Sherrell Healthcare Limited

Sherrell House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was undertaken on 28 and 29 November 2016 and was unannounced.

Sherrell House provides accommodation and nursing care to up to 92 people. People living in the service may have care needs associated with dementia. There were 79 people living at the service on the day of our inspection.

A registered manager was not 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 registered manager left the service in March 2016. A new manager had been appointed but has not yet made application to the commission as required.

People were not protected from the risk of harm. Risk management plans for individual people did not support people's safety. Staff and management had not acted to protect people and safeguarding matters were not reported. People's medicines were not safely managed and they were not protected from the risk of harm to their wellbeing.

Up to date guidance about protecting people's rights had not been followed so as to support decisions made on people's behalf and to comply with legislation. Staff were not provided with suitable training and support to enable them to meet people's needs effectively. Staff performance was not suitably monitored and appraised to ensure good practice was in place.

There was a lack of clear management oversight and leadership in the service that had impacted on the quality and safety of the care people received. The provider's quality assurance processes were not sufficiently robust or effective as they had not identified the failings in the service at an earlier stage to enable corrective action to be promptly taken. The provider had failed to notify the Commission of events as required.

Improvements were needed to recording aspects of the care and treatment people received, such as their food and fluids intake or application of their prescribed creams as well as to guidance for staff on how to support some areas of people's care. People's opportunities to participate in social activities and meaningful engagement also needed to improve.

People were supported by sufficient numbers of staff to meet people's needs effectively and staff were safely recruited. Arrangements were in place to support people to gain access to health professionals and services. People had choices of food and drinks that supported their nutritional or health care needs and their personal preferences.

People living and working in the service had the opportunity to say how they felt about the home and influence the service it provided.

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?

Inadequate

The service was not safe.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

The service did not have robust procedures in place to safeguard people. Medicines were not safely managed. Reporting systems for the safe management of safeguarding matters and medicines concerns were not reliable.

Staff recruitment processes were thorough to check that staff were suitable people to work in the service and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not been effectively trained and supported to carry out their roles and responsibilities.

Staff did not have an understanding of the Mental Capacity Act or the Deprivation of Liberty Safeguards and guidance was not being followed.

People's dining experiences varied and comments from people about the meals were mostly positive. People had access to healthcare professionals when they required them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

While we noted many positive interactions some staff communication with people was limited.

There was limited evidence that people involved in decisions about their care, however people were able to make day to day choices.

People's privacy and dignity was supported overall.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not reliably planned so that staff had guidance to follow to provide people with consistent person centred care.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement.

The complaints system was not properly implemented and did not always support a clear overview.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Management of the service was not stable or effective and there was a lack of managerial oversight of the service as a whole.

The provider's systems to check the quality and safety of the service were not robust and had not identified shortfalls in the quality of the service.

Sherrell House

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 undertaken 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 28 and 29 November 2016 and was unannounced.

The inspection team on the first day consisted of two inspectors, two Specialist Advisors whose specialist areas of expertise related to nursing, end of life care and tissue viability 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, in this care, dementia care. The inspection team on the second day consisted of two inspectors.

Prior to the inspection, we had received information of concern regarding the service from the Local Authority and so brought our scheduled inspection of the service forward. A Provider Information Response request was therefore not sent prior to this inspection. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider is required to notify us about by law.

During the inspection process, we spoke with 19 people who received a service and three visitors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager, five members of the provider's quality and management team and 19 staff working in the service.

We looked at 17 people's care and 26 people's medicines records. We also looked at the provider's arrangements for supporting staff, managing complaints and monitoring and assessing the quality of the services provided at the home.

Inadequate

Is the service safe?

Our findings

Risks to the individual were not always comprehensively or accurately assessed to support their safety. One person's records showed they could decline their prescribed medicines or hide them in their hand and put them in a pocket. There was no assessment of the risk to the person of not taking their medicines, or for other people in the service living with dementia who may access and take these medicines not prescribed for them. Records and our observations showed that at least three people became distressed at times in a way that put themselves or staff and others at risk of emotional or physical harm. One person attempted to leave the building during our inspection and records showed that the person also locked themselves in their room on occasions. Assessment of these risks were not recorded to determine the strategies required to support these people's safety.

