Mrs R Ghai

Marlyn House

Inspection report

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Tel: 01543504009

Date of inspection visit:
20 March 2018

Date of publication:
09 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection at Marlyn House on 20 March 2018. Our last inspection was on 6 March 2017.

Marlyn House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 18 people in one adapted building. At the time of our inspection, there were 14 people living there, some of whom were living with dementia. There is a communal lounge and separate dining room on the ground floor and a garden area that people could access with the support of staff.

There was a registered manager at the service. 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.

At our last inspection, we rated the service as 'requires improvement'. We found the provider was not meeting the regulations because applications had not been made for legal authorisation when people were being deprived of their liberty. Improvements were also needed to ensure staff were deployed to meet people's needs at all times, that people's medicines were always managed safely and that there were effective systems in place to identify shortfalls and drive improvements at the service. The provider submitted an improvement action plan to show what they would do and by when to address the breach of the regulations and to improve the service to at least 'good' in the key questions safe, effective and well led.

At this inspection we found the provider had met the legal requirements when people were being deprived of their liberty. However, we found that further improvements were needed and identified new breaches of the regulations. This is the third consecutive time the service has been rated as 'requires improvement'.

We found that people's rights were not always being upheld when they were unable to make certain decisions for themselves. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

We were unable to satisfy ourselves that the provider followed safe recruitment procedures. The registered manager was unable to provide us with records for staff who had been recruited since our inspection and the information they provided after the inspection did not demonstrate that all the necessary pre-employment checks had been carried out. Staff received training but the registered manager did not have suitable systems to ensure this was kept up to date and in line with best practice.

Staff were available to meet people's physical care needs but people's emotional needs were not always met and care was often task focused. People did not feel involved in the planning of their care and their diverse needs were not always respected. People were not always offered choices and were not supported to follow their interests and engage in activities that interested them. Improvements were needed to ensure people could access the garden areas safely to promote their wellbeing. Procedures needed to be developed to ensure the home environment was consistently clean and hygienic and people were always safe from the risk of infection.

Staff understood people's needs and knew what action to take to protect them from avoidable harm. However, risk management plans needed to be more detailed to ensure new or temporary staff always had the information they needed to support people safely. People received their medicines when needed but improvements were needed to ensure medicines were always reviewed regularly and recorded safely. Staff were aware of their responsibilities to protect people from the risk of abuse but were not always sure of how to escalate their concerns to the local authority for investigation if they needed to.

People and their relatives were not always satisfied that action was taken when they raised concerns and complaints. The provider did not have a consistent approach to investigating complaints to make sure improvements were made where needed. The provider did not have effective systems to gather and act on people's feedback to make improvements where needed.

The provider's governance and quality assurance systems were ineffective; they had failed to identify the concerns identified at this inspection and had not made or sustained the necessary improvements since our last inspection. There were no systems in place to ensure lessons were learnt when things went wrong. The registered manager had not notified us of important events that occurred in the service, as required by their registration with us.

Staff respected people's privacy and promoted their dignity. People enjoyed the food at the home and had access to their GP and other health care professionals when needed. People were encouraged to maintain relationships with family and friends and visitors were not restricted.

We found a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment procedures were not sufficiently robust to assure us that staff were suitable to work in a caring environment. The provider did not monitor staffing levels to ensure people's needs were met at all times. Staff understood how to keep people safe from avoidable harm but improvements were needed to ensure risk management plans had detailed guidance on all aspects of people's care. Improvements were needed to ensure clear procedures were in place to protect people from the risk of infection. Systems were not in place to ensure adverse incidents were thoroughly investigated and lessons learnt to prevent reoccurrence. People received their medicines as needed but improvements were needed to ensure they were always recorded and managed in line with good practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought verbal consent before providing care. However, people's rights were not always upheld in line with the Mental Capacity Act 2005 when they lacked the capacity to make certain decisions. Staff received training but the provider needed to develop systems to ensure this consistently supported them to provide care in accordance with best practice. People were supported to have sufficient amounts to eat and drink but improvements were needed to ensure they always had a positive mealtime experience. People were supported to manage their day to day health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel the staff listened to them and treated them with respect. People were not always involved in choices and decisions about their care. Staff routines did not always consider people's preferences and care was often task led. People were able to keep in touch with people that mattered to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to be involved in decisions about their care and did not always receive personalised care that met their individual needs and preferences. People were not always supported to take part in activities or follow their interests to promote their wellbeing. Action was not always taken when people raised concerns and complaints were not consistently managed. People were supported to have a dignified and pain free death.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have effective quality assurance and governance systems. There was a lack of management and oversight to ensure legal requirements were met and improvements seen at the last inspection had not been sustained. The culture of the service was not always open and inclusive. People's views were not always listened to and used to make improvements at the service. The registered manager had not notified us of important events that occurred at the service, as required by their registration with us.

