St. Cloud Care Limited

The Boynes Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Boynes Care Centre provides accommodation and nursing care for up to 40 people. On the day of our inspection there were 23 people living at the home. The home was split into two units, Malvern unit supported people living with Multiple Sclerosis, some people were short stay and others lived at the home permanently. Cedar unit provided support for people living with dementia.

We undertook a comprehensive inspection of this service on September 2016. At that inspection the service was rated as requires improvement overall and we identified short falls in two regulations. We asked the provider to complete an action plan highlighting what they would do to improve the quality of care. We found some improvements, however not all of the action points on the providers plan had been completed.

After this inspection we received concerns in relation to how people were safely cared for and how their care was managed. As a result we undertook an unannounced comprehensive inspection to look into those concerns on the 27 and 28 September 2017. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience.

At the time of our inspection there was no registered manager in place. The previous registered manager had left in August 2017. There was a new manager in post who was completing the registration process, they had been in post two and a half weeks at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We saw there was not always sufficient staff effectively deployed to ensure people remained safe. People had not always had their risks identified, and these risks assessed and mitigated. Staff were not always aware of the safe way to support people. Accidents and incidents were not consistently investigated and actioned. Incidents of potential abuse were not always reported to ensure the manager took appropriate action. The management team had started to take action with some of the areas that needed improving. People told us they had their medicines as prescribed.

People were not always assessed when needed to ensure they were able to consent to their care. People may have been deprived of their liberty without a best interests assessment being completed. Staff told us they were not confident to complete assessments despite the training they had received. Staff respected people's rights to make their own decisions and choices about their support. People had food and drink they enjoyed to maintain a healthy diet. People said they had access to health professionals when they needed to. Relatives were confident their family member was supported to maintain their well-being.

People said they were supported by kind staff. Relatives told us they were happy with the care their family member received. However we saw staff were not always able to spend the time they needed to meet

people's needs. Staff were not consistently focussed on people, we saw there was a culture of task focussed care. Staff did not show a consistent dignified approach to supporting people living at the home. People living at the home were able to see their friends and relatives as they wanted. Staff knew people well, and worked with people to maintain their independence.

People told us they did not always have interesting things to do. The management team had identified people needed more interesting things to do. They were looking at increasing staff support in this area. People and their relatives had had access to regular meetings and further meetings had been arranged to keep them updated with changes in the management team. They knew how to raise complaints and were confident to raise them. There was had a complaints process in place to ensure people were listened to and action taken if required, however we found learning from one complaint had not been fully actioned.

The provider had not taken action to ensure systems in place were robust and effective to provide quality safe care. Staff were demoralised with the constant changes in management and lack of staff support to manage complex people's needs. The provider had systems in place to monitor the quality of care and treatment people living at the home received. These were not always effective at responding to changes in people's care provision. Where improvements had been identified there was a plan in place however actions were not completed or sustained.

You can see what action we told the provider to take at the back 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 consistently safe

People were not always supported by sufficient staff, deployed effectively to ensure they remained safe. Staff did not always report incidents of potential abuse to ensure people remained safe. People did not consistently have risks identified and assessed, or their identified risks mitigated.

People were supported with their medicines by staff who had been trained.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were not always supported to make decisions about their care when they needed. The provider had not ensured people were assessed when they needed to be so they were able to consent to their care. Staff did not always have the confidence and skills they needed to ensure people were not restricted against their best interests.

People were supported by staff that had up to date training to meet their needs. People received meals they enjoyed and were offered regular drinks. They were offered they food they liked and given sufficient choice. People were confident staff had contacted health care professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff could not always attend to people who were not able to voice their needs. However, people had good relationships with staff who were caring. Staff did not consistently protect people's dignity. They encouraged people to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People did not consistently have their needs met, and their preferences identified. People did not always have interesting things to do with their time that were individual to their needs People benefitted from regular meetings to share their views and updates about the service. People who lived at the home and relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

People did not always benefit from consistent leadership to ensure people were supported effectively. The provider had not ensured improvements were identified and implemented in a timely way. The provider had systems in place to monitor the quality of the service and some improvements had been identified; however, the improvements had not been completed or sustained.

