Indigo Care Services Limited

The Heathers Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit was unannounced and took place on 4 January 2017. Since our previous inspection the provider has changed, however, the registered manager and staff remained the same so we have made reference to the previous inspection visit on 28 January 2016. At that inspection we asked the provider to make improvements to the safety aspects of people's care, supporting people when they lacked capacity and systems to support the running of the home. The provider sent us an action plan on 6 April 2016 explaining the actions they would take to make improvements. At this inspection, we found improvements had not been made in all these areas.

The service was registered to provide accommodation for up to 47people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 43 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had not ensured that the risks to people's health and safety had been assessed and the information cascaded to ensure consistency of support was offered. There was not sufficient staff to support people's needs. People had to wait when they required support with their personal care needs. The service was not consistently meeting the requirements of the Mental Capacity Act 2005. Assessments had not been completed and we could not be assured that when people lacked capacity their needs had been considered in line with the Act. People were not always given choices about their meals and beverages. Some people felt the food was good quality and they had meals they enjoyed.

Peoples care was not always documented to ensure people received care that met their needs. When people had behaviours that challenged these were not supported to provide staff with clear guidance and support.

There was mixed feelings about the activities provided to support stimulation and people's hobbies or interests. Some people received limited stimulation and others received a range of support and access to outings and events.

The provider had not completed audits to support the development of improvements or to consider any trends in areas of concern. People's views had not been considered to develop the home and peoples experience.

There were systems in place to reduce the risk of abuse. People felt supported with their medicines and the

provider had established systems to support checks were competed to maintain safety. Staff were checked to ensure they were suitable to work with people

People's health care needs were monitored and any changes in their health or wellbeing prompted a referral to their GP or other health care professionals. Staff had the training and skills they needed to meet the needs of the people they were supporting.

We saw that the previous rating was not displayed in the reception or on the company website. The manager understood their responsibility of registration with us in relation to notifications to us of important events that occurred at the service.

We found 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
Risks to people's health and safety were not always assessed or well managed. There was not always sufficient staff deployed to support people. Staff checks were made to ensure they were suitable to work with people. People felt safe and there were systems in place to reduce the risk of abuse. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective

The service was not consistently meeting the requirements when people lacked capacity in line with the Mental Capacity Act 2005. People were not always given choices around their meals and beverages. People's health care needs were monitored and any changes in their health or wellbeing prompted a referral to their GP or other health care professionals. Staff had the training and skills they needed to meet the needs of the people they were supporting.

Is the service caring?

Requires Improvement

The service was not always caring
People's privacy and dignity was not always respected. Staff did not always have the time to provide care that was individual, caring and compassionate. People were able to follow their choice of faith.

Is the service responsive?

Requires Improvement

The service was not always responsive
People did not always receive consistent care and information was not cascaded or made available. Some people did not receive stimulation in their activities and interests, however others did receive this. When complaints had been received they had been responded to.

Is the service well-led?

Inadequate

The service was not always welled

Effective systems were not in place to assess, monitor and improve quality of care. People were not engaged in sharing their opinions about the service. Staff felt supported, but they had not received ongoing professional development. Areas of concern identified in our previous inspection had not all been addressed.

The Heathers Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection visit 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. Our inspection was unannounced and the team consisted of two inspectors 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.

This location had an inspection in January 2016 when it was managed by a different provider. The new provider registered with us in June 2016. The registered manager and staff transferred to this provider. We have referred to the previous inspection within this report.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We also spoke with the local authority who provided us with their current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us during the inspection visit.

We spoke with four people who used the service and six relatives to gain their feedback on the care they received. Some people were unable to tell us about their experience of living in the home, so we observed how the staff interacted with people in communal areas.

We also spoke with four members of care staff, two nurses, a peripatetic manager and the registered manager. We looked at the training records to see how staff were trained and supported to deliver care

appropriate to meet each person's needs. We looked at the care records for six people to see if they were accurate and up to date. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2016 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured risk plans were in place and followed, to manage wound care. Systems were not in place to ensure people received their medicine safely. At this inspection we found that some improvements had been made but that further improvements were still required to ensure that people were kept safe.

