NR & VGP Carehomes Ltd

Fleetwood Nursing Home

Inspection report

Grange Road
Fleetwood
Lancashire
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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**

Summary of findings

Overall summary

Fleetwood Nursing home provides support for people who require residential or nursing care. The home has two floors a lift is available for access to both floors; some rooms are en-suite.

Fleetwood Nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Fleetwood Nursing home was last inspected February 2016 and received an overall rating of Good. This inspection took place on 18 January 2018 and was unannounced. A further inspection site visit to conclude the inspection took place 01 February 2017 which was announced.

There was a registered manager in place during the first inspection visit. However the registered manager was not in post from October 2017 and had stepped down and de-registered as of 31 January 2018. There was a new manager appointed who had not yet registered with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked the registered manager how they monitored accidents within the home. We were told all accidents were reported using accident forms. We reviewed the records and found no oversight of the accidents and no action taken following these to lessen the risk of accidents happening again.

We viewed three care records to look how risks were identified and managed. We found inconsistencies in individualised risk assessments and the plans in place to mitigate these. The documentation did not always contain information to adequately mitigate the risks to individuals.

From the documentation reviewed we saw fire safety equipment audits had not been completed at the home since September 2017. Therefore we could not be assured that the fire safety equipment at the home was safe, this put people at risk.

We looked at how the service managed medicines. We found that there were gaps in peoples records. There was no documentation in the care plan to guide staff around how the medicines should be given to individuals. We found people did not have support plans to guide staff when giving medicines which are taken "as needed". Therefore staff did not have all the relevant and necessary information to give the medicines appropriately and safely.

We found people had been assessed for the use of moving and handling equipment. However, people did not have personalised equipment such as the correct slings in place.

The above matters were in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. We found people's capacity to consent to care had not always been assessed and information was, at times, conflicting. For example, in one person's care file their next of kin had signed for the consent to the service where the person's mental capacity had not been considered. In another person's care file the next of kin had given consent to medical treatment without the legal authority to do so. The MCA stipulates that if a person lacks capacity to consent to a decision then a best interests process needs to be carried out. Therefore the correct processes had not been followed.

This failure to follow the MCA code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent.)

We spoke with the registered manager to assess their understanding of their responsibilities regarding making appropriate Deprivation of Liberty Safeguards (DoLS) applications. We noted people had bed rails in place. We asked the registered manager if DoLS applications had been made regarding the use of the rails. The registered manager told us they had not.

We found staff were able to tell us about safeguarding principles and recognised signs of possible abuse. However, they did not always put this knowledge into everyday practice. For example, we found not all safeguarding incidents had been appropriately reported to the relevant authorities, in line with current legislation and the policies and procedures of the home.

The above matters amounted in a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safeguarding service users from abuse and improper treatment.)

We reviewed five care files and found people's current needs were not always identified. Care plan information was not always an accurate, complete and contemporaneous record. Person centred information in care files was inconsistent.

The above concerns amounted to a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the management and registered provider to tell us how they monitored and reviewed the service to make sure people received safe, effective and appropriate care. We found the service did not have a robust quality auditing system.

The inconsistencies we found across the service also demonstrated the lack of oversight from the registered provider. From the evidence we found during the inspection it was apparent the leaders in the home lacked the knowledge to ensure the home was run effectively. The registered manager informed us that they were mainly working as a nurse on the floor.

These shortfalls in leadership and quality assurance amounted to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers of health and social care services are required to inform the Care Quality Commission, (CQC), of important events that happen in their services. The registered manager of the service had not informed CQC

of significant events as required. This meant we were unaware of the events and could not check appropriate action had been taken.

This was in breach of Regulation 18 (Notification of other incidents) CQC (Registration) Regulations 2009.

We found there was no staff dependency tool in place at the home. A tool such as this helps determine the amount of staff that are required to ensure people's needs are met. We have made a recommendation about this.

We walked around the home to check it was a suitable environment for people to live. There was very little signage to orientate people in the home. We have made a recommendation around this.

