Springcare (Sandiway) Limited

Sandiway Lodge Residential Home

Inspection report

Dalefords Lane
Sandiway
Northwich
CW8 2DR
Tel: 01606 889211
Website: www.springcare.org.uk

Date of inspection visit: 11th and 18th of May 2015
Date of publication: 07/10/2015

Ratings

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

Overall summary

We visited this service on the 11th and 18th of May 2015. Both these visits were unannounced.

Our last inspection had taken place on the 11th of October 2013. The service was found to be compliant with the regulations assessed. .

Sandiway Lodge is situated off Chester Road in Sandiway which is approximately three miles from the towns of Northwich and Winsford. The home provides accommodation and personal care for up to a maximum of 36 people. We were given conflicting information in respect of how many people were living there. It was confirmed on the 18th May 2015 that there were 27 people living at Sandiway Lodge at the time of our visit.

A manager had been in post since July 2014. This person had replaced the previous registered manager who had moved to another service. The manager had started to

Summary of findings

apply to us to become the registered manager but this process had not yet been completed. 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.

Prior to this inspection we had received concerns in respect of the safety of people living at Sandiway. We used this information when we inspected this service.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the registered provider.

We found that staff did not always uphold the privacy and dignity of people using the service.

Staff had not received the appropriate training in order to understand the process for assessing the capacity of people to make decisions for themselves. This meant that people using the service did not have their best interests served by a staff team aware of the mental capacity act.

The premises was not always a safe place for people to live with specific hazards in the environment not made safe. Hazards included inadequate measures to ensure that people did not fall down a staircase and a cupboard containing exposed pipework and electrical equipment was left unlocked. The environment was not clean in places which led to the risk of infection spreading.

Although staff have been provided with training they did not have a clear understanding of how to identify, prevent and safeguard vulnerable people from harm. We found that staff had not used whistleblowing procedures in an effective way to raise concerns. This meant that people using the service were placed at risk of harm.

People's nutrition had not always been promoted in an effective manner in some cases and that the process for people to make complaints was incomplete and did not meet the communication needs of people.

We found that the management of the service had not been effective. Staff did not receive supervision consistently and no annual appraisals had been undertaken. We found that audits of key accidents and incidents had not been undertaken. The quality assurance systems used by the registered provider had not identified the issues which adversely affected people living at Sandiway Lodge.

The registered provider had failed to notify us of significant incidents which are legal requirements.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

.

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?

Inadequate

The service was not safe.

The staff team did not demonstrate a thorough understanding of safeguarding adults despite having received training

The premises did not provide a safe environment for people to live in and infection control practices put the health of people at risk. Staff who came to work at Sandiway Lodge did not always receive an induction into the policies and procedures of the service.

People we spoke with said they felt safe living there although they did have some concerns about staffing levels at night which were addressed.

Is the service effective?

Requires improvement

The service was not effective

People who lived at Sandiway Lodge told us that in the main meals provided to them were good and that alternatives were available if they wanted something else.

We found that there was no evidence that all new members of staff had received an induction into the work practices with in the service. We found that not all the staff team received consistent supervision from their line manager and that no-one had received an annual appraisal assessing the standard of their work.

Staff had not received any training in the Mental Capacity Act (2005) and had no knowledge of the legislation or indeed Deprivation of Liberty Standards (DoLS).

Is the service caring?

Requires improvement

The service was not caring

We found that the privacy and dignity of people was not always promoted. We also found that instructions within care plans on checking people who could not leave their rooms were not always carried out.

People had limited choices in respect of hot drinks and had generally not been involved in their own care or the running of the service.

Is the service responsive?

Requires improvement

The service was not responsive

Care plans were not person centred and were not responsive to changes in people's needs.

Summary of findings

Activities were available to people and the registered provider had employed an activities co-ordinator. The complaints procedure was not easily accessible to people who lived at Sandiway Lodge and was not presented in a format to meet their communication needs. The provider did not maintain records of all complaints made.

.

Is the service well-led?

Inadequate

The service was not well led.

