Elder Homes Wellingborough Limited

Dale House Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 6 and 8 March 2017.

Dale House Care Centre is situated in Wellingborough in Northamptonshire. They are registered to accommodation for nursing and personal care, as well as treatment of disease, disorder or injury and diagnostic and screening procedures. They can accommodate up to 66 older people at the service, some of whom may be living with dementia. At the time of our inspection there were 22 people living at the service, over two floors.

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

The service did not have a registered manager in post, however; there was a manager and they were in the process of registering 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.

There had been improvements to the way that risk was assessed and managed by the service, however; we observed that staff practice did not always ensure that risks to people were minimised. Medicines were not always well managed. We found concerns in the way that some medicines were recorded, stored and administered. The systems in place for checking this, had failed to ensure that medicines were robustly managed.

New tools had been introduced to determine the required staffing levels at the service, however; these did not always provide a reliable figure of staffing requirements and the staff on duty did not always match what the tool stated was required. The distribution of staff was not always effective in ensuring that people's needs and preferences were being met. Staff members had however been through a robust recruitment process to ensure they were suitable for their roles and to work at the service.

Consent to arrangements for care, treatment and support was not always sought from people or other relevant people where appropriate. We observed staff providing care without seeking consent. There a lack of documentation in respect of consent within people's care plans. The principles of the Mental Capacity Act 2005 had not always been followed for those people who lacked the mental capacity to make their own decisions.

There was a lack of person-centred care at the service. People were not provided with regular activities which engaged and stimulated them, they were not supported to take part their own individual hobbies or interests. Care plans had been redeveloped but still lacked key person-centred information about people's individual needs and preferences. There was also a lack of involvement of people and their relatives in the production and review of care plans.

Improvements had been made to the quality assurance procedures at the service. There were an increased range of checks and audits being carried out, however; they were not always effective in identifying those issues we found during our inspection. Concerns were not always identified as part of these processes and the action plans which were in place were not effective in driving improvements.

In general staff treated people with dignity and respect and worked to develop positive relationships with them, however; there were times when we found that care was task-orientated and staff provided people with little or no interaction or communication.

There was improved training for staff at the service however; staff supervisions were still a work in progress and staff did not all receive regular and consistent supervision opportunities. Staff members did feel that the manager was approachable and were able to go to them if they had any issues or concerns. Staff culture was positive and they were motivated to perform their roles and meet people's needs, although this was not always in a person centred manner.

People felt safe living at the service and had confidence in the staff that supported them. Staff members were trained in abuse and safeguarding procedures, to ensure that people were protected from harm. People were happy with the food and drink provided and we found that their nutritional needs and preferences were well catered for. Appointments with healthcare professionals were also supported and facilitated by the service, to help ensure that people were as healthy as possible.

People were also aware of the manager and felt they were accessible when they needed them. They were responsive to complaints or feedback and took action to address any issues they raised.

Full information about the CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded.

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.

Systems for managing risks at the service were not always effective.

Medicines were not always managed appropriately. Medicines records were not completed fully and stock controls were not robust.

Staffing levels were variable and not sufficient to meet people's needs at all times.

Recruitment practices were suitable to ensure that all staff members were suitable to work at the service.

People felt safe and were care for by staff that were aware of their responsibilities in terms of safeguarding and potential abuse.

Is the service effective?

Inadequate

The service was not effective.

People's consent to their care, treatment and support arrangements was not always sought by the service. For people who lacked the mental capacity to do this, the principles of the Mental Capacity Act 2005 had not consistently been adhered to.

Staff members did not always receive regular supervision, however; they did receive regular training, to equip them with the skills they needed.

Food and drink was provided, to ensure people's dietary needs were met. People had a choice of what they ate and their specific wishes and needs were catered for.

People were supported to maintain appointments with healthcare professionals within the service and the local community.

Is the service caring?

Requires Improvement

The service was not always caring.

People and other relevant people were not always involved in planning their care.

Staff treated people with kindness and support and worked to develop positive relationships with them. However they did not always communicate in a meaningful manner with people in line with their preferred needs.

People were not always treated with dignity and respect by members of staff who worked to maintain their independence.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported to take part in activities and did not have the opportunity to engage in their individual hobbies or interests.

Care was not reflective of people's individual needs and preferences. Care plans were not person-centred and because of this staff were not always aware of people's current care and support needs.

There were systems in place to receive and act on any complaints or feedback raised.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance systems at the service had been improved so as to provide better oversight of the service. However; they were not always effective in identifying areas of concern or driving improvements and had failed to identify those issues we found during this inspection.

People and their family members were familiar with the manager and were able to discuss any concerns they had with them.

Staff members were positive about working at the service and working with the people they provided care for. They were supported by the manager.

Dale House Care Centre

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 6 and 8 March 2017 and was unannounced. The inspection was undertaken by a team of two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We spoke with the local authority and clinical commissioning group (CCG) to gain their feedback as to the care that people received.

During our inspection and over the course of the two days, we observed how staff interacted with the people who used the service during individual tasks and activities. We also observed breakfast and lunch time over the both days, to ensure that people's needs were met in line with their assessed needs.

We also 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 spent time observing people within both units of the service.

We spoke with five people living at the service and three of their relatives. In addition we spoke with the registered manager, the deputy manager, one nurse, three care staff, two senior carers, a housekeeper and a member of catering staff. We also spoke with the operational manager who had been bought in to the service to work on making improvements following the last inspection. In addition to this we spoke with a visiting doctor to gain their views on the provision of service to people.

We looked at eight people's care records to see if they were up to date and reflected their current care needs. We reviewed other records relating to the management of the service, including staff recruitment, medication charts and quality audit records to determine what improvements had been made since our last

inspection.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 25 August 2016, we found that the service was not safe. Appropriate action had not been taken to assess the risks to the health and safety of people, visitors and staff at the service. There was a lack of guidance regarding risk and actions staff should take to mitigate assessed risk. In addition, the systems for the management of people's medicines were not effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that some improvements had been made in relation to the process by which risk was assessed and the guidance available to staff as a result of this. However we found that people were not always protected from avoidable risks and that despite having appropriate guidance in place, this was not always used to protect people. We also found that there were still some concerns in relation to the management of people's medicines.