Two people were identified as at nutritional risk, yet neither had a supporting risk assessment in place to ensure they received sufficient food and drinks. One person had a risk assessment in place that stated they were at risk of choking and might go into other people's rooms and pick up food. A second care record for this person's care stated that the person had no swallowing concerns. The inconsistency in information placed this person at risk of unsafe care, especially taking into account there were agency staff working in the service who may not have known about the person and their specific needs.

Records to ensure the correct functioning of equipment had not been consistently completed placing people at potential risk of injury or developing pressure areas should these fail as it could not be determined if the checks were taking place as required. One person's daily bed rail safety check was not recorded as completed on 11 of the 24 days prior to the inspection. Checks of people's pressure relieving mattresses were not always recorded as completed; one person's record was not completed on four of the last nine days. The management team were made aware of our findings. They confirmed that they would add these issues to their existing action plan to be addressed.

Management of medicines was not safe and records were not well maintained. Gaps were noticed in some Medication Administration Records (MAR) on the second day of our inspection. In some cases the medications relating to these were still in the person's monitored dosage system, which meant that the person had not had their prescribed medication. In other cases, medication was not in the pack, indicating that it may have been given and the records not accurately maintained. Prescribed creams were not routinely recorded to show that they had been administered to people as required. Where a variable dose of medicines was prescribed, staff were not always recording how much medicine was administered to the person on each occasion. Records showed contradictory information of the date that people's medicated patches were administered. We observed an occasion during the medication round when a staff member did not ensure that a person had actually taken their medicine before the staff member left the dining room.

The Local Authority had made us aware of their identified concerns that people had not received their prescribed medicines safely. This included events where action had not been taken to report that people's medicines were not available, on occasions for a period of 12 days, so that action could be taken to ensure

the person's well-being. The management team of the service confirmed that, as part of their action plan responding to these concerns, a written medication check was to be completed at the end of each shift by the person in charge. We looked at records of this check on Charleston unit and found that the record was not signed as completed on shift changes on five separate days in the past month. Medication error reports showed that medication errors continued to occur in the service. This showed that actions put in place were not effective and had not improved the quality of medication management in the service as required.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some people and their relative told us they felt safe in the service, this did not always concur with our findings. One person told us for example that they felt safe in the service and said, "Yes I do feel safe here, I could not wish to be in a nicer place". A number of people said, "I feel safe here because there are people here to look after me."

We found that people did not always receive a safe service. Staff we spoke with were clearly aware of how to identify abuse and correct procedures to report it. They had received training on safeguarding and this was confirmed in information provided by the service. In their review of the service in September 2016, the local authority had identified a number of matters of concern that had not been identified or reported under safeguarding procedures as required. The Local Authority advised at the time of this inspection of a number of further matters in the service that had continued not to be reported appropriately under safeguarding procedures or had not been reported in a timely way when the manager was made aware of them. We also identified an additional event during our inspection that the manager confirmed had not been referred as required. We checked with the Local Authority a few days after our inspection visit and found that, although we had made the management team aware of the concern, it had not been reported to the Local Authority safeguarding team as required. We confirmed that the Local Authority aware of the concern and they confirmed they would take appropriate action.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments varied regarding the suitability of staffing levels. Two people told us that staff were often very busy while other people felt that there were suitable staffing levels in place. One person said, "They look after me here and come if I buzz for them." All except one staff member told us that that staffing levels were reasonable and that the manager endeavoured to arrange cover from agency staff where this was possible to ensure the staffing levels were met. Two people had to attend hospital unexpectedly during our inspection and a staff member was sent to support each person. While this left the shift somewhat stretched, staff arrangements were reviewed and staff were redeployed to provide the best arrangements in the circumstance. Our observations found that staff deployment overall was suitable to meet people's needs.

People and staff told us while suitable staffing levels may have been in place, the impact of inconsistent agency staff meant that people's support was not provided as promptly as these staff did not know what support people needed. A staff member said, "It takes much longer as we have to explain everything, they do not know what to do and where things are." Five people told us that the regular staff knew what they are doing and this meant that care and support was provided more promptly and easily than when there were agency staff who did not know people and their needs. The management team told us they were aware of the impact of high numbers of agency staff and were undertaking a recruitment drive that had begun to have success in attracting permanent members of both care staff and nursing staff.

