this inspection that there had been sufficient improvements.

People liked the food at the service. Comments included, "The food is very good, I have no complaints about that", "(The food) is superb and excellent" and "The food is very good, I choose the day before what I want." One relative told us, "The food is very good, (the chef) will do whatever you want."

We observed that lunch time was a positive experience for people. Tables were nicely laid and volunteers and staff were encouraged to sit and chat with people whilst they ate their meals. People were offered choices of the food regardless of their dietary need. All meals were very well presented and inviting. People in their rooms were also offered meals in the same way. Those
that needed assistance were supported by staff to eat their meal in a calm and unhurried way. 'Nite bites' were available for people to have during the night .

The chef was given information about people's dietary needs by care staff. Information about allergies, texture-modified diets and dietary requirements for people with diabetes was displayed in the kitchen. People's preferences about their meals and drinks were also recorded, such as how they preferred their hot drinks and how they liked their meals to be served. There was a system in place to monitor food and fluid intake where necessary. Records had been completed accurately and reflected what people had eaten and drank. People were weighed regularly and where there was a concern guidance was sought from, for example, the speech and language therapist (SaLT) or GP. One member of staff said, "If someone was always refusing food I would speak to the nurse about this." They understood that this could be a sign that someone was unwell.

People were supported to remain healthy. People told us that they were able to access health care professionals when they wanted and we saw that this was the case. One person said, "The staff would call the GP for me if I needed one." People had access to a range of health care professionals such as the GP, SaLT and dietician. The GP visited regularly and people were referred when there were concerns with their health. Where necessary multi-disciplinary teams of health care professionals supported people with their needs.

Requires Improvement

Is the service caring?

Our findings

On our inspection in January 2016 we found that care and treatment was not designed with the input of people who used the service, staff did not always treat people in a caring way and people were not always supported at the end of their life. On this inspection whilst there were improvements around how caring staff were there were still improvements required around end of life care and people being involved in their care planning.

People and relatives thought that the staff were caring. Comments included, "The staff are very kind, I am made to feel welcome and I know everyone well", "(I am) very happy here, the staff treat me well. If I have to be in a care home this is where I want to be", "On the whole the staff are very caring and they are very good" and "When (their family member) was ill staff were kind and caring to them."

People were still not always involved in their care planning. The interim manager told us (and we confirmed) that they had written to people and the relatives about upcoming reviews of their care and asked them to be involved with this. There was no consistency in the care plans that showed people were involved. One person said that they did not know about their care plan or even if they had one but was aware of the recent letter from the interim manager. However we saw that other care plans did evidence involvement from people.

The care plans detailed the persons' likes and dislikes and what their preferences were. Staff also had an understanding of how people needed to be involved. One member of staff said, "I think care should revolve around the person, you can't go wrong with that." Another member of staff said, "It's important to know people's life history, to help them remember their past and the good times in their life." On the day staff showed knowledge of people and what was important to them.

At this inspection we were aware that one person had passed away however the care that was provided did not reflect all of their wishes or the relative's wishes. We looked at 'end of life' care plans and found that they were not detailed around the specific wishes of people and were limited to what pain relief they wanted and their funeral arrangements. The interim manager told us that they had recognised that the care plans needed to be more detailed and had arranged for each member of staff to complete a booklet of best practice around end of life. They had also arranged for face to face training to be provided by the local hospice.

People were treated with dignity and respect. We observed staff knocking on people's doors before entering. Staff discreetly asked people if they wanted to leave the room to use the bathroom and all personal care was provided behind closed doors. One member of staff said, "I would always knock on people's doors, close the curtains when carrying out personal care and encourage people to choose the clothes they want to wear for the day." They said that they would never just put a clothing protector on people, "I would always ask if they want it." We saw evidence of this choice being offered to people before they ate. People's rooms were personalised and filled with things that were important to them including photographs, ornaments and furniture.

Staff understood people's individual way of communicating. One person was attempting to explain what they wanted however they were unable to do this verbally. A member of staff bent down and gave the person a hug and gently asked them questions around what they thought the person might want based on their knowledge of the person. The person reacted positively to this and nodded their head to indicate, 'yes' to the question being asked by the staff member.

We saw interactions between people and staff on the day that showed staff to be caring and compassionate. We saw a member of staff kneeling down beside someone in the afternoon whilst supporting them to have a cup of tea. The staff member smiled at the person to get their attention which in turn made the person drink her tea. Another person started coughing when eating their fruit during the afternoon. Staff were immediately at their side asking if they were okay. Staff told us that they enjoyed working at the service. One told us, "I like working here, seeing resident's faces and the appreciation they show you."

Family and friends were welcomed into the service to see their family members. One relative said, "The staff are very kind. I am made to feel welcome and I know everyone well because I come in every day."

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in January 2016 care plans were not detailed and people did not always have access to activities. At this inspection we found that some improvements had been made but there were still areas of improvement needed around care plans.

There was a risk that people did not always receive care and support that met their needs. There was a lack of consistency around the planning of care and guidance for staff. Two people had recently moved into the main house of the service from the dementia unit that had closed down. Their care plans had not been reviewed since the last inspection despite us raising the need for this at the January 2016 inspection. There was a lack of detailed guidance for staff around how to meet their needs. One care plan stated, 'Staff to spend time with (them) to reduce agitation' however they was no information for staff on how best to support them to do this. One member of staff told us that they were aware that this person could become agitated but had not been provided with any guidance with how best to approach this. Staff relied upon the knowledge being passed on by other staff that had cared for the person whilst they were living on the dementia unit.