We observed that staff members did not always demonstrate safe moving and handling techniques when supporting people to transfer between chairs and mobility aid or wheelchairs or to help reposition them in their chairs. On a number of occasions we saw that staff members physically held people under their arms or legs to try to scoop or lift them, which increased the risk of people sustaining an injury. For example, we observed one attempt at manual handling whereby one staff member was going to try and move a person on their own. They were seen by another staff member, who came to offer support. They both proceeded to lift the person underneath their arms and legs back into the wheelchair to make them more comfortable.

The Royal College of Nursing states, "No-one should routinely manually lift patients. Hoists, sliding aids, electric profiling beds and other specialised equipment are substitutes for manual lifting. Patient manual handling should only continue in cases which do not involve lifting most or all of a patient's weight." Therefore despite having training and guidance, staff members had failed to use this in a consistent manner so as to keep people safe.

We also saw staff members helping people to mobilise around the service by holding their arms and walking ahead of them, or by resting an arm on their back or waist. On a number of occasions we saw staff doing this and walking slightly faster than the person they were supporting, which gave the impression that they were pulling them along. This again increased the risk of people falling or sustaining an injury as a result of inappropriate manual handling techniques.

In some instances we saw that staff members used moving and handling equipment, such as a hoist and sling, to help move people and when they did so, this was done correctly. However; some of the manual handling tasks we saw staff performing did not employ the use of suitable equipment, for example a manual handling belt, to help them ensure that people's safety was not compromised during the manual handling operation.

We spoke with staff members about manual handling and they told us that they received training and competency assessments in this area from the provider. They told us that they would always use the

equipment available to them and would not hold on to people when lifting or moving them, as they were aware that this could lead to bruising to the person. One staff member said, "We know how to use a hoist; you can't grab people's arms, you might mark them." The observations we had did not match the theoretical knowledge of members of staff and we spoke with the manager and the operations manager about this. They were surprised to hear our observations of moving and handling practices at the service and told us that they would take immediate action to address our concerns.

Records showed that staff members received training in moving and handling and had their competency assessed. People's care records also showed that risk assessments were in place for people in a range of different areas, including manual handling. These had improved since our previous inspection and we saw that there were now actions in place for staff to take to help mitigate risks to people. There were also monitoring charts in place to record and track essential information, such as people's weights, Malnutrition Universal Screening Tool (MUST) and Waterlow (to monitor the risk of developing pressure wounds) scores.

This showed that the service had taken action to address the systems in place for assessing and monitoring risks to people's health and wellbeing. However; action had not been taken to ensure the care people received was provided in accordance with best practice in relation to manual handling, to reduce the chances of people coming to harm.

We also found some concerns regarding the way medicines were managed by the service. We found that records relating to the administration of people's medicines were not always robustly completed and that medicines were not always given in accordance with the prescriber's instructions. For example, on the first day of our inspection we saw that one person was supposed to have one medicine once a week on a Monday morning. This was to be given at least half an hour before any other medicines or food, however; we found that the person's Medication Administration Record (MAR) chart had not been signed to say that it had been given. We counted the stock to confirm that this medicine had not been given.

Best practice guidance for the administration of this medication states, "Patients should be instructed that if a dose is missed, one Risedronate 35 mg tablet should be taken on the day that the tablet is remembered. Patients should then return to taking one tablet once a week on the day the tablet is normally taken. Two tablets should not be taken on the same day. The tablet must be swallowed whole and not sucked or chewed. To aid delivery of the tablet to the stomach Risedronate 35 mg is to be taken while in an upright position with a glass of plain water. Patients should not lie down for 30 minutes after taking the tablet.

We found no guidance to inform staff of the above when they were administering this medication. Therefore the efficacy of the prescribed medication could have been hindered as staff did not apply this knowledge. Staff made no comment on whether the person would be given their missed dose of medication, in line with the above guidance.

We checked topical MAR charts for people as well. These were used to record when medicines such as creams or emollients had been given by members of staff. We saw that there were multiple gaps on these charts and as the medicine was in the form of a cream, we were unable to check stock levels to resolve whether or not this medicine had been given. For example, we saw that one person was prescribed a gel to be administered three times per day. Between 31 January 2017 and 26 February 2017 there were 10 days where this medicine was recorded as being given three times and 11 days when it was signed for once only. Another person had a cream which was prescribed to be given twice a day. We saw that between 3 February 2017 and 26 February 2017 there were four days when it was recorded as being given twice, 12 days when it was recorded as being given once and eight days with no administration of this medicine. We checked the reversed of people's MAR charts and daily records but could not find any recorded reason why these

people's medicines had not been given. This meant that people were at risk of not receiving their medicines as directed by the prescriber, which may have had an impact on the condition they were prescribed for.

The manager and deputy told us that one of the people whose chart we had reviewed regularly refused to have their topical medicines administered by staff, but they also acknowledged that work was needed to improve the way these were recorded. Records did not show when medicines had been refused, or demonstrate what the service had done as a result, to help ensure people were willing to have their topical medicines applied.

On the residential floor of the service we found that a 'homely remedies' system had been introduced. The service maintained a general stock of four medicines such as paracetamol which may be given 'As Required' (PRN) which were not prescribed, but people's GP's had signed to say that it was safe for them to take them. There was a book in place to collectively record when these medicines were given to people, however; this did not always show who had been given the medicines. For example, we checked the book for two of the homely remedy medicines and found 10 entries which did not identify who had been given the medicine. We saw that this concern had been identified by the provider after the homely remedy recording book had been in place for approximately two months. As a result they introduced an additional column in which staff recorded the initials of who these medicines were given to.