People who received nursing care for skin damage had not had their care records updated. We could not always identify the stage of the wound care and when the wound had healed this had not been recorded. This meant we could not be sure the records for people specified the correct level of care needed for their wound.

We saw some people required checks and repositioning at regular intervals to keep them safe. One staff member we spoke with said, "Due to the staffing levels and getting side tracked, we cannot always physically get round." We saw one person who was at risk of entrapment from their bedrails required a check every two hours. However, we found this person had not received these checks and was found by us to be in a position of risk. This person's risk assessment had identified they required extra high bedrails as they were at risk of falling from the bed. We found only one side of the high rails was in use and the side which was in use was not secured as necessary. The records we reviewed for other people showed that they had not always received the checks they required in line with their care plans. This meant we could not be sure people were repositioned and checked as required to ensure they were safe.

Some people had behaviours that challenged however; there were no plans in place to manage these behaviours. For example, one person had been prescribed medicine if they became anxious. There was no plan in place to consider when this medicine should be used or how to manage the person's behaviour. At our request these measures were implemented for this person during the inspection... We saw some other people expressed themselves on occasions with aggressive behaviour. There were no plans in place to provide guidance on how to manage this behaviour. One staff member said, "No one here has a behaviour plan." This meant we could not be sure staff had the correct guidance to enable them to manage people's behaviour as required.

People had not always been encouraged to be independent. A relative said, "They [person who used the service] have not been encouraged to walk. It is easier to manage them in the chair. I have noticed that they do that to other people." Another relative said, "I've seen people trying to get up out of the chair, they can't walk and then I have to put them back. It's not my job." A relative said, "The mobility thing is an issue. Instead of sitting people down and keeping them sitting down they should get the best out of them. They don't ask about physiotherapy and they should keep them mobile." We saw people being guided to use a wheelchair as the staff had not got the time to support people to walk with an aid. One staff member said, "Let's use the chair it's easier." This meant people were not always encouraged to maintain their independence.

People told us and we saw the call bell system was not working and this meant people could not request the support they may require. One person said, "They haven't got the buzzers going at the moment. I have to leave the bathroom light on at night." Another person said, "The buzzers are broken. They are all broken here. You have to bang for the staff or shout if they are about." We saw the system downstairs had broken on the 1 January 2017. The provider had arranged for a maintenance person to attend however, it was identified the system could not be repaired. A system to provide checks on people was implemented on4 January 2017. This meant we could not be sure during the previous three day period if people received the support as and when they required it.

The above evidence demonstrates a continued breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there was not enough staff. One person said, "There has been a bit of a difference since it's been taken over. I don't know which staff are working. They do seem short staffed. I think the different arrangements have made it worse." A relative told us, "They are short staffed and the staff do struggle." Another relative told us, "A lot of the staff left and the new shift patterns have caused problems." And, "They are pushed for staff, and the staff are stressed about the work and the time they have to do it. They are tight at the moment for staffing. They have more work with less staff. There just isn't enough staff and they are stressed but the carers are good."

When people required assistance with their personal care they had to wait. One person told us, "They tell me not to worry, but it's not right." A relative told us, "People have to wait. And, staff say 'bear with me' and it annoys me especially when they know people want to go to the bathroom." We saw on several occasions people had to wait to be supported with their personal care needs when they required two staff to be transferred. For example, one person requested to go to the toilet and was asked to wait whilst the staff finished providing people with their drinks. We observed one person went to the bathroom, which they were able to do independently. However, due to living with dementia they were unable to orientate themselves back to the lounge. We noted after a period of 20 minutes the person had not returned. We asked the staff member about this person, they told us, "I cannot go and find them as I have to stay in here, and they usually wander to a bedroom." A visitor told us, "When I visit I often have to find them, they are often on someone else's bed." This meant we could not be sure this person received the level of support they needed to guide them and ensure their safety.