People who used the service told us that they felt they could approach the manager if they had any concerns or questions.

We found that the Registered Manager had not notified us of all adverse incidents affecting people who used the service and was not able to demonstrate an understanding of which safeguarding incidents should be escalated to the Local Authority team or an understanding of the Mental Capacity Act.

There was evidence provided subsequent to our visit that people who used the service and their families had been asked to comment on the quality of the care they received.

Audits in respect of accidents and incidents were inaccurate and ineffective as they did not suggest a way in which such incidents could be prevented or emerging patterns within them.

Not all staff considered that the manager was approachable and reviews into the future accommodation needs of people had been decided through daily records rather than as part of a wider review.

Sandiway Lodge Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 11 and 18 of May and was unannounced. This meant that the provider did not know of our intention to visit in advance.

On the first day of the inspection, the inspection team comprised of an Adult Social Care Inspection Manager, an Adult Social Care Inspector and an expert by experience. 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 on this occasion was in the care of older people.

On the second day of our visit, the team comprised of an Adult Social Care Inspection Manager and Adult Social Care Inspector. Before our inspection we reviewed all the information we held about the service. This included any notifications received from the registered manager, safeguarding referrals, concerns about the service and any other information from members of the public. We contacted the local authority intelligence and outcomes unit who told us that they were currently monitoring the service. We saw that Healthwatch had conducted a visit on the 19 of February this year. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. Their last report raised recommendations which were similar to the findings of this report. Healthwatch had identified issues with the maintenance of the building, food, the environment, the complaints procedure and the increasing needs of people who used the service.

Before the inspection we had asked the provider to complete a provider information return (PIR). The PIR 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. We also looked at our own records in relation to the registered provider.

We spent time talking to ten people who used the service as well one relative and seven members of staff. We toured the premises and looked at ten care plans as part of our assessment of the quality of support provided. We also looked at other records relating to the support provided. These included staff and training files, medication records, care plans and other relevant documents.

Inadequate

Is the service safe?

Our findings

We spoke to people who lived at Sandiway Lodge. They told us:

"I feel safe in the home and if I had any concerns I would speak with the manager"

"I can talk to staff"

"Yes I feel safe"

We interviewed five staff about the action they would take if they were to become aware of any alleged incident of abuse directed towards people living at Sandiway Lodge. Their understanding of this was not thorough given that they made reference to reporting it to their manager rather than giving a detailed account of the actions they would take. Staff told us that they had received safeguarding training.

We spoke to the manager on the first day of the visit. Recent safeguarding incidents had arisen within the service recently. The manager stated that they had considered them to be 'low level concerns' (by low level we mean those incidents that are as a result of poor practice rather than abuse). When asked about their understanding of the differences between low level incidents and abuse, the manager was not able to demonstrate an understanding of the difference between the two. The manager had failed to inform us of those concerns at the time they occurred.

We asked staff about how they would raise concerns about care practices within the service if they witnessed them. All staff except one stated that if they had any concerns that they report them to the manager. Only one member of staff made reference to reporting concerns to external agencies such as CQC or the Local Authority. Recent safeguarding concerns raised in relation to the service had been identified through a staff questionnaire rather than the whistleblowing process. This demonstrated that either staff were unaware of the appropriate steps to report concerns or that the current whistleblowing process within Sandiway Lodge was ineffective.

During a tour of the premises Further concerns about infection control were present around the kitchen area. We saw a mop bucket with a mop face down in it left outside of the kitchen area. This meant that the health of people was at risk through poor practices. The home employed housekeeping staff who were cleaning the building during both days of our visit.

In some areas, the carpet was dirty and some dining room cupboards had splashes of food down them. We saw that a small refrigerator was available yet this was in need of cleaning. Furniture in lounge areas was old and worn and attention was needed to redecorate doors which had scuff marks at the bottom.

We found that the building was not always safe. We saw that a window on a stair case was not restricted and was open. This was big enough for someone to climb through or to fall from. We saw that staff had access to a basement area. When not in use, the door was locked. When someone was using the basement, the door was locked with only a chain draped across the doorway. This chain would not prevent anyone from accessing the area or falling down the stairs. We brought this to the attention of the manager on the first day of our visit. By the second day, the situation had not been resolved. This meant that vulnerable people were at risk of serious injury.