The Boynes 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 27 and 28 September 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist adviser, who was a specialist with general nursing. Also an expert by experience who had experience of supporting older people with dementia.

The local authority and the clinical commissioning group shared information with us about the services provided at the home. The local authorities and clinical commissioning group are responsible for monitoring the quality and funding for some of the people who use the service. They raised concerns with us about the service which we followed up during the inspection.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required by law to send to us, to inform us about incidents that have happened at the service, such as an accident or a serious injury.

We undertook a responsive, comprehensive inspection as a result of three safe guarding reports and other information of concern raised by other stakeholders. The safe guarding reports were under investigation by the local authority safe guarding team at the time of our inspection. We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 12 people who lived at the home, and four relatives. We looked at how staff supported people throughout the day. We used different methods to gather experiences of what it was like to live at the home. We observed care to help us understand the experience of people who could not talk with us.

We spoke with the manager, the clinical lead, the regional manager, the operations director and 15 staff. We

also spoke with a social worker and continuing health nurse assessor who visited the service. We looked at four records about people's care which included medication records, and care charts. We also looked at complaint files, accident and incident reports involving people who lived at the home. We looked at quality checks on aspects of the service which the provider had completed.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2016 we found the service required improvement about how they ensured nurses were practicing lawfully, and the management of medicines. At this inspection we found improvements in these areas had been met. However we found further areas required improvement.

At this inspection we found staffing levels and deployment were not effective to ensure people were safe. We saw people exhibiting challenging behaviour when left with no staff presence. Records showed nine incidents recorded from 4 August 2017 to 8 September 2017. These incidents related to people living at the home displaying violent behaviour towards staff and their environment. Both care staff and nursing staff stated there were insufficient staff to ensure people were safe. They told us two people, in their opinion required one to one support at times during the day. They told us there were insufficient staff to ensure they could facilitate this consistently, without impacting on other people's care. We spoke with the manager and the clinical lead and they advised they were unable to confirm adequate staffing levels because documents which provided information about people's needs were inaccurate and not up to date. They were in the process of reviewing these documents to establish an effective overview of staffing levels.

Systems and processes in place were ineffective and had not prevented further accidents and incidents. During the period from 8 September 2017 to 27 September 2017 there were six incidents of staff being verbally or physically abused by people living at the home. Four people were reported to have been involved in incidents that put them at risk of injury. The accident and incidents reports had not confirmed what action and learning were taken from these incidents to ensure people were safe in the future. The manager confirmed she had not investigated those incidents at the time of the inspection. The operations director accepted our concerns about staffing levels and immediately added an member of staff to the twilight shift.

We reviewed four people's care documents and found risk assessments were not consistently updated did not reflect people's current needs. One care plan showed inconsistent guidance about the person's ability to mobilise and the support they needed to do so safely. This put people at risk of injury through unclear guidance to staff.

We found notes of two incidents on the 26 September 2017 where one person hit another person. There was no accident report completed and safe guarding action had not been taken. We discussed with the manager and these incidents had not been reported to them, staff had not escalated the concerns to the manager. Therefore people continued to be at risk of abuse because the incidents had not been investigated and the risk mitigated. The manager assured us they would take immediate action to ensure people were safe.

People's risks were not being effectively monitored, and action was not consistently taken to mitigate their risks to their health and well-being.

This was a breach in Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people received safe care and treatment.

The management team and staff explained their responsibilities in identifying and reporting potential abuse under the local authority reporting procedures. We saw where the new manager had taken appropriate action to report potential abuse when staff made her aware. All the staff we spoke with had a clear understanding of their responsibility to report any concerns and who they could report them to. However we saw potential abuse was not always reported effectively. Staff told us they did not always have time to do everything they needed to. Staff explained training on potential abuse formed part of their induction and the completed regular updates.

People we spoke with had mixed views about how safe they felt living at the home. People we spoke with on the Malvern unit said they felt safe. One person told us, "Yes, I am happy and I feel safe yes." However people living on the Cedars unit said they did not always feel safe. One person told us, "No I don't feel safe. I don't belong here." Relatives we spoke with told us they thought their relatives were safe. One relative said, "Yes my [family member] seems very safe here."