All the staff we spoke with felt there was not enough staff. One staff member said, "I don't feel we have the time to spend with people. Sometimes people have to wait." Another staff member said, "We cannot make the time go slower to enable us to get around to everyone, but we could have more staff."
We spoke with the manager about the staffing levels. The manager told us they had changed the working pattern for staff and this had had an impact and some staff had left. They told us they had a programme of recruitment to increase the staffing levels. They also told us they had not reviewed the dependency tool which reflected individual support needs since October 2016.

This demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we raised concerns about the administration and the recording of medicines. At this inspection we saw that improvements had been made. We looked at the current medicine administration records (MAR) in the home. We found them to be up to date with all signatures in place. People's photographs were attached to their MAR to aid identification and any medicine and allergies were recorded. We saw where people required a patch for pain relief, the location was clearly documented and

any administration was completed by two nurses.

People told us they felt confident in the staff supporting them with their medicine. One person said, "The nurses support me with my medicine. I am happy with them doing it. If I need it they give me the medicine under the tongue... If my sugar is high I don't have a pudding. It's been up and down. The nurses take care of that." Another person said, "I am happy with the medicines and I am getting them on time." We saw staff supported people to take their medicines as prescribed. This was done in a safe and respectful way. Nursing staff stayed with the person to ensure they had swallowed their medicines. Where people were not ready to take their medicine the nurse respected this and returned when they were ready. Where people refused their medicines it was recorded on their MAR and then the required medical advice was sought. Processes were in place to ensure any medicines which had been dispensed and not taken were disposed of safely.

Medicines were stored securely and in accordance with their storage requirements and temperatures were checked and recorded daily in line with this. Staff told us and we saw records to confirm they had received training in medicine administration. The nurses had received the current national nursing code of conduct on medicine administration and their competency had been assessed to ensure they followed this guidance. This meant people received their medicines as required by staff that followed the appropriate safety checks.

People were supported by staff who were assessed as suitable. Staff personnel records showed appropriate checks were undertaken before they commenced work. These records included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of the person's identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. We spoke with staff who said, "I had to have two references and wait until they returned before I started." Another staff member said, "I had to wait about six weeks for my references and my DBS."

Staff had received training in safeguarding and understood the different possible signs of abuse around safeguarding and how to raise a concern. One staff member said, "We need to ensure we protect people, I would report any concerns to the nurse." Another staff member said, "I would report any concerns, they would be acted upon. I know I can go to the local authority or CQC."

We saw that the manager had investigated any safeguarding concerns that had been raised and that any actions followed through to reduce any further risks to people in the future. This demonstrated the provider responded to safeguarding concerns and took action to reduce the risk of any further incidents.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

At our previous inspection in January 2016 we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that where people lacked capacity they received an assessment and any decisions made were in their best interest. At this inspection we found that the required improvements had not been made.

We saw where people lacked capacity some assessments had not been completed for the activities or decisions when supporting people. For example, when people required the use of equipment to keep them safe or to consent to them receiving care. The provider had completed their own inspection and they had identified the people who required a MCA assessment. We saw there were assessments outstanding and this meant we could not be sure that people's needs had been identified and they received the correct level of support in line with the Act.

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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Applications for DoLS had not always been made to the relevant authority for some of the people that the provider had identified, where their liberty was restricted. Staff we spoke with did not understand the DoLS legislation, one staff member said, "I have had the e learning, but my mind has gone blank, it about making people feel at home." This meant that the provider was aware that people were deprived of their liberty without legal authorisation and had not ensured the made considerations they should make under the Act.

