Community Integrated Care

Holmdale

Inspection report

2a Company's Close
Weston Village
Runcorn
Cheshire
WA7 4NA

Tel: 01928581448
Website: www.c-i-c.co.uk

Date of inspection visit:
15 February 2017

Date of publication:
07 April 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 15 February 2017. This was an unannounced inspection. At our previous inspection in February 2015, we rated the service as 'Requires improvement'. This was because improvements were needed to ensure people received care that was safe and effective.

At this inspection, we identified that the required improvements had not been made, and we also identified further areas that required improvements to ensure people received care that was safe, effective, responsive and well-led. We identified a number of Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore been placed into 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service is registered to provide accommodation and personal care for up to six people. People who use the service have learning and physical disabilities. At the time of our inspection five people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Risks to people's health, safety and wellbeing were not always assessed and planned for to ensure people

received care that was consistently safe.

People did not always receive their prescribed medicines in a safe, effective and dignified manner.

People's health needs were not always effectively monitored and recorded as planned, and advice from healthcare professionals was not always followed to promote people's health, safety and wellbeing.

The provider's recommended staffing levels were not consistently maintained to ensure people received their care in a timely and responsive manner. There were some gaps in staff training that meant the staffs' training needs were not always being met.

The requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not always followed. This meant some people were potentially being unlawfully deprived of their liberty.

The information staff needed to provide people with consistent care that met their preferences and needs was not always available.

People's dignity was not consistently promoted and, people were not always enabled to be involved in making choices about their everyday care. This was because appropriate communication tools were not always available.

People were supported to eat and drink, but this support was not always provided in accordance with professional advice to protect people from the risk of choking.

Effective systems were not in place to assess, monitor and improve the quality of care.

The registered manager and provider did not always notify us of reportable incidents and events that occurred at the service and the service's inspection rating was not being displayed as required by law.

A complaints procedure was in place for people to follow if required.

Staff knew how to identify and report potential abuse.

We observed some positive and meaningful interactions between the people who used the service and the staff, which showed staff knew people well.

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 consistently safe. Risks to people's health, safety and wellbeing were not always assessed, planned for or managed in a manner that promoted safety.

Effective systems were not in place to ensure that people's prescribed medicines were consistently available.

There was not always enough staff to ensure that people were supported to receive their care in a timely manner.

Staff knew how to identify and report potential abuse.

Is the service effective?

Inadequate

The service was not consistently effective. The legal requirements the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being met.

People could access health care professionals. However, their advice was not always followed to promote people's health, safety and wellbeing. People's health was not always monitored effectively to ensure changes in their health or wellbeing were identified and acted upon.

People were supported to eat and drink. However, mealtimes were not always a pleasant experience and people were not always supported to drink in a safe manner.

Staff had received some training to enable them to meet people's needs. However, some of the staffs' training needs had not been met.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's dignity and right to privacy was not always promoted.

People were not always enabled to make choices about their care as communication styles were not tailored to meet people's individual needs.

Staff knew people well, which enabled them to have meaningful interactions with people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Information about people's care preferences and needs was not always recorded in a care plan for staff to follow. This placed people at risk of inconsistent or unsuitable care.

Individual communication tools were not in place to enable people to be involved in planning for and reviewing their care needs.

A complaints procedure was in place to ensure complaints about care were managed in accordance with the provider's complaints policy.

Is the service well-led?

Inadequate

The service was not well led. Effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to assess and review risks posed to people's health, safety and wellbeing.

The provider did not always notify us of reportable incidents and events that occurred at the service and the inspection rating was not being displayed as required by law.

Holmdale

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.

We undertook an unannounced inspection of Holmdale on 15 February 2017. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of one inspector.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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. We used this information to formulate our inspection plan.

We spoke with four people who used the service. However, due to people's communication difficulties three of these four people were not able to verbally tell us about their care experiences. We spoke with two members of care staff, the registered manager and the provider's regional manager. We also spoke with the relatives of two people who used the service. We did this to gain people's views about the care and to check that standards of care were being met.

We observed how the staff interacted with people in communal areas and we looked at the care records of all five people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

Inadequate

Is the service safe?