We saw that a shower room contained a cupboard which, on the first day of our visit, was not locked. This cupboard had exposed pipework and electrical equipment within it which could have posed a risk to people. On the second day of our visit it had been locked yet there was no sign indicating that this was a hazard or that the door should be kept locked.

We made other observations of the environment. During our visit on both days, the front door was sometimes left open. We were able to access the building without challenge on a number of occasions. This meant that people were not living in a safe and secure environment. Dirty cups and unfinished drinks were left in the hallway and in other places in the building This indicated that hygiene within the home was not always maintained.

This is a breach of Regulation 12(1)(2)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service did not receive safe care and treatment.

Healthwatch had conducted a visit to the service in February 2015 to report on the quality of care provided within the service. They recommended that internal

Inadequate

Is the service safe?

decoration was needed to some of the shabbier areas, for example, damaged paintwork, in order to improve the home environment. This recommendation had not been acted upon.

We looked at how the service recruited new staff and introduced them into working at Sandiway Lodge. We looked at three recruitment files relating to staff that had come to work there since our last visit. We saw that references were not also provided by previous employers. We saw that this was contrary to the policy of the provider.

We looked at how medication was managed. Medication trolleys were stored in a lockable cupboard which in turn was located within a locked office. When medication administration was due, the trolleys were brought out by staff and wheeled around the building. On our second visit, we noted that a medication trolley had been left unsupervised in the main hallway. While the trolley was locked, it was not tethered to the wall and there was a risk of the trolley being taken off the premises without staff being aware. We raised this issue with the Quality Assessor who was present during our second visit. We observed a medicines round within the dining room at lunch on the first day of our visit. We found that the member of staff administering medication approached each person in a helpful and dignified manner. Medication records were signed appropriately after medicines had been given out. We spoke to two members of staff who were responsible for dealing with medication. They told us that they had received training in medication and that their competency to do this had been checked by their senior staff member. We saw that one person had decided to deal with one aspect of their medication. A risk assessment was completed to ensure that this was safe and the manager had undertaken regular audits to ensure that the management of medicines was safe.

We asked people if they thought there were enough staff on duty to meet their needs. They told us that “there are not enough at night, two is too few for 30 people”, “they could do with more staff they are so busy and they work so hard” and “I don’t think there are enough staff at night or at the weekends”. People continued “the staff are wonderful but they do get short staffed”.

We looked at staff rotas. We found that on the first day of our visit, the staffing levels had included senior staff, care staff and ancillary staff. People who used the service commented that they did not confident about staffing levels at night and that sometimes they had been able to alert staff when they had needed them. On the second day of our visit an extra member of staff had been introduced to work at night.

Staff told us that they had had to rely on agency staff of late and that the home was not poorly staffed now but it had been. Others told us that they considered that the home was short staffed at times and that it had been difficult in recent weeks. Staff told us that they considered that the dependency level of people had increased with older people with dementia coming to live at Sandiway Lodge.

We looked at how the service recruited new staff and introduced them into working at Sandiway Lodge. We looked at three recruitment files relating to staff that had come to work there since our last visit. We looked at references and checks made to ensure that people did not have any criminal convictions. Checks were in place for new staff. References were included as part of the recruitment check

Requires improvement

Is the service effective?

Our findings

We spoke to people about the food and drink that they received. They told us that the food they received was good and that they were offered a choice if they did not want the meals on offer. They told us that they could order their preferences in advance. People commented that on occasions some individual items such as vegetables were not very nice in their view. They said they received drinks in between meals regularly although two people commented that they did not have any water in their bedrooms. We observed people being provided with a hot drink during the days of our visits but noted that the preferences of people between tea, coffee or a cold drink were assumed by staff and as a result they seemed to be offered a cup of tea rather than be offered any choice. We also noted that there was no menu on display within the building. People told us that they were never hurried into finishing their meals.