Marlyn 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 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 20 March 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information we held about the service and the provider to assist us to plan the inspection. This included information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received from commissioners who purchase services on behalf of people. We used all this information to develop our inspection plan.

We spoke with six people who used the service and three relatives, five care staff, the registered manager and the provider. We also spoke with two visiting health professionals. We did this to gain views about the care and to ensure that the required standards were being met.

We looked at the care records for five people to see if they accurately reflected the way people were cared for. We also looked at staff duty rosters and quality assurance audits carried out by the registered manager. After the inspection, we asked the registered manager to send us information about staff recruitment and training, health and safety records, minutes of staff and residents meetings and the results of feedback received from people and their relatives. We received most of the information we requested within the specified time frame. However, not all the information we requested in relation to recruitment checks was received.

Requires Improvement

Is the service safe?

Our findings

The provider could not assure us that they followed safe recruitment procedures. Staff told us checks of their background and references had been made before they started work at the service. When we asked to see records for staff who had been recruited since our last inspection, the registered manager was unable to find the information and we asked them to forward this to us after the inspection. However, the information we received did not demonstrate that all the required pre-employment checks had been carried out. For example, it did not evidence that references had been obtained from previous employers or that criminal records checks carried out had not raised any concerns which may require further follow up action by the provider. This was needed to assure us that any potential risks had been considered and mitigated. This meant we could not be assured that all the staff were suitable to work in a caring environment.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found that the registered manager had not acted on concerns raised at the last inspection to ensure that people's medicines were regularly reviewed. We saw that one person's asthma medicine was not being administered effectively and another person was having difficulty swallowing their medicines. The registered manager could not tell us if a review was planned for these people and during our inspection they contacted the GP to arrange these. We found improvements were needed to ensure that medicines were recorded in line with good practice. For example, stocks of medicines were not always carried forward each month and we were not able to check that the stock tallied with what was recorded on the medicine administration record (MAR.) This meant that any errors with stock could not be easily traced. We also found that when the registered manager booked medicines in manually, ie outside of the pharmacy four-week delivery cycle, they did not get another member of staff to check the accuracy. This meant people may be at risk of not receiving their medicines as prescribed.

People told us they received their medicines when needed. One person said, "Staff are very efficient with the medicines. They come around about the same time each day and stay with us while we take them". We saw that staff spent time with people and ensured they had taken their medicines before leaving them. Staff had received training to administer medicines and were observed periodically by the registered manager to ensure they remained competent. We saw that medicines were stored and disposed of in line with legal requirements.

At our last inspection, we found that improvements were needed to ensure staff were deployed to meet people's needs at all times. At this inspection, the provider told us shift patterns had been changed to address this. However, people and their relatives told us that they sometimes had to wait a long time for support. One person said, "The worst waiting time is around meal times when we do usually have to wait quite a long time. We saw that staff were busy and did not always have time to spend time with people. At lunchtime, we saw that staff were focused on serving people's meals quickly and had little time to provide support and encouragement to ensure people's nutritional needs were met as part of a positive mealtime experience. Staff told us and records confirmed that the changes had not made any difference to the period

when staffing numbers were reduced to two staff between 11:30am and 1:00pm. One said, "We have four people who require the support of two staff and this can mean that we have to leave people in the communal areas without support". We discussed our concerns with the registered manager who could not evidence how they had monitored the changes made to ensure they were effective. This showed us they had not kept staffing levels under review to ensure people's needs were met at all times.