You can see what action we told the provider to take at the back of the full version of the report.

People were protected by suitable procedures for the recruitment of staff. The registered provider had carried out checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the home.

During the inspection visit we observed staff as they went about their duties and provided care and support. We saw staff speaking with people who lived at the home in a respectful and dignified manner.

Staff had a good understanding of protecting and respecting people's human rights. Some staff had received training which included guidance in equality and diversity.

We observed lunch being served, we saw some people who had difficulty cutting their food being offered support to eat their meal. We observed people eating in a relaxed manner and they enjoyed their meals. Comments about the food included, "The food is always very good, there is always a good choice."

There were activities for the residents to engage in and people were supported and encouraged to take part. One person told us, "There is entertainment through the week."

The overall rating for this service is 'Inadequate' and the service is therefore in '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.

Following the inspection we asked for some urgent action to be taken to mitigate some of the concerns which were highlighted. We found the whole staff team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

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.

We found not all assessed risks had a completed risk assessment as per the provider's own policy and procedures.

People could not be assured the premises were safe for their intended use and used in a safe way. Environmental risks were not consistently well managed.

Best practice guidance was not always followed in relation to the safe management of medicines.

Staff did not always follow safeguarding policies and procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

Deprivation of Liberty Safeguards applications were not always submitted to the supervisory body as required.

Staff received training to support them in their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We received consistently positive feedback from people who used the service.

There was lack of consistence with care planning.

Records containing people's personal information were not always stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples' needs were not reviewed when they had experienced a change in circumstances.

People's care plans did not contain up to date person centred information.

People and their relatives said they knew how to raise a complaint.

People were not supported to discuss their future wishes

Is the service well-led?

Inadequate

The service was not well-led.

Audit processes had not consistently identified shortfalls found on inspection.

People were put at risk because systems for monitoring quality and safety were not in place.

Policies and procedures were in place but were not always adhered to.

Fleetwood Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 18 January 2018 and was unannounced. A further inspection site visit to conclude the inspection took place 01 February 2017 which was announced.

The inspection team comprised of two adult social care 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 home. The expert-by-experience had background knowledge of caring for the elderly.

Before the inspection visit we contacted the commissioning department at Lancashire County Council. In addition we contacted Healthwatch Lancashire. Healthwatch Lancashire is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced accessing the home.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually as this was not returned in the set timeframe. We asked the registered manager about this and they were not at the service at the time it was sent. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the time of inspection there were 17 people living at Fleetwood Nursing home. We spoke with a range of people about Fleetwood Nursing home. They included eight people who lived at the home, five relatives, the registered manager, the new manager, the deputy manager and four staff members.

We closely examined the care records of four people who lived at the home. This process is called pathway tracking and enables us to judge how well the home understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including policies and procedures, safety and quality audits, four staff personnel and training files, records of accidents, complaints records, various service certificates and medicine administration records.

We observed care and support in communal areas and had a walk around the home. This enabled us to determine if people received the care and support they needed in an appropriate environment.

Inadequate

Is the service safe?

Our findings

We asked the registered manager how they monitored accidents within the home. We were told all accidents were reported using accident forms. We reviewed the records and found no oversight of the accidents and no action taken following these to lessen the risk of accidents happening again.

During the inspection visit undertaken on 18 January 2018 we looked at accidents and incidents that had occurred at the home since the last inspection in February 2016. Seven instances of unknown skin tears and one incident of unwitnessed bruising were recorded. There was no further investigation documented and no oversight of the incidents evidenced. We checked the documentation for the people concerned and found care plans and risk assessments had not been updated following the incidents. This put people at risk as there were no plans in place to prevent the incidents from occurring in the future.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

We found staff were able to tell us about safeguarding principles and recognised signs of possible abuse. However, they did not always put this knowledge into everyday practice. For example, we found not all safeguarding incidents had been appropriately reported to the relevant authorities, in line with current legislation and the policies and procedures of the home. We identified 11 safeguarding concerns. Additionally on the inspection visit on 01 February 2018, upon reviewing the daily notes of one person, we identified a further six safeguarding concerns. The safeguarding concerns included unwitnessed skin tears and bruising, injuries caused by moving and handling and allegations of abuse and neglect. We spoke to the registered manager and the deputy manager about the concerns and both were unaware that the incidents should have been reported. Some of the incidents occurred when there was no management at the home.