Another person had epilepsy and had a recent seizure however their care plan did not detail the care that was required for the person in the event that they had a seizure. There was no guidance around how best to provide personal care (showers and not baths), how staff should record the seizure or the impact on the person. We raised this with staff on the day who assured us that this care plan would be addressed that day. We have not had confirmation that this has been completed.

Care and treatment was not always provided that met people's individual and most current needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we did see other care plans that were detailed around the guidance staff needed to provide care. For example, one person had developed a leg ulcer. There was an up to date wound care risk assessment and care plan in place, which contained detailed instructions concerning how and when dressings should be changed and staff were following this guidance. Another person had developed swallowing problems following a stroke. There was a clear plan in place that staff were following to manage the risks of choking as well as written strategies to help improve the person's speech and promote good communication.

Other people's care plans had a description of their medical history, moving and handling, skin care and sleep routine and how people needed and wanted to be supported. There were examples where a person's needs had been identified and care was provided that met their needs. Staff discussed people's most up to date needs through daily handovers and 'take ten' meetings.

We asked people and relatvies about activities. One relative told us, "Activities are improving." One person told us that they did not get bored. Activities were available for people but staff recognised that these needed to be more person centred. One member of staff said, "There is not always enough for people to do

in their rooms, they sleep because of the boredom."

There were a variety of activates for people to participate in including entertainers, singing, arm chair exercises, a 'fair weather garden club' and flower arranging but these were aimed at people who were more able to participate. The activities coordinator was supported by a volunteer each day. On the day we saw people enjoying a quiz in the morning and a 'sherry morning' but there were people in their rooms who were socially isolated from activities. A member of the service recovery team told us that more work was being undertaken to ensure that people in their rooms were not being left on their own for long periods of time. The activities coordinator confirmed this and one person who chose to stay in their room said, "Staff come in and chat to me."

There was a complaints procedure in place which was displayed in reception. People did tell us that they would make a complaint if they needed to. Complaints were recorded and included a response from the manager. On one person's care plan we saw that a relative had written in to complain about their family member's care. A letter was sent to the relative and a copy was placed on the complaint file. Staff understood how to support people if they wanted to make a complaint. One told us, "I think it's always good to listen to what they (people) are saying, if you can't help them then ask if they want to speak to a nurse."

Requires Improvement

Is the service well-led?

Our findings

On the previous inspection in January 2016 there was not always consistent and visible leadership around the service. On this inspection we found that there had not been sufficient improvement in this area.

In the past six months there has been three interim managers at the service. People we asked were unable to tell us who the manager was and felt that there had been too many changes. One person said, "I don't know who the manager is." However they did say that they had been kept up to date with changes within the service. Staff told us that there had not been stable management in place since the last inspection. One told us, "We have had inconsistent management" whilst another told us, "Management is always changing but I just do my job." We were advised by the service recovery team that a new manager was starting and would be applying for the position of registered manager to provide consistent support for people and staff. Since the inspection we have had confirmation that the new manager has started working at the service.

On the previous inspection there were not effective systems in place to quality assure the care that was provided. We found on this inspection there had not been consistent improvements in this area.

Effective management systems were not always in place to assess, monitor and improve the quality of service people received. Although people's views had been sought these had not always been used to improve the quality of care. We looked at the surveys undertaken in May 2016 with people and their relatives. Where concerns had been raised by them these had not been addressed at the time of the inspection. For example, around the lack of involvement in care planning, people being put to bed too early by staff, the lack of visible staff and people not always feeling listened to. A staff survey had taken place in April 2016 and concerns had been raised around the lack of information available to them about changes and staff feeling 'rushed' with the work that they had to undertake. There was no action plan to show how these had been addressed. The management team on the day of the inspection were not aware that the surveys had not been responded to and advised us that action plans would be implemented. They showed us further surveys were currently being undertaken with people and staff to gain their most up to date views.

An internal audit conducted by the provider took place in May 2016. Concerns identified staff supervisions and appraisals were not up to date and daily records were not person centred. There was a service improvement plan as a result of the audit but the necessary improvements had not been made. The audits had not identified the shortfalls around mandatory training, the lack of MCA assessments and other areas identified in this report. Another internal audit was undertaken by the provider in June 2016 where the lack of training for staff had been identified. However on the day of the inspection none of these concerns had been addressed. Accidents and incidents were recorded but with no information how they had been analysed to try to prevent future accidents.

Residents and relatives meetings were taking place at the service. We saw minutes from the last meeting where changes to the service were discussed and other concerns that people had that had been raised on their survey. However sufficient action had not taken place to address their concerns.

Since the inspection in January 2016 the provider had been sending in weekly action plans to show how they were meeting the warning notices that were issued. The action plan detailed timescales to make improvements but these timescales were not being met.

Appropriate systems were not in place to assess, monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas had been improved as a result of quality assurance checks. Since the internal audit in May and June 2016 cleanliness had been improved, complaints had been recorded appropriately and wound care plans had been updated. There was positive feedback provided on the survey by people who lived at the home. People said the staff that supported them were kind and caring. Relatives said their family members were cared for by friendly staff. We found that records were kept securely to ensure confidentiality.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager had informed the CQC of significant events in a timely way so we could monitor what was happening in the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided that met people's individual and most current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that people who used services were cared for by sufficient numbers of qualified, competent and experienced staff.