Risks associated with people's care were identified and assessed and staff knew what actions they should take to keep people safe. However, risk management plans were not always sufficiently detailed , for example, the plans did not include full details on the safe use of slings when equipment such as a hoist was used to support people to mobilise safely. This meant that new or temporary staff may not always have the information they needed to support people safely. We discussed this with the registered manager who confirmed that the plans would be updated to include this information.

The registered manager recorded accidents and incidents. However, we saw that the records lacked detail and did not show what action had been taken to minimise reoccurrence. We saw that three falls had occurred between November and December 2017. Although we found the registered manager had taken action as a result of these incidents, there was no record of any investigation to show that all possible action had been taken to improve safety for people living at the home. In addition, the local authority safeguarding team had recently carried out an investigation at the home. The registered manager could not demonstrate how they had reflected on the events and changed their procedures to ensure the situation would not reoccur. This meant we could not be sure lessons were learned when things went wrong.

People, their relatives and professionals told us they felt that the home environment was not always as clean as it could be. We saw that the home was generally clean although but there was a strong malodour from one of the bathrooms and ant traps had been placed in the corner of the dining area off the communal lounge. One of the traps was broken and it was not clear if they were effective. Our observations and discussions with staff showed that they understood their responsibilities for maintaining good standards of cleanliness and hygiene. We saw staff had received training, had clear procedures for hand washing and wore personal protective equipment such as aprons and gloves. However, there were no cleaning schedules in place and the registered manager did not carry out any checks to ensure the home was always clean and safe for people.

Staff could tell us how they would recognise the signs of abuse and were confident that any concerns raised would be taken seriously by the registered manager. Some staff were unsure of how to escalate their concerns to the local authority safeguarding team if they needed to. We found that safeguarding training had been arranged to ensure staff had up to date knowledge. The registered manager told us they would ensure staff had information on local safeguarding procedures as part of this. Discussions showed the registered manager understood their responsibility to refer any concerns to the local safeguarding team to protect people from the risk of abuse.

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).

At the last inspection, the registered manager had not made applications for legal authorisation where people were potentially being deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the registered manager had met the legal requirements and made an application to the local supervisory body to ensure a person was being deprived of their liberty lawfully.

However, we found that staff were not always following the legal requirements of the MCA when people lacked the capacity to make certain decisions. We found some decisions were being made on behalf of people who staff said did not have the capacity to do so. For example, we saw a sensor mat had been put in place to alert staff when a person was out of bed and bed safety rails were in place for two other people. We found the registered manager had not carried out assessments of people's capacity to make these decisions and their care records did not reflect how the decisions had been reached. Staff told us it had been some time since they had received training in the MCA and were not able to describe the principles of the Act and what it meant in practice. This meant the provider had not followed the action plan they sent to us after the last inspection, which stated that training would be provided by April 2017. This showed us the provider had not always ensured staff understood and followed the requirements of the MCA when obtaining people's consent to their care.

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

We saw that where people were able to give consent, staff explained what they wanted to do and sought people's agreement before proceeding. One member of staff told us told us, "If somebody refuses a wash we would accept their decision but go back to them again later to see if they had changed their mind". This showed us the staff understood the importance of gaining verbal consent.

The provider did not have a consistent approach to training and supporting staff to have the skills and knowledge to provide care in line with best practice. Staff told us they received training in a range of areas and staff who were new to care completed the care certificate. This is a nationally recognised qualification which supports staff to gain the skills needed to work in a health and social care environment. However, we found gaps in staff knowledge of how to apply the MCA and some staff were uncertain about how to

escalate safeguarding concerns. The registered manager did not record and monitor training and was not able to demonstrate that staff received ongoing training in areas relevant to people's needs. This meant we could not be sure staff always had the skills and knowledge they needed to provide effective care. However, the registered manager showed us that training was planned in safeguarding and MCA and a range of other areas relevant to the people living at the home. We will follow this up at our next inspection.

The home's environment was not adapted or decorated to a consistent standard to meet people's needs. People were not able to access the garden and risk assessments had not been carried out to establish how measures could be introduced to support people to access this space to improve their wellbeing. The registered manager told us they had recognised the need to improve the decoration at the home and told us they would look at how the access to the gardens could be improved upon.