This amounted to a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and improper treatment).

We asked the new manager to report the above accidents and incidents to the local safeguarding team.

We looked at medicine administration records (MARs) of people who lived at Fleetwood Nursing Home. We checked the records and found several omissions in the documentation. Audits of MARs documentation had not been carried out since June 2017. There was no evidence of explanations for the errors or of actions taken to prevent further incidents.

We looked at people's care plans and found gaps in information regarding their medicine regimes. There was no documentation in the care plan to guide staff around how the medicines should be given to individuals.

We saw that staff were not following the service's policies and procedures in relation to medicines management. We found people did not have support plans to guide staff when giving medicines which are

taken "as needed". Therefore staff did not have all the relevant and necessary information to give the medicines appropriately and safely. This put people at risk of medication mismanagement. We found one person was given "as needed" medicines consistently over seven days with no explanation for this. We spoke to the manager about this and they confirmed to us there were no support plans for "as needed" medicines in place.

We saw there was an overstock of many medicines and the home had dressings on the premises for people who had passed away over 12 months previously.

Controlled medicines were kept separate in a secure cupboard; records for these medicines were completed in full.

These shortfalls in the safe and proper management of medicines amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed three care records to look how risks were identified and managed. We found inconsistencies in individualised risk assessments and the plans in place to mitigate these. The documentation did not always contain information for staff to follow to adequately reduce the risks to individuals. Where plans were in place to mitigate risks they were not always followed by staff. For example, for one person who required regular pressure care, the staff were not documenting this. We observed this person was sitting for a prolonged period of time without adequate pressure relief. This person had a pressure sore which was documented as not healing.

A lack of sufficient risk management for individuals amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

We saw one person had been losing weight. They had lost 4.7kg in one month. Additionally this person had not been weighed again following the weight loss. There was documentation from health professionals stating that the person was to be weighed monthly. We spoke with the registered manager who stated peoples' weights were recorded and audited. However this person was not able to be weighed with the current equipment at the home. The service had not sought alternative means of monitoring the person's weight.

We found people had been assessed for the use of moving and handling equipment. However, people did not have personalised equipment such as the correct slings in place. The health and safety executive guidance states that the selection of the wrong size sling can result in discomfort, inadequate support and a risk of falling.

These unsafe practices amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

We looked around the home and found cleaning products and hazardous chemicals had not been locked away. We found items were exposed in bathroom areas such as urine bottles, toilet rolls and personal protective equipment. We found the premises were not well maintained. We found a broken toilet seat, not all radiator covers were secured to the wall. A bath seat was seen to be visibly dirty and rusting and the flooring in one bathroom was cracked. We also found screws that had come loose and had been left on people's windowsills. This presented a safety risk due to supporting people with dementia who could access them.

We observed staff did not make appropriate use of personal protective clothing (PPE) such as disposable gloves and aprons for one person who was 'barrier nursed'. Barrier nursing is one way of preventing the spread of infection from one person to another. PPE such as gowns, gloves, masks, and goggles provide physical barriers that prevent the hands, skin, clothing, eyes, nose, and mouth from coming in contact with infectious agents. This put people at risk of the spread of infection.

These unsafe environmental issues amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

We viewed maintenance records for water temperatures however these had not been completed since November 2017. From the documentation reviewed we saw fire safety equipment audits had not been completed routinely at the home. We spoke to the registered manager who confirmed this was correct. Therefore we could not be assured that the fire safety equipment at the home was safe, this could put people at risk.

The issues found with the water and fire audits amount to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment).