The provider had safe processes in place for the recruitment and selection of staff to ensure that staff were suitable to work with people living in the service. Records showed that the required checks were completed including in relation to identity and previous employment references. A system of risk assessment was in place at the time of recruitment should a report of the person's criminal history not be received prior to the person starting work. Staff confirmed that the recruitment process was thorough. Each file showed that the content had additionally been checked and signed for as complete as part of the robust recruitment procedure. The management team told us that there had been a high usage of agency staff in recent months to cover vacancies but that successful recruitment had now been achieved, especially of permanent qualified nursing staff.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that this was not consistently applied.

Records showed that in some cases people's capacity to make basic daily decisions was assessed and decisions made in their best interests where needed. However, this was not completed in all cases. For one person receiving covert medicines, that is where people are given their medicines without their knowledge, evidence was not available to show that this decision was properly assessed and had included advice from relevant people such as the pharmacist. One person said, "I have that mat on the floor and if I get up and stand on it, it alerts the staff." Where people had a sensor mat in their room to alert staff to their movement, appropriate assessments had not be completed to show that this was the least restrictive measure in the person's best interest or that the person had consented to it. The management team sent us information to show that while some DoLS assessments had been requested, completed and authorised for people in the service, assessments had not been requested for other people where required. The management team confirmed this would be completed without delay.

The majority of staff had completed online training on MCA and DoLS. We noted overall through observation and discussion with staff that they had some intuitive understanding of gaining people's consent, of supporting people to make their own decisions and doing what was best for the person based on their knowledge of people's responses, preferences and routines. However some staff found it difficult to explain what the training on MCA and DoLS had included, how people's capacity was assessed and showed limited understanding of what it meant or how to apply it in practice.

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

Staff had not been provided with effective training and support. Staff told us and records confirmed that staff received an orientation induction to help them to get to know the building and the service's procedures. While staff indicated that they completed an industry recognised induction programme, some staff were unaware of the workbooks attached to this to demonstrate competency, considering that the Care Certificate was attained on completion of only electronic learning. The management team advised us of difficulties in accessing the organisation's electronic password system to provide evidence of staff achievement of the programme. The manager confirmed that some staff had not completed the workbook or been assessed as competent to carry out their role. The manager told us that, while action to address this should have started two week previously in line with their action plan, that had as yet been able to due to

the overwhelming amount of other improvements needing to be completed in the service.

Staff told us they received training and updates to equip them for their role and this included practical training in relation to moving and handling. Records provided by the management team showed that staff completed a rolling programme of training in basic areas and a system was in place to identify when staff were due to attend training so this could be arranged. Figures showed, for example, that 94% of staff had attended MCA training and 89% had attended DoLS training. However we found that there was lack of evidence to show that the training had provided staff with suitable learning and understanding. Staff had safeguarding training as part of their induction yet a number of safeguarding matters had not been identified and referred which also indicated that the training provided was not suitable to fully equip staff for their role. Following the recently identified failings in reporting safeguarding concerns, staff had attended or were booked to attend, updated face to face safeguarding training.

Staff told us they received formal supervision and appraisal and views varied as to its frequency and usefulness. Records showed however that while supervision was used on occasions in relation to staff performance management, it was not consistently a two-way supportive process, rather an arrangement for staff to receive pre-printed information and to sign to confirm this. Supervision was not used to help staff reflect and receive feedback on their practice, to discuss concerns or training needs or to put plans in place to develop these to improve outcomes. We noted, for example, that there was little evidence of learning/reflection or clinical supervision following pressure ulcer incidences in the home and the team were not routinely invited to reflect, and contribute to the agreed set actions to add to collective learning.

We queried the training and competencies of the staff providing supervision to other staff. The management team acknowledged that improvements were needed to the system of supporting staff development. They subsequently sent us confirmation that training on supervision was booked for a number of staff to enable them to provide effective support to other staff in the service.