Our findings

We found that some risks to people's health, safety and wellbeing had been assessed and planned for. However, improvements were needed to ensure that all significant risks posed to people and staff had been assessed and planned for, to ensure people received safe and consistent care. For example, staff told us and one person's care records showed that they occasionally displayed signs of aggression towards the staff. The risks associated with this person's behaviours had not been formally assessed and planned for and no guidance was available in this person's records for the staff to refer to. Care records showed that this had resulted in staff using different approaches when this person displayed aggression towards them. For example, most records recorded that staff told the person that it was, 'Not nice to swear' or, 'Not nice to shout' during incidents of aggression. However, one staff member told us and had recorded that they sought assistance from another staff member during an incident of aggression. They said, "I take a step back. It's [person who used the service's] way of telling us they want help from someone else". This meant that this person's risks had not been managed in a consistent manner, placing them and others at risk of harm.

We saw that some people's risks were not managed as recommended by visiting healthcare professionals. For example, a visiting healthcare professional had identified that a person who used the service was at high risk of choking when they ate food. The health care professional had left detailed guidance for staff to follow to ensure this person's risk of choking was reduced. However, we saw that this advice was not always followed as we saw staff assist the person to eat potentially unsafe food against professional advice on the day of our inspection. A staff member and the registered manager told us that they felt the person could eat the food that was served to them safely. We did not observe the person choking as a result of eating this potentially unsafe food, but this showed that their risk of choking was not managed in accordance with professional advice.

We found that medicines were not managed safely. People's medicine administration records (MAR) did not always contain an accurate record of the medicines they were prescribed. For example, one person's MAR showed two medicines that they were no longer prescribed. Staff had not recorded that these medicines had been discontinued, which meant the person was at risk of receiving medicines that they no longer required from new or temporary staff who may not know the person's current needs. One person's MAR also contained significant gaps that suggested they had not received one of their prescribed topical medicines for at least a 52 day period. Staff told us they administered this medicine regularly, but this had not been recorded on the person's MAR to show this. Therefore we could not be assured that the person had received this medicine as prescribed.

We could not be assured that people received medicines that were safe for use. For example, one person's prescribed medicine showed it had been dispensed in June 2016. The instructions for this medicine stated that the medicine should be disposed of three months after opening. However, no opening date had been recorded. Therefore we were unable to identify if this medicine was still safe to be used.

Care records showed that people did not always receive their medicines in accordance with professional advice. For example, one person's care records showed they were at high risk of constipation. A visiting

healthcare professional had advised that the person's laxative medicines should be increased if the person had not had a bowel movement for a three day period. This person's MAR showed that their laxative medicine had not been increased as recommended by the visiting healthcare professional on at least two occasions in February 2017. Care records showed that this omission led to the person not having a bowel movement for a significant time period which may have caused them discomfort. Another person's care records showed a community pharmacist had recommended that one of their medicines was administered in the same type of food or drink each day to ensure it was absorbed effectively. We saw this medicine was placed into different foods at lunch and dinner during our inspection. This meant this person's medicine was given in a manner that didn't ensure its effectiveness.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a consistently safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to ensure people's needs were met in a timely manner. One person told us they didn't always receive timely support to access the toilet when they needed to. They told us this made them feel upset at times. A staff member confirmed that there were some occasions when they could not promptly attend to this person's continence needs if staff were supporting other people at the same time.

A relative we spoke with told us, "I think there is enough staff on". However, they told us this was because when they recently visited there had been four staff members on shift for the five people who used the service. On the afternoon of our inspection there were only two staff on shift. Staff rotas showed this was a regular occurrence. Three people who used the service were present for lunch and four people were present for dinner. Every person who used the service required full assistance from staff to eat and drink. This meant staff could only support two people at a time during lunch and dinner, which meant some people had to wait longer to receive the support they needed to eat and drink. At lunch time all three people were bought to the dinner table at 12:15pm. Staff supported two people to eat and the third person sat at the table waiting for their food for a 30 minute period. At 12:20pm, the registered manager said to the person, "Yours is coming in a second or two. I know you're hungry" and at 12:33pm they said, "You can have your lunch in a minute. We're just helping [two people who used the service] first". The person who waited for the 30 minute period at the dinner table watching other people receive support to eat and drink was vocal and active with their arms during this time. However, we were unable to identify if this was an indication of any distress caused by their wait.