The service did not have a tool in place to calculate the number of staff required. We spoke to the manager about this. They confirmed they could not provide evidence staffing levels were determined based on people's individual needs. We reviewed staff rotas and spoke with staff who told us that there were not always enough staff on night duty to meet people's needs. People who lived at the home told us, "I couldn't comment on the staff numbers, they do their best." And, "If I ring the call bell they usually come as soon as they can." During the inspection visit we observed that staffing appeared adequate for the day we were present.

We recommend that the service completes assessment of need for people who live at the home and use a staffing dependency tool in line with best practice guidelines.

Under current fire safety legislation it is the responsibility of the manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEP) needs to be completed for each individual living at the home. We looked at PEEPs during this inspection and found people had up to date PEEPs in their files to aid safe evacuation.

People were protected by suitable procedures for the recruitment of staff. The registered provider had carried out checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the home. The checks included written references from previous employers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Requires Improvement

Is the service effective?

Our findings

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at how the service gained people's consent to care and treatment in line with the MCA. The service provided care and support to people who may have an impairment of the mind or brain, such as dementia. We found people's capacity to consent to care had not always been assessed and information was, at times, conflicting. For example, in one person's care file their next of kin had signed for the consent to the service where the person's mental capacity had not been considered. In another person's care file the next of kin had given consent to medical treatment without the legal authority to do so. The MCA stipulates that if a person lacks capacity to consent to a decision then a best interests process needs to be carried out. Therefore the correct processes had not been followed.

Records confirmed staff had undertaken training in MCA and DoLS. However, when we spoke to staff they told us they were unsure of how this applied to their practice. We asked staff and the registered manager about their understanding of the MCA and were not assured by their knowledge. The registered manager informed us they had only a "rudimental" knowledge of the MCA.

This failure to follow the code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent).

We spoke with the registered manager to assess their understanding of their responsibilities regarding making appropriate Deprivation of Liberty (DoLS) applications. We were told there was one authorised DoLS in place and no further applications in place at the time of our inspection. The registered manager told us they were aware of the processes to follow and would ensure these were followed if the need arose. During the inspection we noted one person had bed rails in place. We asked the registered manager if DoLS applications had been made regarding the use of the bed rails at the home. The registered manager told us they had not. We noted that the DoLS application for one person did not include the restriction of the Kirton chair that they were observed to be sat in throughout the inspection visit. We noted in the daily notes for another person that the they had been stopped from leaving the building by staff and brought back into the home. There was no DoLS application in place for this person.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safeguarding service users from abuse and improper treatment).

We found the service promoted staff development and had a rolling programme to ensure staff received training appropriate to their role and responsibilities. We asked staff if they received training to help them understand their role and responsibilities. One staff member told us: "Training is on offer and we are supported to do it."

We reviewed staff supervision and appraisals at this inspection and found these were not taking place. Staff told us they were able to access informal support from other staff members and management in between supervisions.

We reviewed documentation which evidenced people were supported to see other health professionals as their assessed needs required. This demonstrated information was communicated to ensure people received care and support which met their needs. For example, we saw people were referred to doctors and district nurses if there was a need to do so. However, we noted care records were not always updated to reflect the health professional's advice.

We found the home was pro-active in supporting people to have sufficient nutrition and hydration. We observed people were encouraged to take fluids. People had been assessed on an individual basis and care plans showed associated risk. However, action plans did not always contain information to mitigate the risks and people's preferences were not always noted.

We walked around the home to check it was a suitable environment for people to live. We saw the decoration of the home was dated and there were marks on the walls and woodwork. There was very little signage to orientate people in the home. There was a lift which serviced the building and all rooms could be easily accessed. Each person's door had a name on the outside to help them identify their own room.

We recommend that the service seeks guidance and follows best practice for supporting people living with dementia.

We observed lunch being served, we saw some people who had difficulty cutting their food being offered support to eat their meal. We observed people eating in a relaxed manner and they enjoyed their meals. People were offered a variety of meal options, such as two choices at lunch. In addition, a staff member told us if someone did not want what was available they would provide another alternative. People we spoke with told us they enjoyed their meals. Comments about the food included, "The food is always very good, there is always a good choice." And, "The food is very good in fact lunch was lovely."