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

People's comments about the food were mainly positive and while one person said, "Sometimes the food is good and sometimes it is not", other comments included, "The food here is very good and you do have fresh vegetables." We observed the lunchtime meal in each of the dining areas and found that people's dining experience varied. Some people were told about and offered choices of meals, drinks, desserts and had access to condiments, while other people, particularly those living with dementia, did not have such a positive experience. One person's care records identified that they were unable to communicate verbally but could choose a meal using pictures of the foods and explanation, however this did not happen. People were served meals without being reminded what was on their plate and when assisted to eat by staff, people were not told what they were about to eat. In some areas, staff and people chatted and the lunchtime meal was a lively social experience. However, we observed that a staff member supporting a person with their meal did not speak to the person or offer any words of encouragement during the ten minute period, although the staff member spoke to another person in the room.

While people's nutritional requirements had been documented, effective management of this was not supported by good record-keeping. Staff were not always promptly recording people's fluid and food consumption, which meant that records to demonstrate suitable intake may not always be reliable. An agency member of staff told us, "The records are only as good as what is put on the system. Look at the daily care record and compare that to the fluid balance charts and there is usually inconsistency." A member of the management team told us, "Staff tend to write on a bit of paper what people have eaten and then

update the person's (electronic) record at the end of the shift." Where people were at risk of poor nutrition referrals made to suitable healthcare professional services, for example, dietician or Speech and Language Therapy Team to ensure and maintain the person's health and wellbeing. We saw that where a person was prescribed a thickener for their fluids, staff were aware of the correct amount to use and had ensured the person received this.

People told us that their health care needs were well supported in the service. Records provided by the management team indicated some lack of clear communication and care plan management between the service and a healthcare team. This was being followed up by the management team as part of the Local Authority's identified concerns action plan response. Otherwise people were noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments and to see their GP. One person said, "I have a bad leg. The district nurses come several times a week to dress it for me." Another person told us, "The doctor comes in once a week to see if you are alright." Relatives confirmed that they were kept informed of people's healthcare needs and their healthcare appointments. One relative said, "[Person] had a hospital appointment and they asked if I would like them to take [person] but I prefer to go with [person] myself.

Requires Improvement

Is the service caring?

Our findings

Improvements were needed in relation to end of life care planning and support. The provider's policy on end of life care stated that they followed the Department of Health and the National Institute for Care and Excellence (NICE) guidance on end of life care and were committed to their care homes achieving the Gold Standard Framework Award (GSF). We found that, even where care plans were in place in relation to end of life care, they were limited in detail and did not comply with good practice guidance or the provider's policy.

One person's care records, for example, identified that the person's relative had signed a Preferred Priorities for Care document. This indicated the person's views as to where they would wish to be cared for at the end of their life. Staff were unable to locate this document for us and both the staff member and a member of the management team told us that they had no idea what the document looked like. There was no care plan in place to include any emotional or spiritual support the person may need or to identify any anticipatory medicine that may be required, particularly in relation to the management of pain. The person's wishes not to be resuscitated were clearly and properly recorded.

There was limited evidence in any of care records that people were involved in the planning and decisions regarding their care. However, relatives were aware of the care plans and one relative said, "I have been involved in the care plan but not for some time." Another relative told us, "I have just been updating the care plan with them here."

People were provided with opportunities to make everyday choices. We saw that staff offered people the opportunity to wear an apron at mealtimes to protect their clothing and accepted people's choices regarding this. On most occasions people were offered a choice of drinks. People told us they could decide where to spend their time, whether they chose to join in with activities or spend time alone. A relative told us, "My [family member] can go to bed and get up when they like."

People told us that staff were kind and caring towards them. Our observations supported this and we saw that staff offered people compassion and comfort. One person told a staff member about their concern regarding a recent medical intervention. The staff member took time to listen to the person and responded with kind and comforting words. We saw that people hugged staff and that staff accepted this in an appropriate and gentle way. People knew the regular staff and told us they were kind in their approach. One person said, "The regular staff are very kind and caring but we have a lot of agency staff and they do not know you." A relative said, "The staff here are very kind, but so busy they do not have time to talk to you."

Whilst we saw a nurse inappropriately ask a person if they could apply prescribed cream to the person's leg while the person was sitting at the dining table at lunchtime, the majority of staff treated people with dignity and respect. This was brought to the management team's attention. We saw, for example, where one person became unwell during lunchtime, staff used portable screens to provide privacy. We noted that staff knocked on people's bedroom doors before entering and that staff spoke discreetly to people about matters relating to personal care. This was confirmed by people we spoke with who also confirmed that staff treated

them with dignity and respect while they were providing people with personal care. Staff showed a clear understanding in discussion of how to respect people and how staff included these as part of their daily practice.