This demonstrates a continued breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people did not always have choices about their drinks and meals. Upstairs in the home when people received their mid-morning drinks, they were all provided tea with sugar. No one was offered a different choice of beverage and no snacks were provided. One staff member said, "It's usually tea, if people ask we could get something else." We saw that most of the people were unable to express a spontaneous choice without guidance. This meant that they would not be able to ask for a different drink and would need to be prompted and guided to choose. At lunchtime we saw that one person who was vegetarian was not offered a choice without meat. This person had the potato and vegetables only. The staff member said, "I

am sure if we asked for something else the cook would make it." However, no offer of an alternative was requested from the cook. All of the meals upstairs were plated up with the gravy applied and delivered via a dumb waiter. This meant people received the same portion size and were given no choice in relation to gravy or sauce options for their meal. We discussed this with the manager who told us about the work they had been completing to evaluate this area and said they would continue to work on this to give people a better meal experience.

We observed downstairs that people had a better experience with choices. Several people we spoke with told us, "They do lovely dinners." Another person said, "I enjoyed the food. You never need go hungry. There is enough food and its lovely food. There are lots of cups of tea and you can have them anytime you like." And, "The staff know that I like a small dinner with only a spot of gravy. I am having a sandwich today. There is a pork chop which will mean a lot of gravy and steak and kidney pie with gravy. You have what you fancy." We saw that equipment was available to support people to remain independent and when required support with their meal was offered.

People received support from staff that had been trained to do their job. Staff we spoke with told us they received online training and some face to face. One staff member said, "I like the face to face best, when you have someone you can interact with, ask any questions and someone to answer them." Another staff member told us, "We have a lot of e-learning and I had not used a computer for a while, but I was helped to do what I needed to do. If you get it wrong you have to do it again."
A staff member told us they had recently received some training from the optician. They said, "We tried on different glasses which showed you how it is for the person with that visual impairment." They added, "It was really useful, knowing not to approach people from the side as with some sight problems people cannot see you coming at the side." The manager told us that new staff who had no care experience completed the care certificate. The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. We saw three staff members had completed the certificate. This meant staff were supported to have the skills they needed for their roles.

People received support and advice from visiting healthcare professionals on a regular basis. One person said, "I don't see the doctor unless I want him. They know when I want him. The chiropodist comes here. The hearing people came in and the eye doctor comes in." The provider had a link with the local practice which provided an advance practitioner to visit weekly. The nurses told us that they provide a list of people they need them to see, but they can ring between visits for advice and support. On the day of the inspection the GP visited the home as the nurse practitioner was on leave. At the daily meeting the nurses ensured the list was ready for the GP and we noted that two people who have been unwell during the previous day had been added to the list. This meant people received the support they needed to maintain their wellbeing.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always considered. For example, one person had their door open and because of this they had their dignity compromised. A relative expressed how disappointed they were to not always be able to sit in the dining room with their partner. They told us, "I have to book the table for lunch; otherwise we don't have a table. We often end up eating in their room, as there is no space." They added, "After many years of being together it's important we are still able to eat our meal together."

People we spoke with told us they felt cared for. One person said, "Yes, I am looked after well, they are marvellous" Another person said, "The Heathers is lovely. It's a great place." A relative said, "I would say the staff are kind and compassionate. I hear them talking to people in a mild manner. They know [name] and they do coordinate their clothes. I would give them nine out of ten.." Another relative said, "The carers are very caring, they are very good. I have no worries on that score."

We observed that when staff had the time to interact with people this was done with kindness and care. For example, when a person returned from the hairdresser the staff commented on their hair. Another staff member commented on a person's outfit and the colour suiting the person.
We saw a staff member offer a person a blanket and when the person said 'no', this was respected and placed nearby in case they changed their mind.

Speaking with staff at the home they demonstrated they cared a great deal for the people they supported. One staff member said, "People are at the heart of what we do here." Another staff member said, "I love it here, helping people get dressed and smell nice, giving them what they need."

People told us they were able to follow their faiths. One person said, "The vicar from the Church of England comes from St. Johns. The lady from the Catholic church comes in once a month. I am Church of England so I join them in the lounge." Another person told us, "When the church people come in I join them." Staff we spoke with told us that members of the different faiths come to the home. One staff member said, "We have different church services for Catholics, church of England and the Salvation Army often attend." They also said, "Other faiths had been catered for in the past when they have been requested." This meant people were able to follow their choice of faith.