We observed lunch on the first day of our visit. We noted that people had had to sit waiting for three quarters of an hour before their meals were served. The dining room was very quiet and there was little communication initially between the people who lived there and staff. This changed as the meal progressed. We saw that when required, staff would assist with cutting up meals for people and attended to their wishes. Two people were assisted to eat their lunch. One person refused their meal and was offered an alternative.

We spoke to five members of staff. All outlined the training they had received during the last twelve months. This training involved topics such as health and safety, food hygiene, first aid, safeguarding vulnerable adult awareness and fire awareness. We found that there was only one induction form available for one member of staff with two other inductions forms was unable to be located. This lack of evidence of inductions meant that people who used the service were not always supported by staff aware of the provider's policies and practices.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We asked staff about their understanding of the mental capacity act as well as deprivation of liberty standards (otherwise known as DoLS). DoLS standards aim to make sure that people in care homes such as Sandiway Lodge are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that any provider only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Staff did not have any knowledge of the act or the standards. As a result the people who lived at Sandiway Lodge were not being supported by knowledgeable staff.

We spoke to the manager who confirmed that they had attended Mental Capacity Act training. When asked, they were not able to give an adequate account of the principles involved in this. An application had been made by the manager to assess whether deprivation of liberty safeguards should be applied to one person. This was despite the manager not being able to demonstrate knowledge of the safeguards. The registered provider has a legal responsibility to notify us of any approved authorisation. The application was authorised by the Local Authority in October 2014. No notification was received by us at that time. Care plans did not include reference to the capacity of individuals or records of any best interest decisions.

This is a breach of Regulation 17 (2) of the Health and Social Care Act 2008 Regulations 2009 as the provider had failed to report significant incidents that affected the welfare of people who used the service.

We asked staff about the level of supervision they received. All told us that they had had group supervision prior to our visit and following safeguarding issues that had been raised. Not all staff had received supervision prior to this meeting and in all cases, staff stated that they had not received an annual appraisal. Records indicated that supervisions had either not been done or any evidence that they had taken place.

We looked at how the provider assessed the risk of malnutrition for people. We found that one person had steadily lost weight over a three month period. During the third month, a dietician had been contacted to review the situation. There was no evidence that any plan of action had been made to counter this and no weights were recorded for April or May. The malnutrition risk assessment suggested that this person should be weighed every week yet this had not been done. It was recorded in another risk assessment that a person had not been able to be weighed due to their physical condition. There was no evidence that

Requires improvement

Is the service effective?

advice had been sought to identify alternative ways weighing this person. As a result, this person had not been weighed during 2015 despite the malnutrition risk assessment stating that they were to be weighed weekly.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service did not receive safe care and treatment.

Requires improvement

Is the service caring?

Our findings

People who used the service said staff were caring. They told us It's good, well I've found it so anyway and staff seem to know what I need" 'Staff are helpful" They are very nice and very good and generally respectful" "I feel very cared for and they do as much as they can for you" "I feel this is my home now. They are polite and responsive"

We observed care practice during our visit. Care practice was inconsistent in approach. We observed people were spoken to in a friendly and respectful manner. Attention was paid by staff to the wishes on people. We saw, however, examples where more consideration should have been given to people. We saw one person sitting in a wheelchair in the lounge and did not have their feet on the wheelchair footrests. They had one sock on and one off. This person was left in this position for some time. We heard staff saying that the person had not wanted to move from the wheelchair to a chair but we saw no evidence that the staff member had sought to persuade the individual to move to a more comfortable chair. We saw a person was being assisted to drink in their bedroom but the bedroom door was open and being propped open by a waste paper bin. This meant that the person did not have their privacy or dignity promoted. We did see some examples of people being spoken to in a respectful and friendly manner.

We toured the premises. One person had been identified in their care plan as needing regular checks and supervision in their room given that they were confined to their bed for health reasons. We spent half an hour near to this person's room but did not witness any staff coming to see if the person needed anything.