Records we looked at confirmed all staff who prepared food completed food safety and hygiene training. The kitchen was clean and tidy with modern equipment. Staff completed associated safety and cleaning records, such as appliance temperature checks, to maintain food safety.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback about the staff from people who lived at Fleetwood Nursing Home. One person told us, "I am looked after very well, they are kind, good girls." Another said, "The care is brilliant, the staff are very nice."

We did not see evidence that the service offers information to people and their families about other agencies such as safeguarding or advocacy. Therefore people were not always fully informed about the services available to them. We discussed the provision of advocacy services with the registered manager. We were informed there were no people accessing advocacy services at the time of the inspection.

We did not see that people were fully involved in their care planning. People's beliefs, likes and wishes were not always recorded within care records. Care files did not always contain a comprehensive history of each person to support staff in developing positive and meaningful relationships with them.

We observed staff as they went about their duties and provided care and support. We saw staff speaking with people who lived at the home in a respectful and dignified manner. For example, we observed staff members speaking to people at their level so they had good eye contact.

People's privacy and dignity were respected and promoted. Staff told us about how they protected people's dignity, such as when helping them with personal care. They demonstrated they had a good understanding of the importance of maintaining people's dignity and treating people with respect. However, we found records containing peoples personal details were not always stored securely. We noted the MARs book was left unattended on the medicines trolley in the corridor. This contained personal details of people who lived at the home.

People had their own bedrooms and had been encouraged to bring in their own items to personalise them. We saw people had bought in their own ornaments and rooms were personalised with pictures and paintings.

Staff had a good understanding of protecting and respecting people's human rights. Some staff had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

Requires Improvement

Is the service responsive?

Our findings

We asked people who used the service if staff were responsive to their needs. One person we spoke with told us, "If they don't know what's wrong with you they call a doctor in."

We reviewed five care files and found people's current needs were not always identified. Care plan information was not always an accurate, complete and contemporaneous record. Person centred information in care files was inconsistent. For example, we viewed the file for one person which said they attend the dining room for their meals. However, this person was bed bound; the care plan had not been updated to reflect the person's current needs.

There was no documentation in place to be shared with other professional's about people's needs. For example, when a person visited the hospital. This meant other health professionals may not always have information about individuals care needs to help ensure the right care or treatment was provided for them.

We found that the care plans did not always contain person centred information and did not always reflect current need. For example for one person the moving and handling risk assessment informed staff they could "move from bed to commode independently". However this person was bed bound during our inspection visit and could not mobilise independently. There was nothing in the care documentation that recorded this change in mobility. Another person's care plan documents stated that the person was to be weighed monthly in accordance with professional advice. However, we found that this was not taking place as the person was not cooperative with the weighing methods used. The persons assessed needs had not been taken into account.

Another example we saw was care records for one person which stated that they needed 1-2 staff to assist with walking. However, in the daily notes it was documented on several occasions that this person was wandering unaided.

We saw, from care records, staff had not discussed people's preferences for end of life care. This meant the provider would not know what the person's preferences were and would not be able to respect these on death. At the time of our visit, no one living at the home was receiving palliative or end of life care.

The above concerns amounted to a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service gained the views of others. Surveys had been sent to people who use the service twice yearly. We saw evidence that these were reviewed and improvements were implemented such as a change in the menus.

We found there was a complaints procedure which described the response people could expect if they made a complaint. Staff told us if people were unhappy with any aspect of the home they would pass this on to the registered manager. This demonstrated there was a procedure in place, which staff were aware of to

enable complaints to be addressed. People and relatives we spoke with told us they were aware of the complaints procedure and were confident their complaints would be addressed. At the time of our inspection visit the home had received two complaints that were being investigated.