The service supported relationships between people and their relatives and visitors by making visitors feel welcome. People told us that their visitors can come to see them at any time and that they looked forward to this. A visitor told us, "I can visit here at any time."

Requires Improvement

Is the service responsive?

Our findings

The majority of staff knew the people they were supporting and their care needs and responded to these. A staff member noted a person standing by the bookcase, located a walking frame and brought it to the person. The staff member addressed the person by name and asked the person to use their frame, reminding them why they needed to use it and explaining that the staff member did not want the person to have a fall. Staff were able to tell us, for example, which people had pressure ulcers or were at risk of falls and who had their medication covertly and why. A person told a staff member that they had a pain. The staff member reassured the person and took action to arrange for the person to receive their prescribed pain relief medication.

Each person had a care plan in place that was maintained on an electronic recording system. While care plans contained some good detail of the care and support people needed in some areas, other aspects of the care records needed improvement. Care plans were in place in relation to people who had, or were at risk of developing pressure ulcers. We noted however that there was no clear daily record to show that people's skin condition had been checked in line with their care plan to ensure that this was completed to support good care. Some people lived with dementia, however care plans were not always in place to show clearly how this impacted on their daily lives. Similarly, care plans were not routinely in place to clarify the support to be provided to people who became anxious or distressed. While staff intuitively supported people, this meant that staff did not always have clear guidance on how to best meet the person's individual care needs. Records of the occasions where people became distressed and anxious did not report the events prior to it that might have acted as triggers, or the actions staff had taken and if these were successful in meeting the person's needs. This meant that staff may not be able to identify issues that upset individual people and that people may not receive consistent support.

Staff reported some difficulties in accessing the electronic care recording system. This was because they had not been allocated passwords or terminals were in use by other staff when they needed to record information which meant that information may not be recorded. The management team told us they had identified this and action was being taken to provide regular agency and newly recruited staff with passwords and were in the process of arranging more terminals.

People's opportunities for social and leisure pursuits varied widely and the level of social interaction and involvement people experienced in a day to day way varied in the different units. We found that some people had little opportunity for social interaction at times throughout the inspection. A lack of meaningful activities was noted for people who were cared for in bed or those who were unable to express themselves, perhaps due to their dementia. Two staff were employed to co-ordinate social activities in the service. The management team confirmed that this level of support was being reviewed with a view to increasing it.

People who were more able had access to planned and supported activities such as playing pool, taking part in quizzes and craft. One person told us, "We used to have pat the dog come in, but that has stopped." Some other people chose to stay in their own bedroom. One person said, "The staff do come into my room and have a laugh and joke with me, and they will encourage me to go to the lounge and will help me to sit

out a little at a time." We saw that some care staff took time to chat with people and to engage them at times that people were able to participate. They also did this by signing to and with people in an impromptu way or by talking about current affairs that people had seen on the news. Aspects of the environment had been updated to be more conducive to socialising and a 'bar' area had been set up. The manager told us they also planned to consider ideas for the very large space in the foyer to make it more interesting and available for people to in a social way.

Improvements were needed to ensure the provider's system to manage complaints was effectively operated. Records were maintained within the service of complaints received. The documentation was not easily available when requested nor was it well organised to enable us to form a clear overview as whether suitable actions were taken in response to people's comments. The management team told us that information on complaints was sent to the provider's head office each month for monitoring to identify any trends and to ensure the procedure had been followed and any required actions taken. A summary of the complaints monitoring was requested and sent to us subsequent to the inspection. It showed that, although all complaints had been dealt with and investigated, only 1 of 9 complaints received since August 2016 had been responded to in line in with the provider's timescales. The summary also confirmed that a recommendation had been made by the provider's head office to the service regarding timely logging, investigation and responding to people's concerns in line with the provider's policy.