People on both units consistently told us there were not always sufficient staff available. One person said, "Staff are always so rushed and busy, they are very good but they need more of them." Another person told us, "I'd like a shower every day but I know the staff are pushed for time. I think they need more really." However all the people we spoke with told us the staff worked hard to meet their needs. Relatives we spoke with said there was not always sufficient staff. One relative told us, "You see a fair amount around but it can be a busy at weekends because there doesn't seem as many of them. That seems a pinch point in my opinion." Another relative said, "Sometimes my [family member] has to wait a while for them to come when they want them, you know when they press the buzzer. I am here a lot so I do a lot for them but there are some things I can't do."

Staff we spoke with said there were insufficient staff to keep people safe. One member of staff told us, "Afternoons are awful, people are aggressive and there are just not enough of us." Another staff member said, "We are always rushing, we just don't have time for people in the afternoons." We spoke with the management team and they agreed to put an additional member of staff on duty in the afternoons to support staff to keep people safe, whilst they completed assessments and reviewed peoples support needs.

Staff we spoke with told us the appropriate pre-employment checks had been completed. We looked at two staff files and confirmed these checks were completed. These checks helped the provider make sure that suitable staff were employed and people who lived at the home were not placed at risk through their recruitment processes.

We looked at how people were supported with their medicines. We looked at four people's records which indicated people had their medicines when they needed them and the manager had ensured that regular checks were in place to support this. People told us they had their medicines when they needed them. One person said, "They give me my tablets twice a day, usually in the morning and at tea time. Yes, they tell me that they for. I get a drink. Sometimes they get stuck. [Staff] wait until I've done." A relative told us their family member's medicines were always on time, "They [staff] always ask if [family member] has any pain." We saw staff explain to people as they administered their medicines, what they were taking and sought their consent before they administered them. Staff were trained to be able to administer medicines. They were aware of what to look for as possible side effects of the medicines people were prescribed. There was suitable storage and disposal of medicines in place.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2016 we found a breach in regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people were supported by knowledgeable staff that understood what Deprivation of Liberty Safeguards were and who was effected by them. We asked the provider to complete an action plan to address this shortfall. However at this inspection we found this had not improved and the action plan had not been completed or effective. We found there continued to be a breach regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People continued to be at risk of being deprived of their liberty unlawfully.

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.

The manager told us she had identified there were at least two people who were having their liberty deprived where there had been no assessment made or application applied for to ensure these restrictions were lawful and in their best interest. We saw she had identified these through care plan audits. The manager explained there were potentially more service users who were being deprived of their liberty unlawfully because at the time of the inspection she had a further 12 plans to audit.
The manager told us nursing staff continued to lack understanding and confidence about how to assess people's capacity to ensure people were not restricted unlawfully. The manager confirmed these staff had received training yet this had not been effective in improving staff confidence in this area. One member of nursing staff we spoke with said they did not feel they had enough knowledge in this area. Care staff did not receive support from the nursing staff to embed this knowledge and understanding because the nursing team were not confident of their knowledge. Care staff we spoke with said they were unclear about which service users had deprivation of liberty safeguards in place and what impact this had on how they met their care needs.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Systems in place to review DoLS were not effective. We found one person had been subject to a Deprivation of Liberty Safeguard that had expired in August 2017. The manager confirmed that an application to the local authority had not been submitted. The manager told us this person continued to lack capacity and received the same level of intervention with their care needs. Therefore they were being deprived of their liberty unlawfully.

People were being deprived of their liberty for the purpose of providing care without lawful authority.

This was a breach in Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not ensured people were Safe guarded abuse and improper treatment.

We saw staff asked people before they supported them and offered choice about how they were supported. For example we saw one member of staff gave one person the choice of where they wanted to spend time either in the communal area or in the privacy of their own room.

We saw staff consistently asked people for their consent before supporting them. Staff told us they were aware of a person's right to refuse their support and explained how they managed this to ensure people's rights were respected. The manager was aware of their responsibility to ensure decisions were made within this legislation.