We looked and found that not all of the records in the homely remedy book were on people's individual MAR charts, which the deputy manager told us was the service's policy. This meant that it was not always possible to tell who had been given certain medicines; this raised concerns because it increased the possibility of people receiving more medication than was safe. This meant that there were increased levels of risk to people living at the service; the manager and deputy manager told us that they would take steps to address this straight away.

When we checked medication stock levels at the service we found that there were some discrepancies between the recorded stock levels and the actual amounts of medicine in stock. The systems in place for storing and recording medicines were not always clear and demonstrated that staff members were not always aware of the procedures for logging in new medicines and disposing of out-of-date medicines. For example, we saw that one person had boxed medicines from the previous medication cycle as well as pre-packed blister packs of the same medication. This created some confusion when resolving stock and the deputy manager confirmed that the boxed medicines should have been disposed of when the new medicine came into the service.

We spoke with the manager and deputy manager about the systems they had in place at the service. They explained that these were in the process of being reviewed and we saw that they had raised some concerns with the pharmacy which supplied people's medicines. There was a meeting scheduled with the pharmacy to discuss the way medicines were provided to the service, to help reduce the chances of mistakes occurring in the future.

There were systems in place to record the temperatures at which medicines were stored at, including a medicines fridge. When we checked the records for this we found that staff had consistently recorded temperatures which were outside of the safe range for the fridge, which was recorded on the form which staff filled in. We spoke with the deputy manager about this and they showed us that this was, in part, a recording issue by staff members. For example, we saw that staff had regularly recorded the fridge as being at 0.4 degrees, however the display on the fridge read '04' degrees. Whilst we were able to see that the fridge was probably within a safe range, there was nothing to show that the incorrect temperature ranges which were recorded by staff were highlighted during checks and acted upon, which meant that if the fridge had

been at those temperatures, no action would have been taken to correct this. This meant that the efficacy of the medicines may have been affected and showed that the systems in place were not effective.

The service had introduced systems to assess and mitigate risks to people at the service, however; the actual practice of staff did not always ensure that people were protected from harm. Systems in place for the storage, administration and recording of medicines were not robust and did not ensure that they were being safely managed. This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection on 25 August 2016 we found that staffing levels at the service were variable and were not always sufficient to ensure that people's needs were met. There was no way of assessing the staffing levels required for people's needs; therefore the manager was unable to provide us with assurance that the staffing levels were suitable for the people living at the service. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made in this area, however; there were still some concerns regarding staffing at the service. Staff members were not always employed in such a way to ensure that people's holistic needs were being met. We observed frequent times where people were left unattended in communal areas with no engagement or stimulation. The deployment of staff throughout the service did not lend itself to person centred care and meant that staff only had time to perform task focused care interventions. The service had introduced a system for monitoring people's needs and set staffing levels according to this. However; it was not always clear how this was used, or if actual staffing levels were sufficient.

We received mixed feedback regarding staffing levels at the service from members of staff. Generally staff members told us that they felt there had been improvements and that less agency staff were being relied upon, however; several staff members told us that weekends could be a problem at times and that staffing levels sometimes dropped over the weekend. One staff member told us, "Staffing levels are good usually; it's a problem if somebody is sick at weekends." Another staff member said, "Staffing can be lower at weekends, which means that people can be left waiting longer." A third told us, "There are enough staff for the moment. I haven't seen agency for ages which is really good." A less positive comment from staff stated, "Some days we have enough staff, others not. We are told that three carers is enough but it isn't always. Downstairs we only need two staff, sometimes but not often they have one carer downstairs. "

People and their family members were more positive about staffing levels and told us that they felt this had improved since our last inspection. They explained that by closing the second floor of the service and concentrating people on the ground and first floors, staff were less spread out and therefore more on hand to meet people's needs. One family member told us, "I think there are enough staff, when people call for things they get it done."

During the inspection we saw that there were usually sufficient numbers of staff to ensure that people's basic care needs were being met. At times we saw that people did not have to wait to receive their care, however; we did see people waiting for support in key areas, such as moving from one room to another. For example, after one person who was sitting in a wheelchair had finished their breakfast we saw that they were waiting for over 10 minutes to be supported to move to the lounge. We heard this person say to another person, "Is anyone going to take me back?" The other person responded, "They always take you back eventually." This person was able to take themselves to their preferred place, but the other person who initiated the request to move, had to sit and wait until support came.

We also observed another person, who had finished their breakfast be transferred to the communal lounge. There were then left in their wheelchair for over 10 minutes until staff supported them into a more comfortable chair. Although staff attended people's basic needs, they did not always have time to make their interactions with people individualised and person-centred.

We spoke with the manager about staffing at the service and how this was determined. They explained that the service now had a dependency tool in place to help them set staffing levels. We saw that each person had an individual dependency tool in their care plan, which was then compiled in a central tool for the whole service. We found that there was a discrepancy in terminology between the two tools, with one referring to people's funding stream (for example, residential care, nursing care or continuing healthcare) and one referring to their level of need (set as low, medium or high). It was not clear whether the criteria for assessing people's levels of needs for these two tools were compatible; therefore we could not be sure that the individual dependency tool supported an accurate overall figure.

We also found that the final calculations of assessed staffing requirements were unclear. For example, at the end of February 2017 the tool was used to set staffing for the following month. The tool which was in place stated that there should be 13.2 staff members per 24 hour period. The tool also displayed the staffing levels planned, which were recorded as 12 staff members, including the deputy manager. This showed that the staffing levels which were set were under the figure generated by the dependency tool, however; it was not clear if this was accurate. The manager told us that they would review the tool to ensure it was a true reflection of people's needs and provided the correct information for informing staffing levels on shift.

We reviewed staffing rotas over an eight week period. These showed that staffing levels were not consistent and that there were some weekends with lower staffing levels than others. However; the rotas did not demonstrate when agency staff were used to cover shifts, or when the manager or deputy manager came in at weekends at short notice. It was therefore difficult to determine the consistency of staffing levels at the service over time.

There had been some improvements to staffing levels at the service, however; there was not a robust system in place to ensure that staffing was consistent and sufficient to meet people's holistic needs. The distribution of staffing was not always effective in ensuring that people's needs and preferences were being met. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities).