Requires Improvement

Is the service responsive?

Our findings

Staff were not always aware of people's life histories A relative told us, "They completed a history about [name] and their role in the war. They like to talk about this time in their life, but it is never mentioned." We saw the care plans were not always consistent, for example, one staff member told us about an occasion when a person had discussed their past. The staff member consulted the care plan wishing to validate the information and found this section had not been completed. Care staff told us they did not have the time to read the care plans. One staff member said, "I have not read the care plan, I find the summaries of people's care really useful, but not everyone has one." We saw there was inconsistency in their completion and where they were stored. Some were located in the office with the care plans and others were in the person's bedroom. This meant we could not be sure staff had access to the information they required to support the person and ensure they knew the person's interests.

People did not always have care plans which identified their preferences. A relative told us they had requested [name] had a daily bath. This information had not been added to the care plan and the relative told us they planned to raise this again with staff. The staff we spoke with told us they were not aware of this request.

We saw that information was not always cascaded or followed. The care records identified a person required a specific amount of fluid as directed by the health care professional. We saw the fluids recorded were not always totalled so we could not be sure the person had received the recommended levels of fluid as required. Staff we spoke with were not familiar with the level of fluid required for that person. This meant we could not be sure requirements and requests for people's care were carried out as per the health care professional request. .

There was mixed feelings about the support available to stimulate people and encourage their interests and hobbies. During the inspection we saw that no activities took place upstairs. Records showed for some people the last entry of an activity was in August 2016. In the lounge area there was a staff member present at all times. We were told this was due to two people being on a sensor mat, following several falls. We saw the different staff members present in the lounge did not engage with people, they observed the people on the pressure cushions. When these people rose from their seat, an alarm was activated. The people were encouraged to sit back down without staff exploring the reason they had raised the alarm. A staff member told us, "I would love to have time to talk to people." Another staff member said, "We don't have time to do activities with people, we used to play dominoes and sit, now it's just one job after another." We discussed this with the manager, they acknowledged that they needed to provide clearer advice and guidance to the staff on how they should utilise their time whilst supporting people in the lounge.

This demonstrates a continued breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people downstairs in the home were able to enjoy a range of activities. One person said, "There are

plenty of things going on. The activity co-ordinator is very good. We have been out on a canal trip. We went to the Prince of Wales theatre. There is plenty of entertainment. We saw crafts being completed and the homes pet guinea pigs were taken from their cage for people to observe and hold. This meant there was a different experience for people living downstairs.

There was a complaints procedure in place; we saw that all complains that had been received had been responded to. For example, one person had complained their relative room had not been cleaned. We saw this had been responded to and the relative had sent a note of thanks following the completed action. All other written complaints had been addressed in line with the provider's complaints procedure.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we asked the provider to make improvements in the auditing and monitoring of the home. They had not completed reviews on care plans to identify people's changing needs. After the previous inspection the provider had completed an action plan, we saw that areas they told us they would address had not been completed. In our last report we identified several breaches of the regulations and found at this inspection some of these had not been addressed.

At this inspection we found people were not routinely asked their views about the home. One relative said, "I haven't done any surveys or my relative, I think they would have said if they had." Another relative said, "I haven't seen any notices for meetings or seen any questionnaires or surveys." We saw records that showed the regional manager had held a meeting at the home. As part of this meeting there were several references made about the staffing levels and people were given assurances this would be followed up. One relative told us, "The new boss came in; it made no difference not really. It's not changed anything."

The regional manager had given assurances the dependency tool would be revisited by the end of December 2016. The manager confirmed they had last completed the dependency tool in October 2016. A dependency tool reflects the needs of each person and the level of support they require to remain safe. Due to the concerns we have raised in relation to staffing levels we could not be sure the level of staff reflected the identified needs of the people using the service.