There were activities for the residents to engage in and people were supported and encouraged to take part. One person told us, "There is entertainment through the week." Another said, "We have a singer come once or twice a week." During the inspection we observed people sitting in the lounge watching a film.

Inadequate

Is the service well-led?

Our findings

People told us, "The manager is really nice." And, "Matron is alright knows what care we need she looks after us alright."

We asked the management and registered provider to tell us how they monitored and reviewed the service to make sure people received safe, effective and appropriate care. We found the service did not have a robust quality auditing system. There were no audits for care files or daily notes. Audits of medication administration records had not been completed since June 2017. The maintenance and safety audits had not been completed since November 2107. We found issues which could have been identified by audits such as errors in care documentation and environmental issues.

The inconsistencies we found across the service also demonstrated the lack of oversight from the registered provider. We spoke to the provider about any oversight that they had during the period the registered manager was absent from the service. The registered provider informed us that they had visited the service and spoke to staff over the phone. However, there were no documented formal checks which looked at care plans, medicines or health and safety. This highlighted the need for robust oversight and monitoring to ensure the response was appropriate and without delay.

We reviewed the provider's policies and procedures. We found these were not being followed by management or staff. We found records were not always stored securely. We noted the MARs book was left unattended on the medicines trolley in the corridor. We asked to see this and on viewing it, we found this contained personal details of people who lived at the home.

The registered manager was not aware of accidents and incidents that had happened during the period of which they were in work and families had not been made aware. Failure to maintain robust recording systems around accidents and incidents meant that the service was not effectively monitoring and auditing its daily practices to allow lessons to be learnt and to keep people safe.

Staff had access to online training however this was not embedded into their practice. The registered manager had not ensured that the staff working at the home had been competency checked following incidents to ensure they had the correct knowledge and skills to care for people effectively. For example there were three incidents where moving and handling had resulted in injury. No additional resources had been accessed to help develop the staff team and drive improvement in the home.

From the evidence we found during the inspection it was apparent the leaders in the home did not have the oversight needed to ensure the home was run effectively. The registered manager stated they did not have the time to perform the tasks required as a registered manager due to them being needed as a nurse on the floor. This was due to issues the service had in recruiting nurses.

These shortfalls in leadership and quality assurance amounted to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers of health and social care services are required to inform the Care Quality Commission, (CQC), of important events that happen in their services. The registered manager of the service had not informed CQC of significant events as required. This meant we were unaware of the safeguarding incidents and could not check appropriate action had been taken.

This was in breach of Regulation 18 (Notification of other incidents) CQC (Registration) Regulations 2009.

There was a registered manager in place during the first inspection visit. However the registered manager was not in post from November 2017 and had stepped down and de-registered as of 31 January 2018. There was a new manager appointed who had not yet registered with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the registered manager was familiar with people who lived at the home. We observed people smiling when they saw them and approaching them without hesitation. It was clear from our observations that people knew the staff team.

The home had on display in the reception area of the home their last CQC rating, where people who visited the home could see it. This is a legal requirement from 01 April 2015.

Following the inspection we asked for some urgent action to be taken to mitigate some of the concerns which were highlighted. We found the whole staff team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider of the service had not informed CQC of significant events as required. Regulation 18 (1) (e)

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care. The provider had not ensured that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. Regulation 9 (1).

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements to ensure the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005.

	Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable risk management arrangements to make sure that care and treatment was provided in a safe way for all service users. Regulation 12 (1) (2) (a) (b) The provider must ensure that staff follow plans and pathways to ensure that safe care and treatment of individuals. Regulation 12 (1) (2) (b) The provider did not have suitable arrangements to ensure medicines were managed in a safe way. Regulation 12 (1) (2) (g) The registered provider had not ensured the premises were safe for their intended use and used in a safe way. Regulation 12 (1) (2) (d) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse and improper treatment. People who lived at the home were not always lawfully deprived of their liberty. Regulation 13 (1) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes they had to monitor quality and identify areas for improvement were always effectively implemented. Regulation 17 (1) (2) (a) (b) (c) (f).