The above evidence shows that people's needs were not always met in a timely manner as staff were not always available to provide prompt care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the registered manager could not demonstrate that all staff who worked at the service were of suitable character to do so. At this inspection, we found further improvements were still required. Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. However, we found that when checks of staffs' criminal history checks came back positive, risk assessments were not always completed to identify if the individual staff member was suitable to work with people at the home. Despite this, people and their relatives told us that they or their relations' felt safe around the staff. One relative said, "They're all nice". Another relative said, "There's nothing I wouldn't trust them with". We saw that people were relaxed around the staff which showed they were comfortable in their presence.

We found that people were protected from the risk of abuse. Care records showed that no recent incidents of alleged abuse had occurred. However, staff explained how they would recognise and report any potential abuse should it occur.

Inadequate

Is the service effective?

Our findings

We saw that staff informally asked people for their consent to everyday care. For example, we heard one staff member ask a person, "Are you ready for your lunch", before they provided the person with assistance. However, we found that the requirements of the Mental Capacity Act 2005 (MCA) were not always followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's care records contained some evidence that mental capacity assessments and best interest decisions had been completed for some parts of their care. However, these had been completed by visiting health care professionals rather than the provider as they related to each professionals specific interventions with people. Staff showed an understanding of mental capacity and gave us their views on who they felt had capacity to make decisions about their every day care and who couldn't. However, care records did not contain mental capacity assessments that assessed people's ability to consent to the care and support they received from the staff at Holmdale. This meant people's ability to consent to their care at Holmdale had not been formally assessed by the registered manager and provider.

We found that some people were potentially being unlawfully deprived of their liberty. 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). Care staff showed a good understanding of what constituted a potential deprivation of liberty and they told us and care records showed that at least three people were subject to high levels of supervision and monitoring or restrictions on their movement. For example, one person's care records showed and staff confirmed that they had a specialist lap belt fitted to their wheelchair that they could not open independently, as they had a history of opening their wheelchair lap belt, placing them at risk of falling from their wheelchair. Records showed and staff also told us that an additional set of breaks were applied to the wheelchair that were out of this person's reach to prevent them from removing the breaks and moving their chair freely. The safety lap belt and breaks both restricted the person's right to move freely. Staff told us that the person did not have the capacity to understand why these restrictions were in place. However, we found that the person's care records did not show that the person's mental capacity had been formally assessed in relation to this decision. The registered manager also confirmed that no DoLS application had been made as they had not identified this as being required. This meant the requirements of the MCA and DoLS were not being met and people were potentially being unlawfully deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had access to health care professionals when needed. However, care records showed and we saw that professional advice was not always followed to promote people's health and wellbeing. For example, one person's care records showed they required daily prescribed exercises to help to promote and maintain good lung health. Their care records showed gaps in the completion of these exercises and the person was being treated for a chest infection. This meant we could not be assured that the prescribed

exercises were being completed as recommended to promote good lung health.

We found that people's health needs were not always monitored effectively to promote their health and wellbeing. For example, some people who used the service experienced seizures that required close monitoring to pick up potential changes in the presentation of their seizures. We found that the annual seizure monitoring charts were not completed accurately so changes could not be identified. For example, two observed seizures were missing off one person's seizure records for January 2017. The registered manager told us that this person's seizures were stable. However, the person's care records showed there had been a significant increase in their seizures in January 2017, compared to November and December 2016, but this had not been identified or handed over to a health care professional. This showed that people's health needs were not always monitored and acted upon to promote their health and wellbeing.

Some people who used the service required specific assistance to drink safely. We found that professional advice relating to the preparation of drinks and the assistance provided to people to enable them to drink safely was not always followed. For example, we saw one person's thickened drink had a thicker layer of fluid at the bottom of the cup compared to the rest of the drink. A staff member told us, "That's how it always goes, with a thicker bit at the bottom". This meant their drink had not been prepared in accordance with professional advice as thickened drinks should be the same consistency throughout to prevent people from choking.