Staff members told us that they had been through a robust recruitment process at the service. They explained that they were not able to start at the service until the provider had carried out a number of checks, including previous employment references and Disclosure and Barring Service (DBS) criminal record checks.

We reviewed staff recruitment files and saw evidence that this robust process had been followed. There was evidence of full employment histories being sought alongside background checks and references. We also saw that the service had been reviewing staff files and had been seeking information such as full employment histories for staff who had been employed at the service for a number of years, to ensure the information in their file was as robust as that in a new member of staff's file.

People told us they felt safe living at the service. One person said, "I'm safe here." Family members also told us that they felt their relatives were well cared for and were safe from abuse or improper treatment. One family member told us, "Yes I am happy. They take action to keep people safe. I've not had any concerns about her safeguarding or wellbeing."

Staff members took people's safety seriously and worked to ensure they were not at risk of harm or abuse. They told us, and records confirmed that they had received safeguarding training and were able to recognise signs of potential abuse. They were also aware of the reporting procedures at the home and made sure any concerns were recorded and the manager informed. If they were not happy with the action which was taken thereafter they told us they would be prepared to contact external organisations, such as the local authority or the Care Quality Commission (CQC), safeguard people against harm.

We reviewed the incidents which had been reported and the actions which had been taken. We saw that the manager reviewed incidents and made safeguarding referrals where appropriate. They maintained a log of incidents and the referrals which they had made to the safeguarding team and the CQC, as well as action they had taken within the service, such as reviewing a person's care plan. This helped the service to maintain a safe environment for people where any potential abuse was responded to in a robust manner.

Inadequate

Is the service effective?

Our findings

During our previous inspection on 25 August 2016, we found that care and treatment was not always provided with people's consent. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 (MCA) had not been adhered to. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we continued to find areas of concern in relation to consent and the application of the MCA. People and their family members told us that staff members usually sought their consent and asked them before they provided them with care and support, however; our observations during the inspection showed that consent was not consistently sought. For example, on more than one occasion we saw a staff member approach somebody in a wheelchair from behind and wheel them out of the room without discussing this with them first. They failed to establish where they wished to go or if they were happy with that decision. We also observed manual handling taking place without consent being gained first; for example, staff failed to ensure people were happy to move from wheelchair to chair. However, we did see other situations where staff did provide people with choice and sought their consent, such as when choosing what people wanted to eat or drink.

We reviewed people's care plans to see how consent had been recorded. None of the care plans we reviewed had evidence that the content of the plan had been agreed by the person or a representative on their behalf. There was nothing to show that the content of the plans had been discussed with people to make sure they were happy with what had been recorded and that they agreed to the actions which were recorded for staff to take. This meant that the care that staff were providing may not have been given in accordance with the consent of the person receiving that care.

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 whether any conditions on authorisations to deprive a person of their liberty were being met. We found that some improvements had been made in this area, however; there was still not a robust application of the MCA at the service.

Staff members were able to tell us about the principles of the MCA and explained that they had been trained in this area. One staff member said, "We are applying the MCA on a daily basis. Its ways that we can help people with making choices, people have the right to choose." Staff training records confirmed that MCA training took place however; we found that the principles of the Act were not being robustly followed when

people may have lacked mental capacity.

We saw that some people's care plans did have MCA assessment forms in place, whereas others, which did not have people's views or consent recorded, did not. When MCA assessments had been completed, they were not always indicative of the specific decision being made for people, as per the guidance in the MCA. At times the assessment and care plan provided conflicting information. For example, we saw an MCA assessment for one person which recorded a decision as, 'Living at Dale House for care and support around daily routine' and stated that the person lacked mental capacity in this area. When we read the 'Cognition' section of their care plan it stated that the person had mental capacity and was able to make their own day-to-day decisions. This meant that staff members may not provide people with the opportunities to make their own decisions about their day-to-day care, as paperwork suggested they lacked mental capacity.

We saw that one person had two MCA assessments which found that they lacked mental capacity despite the second stage of the test not being completed fully. We also saw that one of the decisions which the person lacked capacity to was, 'Communication and English not being her first language'. The assessment did not detail how the service had tried to understand the person's specific communication needs or involved a translator to help them to express their own decisions. This suggested that the service had found that this lacked mental capacity because English was not their first language, which did not follow the principles of the MCA and also meant that staff were not fully supporting this person to make decisions which might impact upon their health and wellbeing.

We found that the MCA forms which were completed were not robust and did not provide evidence of how the service had assessed people's capacity, or the steps they had taken to try to encourage people to make their own decisions. For example, MCA assessments had a box ticked to state that the service had explored other ways to enable decision making, but there was nothing recorded to show what steps had been taken. In addition, we found that there was a lack of involvement in decision from people and their circle of support. The MCA states that people should be involved as much as possible and that family members and those close to them should also be consulted in the decision making process, however; the MCA assessments we reviewed only recorded the involvement of one or two members of staff. The MCA also sets out a best interests' process to be followed when making decisions for people who lack capacity. This was not being robustly followed by the service and in some cases a number of the questions on the checklist were not answered. This showed that the service were not always following the principles of the MCA and were not always working to ensure that decisions made were in people's best interests'.

In respect of end of life care plans, we found examples of where people's decisions had not fully been documented. We discussed this with the manager and operational manager and acknowledged that the service had tried to engage with family members for a decision to be made. However we again found that the principles of the MCA had not always been followed in planning end of life care. For example, for one person with a DNACPR in place, it stated that the decision had been made in best interests; there was however nothing to indicate that this was the case and staff could not provide us with any information to suggest that the correct process had been followed.

For two other people who had end of life care plans in place, we found these to be inconsistent in their completion. The end of life care plan stated for one person stated, "Awaiting DNAR." This entry was dated 24 November 2016, but although we could see that some attempts had been made to contact the family to discuss this, the matter had not been progressed. The care plan went on to state that staff were not to touch the person's body after death as requested by the family; there was nothing in the notes to determine if this was the person's own expressed wishes. In fact, an earlier entry stated that the same person was 'non practising' in their religion. This meant that the person themselves had not been consulted in the decision

making process.