People's dietary needs were met. People told us the food was good and there was always a choice. Comments included, "The food is good, quite varied and enough to eat", and, "There is a menu with about three choices and they do change it from time to time". Whilst people did not raise concerns with us, the lunchtime meal was a very quiet affair; people did not chat with each other and there was no background music. As noted in the safe domain, staff were busy and did not have time to encourage conversation between people. This meant the mealtime was a rather sombre affair. We brought our concerns to the attention of the provider and registered manager.

People told us they were supported to access other health professionals when needed. We saw that the service worked closely with the community nursing team where people were at risk of skin damage when they were cared for in bed. One professional told us, "The staff make referrals when they need to and take on board advice for ongoing care". We saw that the provider planned to introduce the use of a risk assessment tool, the waterlow score, which is used in hospitals and community nursing. This would ensure they had a consistent approach to identifying and escalating risks in relation to people's skin integrity. Records showed that people were referred to other professionals including the GP, occupational therapist, optician and dietician which showed us people were supported to maintain their day to day health needs.

Requires Improvement

Is the service caring?

Our findings

People had mixed views when we asked them if the staff were kind and caring and treated them with respect. Comments included, "The staff are kind and I don't have any complaints", "Some staff are very nice but some can be a bit rough and abrupt", and, "I don't think the staff really understand or appreciate what it's like to live here, they just have a job to do. I think they do care but they can go home and we just have to do the same thing every day".

People told us the staff met their physical needs but there was a lack of emotional support because staff did not have enough time to have a meaningful conversation with them. One person said, "The staff rarely ask me how I am or talk to me about anything interesting. I get upset about things and I think talking might help me". At lunchtime, we saw the person's head was lowered and they were not engaging with the person sitting opposite them. Staff were busy administering medicines and supporting people with meals in their rooms and did not notice that the person may be need reassurance. This showed us that staff did not always recognise people's needs and provide care and support in a compassionate, person-centred way.

Some people did not feel they had choice and control over their daily routine. One person said, "I pretty much do as I am told. They get me up in a morning whenever they are ready and take me to bed when they have time". Another said, "I get up early when the staff arrive. I don't usually ask to go to bed, they just come and tell me that is what is happening".

Some people felt they were not supported to express their views and be actively involved in making decisions about their care. One person said, "Everything is regimented and we are all treated alike. I am never asked what I might prefer to do, they just assume I want a wash and get dressed". Another person said, "No one has time to talk to us properly so we all get treated alike". A third person said, "No one ever really asks me about doing things differently, it's the same routine every day".

Some people felt that the staff did not support them to be as independent as they would like to be. One person said, "I do think that sometimes they restrict my independence and interfere to help without asking". We saw that people were not always given choice, for example, drinks were put in front of people without asking if it was what they wanted. We heard one member of the care staff say, "Here is your cup of tea as usual". We observed a member of staff assisting a person to the dining room; they told the person to leave their handbag behind because it was too heavy to carry with their frame and did not ask if they would like it to be brought to them.

People were not always treated as individuals. For example, at lunchtime, people sat quietly in the dining room after their meal whilst a member of staff administered medicines. The member of staff told us, "They are just waiting for their medicines to be administered and then they will go into the lounge after that". Discussions with the member of staff and registered manager showed that people had not been asked how and where they would like to receive their medicines. This showed us that the staff routines did not always consider people's preferences and care was task focused.

We did see examples of positive interactions between staff and people, which showed that people were treated with kindness and had their dignity promoted. Staff were patient when supporting people to move around and were discreet when responding to people's requests for support to go to the bathroom. Staff knocked on people's bedroom doors and waited to be invited in. Staff told us they always explained what they were doing and made sure people were comfortable before supporting them with personal care to promote their dignity.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their individual needs. One person told us the home had a blanket policy that people could not use the lift unescorted. This meant that although they could mobilise safely using a walking stick or a frame, they had to wait for staff to become available when they wanted to go downstairs. They told us, "I have mentioned to the manager that I would be much happier if I could be allowed to get about on my own. We have talked about me having a downstairs room to overcome the problem with the lift and needing to be accompanied. However, she said they prefer to keep the downstairs rooms for the people less able, so I am still stuck up here".