Staff we spoke with said they had regular training to keep their skills up to date. One member of staff said their induction had been effective at supporting them to meet people's needs. They had been mentored by another member of staff. Another member of staff explained they had attended specific training to support people living with dementia. They went on to say they had shared best practice with other staff, however felt other staff would benefit from this training. The manager explained they were aware that some staff had completed training but were not confident with applying the knowledge they had acquired. For example MCA and DoLS training and dignity training. The manager told us they had identified these shortfalls and was arranging for additional face to face training for all staff. We saw by the end of the inspection this training had been arranged.

Staff we spoke with said there had been many managers over the last three years. One member of staff explained that communication was sometimes difficult because each manager brought in a different view point on how things needed to be done. Staff told us they had regular team meetings and one to one time with their manager and were hopeful this manager would stay.

People we spoke with told us they were happy with the food provided. One person said, "Yes lovely, very tasty." Another person told us, "Yes the food is lovely here. Yes, lunch was nice." Relatives we spoke with said the food appeared good and their family member ate well. One relative told us, "The food here is very nice. I don't eat here but I can make toast at the kitchenette in Malvern I help to give my [family member] their lunch. They have some lovely food. There's always a choice of main and then a pudding." We saw there was a choice of condiments and sauces and people were asked what they would like.

Staff we spoke with explained how they offered meal choices to people living at the home. One member of staff told us, "If we think that a [person] needs some help deciding what to eat we use the folder. We go around each morning to ask what people would like once we know what's being cooked. Some people need to see a picture of a meal to be able to choose." We saw people were supported with their meal choices according to their needs.

We spoke with kitchen staff and they showed us how people's nutritional requirements were met. We saw there was information available to ensure the kitchen staff provided suitable food choices, for example for people with diabetes. We saw staff provided support for people when they needed it with their meals. We saw people being offered regular drinks and food when they wanted them. Food and fluid charts were in place where concerns were identified. The manager had identified these were not consistently being monitored effectively. We saw they had taken action and met with staff to remind them to take this action.

People told us they had access to their GP, dentist and optician when they needed to. One person said, "If I am not feeling well yes they will get the doctor. If I need one. I can't remember when the doctor last came

but yes when I had the flu they got the doctor." Relatives said their family member was supported to see health and welfare professionals as required. One relative told us, "If they [family member] appear at all unwell, the staff will ring me and tell me and get the doctor." Another relative said, "I am told they can see the GP as routine." We saw records where health professional had been involved with people living at the home.

Requires Improvement

Is the service caring?

Our findings

When we inspected in September 2016 we found the service was not consistently caring and required improvement. We found there was a breach in regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not ensured people were being cared for with dignity and respect. We found improvement was required relating to staff practice around people's dignity and how they involved people in planning and influencing their care. We asked the provider to complete an action plan about how they would make these improvements. We found improvements had been made, however there continued to be further improvement needed in these areas.

We saw inconsistent practice by staff when supporting people at the home. We saw some staff continued to be task focussed. For example, on one occasion we saw staff supporting people at meal times did not consistently sit with people to encourage them to eat. We saw that staff were focussed on delivering meals to people rather than spending time supporting them to eat. We also saw an example where staff had left a modern music channel on one person's television. One member of the inspection team asked them if they wanted to continue watching, and they asked us to turn the channel over to something they preferred. One person told us about staff, "They don't have time to talk for very long. It's in and out when they come." We saw other examples where staff were focussed on the people they were supporting and it was evident they knew people well and went at their pace. We saw one member of staff as they served lunch explained to each person what the meal was and described the food.

All staff we spoke with understood that people living at the home would benefit if they had more time to spend with them. They were clear about their role to provide care was about people and not just the care task. However staff told us this was not consistently happening and they had not had the opportunity to sit and spend time with people regularly because of the volume of other work. Staff explained if they had more time to sit and chat with people particularly in the afternoons it would improve people's well-being and assist in supporting people when they became upset. They said some people living at the home had high dependency and there was not enough staff to meet their social needs consistently.