We spoke with the manager and the operations manager about the application of the MCA at the service. They acknowledged that improvements were required in this area and showed us that a new pro-forma had been introduced for the application of the MCA. This was more robust than the previous paperwork and included a section to record who was involved in meeting to discuss the decision in question and a way of recording their input to the discussion. In addition, the best interests' checklist had been improved. Rather than tick boxes to answer questions they were now open text boxes which would prompt whoever was completing the form to provide details about how each question had been answered.

The manager also showed us that they had implemented a tracking tool to record and monitor when applications had been made to deprive people of their liberty under DoLS. We reviewed this tool along with people's DoLS applications. We saw that the service had made applications for people appropriately and were waiting to have some of these approved by the local authority. The manager had recorded when applications had been made and whether or not authorisations had been granted. We did find that some applications were awaiting approval and had passed the expiry date, due to a backlog with the local authority. In these cases there was no evidence to show that that DoLS authorisation had been re-applied for or that the manager had contacted the DoLS team to see if this was required. We spoke with the manager about this who assured us that they would look into this.

People's care and treatment was not always provided with their consent or that of the relevant person. Where people were unable to give consent as they lacked the capacity to do so, the service had not acted in accordance with the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the previous inspection on 25 August 2016 we also found that staff members were not provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had made some progress in this area, however; there was still room for further improvements. Some staff members told us that they had not received supervision as regularly as they would have liked. For example, one staff member stated that they had not had supervision for over a year. They explained that this impacted on their development as they were unable to discuss areas in which they would like further training or opportunities. Other staff members told us that they had received regular supervision and that they found that this was a useful process which allowed them to raise any concerns and discuss their training needs.

We spoke with the manager about staff supervisions at the service. They told us that this was an area which they had worked on and improvements were in process. They told us that they aimed to provide all staff with regular supervision and showed us a tracker that they had developed to help them log staff supervisions and schedule future ones in. We also saw that some supervisions were recorded in staff files, however; this was not always consistent. We did see that future supervisions had been scheduled and that work was taking place to drive improvements in this area. We also saw that there was a supervision matrix in place for staff members. This showed that staff received a mixture of individual and group supervision opportunities. This demonstrated some inconsistency in approach, for example we saw that some staff members had not received an individual supervision for over a year, whilst others had received one, two or three in that time. There were group supervisions for most staff members, but some staff had not received supervision as regularly as others.

People and their relatives told us that staff members received training to enable them to perform their roles. They stated that they were confident in staff members' abilities and felt that they knew what they were doing. When we asked one person if staff members had regular training they nodded and said, "Yes they do. They're very good." A relative said, "I think they do have training." Another told us, "Training? On the whole yes they do. A lot of staff use their initiative as well which I think is a good thing."

Staff members were positive about the training and development they received from the service. One staff member said, "The training has been very good, very handy." Another told us, "We get lots of training." Staff members explained that new staff members received an induction which helped prepare them for working at the service. This included training and shadow shifts where they observed experienced staff members and got to know the people they would be supporting. We saw records which evidenced that staff members received induction training which included modules of the Care Certificate, to help ensure they had the essential skills they needed to perform their roles.

There was also ongoing training and development for staff members to help them develop new skills and maintain their current ones. We saw that a number of training courses were provided, including fire safety, safeguarding and infection control. Records showed that staff members completed this training on a regular basis and that future training was booked in. We also saw that staff members were able to complete additional courses, such as vocational qualifications to help them continue to develop their skills.

People were happy with the food and drink they received from the service. One person told us, "The food is good, it's nice; no complaints." Another person said, "Oh yes it is nice, they give you different options." Relatives also told us that the food at the service was good quality and that there was plenty for people to eat and drink. One relative told us, "Yes I think the food is very good, there is plenty of choice."

Staff members told us that the felt the food at the service was good. Care staff explained that they felt the kitchen had improved in the past year and that the catering team had developed a good understanding of people and their individual dietary needs and preferences. We spoke with the chef who clearly knew what people liked to eat and we saw that they developed menus based on this, which changed on a daily basis. Menus had a number of different options but the chef was also able to prepare something specific for people if they did not like choices that day. Where necessary, they provided people with soft or pureed meals which were presented in an attractive way to ensure people still had an enjoyable meal time.

Care plans contained information about people's dietary needs and preferences and staff members worked with the kitchen staff to ensure people received the food and drink that they needed. There were also systems in place to record what people ate and drank if this was required. Where there were concerns about people's weight or diet, referrals were made to the dietitian, to seek expert advice.

People told us that they were supported to book and attend appointments with healthcare professionals when they needed them. One person told us, "They make sure I see the GP when I need to." Relatives told us that staff members were able to help their family members with appointments if they were not able to do so themselves. They explained that staff members kept them informed of any developments from appointments and made sure any medical recommendations were followed up.

Members of staff confirmed that they were able to support people with medical appointments both in the service and the community. During our inspection we spoke with a GP who was visiting the service to do a round. They told us that there had been vast improvements in the organisation of these rounds by the service, explaining that they were provided with information about who needed to be seen before they arrived. They also told us that they felt the communication with the service had improved and they were

confident that staff members would follow any instructions or directions they were given, to help meet people's medical needs.

People's care records confirmed that people were supported to see healthcare professionals when they needed to. The outcomes of these appointments were recorded in people's care plans to help inform staff practice and ensure that people received the care that was needed.

Requires Improvement

Is the service caring?

Our findings

People and their family members were not always involved in planning people's care and support arrangements. None of the people we spoke with could recall being asked about their care plan, or the information they wanted it to contain. Family members gave us mixed feedback regarding this, with some telling us that they had been involved whilst others hadn't been. One family member told us, "Care plan? I haven't seen it in a long time. Now and again they ask me about it." Another said, "I know there is a care plan in place, we were asked about it."