Information on how to access the complaints procedure was displayed in the service. People told us they felt able to express their views about the service and felt they would be listened to. Two people told us that they came to a meeting held in the service after all the recent complaints. People told us the owner attended the meeting and had given them reassurance about all the concerns raised. This was also confirmed by relatives.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led. The registered manager and the care manager left the service in February 2016. A number of temporary managers had been subsequently appointed by the provider, however none of these had been suitable for varying reasons. One person said, "I used to be very happy here, the old manager was very nice but they left and things have not been so good." The current management team told us that a number of permanent staff had left to follow the previously registered manager. This meant that, as well as a lack of an effective management team in the service, there had also been reduced consistency of established staff supporting people. These changes had led to a lack of leadership and oversight of the service.

The provider's systems to monitor and improve the quality and safety of the service were not robust. Records were not well completed, organised and accessible to support the manager and the provider to have current information and an accurate overview of the service. The provider had a range of quality assurance processes and reporting systems in place. These included medication and care plans audits which had failed to find the issues identified both by the Local Authority and by our inspection.

The provider had their own external monitoring system whereby staff from the provider's quality team visited to assess and report on the service. The reports of this regional team for both May and July 2016 did not include all areas of the review, were identical in content and found no concerns relating to safeguarding. There was clear evidence regarding the gaps in staff medication competency assessments, staff induction, supervision and appraisal in the September 2016 audit. These had not resulted in the provider taken prompt action to address the failings within the service and action was only taken following an assessment of the service by the Local Authority. The management team confirmed that the failings in the quality system was acknowledged.

As a way of ensuring up to date information on care needs, the management team told us that daily meetings had been introduced and held on the units at 11am each day where areas such as pressure ulcer incidents were discussed. At 11am we asked who was leading the meeting on one of the units and were told that the meeting was cancelled as the manager was not on duty. This meant that, while new processes had been introduced, these were not robust and contingencies were not in place to impart information when these meetings could not go ahead.

While the provider had responded to the Local Authority's concerns and put action plans in place, we were not reassured that the service was sufficiently well led and that systems were suitably established. A staff member said, "There are a lot of management floating about but we need leadership." There were a number of external management staff supporting the home and the manager at the time of our inspection, yet there remained a lack of clear and effective oversight. This was demonstrated in the continued concerns found regarding the management of people's medicines and of the failure to promptly report events to the local safeguarding team, even at the time of our inspection.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Providers of health and social care services have to inform us of important events which take place in their service. The records we hold about this service showed that the provider had not told us about all of the DoLS applications that had been authorised. This was confirmed in information provided to us by the management team during and subsequent to our inspection.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The current manager was appointed in August 2016. They told us they were taking the necessary steps to enable them to make an application to register with the Commission as required. People and staff told us they found the new manager to visible in the service and to be very nice. The management team told us that a different approach was being taken to the lines of accountability and leadership within the units. A new role was being established and recruited to provide a suitably qualified person to lead each unit and to report to the manager in the service. The manager also told us of future plans to realign the allocation of people to units with the service, which would have to be agreed by people or their commissioning authority.

The provider had staff reward schemes in place to retain and acknowledge staff loyalty and good practice. The manager advised these would be revisited and re-established in the service. Several staff told us that while there had been difficulties in recent months, they enjoyed working in the service.

Opportunities were being provided to obtain people's views. The provider and management team had met with people and their relatives to share the outcome of the Local Authority findings and decision to suspend placements to the service. The manager told us that the monthly resident meetings would be established in a more refined format, such as with a resident food committee to provide direct feedback to the chef so as to influence menu planning. Information on planned dates for relatives meeting was displayed clearly in the service so that relatives had opportunity to make arrangements to attend.

The manager demonstrated that they were open to working with others organisations to improve the safety and quality of the service people received. The home was part of a project to improve safety, reduce harm such as from falls and pressure ulcers, and to reduce emergency hospital admissions for people living in care homes. Training to support this was provided by the Local Authority in agreement with the provider. The manager also told us of their plans to be part of other local initiatives to improve the quality of the service people received.

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 The provider had not notified us without delay of incidents that had occurred in the service. This included abuse or allegations of abuse and the outcome of all applications made to deprive service users of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment were not provided with consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks of inappropriate care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not operated effective systems to protect people against the risks of inappropriate or unsafe care as robust arrangements were not in place to assess, monitor and improve the quality of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not provided staff with necessary support, training, supervision and appraisal to enable them to carry out their duties.