The person also added that the registered manager had not considered other preferences, for example to have an alcoholic drink at night. They told us, "I asked if I could have one here but the manager was not happy about it; I don't see why they should make choices for me like that". The registered manager confirmed they had discussed this with the person and had concerns for their safety and health needs. However, they could not provide us with any evidence to show that they had explored this fully with the person, for example by considering how any risks could be managed. This showed us they did not always consider people's abilities and empower them to have as much choice and control as possible. Another person told us they were not supported to manage their needs in relation to a sensory impairment. They told us, "I am losing my sight which has upset me as I used to watch TV and read a lot; no one has ever suggested things like talking books to me. I think that would be great". The person's care plan did not demonstrate that this had been considered. This showed us the provider was not complying with the Accessible Information Standard, which requires providers to identify the information and communication needs of people with a disability or sensory loss. This evidence shows the provider did not always recognise and respect people's diverse needs.

People's care plans focused on their clinical needs and although we saw they were reviewed when people's needs changed, there was little evidence that people were involved in agreeing how they wanted to be supported. One person said, "I am not really aware of any care plans nor do I have any regular involvement in discussing my needs". A relative told us, "The staff don't really ask us or involve us about any care planning". There was limited information on people's background or history, although staff we spoke with did know what some people had done as a career. However, this information was not always recorded in people's care plans. This demonstrated that the planning and delivery of people's care was not person-centred.

People told us there were not enough activities relevant to their interests. One person said, "There are no activities to speak of. I am usually so bored that I go to bed about 7pm and read. When I was at home I would not have gone to bed until much later and I would not have sat around all day". Another person said, "We don't have anyone to organise activities so the carers have to do it. As you can imagine, they are really busy so it's the first thing to get forgotten". A third person said, "There's nothing to do, I just stare at the walls and go to sleep in between meals". We saw that people sat in the lounge or stayed in their rooms throughout the morning of our inspection and staff did not engage with people unless it was in relation to a

care task. After lunch, a member of staff played a game with people, but the layout of the room made it difficult for everyone to join in easily and some people kept asking the member of staff to repeat what they had said, which did not enhance their enjoyment. We saw there was an activity timetable displayed on the noticeboard in the home. However, this did not seem to vary and displayed the same five activities for each week. People told us the activities listed were rarely offered. The registered manager told us they asked people what activities they wished to engage in as a group but there was no evidence that people were supported to follow their individual hobbies and interests. Staff told us there were no set arrangements for activities and they supported people when they had time. They told us that outdoor activities such as garden parties were arranged in the garden in the warmer weather. However, people and their relatives did not recall such events. These concerns were identified at the last inspection and show that the provider had not taken action to ensure people had access to activities that would support their wellbeing and meet their individual needs and preferences.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their relatives felt able to raise any concerns about the service but were not always satisfied with the way in which complaints were dealt with by the provider. Some people told us they had repeatedly raised issues with the registered manager and these were not always resolved to their satisfaction. For example, some people's radiators had not been working for some time and portable electric heaters were being used as a temporary measure. The registered manager told us that work was planned to address this but could not confirm when this would take place. We saw that the system to record and respond to complaints was limited and where complaints had been recorded, there was little evidence of any investigation and learning applied. This meant we could not be assured that people's concerns and complaints were responded to in a timely way and used to make improvements where needed.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider ensured people were supported at the end of their life to have a comfortable, dignified and pain-free death. We saw that people's wishes were recorded and the provider worked closely with healthcare professionals to ensure that people's changing needs could be met. People's relatives were encouraged to feel involved and kept informed when their family member's needs changed.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. At the last inspection, the provider had made improvements to their audits to meet the legal requirements. At this inspection, we found those improvements had not been sustained and we found there was a lack of monitoring and oversight of the service to ensure legal requirements were being met. Audits were not always up to date or shortfalls were not addressed in a timely way, demonstrating a lack of drive for improvement. For example, a medicines audit had not been carried out since October 2017 and the registered manager was not aware of the concerns we identified with recording and review of people's medicines. We found the registered manager had an inconsistent approach to record keeping and there were no systems to monitor the safe recruitment and ongoing training and deployment of staff. Safety-related information and concerns were not always gathered and monitored to look for themes and trends. For example, accidents and incidents such as falls were recorded but not analysed to identify patterns or trends that could reduce the risk of reoccurrence. This showed us the registered manager and provider did not recognise the importance of reflective practice to ensure learning and service improvement. The cleanliness and hygiene of the home environment was not monitored and when people raised concerns about their radiators not working, repairs required to the heating system were not acted on promptly. Furthermore, we saw that the fire risk assessment dated February 2018 had identified that a large amount of surplus paper and records needed to be removed but this had not been acted on. In the PIR, the provider stated they needed to improve their auditing process to ensure it provided them with consistent managerial information. However, it also stated that this would take 12 months to implement. This showed us the provider was not taking all possible steps to assess, monitor and mitigate the risks to people's safety and wellbeing.