We spoke with staff members about people's care plans. They told us that nurses and senior staff were responsible for writing the care plans and they were not sure if people and their families had been involved or not. One staff member told us, "The nurse does the reviews or the seniors. They see if things have changed at all and update the care plans. I don't think there are individual relative reviews. The care plans are mainly written by the nurse and seniors. I think everyone should be involved." We reviewed people's care plans and found that there was nothing to show that people had been involved or consulted about the content of their care plans. The care plans we reviewed had been written by a single member of staff. They did not show how the evidence within them had been collected or whether or not people had been provided with information about how they would be cared for.

We spoke with the manager and the operations manager about this. They told us that they had made efforts to engage with people's family members in order to inform them that they could review people's care plans at any time. We saw minutes from a meeting which had been held with people's relatives which confirmed this. However; from the minutes it was not clear who, other than staff from the provider, had attended this meeting or if the minutes had been circulated amongst people and their relatives.

The service had made some efforts to involve people and their relatives in the planning of their care, however; they had not been proactive in discussing care plans with them or arranging meetings for this to take place. The care plans which were in place did not evidence that people or their family members had been involved; therefore we could not determine whether or not the arrangements for people's care and support had been planned with input from those receiving the care, or their family members.

Staff members did not always communicate with people in a way which was sensitive to their individual needs and preferences. We saw that there were some people for whom English was not their first language. There was a lack of clear guidance for staff to follow in order to communicate with them or to ensure they understood what staff had said to them. The manager told us that cards had been produced to help staff communicate with people, however; these were not referred to in people's care plans and we did not see any evidence of these being used during our inspection.

Some people had complex needs and were not always able to communicate easily. We found that although staff were caring in their approach to people, they did not take time to engage in a meaningful manner. For example, when people were supported with meals, staff did not use the time to discuss the day ahead or simple things such as what the weather was like. Communication was very limited, to one or two words. We

observed that people were often left for long periods of time in communal areas, whilst staff attended to other tasks. Staff often failed to communicate with people or to check they were ok, when they passed by the communal areas; this meant that people were not given the opportunity to express any concerns or issues they might have had.

We observed that staff engaged more freely with those people who were able to express themselves. Where communication was more difficult, staff engagement was more limited,

People were not always treated with dignity and respect by members of staff. We did observe some positive interactions between people and members of staff and saw that generally staff treated people with kindness and respect, however; we found that this was not always the case. For example, we saw that there were prolonged periods of time where people were left without staff support in communal areas, which meant their needs could not be met at those times. We also saw long periods of time where one staff member was in a communal lounge with several staff members and failed to interact with them at all.

Over two days of inspection, we observed that one person sat with part of their legs exposed in their chair. We discussed this with the manager who advised that staff offered blankets to cover them but they chose to decline this and were happy with how they sat. There was however nothing in the care records to show that this had been discussed with the person or that this was their preference. Another person resorted to using a tie as a belt to keep their trousers up. We also discussed this with the manager who advised that they would contact the relative to see if another belt could be purchased. Although this issue was addressed, staff had not bought this to the attention of the manager; without our intervention it may have continued and meant that the person concerned was placed in an undignified position.

During our inspection, a staff member came to find the manager and informed them that one person had removed their lower clothing in the communal lounge area. They reported that there was no staff in the vicinity; therefore this person had been exposed to a lack of dignity. Had staff been in the communal lounge they could have prevented this from occurring.

There were generally positive relationships between people and members of staff. People told us that they were happy with the staff that cared for them and felt they were well looked after. One person told us, "They are brilliant." We heard another person say to a staff member, "You're alright you lot, you like a laugh like I do."

People's relatives were also positive about the care that staff members provided them with. One relative told us, "I'm very happy with the care home. I think it's a cracking place." Another relative said, "The staff? We think that they are fab." A third relative told us, "The care is pretty good." A comment from a recent satisfaction questionnaire stated, "All staff, especially carers are understanding and caring. They sort out all problems as quick as they can."

Inadequate

Is the service responsive?

Our findings

At our previous inspection on 25 August 2016 we found that the care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. There was a lack of activities and stimulation for people and systems were not in place to ensure that people were able to take part in their individual hobbies and interests. Care plans lacked person-centred information and did not provide staff with essential information which they needed to provide care which was tailored to their individual needs and wishes. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that there had been some minor progress in this area, however; there were still concerns about the levels of person-centred care that people received.

We spoke with people and their relatives about the activities and entertainment available at the service. They told us that there were some activities provided, however; they felt there could be more done to help keep people's minds active and stimulated and that there was often nothing for people to do. One relative told us, "They used to do more, carers do what they can. Now and again they have somebody come in and sing but the days they don't they need something." Another relative told us that there were activities at the service but that these were limited as there was not a staff member responsible for ensuring people had activities. They said, "You can have an entertainment coordinator, which must help."

Staff members also told us that they felt that people would benefit from having additional activities at the service. They explained that they did what they could to keep people busy and stimulated, however; this was something they had to try and fit in around their care related tasks. One staff member told us, "I find that they don't have enough activities, stimulation and going out. I find it depressing." They went on to say, "You don't get enough time to spend with each individual person. You get to know people's basic needs, but not them in depth."

During the two days of our inspection we observed very few opportunities for people to take part in activities. There were long periods of time where people were left with nothing to do in communal areas and their bedrooms, often with the television on but nobody watching it. We saw that people appeared to be bored and many fell asleep once they came into communal lounges after having breakfast and lunch and then spent long periods of time asleep. We did see that staff members attempted to provide activities, but these were limited and did not meet the needs and interests of all the people living at the service. For example, we saw staff establish a game of bingo for people in one of the lounges. People were not given a choice of activity; this was chosen by staff.