Staff told us they had completed dignity in care training. However we saw two examples where staff did not display the ethos of that training. We saw two staff had a private conversation over the top of a person living at the home whilst they were sitting in the lounge. We also heard another member staff say about one person, "They are wet," in front of other people living at the home in the communal area. We also saw examples where staff showed kindness and consideration towards people living at the home. For example, we saw staff spend time reassuring people when they were upset, and use distraction techniques to improve their well-being. We saw other staff when they arrived on shift say hello to each person sitting in the lounge, reassuring them with a gesture or touch of their hand. However we saw and staff told us at other times, because of the number of the people who were upset staff did not have sufficient time to spend with people to reassure them. People who could vocalise their concerns received the attention of staff and others who were quiet lacked interaction from staff. We spoke with the management team and they were reviewing staffing levels and deployment. They understood changes were needed and were recruiting to ensure they had sufficient staff.

The home was split into two units. Malvern Unit provided support to people who had a specific health condition, multiple sclerosis (MS) whereas the Cedar unit supported people living with dementia. At our last inspection we found all staff distinguished people by their health condition, rather than talking about people as individuals. At this inspection we found there had been some improvement and staff referred to people by their names. However, we continued to find staff referring to the different units depending on people's health condition. Two staff we spoke with referred to the different units as the, "Dementia unit" and the, "(MS) unit." We spoke with the management team and told us they were working with staff to change their mind set, to see people and the units they lived on as individuals not their conditions.

People we spoke with described the staff as, "Kind and caring", "Excellent staff" and "Lovely staff." One person told us staff were "Very good, however there is not always enough of them." They explained staff always asked them, "What would you like to do?" Which they went on to saw helped them feel in control of their day. Relatives said staff supported their family members in a compassionate way. One relative told us, "It's lovely here. Residents and relatives can use the kitchenette areas to make a drink or warm things up at any time. It's like home from home." Relatives explained they felt involved and included in the care for their family member. They said they felt welcome to visit the home at any time.

Staff explained they encouraged people to be as independent as possible. One member of staff gave the example of how they asked people when they wanted to get up; if the person was not ready they would return at a later time. They explained this improved the person's well-being.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with explained they had different experiences depending where they lived at the home. People we spoke with on the Malvern unit said they had their needs met. They told us they were able to choose how they spent their time and what time they got up and went to bed. One person said, "I like it here. I get up when I want." However people we spoke to on Cedar unit told us they could not always chose what they wanted to do with their time. Two people we spoke with told us they wished to go outside and walk in the grounds. However we saw staff did not consistently have sufficient time to support people to go outside as they wanted to. One person said, "I am stuck in here, upstairs," they explained they were not able to access the outside because of their frame. They went on to say, "I feel so lonely. I don't want to sit down there with all those people. I have nothing in common with them. I like to sit and talk. I'd like some company from time to time." Staff we spoke with explained they were too busy to consistently support people as they would want to support them.

We were told by the management team there was a mini bus available which took people out on day trips. People we spoke with living on Malvern unit went out on trips most days during the week. They had access to the outside grounds and expressed they had interesting things to do with their time. Staff told us the mini bus was used to take people out on Cedar unit once a week, and the activity co-ordinators were frequently involved with trips out therefore were unable to always support people who were unable to go out on the trips. We saw there was an outside area where people in the Cedar unit could access. However we did not see staff use this facility. One member of staff told us they were too busy to take people outside because of the high level of need of other people living at the home.

We reviewed four care planning documents and found they were not consistently completed to ensure staff had the knowledge to meet people's needs. The manager had identified the lack of information and was completing audits to ensure these documents were updated effectively. However we saw staff supporting people had knowledge of people's likes and dislikes.