The provider did not have effective systems to gather people's feedback on the service. People and their relatives could not recall being asked for their views on how things could be improved at the service. One person said, "We have never been given a questionnaire to complete about how we feel and I'm not aware my relatives have ever been asked. There are no resident's meetings". Another person said, "They never ask us what we think, I don't think they would like the answers". A relative said, "We have never been invited to any meetings or asked to complete any feedback forms". We discussed this with the registered manager and provider who told us they sent out surveys and held resident's meetings. However, they were unable to find any information to support this. Following the inspection, they submitted information relating to surveys carried about activities and the meals at the home; the registered manager could not provide us with a clear analysis of the results. We saw minutes from a residents meeting held in October 2017 but these did not clearly record people's views and there was no evidence to show that any concerns raised had been addressed. For example, a person had wanted to provide a quiz but there was no evidence they had been supported to do this.

At the last inspection, the provider told us that improvements were planned to the home environment and an improvement plan would be drawn up to monitor progress. At this inspection, we saw that some decoration work had been carried out but there was no plan in place to identify what other works were required. People and their relatives felt that improvements were needed to the home environment and we

saw that areas of the home were cluttered, which made it difficult for people to move easily around the home when using frames. As noted in 'Responsive', complaints about the heating system had not been acted on which showed us people were not always listened to when they raised concerns about the service. This demonstrated there was a lack of focus on people's experience of care or their opinions on how things could be improved.

The failure to continually assess, monitor and mitigate the risks to people and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was a registered manager in post. We found they were not meeting the requirements of their registration with us. We found that they had failed to notify us of three falls and a death that had occurred at the home. This meant we were not kept informed of significant events that had occurred at the service, which enables us to check that appropriate action has been taken. Although we saw that they had completed some of these notifications, they had not sent them to us or checked that they had been received by us. This information enables us to check that providers are taking appropriate action when significant events occur at the service.

These are breaches of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The culture of the service was not always open and inclusive. People's views were mixed on how approachable the staff and registered manager were. One person said, "I am confident that if I was not happy about something, I could talk to one of the staff". Other people did not feel able to give their views. One person said, "I like to keep myself to myself and not rock the boat. They never ask me if I am happy here". A relative told us, "We speak up when we need to but they never pro-actively ask if we are happy with the care". Staff views around the support they received from the registered manager were mixed. Some staff told us felt they didn't always feel able to talk to the registered manager and others said the registered manager was very flexible and supported them when needed. This showed us the registered manager's leadership was inconsistent. The provider told us they had recognised that the registered manager was not leading the service effectively and had contracted the services of a consultant to support them to make improvements at the service. The provider shared minutes of meeting they had held with the consultant but no action plan was in place to manage the process.

We spoke with professionals that visited the service on a regular basis. They confirmed that the registered manager and staff worked collaboratively with them to ensure people's healthcare needs were met.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the reception area of the home.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify us without delay of the death of a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of serious injuries sustained by service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported to be involved in decisions about their care and did not always receive personalised care that met their individual needs and preferences. Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always upheld in line with the Mental Capacity Act 2005 when they lacked the capacity to make certain decisions. Rgulation 11 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have a suitable system to ensure any complaint received is investigated and prompt action taken to address any failures identified. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance and governance systems to ensure that shortfalls were identified and addressed and legal requirements were met. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not assure us that they followed robust procedures to ensure staff recruited were of suitable character to work in a care environment. Regulation 19 (2)