Some of the people engaged in this activity, but others chose not to. We found that everybody in the lounge was given a score card and pen. However not everybody was able to mark off numbers and some did not understand what to do, either because of a language barrier or their ability to comprehend the game. There was two staff present in the room, one of whom was calling out numbers and another who was supporting one other people to play. The general atmosphere in the room was not conducive to people enjoying the

game; visitors were in attendance, there was music playing which meant that numbers could not be heard easily. Some people seemed confused as to what to do and did not therefore gain any enjoyment from the activity; giving up and withdrawing from the activity. For these people there were no alternatives available, therefore they left with nothing to do.

We spoke the manager and the operations manager about activities at the service. They told us that they had tried to get an activities coordinator working at the service, however; they had not been able to find anybody who they thought would be suitable for the role. They showed us that a weekly activities schedule had been put in place to help ensure that some activities did take place. We looked at these schedules and found that they provided basic information about group activities which could be arranged, however; we found that there was not always a wide range of activities on offer. For example, one week we saw that the Monday morning activity was: 'Chiropodist.' On the Wednesday morning of the same week the activity was: 'Ground floor - hairdresser for the ladies'. There was nothing recorded for the first floor or for the men living at the service.

There was nothing to show us how activities had been planned, or if people had been asked about the activities that they would like to take place at the service. We found that the service had implemented a system to record people's activities, however; this further demonstrated that people were not in receipt of regular stimulation or opportunities to take part in activities. For example, we saw that one person had activities recorded between 08 February 2017 and 07 March 2017. During that time there were 13 recorded activities on separate days, one of which was a visit from a family member. This showed that there were a number of days when no activity recorded as being offered for this person.

We found that there had been some improvements made to people's individual care plans, however; they did not always provide members of staff with the information they needed to provide people with care in a holistic, person-centred way. Staff members told us that the care plans provided them with the information they needed to ensure that people's care needs were being met, however; they did not contain useful information about people's backgrounds, hobbies and interests which meant they weren't always able to ensure that those interests were reflected in the care that they provided. One staff member said, "You don't get so much time to read the care plans. Care plans have a lot of information but can be clinical and difficult to understand. Care plans tell you about medical history but not what peoples' needs and preferences are. You would like to know more about history so that you can talk to people about their past."

We reviewed people's care plans and found that they provided staff with information about the care that people required. We saw that these had been improved since our previous inspection however; they were not always detailed and did not give staff key information about people. For example, we saw that one person's care plan stated that they had two grandchildren but information such as their name, gender or age had not been recorded. This meant that staff may struggle to initiate a simple conversation with the person about their family and trigger happy memories for them. We also saw that there were documents which had been placed in people's bedrooms which contained basic information about their preferences and care needs. There were also 'This is me' documents for some people, which gave staff some more information about people's backgrounds. This helped staff to quickly make sure they were meeting people's needs.

Care plans had been reviewed on a regular basis to try to keep the information which was in them up-to-date. We saw that the service had introduced a 'resident of the day' system. This meant that each person had one day a month where their care plan was reviewed and updated. We saw that this took place and that evaluations of each part of the care plan were recorded. However; these evaluations did not show that the person had been involved, rather that a member of staff had reviewed the content and made the changes

they felt were appropriate. In addition, in some cases we found that the changes recorded in the care plan evaluation had not been transferred into people's active care plan.

For example, the manager discussed how one person's behaviour had changed and that they were prone to washing their hands in an inappropriate place. The records did not contain any reference to this, which meant that staff might not have been aware to monitor for such behaviour; which could have placed the person at risk of infection control issues. For another person, the evaluation stated that staff should use picture cards if someone had problems with understanding. This information had not been pulled through into the care plan. This meant that care plans did not always reflect the most up-to-date information for staff about how to provide people with their care.

We spoke with the manager about this and they confirmed that care plans should be updated with the latest developments from people's care plan evaluations. They told us that they would look into improving this in the future. They also showed us that the 'resident of the day' system extended beyond making sure the care plan was up-to-date. It also required that different departments within the service reviewed how they were caring for the person, including management, catering and housekeeping. Each department was scheduled to meet with the person and discuss their needs and preferences and how they could help meet them. We saw that there were recording sheets in place to document these discussions however; we saw that each person did not always have a recorded discussion with each of the departments on the sheets. This meant that there was a missed opportunity to improve people's care and ensure their person-centred needs were being met.

People's care, treatment and support did not always meet their needs or reflect their preferences. Care plans were not produced in collaboration with people or their family members and were not designed with a view to achieving their preferences. Activities and stimulation in accordance with people's preferences and wishes were not always available. This was a breach of regulation 9 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager about the systems in place for new admissions to the service. They told us that there had been no new admissions since our previous inspection; therefore they had not carried out any additional pre-admission checks since we were last at the service. They showed us that they had been working on the systems for the new admissions to the service to ensure that any future placements would be robustly assessed so that they could be sure that the service could meet their individual needs. We saw that there was new documentation in place to support this process.

People and their relatives told us that they could always approach the manager with feedback, comments or complaints about the care they received. They told us that they were happy with the care they received and did not have to make many complaints, however; they were confident that if they did, they would be taken seriously. One person told us, "I have no complaints." A relative said, "I do complain sometimes. Every time they sort it for me; people listen to me."

We spoke with the manager about complaints at the service. They told us that people and their families were encouraged to give them feedback about their care and support needs, including complaints which were recorded and acted upon. We saw that there was a complaints log in place to document the issues that people and their families raised, along with the action taken by the service in response.

We also saw that people and their relatives were asked to complete satisfaction surveys. These were used to gather collective feedback about the service and to identify areas where they could improve. We saw that surveys had been sent out and the service was in the process of reviewing and analysing the results from

these surveys.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 25 August 2016 we found that there were not effective and robust systems in place to assess, monitor and improve the quality of care being provided by the service. There was a lack of quality assurance systems in place and those that were in place were not effective in driving improvements at the service. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that there had been an increase in the number of checks and audits being carried out to attempt to improve the managerial oversight at the service. However; we found that these systems were not always effective at identifying where improvements were required and helping the service to develop.

The manager spoke to us about the checks and audits that had been introduced at the service. They told us that there were now more checks and audits carried out by themselves and the clinical lead. In addition, they told us that the provider carried out visits on a regular basis to review the systems in place and to help identify areas for improvement.