We looked at how people were involved in the care that they received. Other than some observations of staff informing people of how they were be supported on a practical level (for example when transferring them or enquiring about their immediate welfare), we saw little evidence to suggest that people were involved in their care. We saw that two people had signed their care plans agreeing to how they would be supported but this did not extend to everyone. We were given conflicting information about whether meetings with people as a group took place. One person told us that they had "lots of meetings" yet other told us there were none. We did not see any evidence that people had been involved in the evaluation of their care plans or any reference made to local advocacy groups that were available. Care plans suggested that there were people who had limited communication abilities. We saw no evidence of how people with limited communication should be approached and spoken with.

Requires improvement

Is the service responsive?

Our findings

People who used the service said they were not involved with their care. They told us "I have never seen a care plan ... no" "Yes, I have had someone to do that but I don't think I have seen my care plan". I am happy with the care provided"

We looked at choices given to people who used the service. We looked at how people were given choices in things such as being offered hot drinks. No choice was given in respect of hot drinks. People were asked if they wanted a cup of tea rather than if they wanted a choice of hot or cold drinks. In addition to this we saw that there was no menu on display in the dining room.

We looked at care plans. All care plans were securely stored in a locked office. We saw that care plans did not reflect changes in the health needs of people. One person had developed a small pressure sore which had been identified in April 2015. Initially we were not able to locate the daily records for this. When they were located, we found that no changes had occurred to the care plan to take this health need into consideration. Another care plan indicated that a person requires some light physiotherapy to assist with breathing. Again there was no evidence that this had been implemented and the only reference made to it was a visit by a doctor and prescribed medication. Daily records and a body map for another person indicated that bruising had been noted but with no explanation of this. Body maps were inconsistently dated.

Risk Assessments were found to incomplete and did not mitigate risks for people. We saw two examples where people with pressure ulcers had been admitted into Sandiway Lodge yet in both cases, risk assessments relating to these pressure areas had only commenced eight and seven months later respectively.

Falls risk assessments were either commenced some months after people had been admitted or were not recorded in daily record sheet. In one instance, a person had been sent to hospital following a fall. There was no indication in the care plan to suggest what the outcome of this visit was. A number of unwitnessed falls had been recorded with little or no evidence to suggest that the causes for these had been investigated. In two cases, accidents had been witnessed by staff yet their recorded explanations for these were not clear with no evidence that causes had been looked in to.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service did not receive safe care and treatment.

We looked at how the registered provider dealt with any complaints that were raised to them. A complaints procedure was available in the porch area yet this was high up on a notice board and would not be accessible to people who used a wheelchair. While the procedure contained all the information needed to raise complaints, the procedure was not presented in alternative formats to meet the communication needs of everyone. We looked at complaints records. One complaint was in this. We were told that two more complaints had been made yet no record of the details or investigation into these had been maintained. People we spoke with said that they would speak to the manager if they had a complaint.

People told us that there were things to do in the home and told us that there was an activities co-ordinator who organised events through the year and arranged for entertainment such as singers to come in to perform for people.

We spoke with the activities co-ordinator. They told us that the nature of the needs of people had changed and this had been a challenge to the provision of activities. They told us that activities at present ranged from one to one social chats to social groups involving conversations, music and light exercise. We saw evidence that people had gone out to places of local interest or entertainment. Links with the local community were in the early stages of development.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service did not have any complaints investigated appropriately.

Healthwatch had conducted a visit to the service in February 2015 to report on the quality of care provided within the service. Their report highlighted that the daily menu was not displayed for anyone to see. The manager

Requires improvement

Is the service responsive?

had stated that they were going to introduce menu cards for each table. Our visit noted that this had not been done and that it had been a suggestion from the predecessor of Healthwatch in 2012.

Inadequate

Is the service well-led?

Our findings

People who used the service told us that the manager was approachable and that they could talk to them. They said

“Oh yes I know the manager, she told me that they would get the doctor in if I was still not well”

“The manager listens and is approachable” “The other manager left and we have a new one, she pops her head in to see if I am alright”

Since our last visit, the registered manager had left the service. A new manager had been appointed and had applied to us to become the registered manager. An application had been made in August 2014 and was still on-going. The manager was present on the first day of our inspection; however by the second day of our inspection, the management arrangements had changed and a temporary manager had been appointed.