The same person's care records showed that for safety reasons a healthcare professional had recommended that they were supported to only have half a cup of their chosen drink presented to them at a time. It was also advised that they were to only drink three sips at a time to reduce their risk of choking. We saw this person was given full cups of their chosen drinks throughout the day and they drank more than three sips at a time. This meant that professional advice was not always followed to ensure people were supported to drink in a safe manner.

The above evidence demonstrates that the advice of health care professionals was not always followed to ensure people received care that promoted their health, safety and wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us and we saw that people appeared to enjoy the food and drinks provided to them. This person told us they liked to eat bread and quavers and they confirmed they enjoyed these foods on a regular basis. People's weight was monitored on a regular basis to ensure their nutritional needs were met. However, we found that improvements were needed to ensure people's mealtime experiences were consistently positive. Our observations at lunch and dinner time showed that people waited lengthy periods before they were supported to eat because only two staff were available to support three people at lunch and four people at dinner time, all of whom needed full assistance from the staff to eat. For example, one person sat at the dining table watching other people being supported to eat for a 30 minute period before they were supported to eat. We also saw that at mealtimes, drinks were also only offered to people following their meals, rather than being offered alongside their food.

At our last inspection, we told the provider that improvements were needed to ensure the staffs' training needs were met. At this inspection, we could not be assured that the required improvements had been made. Although staff told us they had received some training, training records were not kept up to date to record the training staff had completed. For example, one staff member told us they had recently completed first aid training, but the staff training matrix did not record this. At our last inspection, some staff told us they would like to complete dementia training. However, staff told us and records did not show that this training had been completed as requested. This meant some of the staffs' training needs were not being

met.

Requires Improvement

Is the service caring?

Our findings

We found that people's dignity and right to privacy was not always promoted. For example, we saw a member of staff and the registered manager administer people's medicines in an undignified manner. One person's eyes drops were administered at the dining table at mealtimes and another person's trousers were lifted up at the dining table so that staff could apply their prescribed topical medicines to their knees. On these occasions other people were sitting at the dining table eating their meals. This did not promote people's dignity or right to privacy.

We found that some people were encouraged to make some choices about their care. For example, we saw a staff member show a person the three flavours of milkshake they could choose from when they were offered a drink. This person was able to make and show their choice using this method of communication. However, we found that some people were not always supported to make choices in a manner that reflected their ability to process information and communicate. For example, pictorial menus were not used to enable people to make choices about the foods they ate. Staff told us that menus were planned for people on their behalf based on the staffs' knowledge about people's likes and dislikes. One staff member said, "It's difficult, we don't have picture cards". This meant people were not always supported to be as involved in making choices about their care to their maximum potential.

People and their relatives told us that they were happy with the care and support at Holmdale. One person told us they were very happy living at Holmdale and a relative told us how their relation had settled well at the home. They said, "[Person who used the service] settled quickly. I'm shocked at how soon they did settle and how happy they are here". Another relative said, "The staff are lovely with everybody, I can't fault them".

People told us and we saw that that independence was promoted where possible. One person told us how they liked hoovering. The staff member supporting this person told us how they enabled them to participate in this activity to promote their independence. We saw that staff promoted people to be as independent as they could be. For example, we saw staff encouraged one person to use their wheelchair independently to move to the dining table. The staff member said, "I'm not going to do it for you. Come on, be independent, I'll help you on your way". The person responded positively to this and started to independently self-propel their wheelchair.

We saw that staff knew people well which enabled them to have meaningful conversations and interactions with people. For example, we saw one staff member talk with a person about their personal clothing preferences. The staff member then complimented the person about the clothes they were wearing, which made the person smile.

Requires Improvement

Is the service responsive?