We looked at the audits and checks which were being completed. We found these systems were an improvement on what we found at the previous inspection, however; we still found that there were areas which were checked and improvements had not been identified. For example, we saw that as well as the reviews of people's care plans as part of the 'resident of the day' system, care plan audits had been carried out for each person. We saw that these had been completed on a regular basis and that the new audit template which had been put into place was robust. However; the process had failed to highlight key issues in people's care plans which we raised during out inspection. This included the lack of person-centred care planning, the lack of involvement people and the fact that care plans did not record people's consent or application of the Mental Capacity Act 2005 (MCA). We found that the care plan audits had rated most care plans as 'green' and had not identified these areas as those which required development. This meant that the audit process of people's care plans was not always effective at identifying and driving areas for improvement.

We saw that there were other checks and audits which were carried out to monitor the service. A medication audit was completed on a monthly basis, which included a check of a sample of the stock of people's medicines. We saw that the January 2017 audit had not included a stock check, however the February 2017 one had. The stock check and the audit had not raised the concerns that we identified when checking medicines, despite some of these concerns being present during that time. This showed that the procedures for checking medicines were not always effective at identifying areas for improvement.

There was a system for logging all the reported incidents which took place at the service and these were reviewed by the manager on a monthly basis. They collated the incidents which occurred and recorded the different types and times that they took place. There was not however; evidence of these results being analysed or used to help drive improvements at the service. For example, we saw that that three falls had

been recorded as happening in one particular time frame. There was nothing to show how this information was being used to help improve the service. We spoke with the manager and the operations manager about this. They told us that in this particular example all three incidents related to one person sustaining falls during this time frame. As a result they had reviewed and updated that person's falls risk assessment. This suggested that the audit had helped them to take action to improve people's care, however; there was nothing to evidence to show the link between this audit process and the action taken.

We found that there was a template in place for the manager to record actions highlighted from the audits which were carried out each month. We saw that this had been filled in for January 2017, but not February. In addition, the action plan did not evidence whether or not steps had been completed or any progress made against each point raised. We discussed this with the manager and the operations manager, who told us that they would look at ways of ensuring there were systems in place to highlight areas of concern and to evidence the work that had been completed as a result. We also found that there was a system in place to review audits and action plans each month, to identify actions which still needed to be addressed.

Despite the improvements which had been introduced to the quality assurance processes at the service, we still found that there were not always effective procedures in place for effective governance. Checks and audits had been introduced but they did not always identify areas of concern or potential development. Overall there had been some improvements across the service, however; progress in general had been slow and a number of concerns were still highlighted during our inspection. This showed that the systems and processes in place for quality assurance were not effective in assessing, monitoring and improving the quality of care at the service. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives told us that they had some uncertainty about the future of the service. They explained that they were aware that there was an impending sale, however; they were not aware of the details of this and were concerned about the impact this may have on their family members care. One relative told us, "I am concerned about the new owners and their future intentions. We've had nothing but change for the past four or five years. There has been a lack of consistency that would give you peace of mind." We spoke with the manager about this. They explained that they shared as much information with people and their family members as they could and would continue to try to put people's minds at ease. We saw that meetings were held with people and their family members and that the future of the service was discussed.

The service did not have a registered manager, however; the manager had been in post for some time and was in the process of registering with the Care Quality Commission (CQC). They told us that they would chase their application after our inspection, as they had not heard back from CQC regarding this recently. People and their relatives were positive about the manager and felt they were friendly and approachable. We asked one person about the management at the service, they told us, "I can talk to them at any time." A relative said, "I can go to [Manager's name] at any time and talk to her one-to-one." Another relative told us, "If I had an issue I'd talk to [Manager's name]."

Staff members were also positive about the manager and the support they received from the management team at the service. They told us that both the manager and the deputy manager were approachable and would listen to any concerns or ideas that they had. One staff member said, "From my point of view the management is good. We do what we can to put things right, it wasn't easy at first. There are no concerns at the moment and I like to go and ask questions." Another member of staff told us, "They are approachable and firm but also friendly."

There were systems in place to record and report accidents and incidents at the service. There had been

improvements to these systems and we saw that the manager now checked each incident to ensure that appropriate action had been taken. Where necessary, they completed referrals to external organisations and took steps to meet their obligations, such as sending the CQC statutory notifications.

The staff we spoke with were motivated to perform their roles. They wanted to provide people with the support they needed and cared about each individual living at the service. They had a positive ethos and there was an open culture amongst staff. We found that there had been improvements in the way that different departments worked together at the service and this had a positive impact on the care that people were able to receive. Staff members put people first and were prepared to follow the provider's whistleblowing procedures if they felt that people were at risk of abuse or if the service had not done enough to protect them from harm.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care, treatment and support did not always meet their needs or reflect their preferences. Care plans were not produced in collaboration with people or their family members and were not designed with a view to achieving their preferences. Activities and stimulation in accordance with people's preferences and wishes were not always available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's care and treatment was not always provided with their consent or that of the relevant person. Where people were unable to give consent as they lacked the capacity to do so, the service had not acted in accordance with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had introduced systems to assess and mitigate risks to people at the service, however; the actual practice of staff did not always ensure that people were protected from harm. Systems in place for the storage, administration and recording of medicines were not robust and did not ensure that they

were being safely managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Despite the improvements which had been introduced to the quality assurance processes at the service, we still found that there were not always effective procedures in place for effective governance. Checks and audits had been introduced but they did not always identify areas of concern or potential development. Overall there had been some improvements across the service, however; progress in general had been slow and a number of concerns were still highlighted during our inspection. This showed that the systems and processes in place for quality assurance were not effective in assessing, monitoring and improving the quality of care at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There had been some improvements to staffing levels at the service, however; there was not a robust system in place to ensure that staffing was consistent and sufficient to meet people's holistic needs. The distribution of staffing was not always effective in ensuring that people's needs and preferences were being met.