Staff told us they felt supported; however they had not received regular supervision. One staff member said, "Not had one for a while." Another staff member said, "Not had one for a long time, I cannot remember when." We discussed this with the manager, they told us, "We have a new system set for supervisions and they have started, however it will take us a while to see everyone. We have been focusing on team supervisions to cover specific areas of concern." This meant we could not be assured staff had received the support they required.

At the previous inspection we raised concerns that care plans had not been regularly reviewed. We saw this continued to be an area of concern. For example, one person had not had their care plan reviewed from August 2016 until December 2016. The nurse told us, "We hope to ensure that doesn't happen again as we have introduced the resident of the day." This is a system where there is a focus the person and their care plans, daily logs and room checks. The provider told us in their action plan after the previous inspection, 'Implement 'resident of the day' and fully audit care plan and all associated documents on the designated day'. This had a completion date of 30 July 2016, however, we saw this had not commenced until the day before our inspection. We checked the records for that resident of the day and saw there were gaps in the paperwork. This meant we could not be sure that the system would resolve the concerns we had in maintaining people's records are kept up to date.

The provider had used agency staff to support the short fall in staffing numbers. In the providers compliance

inspection they had identified that they needed a handover folder for agency staff. This action was dated as completed. We spoke with an agency staff who had not received this handover and was unable to tell us about some people's needs. One staff member told us, "We always ensure they are with someone." However, we saw the agency staff in the lounge on their own. This meant we could not be sure agency staff had the information they needed to support people as required.

We found that systems were not always in place to monitor the quality of the service. We saw that audits had not been completed in relation to accidents and incidents. For example, seven records had not been entered on the audit for December 2016 and there had been no analysis to consider reoccurring themes for the month or across several months. We saw a bed rail audit had been completed which identified that all the beds with rails required different support coverings. These had been ordered and the audit showed as the item was completed. However, we saw that the new coverings had not been placed on all the rails and this impacted on one person continuing to be at risk of entrapment. We discussed the audits with the manager they told us, "This is an area I am learning to develop, with the support of the other manager." This meant we could not be sure the provider used the audit systems to drive improvement.

The manager had introduced a tracking system relating to the DoLS applications to check on their progress with the local authority. The provider acknowledged in their own compliance inspection that DoLS applications were outstanding for many people and that this was an action of importance they needed to complete. The provider had also identified that many people needed capacity assessments and they had set a deadline date as the 6 Jan 2017. We saw these assessments had not been completed and the manager confirmed that the assessments would not be completed by the deadline date. This was an area of concern at the previous inspection and meant we could not be assured this would be completed as a priority.

We spoke with the manager about the lack of information in the care plans, and the areas of concerns which had not been addressed from out previous inspection. They told us, "I have found it overwhelming all the system and complete changes." The manager told us the provider had completed their own compliance inspection in December 2016. The manager had requested support to implement all the changes they had identified. The provider had allocated another manager to support the home with all the actions identified on their compliance inspection.
The above evidence demonstrates a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not displayed their rating or published the rating on their website. We discussed this with the manager who immediately displayed a copy of the ratings poster on their noticeboard which was visible to everyone. They also contacted the provider to arrange for the report to be published on their website.

Staff told us they felt the home was a nice place to work. One staff member said, "If I have a problem I can talk to the manger and feel I am listen to." Another staff member said, "I enjoy it here, the people are really interesting." We saw the manager reported relevant information and concerns to us. This mean they were following the requirements of the registration to us.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The information was not always available in the care plans to provided the details to support peoples needs and preferences and provide staff with the information they required. The home provided limited activities upstairs in the home to provide people with stimulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interest when they were unable to make decisions themselves. Restrictions to deprive people of their liberty had not always been referred to the authorising authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not established to

ensure the quality and safety of the services provided was assessed and monitored. Staff did not receive the supervision they required to support their role. Feedback from people and ongoing communication with them had not been developed for continually evaluating and making improvements. Areas of concern raised at our previous inspection had not been addressed. The previous rating had not been conspicuously displayed in the home or on the providers website.

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 considered the changes made for people's needs to be met by the level of staff available. There were not always sufficient staff to keep people safe at all times.