Our findings

One person told us that they were supported to participate in their preferred hobbies and interest inside the home and in the community. For example, this person told us they were supported to attend a day service and go shopping. They confirmed these were two activities that they enjoyed. Care records showed that people accessed the community and participated in some activities at the home. However, we were unable to confirm that these activities met people's preferences and likes as this information was not always recorded in people's care records. For example, one staff member told us one person enjoyed going to the theatre to watch shows that were bright, colourful and musical. They said, "They always respond more and stay alert when they watch shows that are colourful and musical, they seem to keep their attention a bit more". However, this information was not recorded to be a preference for this person in their care plan. This meant new or temporary staff may not have access to the information needed to enable this person to participate in activities that were meaningful to them.

We found that plans were not always in place for the staff to follow to ensure people's care needs and preferences were met. One person did not have a formal care plan in place despite using the service for just under a year. The registered manager showed us a care plan from another service that the person previously used, but this was not specific to the care and support they received at Holmdale. The registered manager confirmed that a care plan was not yet in place for this person that planned for their care at Holmdale. Despite this lack of information, staff gave us consistent information about how they provided this person with care and support. However, in the absence of a care plan, we were unable to confirm that this person's care needs and preferences were being met.

Advice from healthcare professionals was not used to formulate individualised care plans. For example, a visiting health care professional had given detailed information that showed how a person showed their care needs in a non-verbal manner; such as how they showed they were distressed. This information had not been incorporated into a care plan that gave the staff the information they needed to recognise and respond this person's distress. Despite this, the staff told us how they recognised and managed this person's distress in a consistent manner. This showed the staff knew this person's needs well. However, there was a risk that any new or temporary staff would not have access to the information needed to meet this person's needs in a consistent and responsive manner.

Staff completed monthly reviews where they set goals for people to achieve. For example, staff set one person a goal to make a Christmas photo album. We saw that this goal had been achieved as staff showed us the completed album. However, we found the goals staff set were not always achieved or acted upon. For example, one person's goal from their most recent review was to try new activities. We found no evidence that any new activities had been planned for or completed. Staff confirmed that most people who used the service were unable to participate in these reviews as communication aids were not in place to help people to process information and communicate their care needs and preferences. This meant that people were not supported to be as involved in this process to their maximum potential to ensure care reflected their personal preferences and needs.

People who were able to verbally communicate told us they would tell staff if they were unhappy with their care. People's relatives told us they felt able to approach the registered manager to raise a complaint if required. One relative said, "I'd tell the manager. I've not needed to yet, but I wouldn't be afraid to". A complaints procedure was in place and complaints records showed that no recent complaints had been made about people's care.

Inadequate

Is the service well-led?

Our findings

Effective systems were not in place to ensure that any risks posed to people's health, safety and wellbeing were assessed and planned for. For example, risks associated with people's behaviours that challenged, such as aggression had not been assessed and planned for. The risks associated with any positive staff criminal history checks had also not been assessed and planned for to ensure people were protected from any risks posed to them as a result of these checks.

Care records showed that some people's risks were not regularly reviewed to ensure any risks to their health, safety and wellbeing were being managed effectively. For example, one person's care plan showed they required assistance from one staff member to use a hoist to manage their complex moving and positioning needs. This person's risk assessment and care plan had not been reviewed since 2014 to ensure their complex needs were being effectively managed with the assistance of just one staff member. Staff we spoke with told us they felt they could meet this person's needs safely on their own. However, this showed that systems were not in place to ensure risks to people and staff were regularly reviewed to ensure and promote safety.

Effective systems were not in place to ensure the advice of healthcare professionals was incorporated into people's care plans and followed by staff. For example, the information shared by a visiting health care professional about a person's communication needs had not been used by the registered manager to formulate a communication care plan detailing the information staff needed to consistently meet this person's needs consistently and effectively. We saw that staff didn't always follow safety advice recorded by visiting healthcare professionals to promote people's safety. For example, one person was given a potentially unsafe food during our inspection. The staff member and registered manager told us the person would be able to swallow this food safely, despite this contradicting the information recorded by the visiting health care professional. This meant people were placed at risk of not having their needs met in a safe and effective manner.