Before our visit, we looked at our records to see what notifiable incidents the provider had made us aware of. Our review of records during our visits found that a number of incidents had occurred which the registered provider failed to notify us of while some had been reported. We had not been notified that two people had been admitted into Sandiway Lodge in 2014 with grade 4 pressure ulcers (which is the most severe form of pressure sore). We had not been informed of the authorisation of a deprivation of liberty safeguard in respect of one person and there had been delays in notifying us of safeguarding incident. The registered provider had a legal responsibility to inform us of these but failed to do so.

Before our visit, we were contacted by the Local Authority safeguarding team who advised us of safeguarding allegations that they had been made aware of by the registered provider. The safeguarding team told us that they had reminded the registered provider to inform us of these allegations in line with legal responsibilities. This had not been done.

One person had been the subject of an application to the local authority under deprivation of liberty safeguards. This had been granted yet we had not been notified of this.

We looked at how the manager checked the quality of the care provided. We saw many examples in care plans and risk assessments suggesting that managerial oversight had been inconsistent and in some cases lacking. We saw that pressure ulcer assessments had been implemented months after they had been admitted despite the fact that assessment information had clearly outlined this. We saw that the weighing of people was inconsistent and did not follow nutritional risk assessments. We saw that outcomes following falls or investigations into why they had occurred were not followed through.

We looked at how the registered provider checked the quality of the service it provided. We found that a questionnaire had been sent to all staff yet the results of these included reference to whistleblowing concerns and used as a vehicle to raise concerns. This demonstrated that staff did not feel that the culture of the service lent itself to raise concerns in a transparent way or that the whistleblowing process was effective.

We spoke to people who used the service about having their views of their care expressed through a questionnaire. No-one stated that they had been asked to complete a quality questionnaire. We were provided with evidence of this subsequent to our visit.

.

We looked at audits in respect of accidents and incidents These were completed by the manager on a monthly basis with a copy sent to the registered provider’s area manager. These highlighted a number of unwitnessed falls that people had had. For 2015, there had been twenty- two unwitnessed falls and five witnessed. Given that this information was made available to other managers within the organisation, there was no evidence that these had been acted upon. No common patterns or themes had been identified to ensure that they could be prevented in future. In addition to this, there were no main reasons given for why these had occurred in the first place. While falls risk assessments were in place, there was no information within records of actual falls about how these could be minimise. We found evidence that one accident report had been completed in daily records four days after a fall. The record was inaccurate and did not contain full information.

We saw no evidence that a representative of the registered provider had conducted regular audits of the service to assess the quality of support provided at Sandiway Lodge. This was despite the previous registered manager having left in 2014. This manager had been at the service for a number of years when the service had met all standards assessed at that time.

Inadequate

Is the service well-led?

We saw that any evaluations of risk assessments were completed by the deputy manager or senior care assistants. There was evidence that the deputy manager had conducted two assessments. One of these care plans was inaccurate as it stated that one person's weight was improving whereas weight records suggested otherwise. The registered provider's audits did not identify or address this inaccuracy.

Healthwatch had conducted a visit to the service in February 2015 to report on the quality of care provided within the service. Their report highlighted some recommendations in respect of maintenance, the environment, the availability of menus and the complaints procedure. None of these recommendations had been acted upon by the manager and they were found to be outstanding on this visit.

These are breaches of Regulation 17 (2) of the Health and Social Care Act 2008 Regulations 2009 as the provider had failed to provide a well led service

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that people who used service had received safe care and treatment. This was in breach of regulation 12(1)(2)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not ensured that people who used service could have any complaints investigated thoroughly. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not demonstrate that the service was well led and subject to appropriate governance. The provider had failed to notify the Commission of key events, had failed to implement effective care planning for people and had failed to adequately audit systems within the service.

The enforcement action we took:
We issued a warning notice