Effective systems were not in place to ensure the provider's recommended staffing numbers were maintained. The registered manager told us that three staff should be on shift to enable people's care needs to be met in a responsive manner. Staff rotas showed and staff confirmed that staffing levels often dropped to two staff, particularly in an afternoon and evening. The registered manager told us the numbers mostly dropped to two staff when only four people used the service, but we saw many occasions when rotas showed only two staff were on shift when all five people used the service. One staff member said, "Two is okay, and we do manage, but three is better". This showed that's the provider's recommended staffing levels were not consistently maintained.

Effective systems were not in place to assess, monitor and improve quality and safety at the service. For example, medication audits had not identified the medicines management safety concerns that we identified; such as the lack of evidence to show topical creams were administered as prescribed. We also found that some audits were not sufficiently detailed to show the areas they covered and the outcome of the audit. For example, the registered manager told us they had completed a hand hygiene audit. The

record of this audit was just a staff signature sheet. The detail of the areas covered in the audit and the outcome was not recorded. The registered manager told us they had discussed hand hygiene theory with the staff and a list had been made of the staff who had been present. This was not an effective audit as the ability of the staffs' compliance with this hand hygiene had not been observed and assessed to identify they followed safe hand hygiene practice.

The registered manager told us that quality monitoring systems were not effective as they only had one day a week management time as she needed to be included in staffing numbers to ensure shifts were covered. We spoke with the provider about this and they reported that this was an ongoing issue as the registered manager had not taken appropriate action to ensure new staff were recruited to the service within the timescales set by the provider.

The provider evidenced that they were aware of most of the concerns we identified at this inspection. For example, the concerns we found with medicines, staffing numbers and lack of care plan reviews had been identified by the provider during recent compliance visits. However, some of the concerns we identified had not been identified by the provider. For example, the potential unlawful deprivation of people's liberty and the failure to follow healthcare professionals advice to promote people's safety. This showed that improvements were also needed at provider level to ensure effective systems were in place to assess, monitor and improve the quality and safety of the care provided to people.

We saw evidence of completed satisfaction questionnaires to gain the views of the relatives of people who used the service. Only two completed feedback forms had been received, both of which contained positive feedback. However, because people's communication needs were not effectively planned for and managed for, people were not always involved in the assessment and review process that related to their individual needs and the needs of the service. This meant we could not be assured that effective systems were in place to gain and use people's feedback to make improvements to the quality of care.

The above evidence shows effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider were not displaying their inspection rating at the home as required by law. The registered manager told us they did not know that this was a requirement, but they would address this the following day. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the registered manager and provider understood the responsibilities of their registration with us. The registered manager and provider had failed to notify us of one person's DoLS authorisation as required under our registration Regulations.

An action plan was in place to address the concerns identified by the provider. However, the target dates contained in the action plan were not always followed to make the required improvements. For example, the medicines concern identified by the provider had a target date of 3 February 2017, but this had still not been actioned by the registered manager at the time of our inspection. The provider had recognised that target dates were not being adhered to and were taking action to address this with the registered manager. This showed that provider was monitoring the registered manager's compliance with the implementation of the service's improvement plan.

People's relatives and the staff told us that the registered manager was approachable and supportive. One

relative described the registered manager as, "A lovely person". A staff member said, "She gets stuck in and if I'm doing anything wrong she tells me". Staff told us they had regular meetings with the registered manager to discuss any concerns. One staff member said, "I get supervision. I'm asked what's working and what's not working and what I would like to change". This showed people's relatives and the staff felt comfortable to share concerns about care with the registered manager.

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	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered manager and provider were not displaying their inspection rating at the home as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available to provide people with the care and support needed to meet their needs in a timely manner.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people received their care in a consistently safe manner. The advice of health care professionals was not always followed to ensure people received care that promoted their health, safety and wellbeing.

The enforcement action we took:

We told the provider to make immediate improvements by 31 March 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The requirements of the MCA and DoLS were not being met and people were potentially being unlawfully deprived of their liberty.

The enforcement action we took:

We told the provider to make immediate improvements by 31 March 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing.

The enforcement action we took:

We told the provider to make immediate improvements by 31 March 2017.