We saw on Cedar Unit there were tactile boards mounted on the walls in the corridors such as a row of scarves attached to hooks. There were numerous items on hand around the unit in baskets and on shelves to support people with dementia as distraction techniques. However we saw staff had little opportunity to use the magazines, games, books or boxes of items to improve people's well-being. One the first day of our inspection we observed people were unsettled and restless, some people were shouting out for long periods of time and others walking up and down and shouting out. This impacted on other people sitting quietly in the lounge who were either sleeping or watching the television. We saw these people became unsettled too because of the disturbance. On the second day of our inspection we saw the activities co-ordinator spent time with people on this unit looking at magazines and talking to them. We saw when people had the benefit of this interaction people's well-being was improved. We spoke with the manager and they told us they were increasing the activity co-ordinators role to provide support for seven days a week, to ensure people had the interaction they needed for their well-being. We also saw entertainment provided for people on Cedar unit in the afternoon of the second day of our inspection. We saw people participated in the entertainment and enjoyed the moment. People who had been upset were reassured and their well-being

improved.

People and their relatives we spoke with said they had regular meetings with staff to keep them up to date with home developments and provide an opportunity to raise concerns. However relatives we spoke with were unclear about who the new manager was. We spoke to the manager and they explained they had arranged a meeting in the near future to update people's relatives about the changes in the management team. They also said they were reviewing how they supported people's relatives to be involved in the home. They were looking at arranging a time for relatives to drop in and speak to the manager on a regular basis.

People we spoke with said they would speak to staff or the management team about any concerns. One person told us, "I would always speak to staff and sort anything." Relatives told us they were happy to raise any concerns with the management team, or staff. One relative said, "If there was a big problem I would probably find a manager or someone in charge otherwise I would probably speak to a [staff member]." We saw there was a complaints procedure in place, and there were three complaints recorded at the time of our inspection. We saw they had been investigated and responded to in line with the provider's policy. However there was a complaint in July about the lack of staff and disruption from other people living at the home. We found the provider had not taken the learning from this complaint to improve the quality of care provided.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections in September 2016 and April 2015 we identified there were issues with governance and that the home was not consistently well-led. At the inspection in September 2016 we found there was a lack of leadership and effective systems to monitor the quality of the care provided. At this inspection we found there continued to be improvement needed. We identified a number of areas that highlighted the lack of systems in place to mitigate people's risks and ensure that governance systems were robust.

There was no registered manager in post at the time of our inspection; the new manager was completing the registration procedure. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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. Staff told us there had been at least seven different managers over the last three years.

The system in place to ensure people's needs could be met was not established or consistently followed by staff when new people came to live at the home. We found the provider had not ensured effective assessments were completed during a period of time between August 2017 and September 2017. There were seven new people admitted to live at the home. The manager told us these seven people had been admitted without sufficient information about what support they needed to ensure the service could meet their needs. The clinical lead said people had just arrived without any information about what their risks were and what support they needed. The management team were not clear if they could meet these people's care needs. We saw on records that one person had regular violent episodes towards other people living at the home and staff. Staff we spoke with confirmed they thought this person needed one to one care which they did their best to provide to ensure people were safe. The management team were unclear if one to one care was needed because this person's care needs were not fully understood or updated.

We spoke with the management team and they acknowledged staff had not followed a safe system to admit these people into the home. They were taking action by reviewing people's care records to ensure they had clear guidance for staff about how people's needed to be supported. They took action after the inspection to provide one to one support for one person and look at a more suitable placement for another.

The management team had identified areas for improvement and had a plan in place to ensure actions were taken to drive up improvement. However at the time of the inspection these actions were neither embedded nor completed, we could not be assured how effective the systems were to improve the quality of care.

We looked at the action plan the provider had put in place to meet the requirement notices issued after our last inspection in September 2016. The regional manager, manager and operations director were unable to confirm if the actions were completed. They confirmed during the meeting that the actions for the breach in regulation 13 had not been fully completed. Staff were not confident to assess and apply for Deprivation of

Liberty Safeguards. Care staff continued to not understand the impact to service users when these safe guards were in place. The provider had not ensured actions were completed to rectify identified failures.

We found systems to ensure there was an overview of accidents and incidents were ineffective. The manager told us they were aware that staff did not consistently report accidents and incidents. The manager had taken action and we saw records that these concerns had been raised in recent staff meetings. However we found two reports of potential safe guarding incidents which had not been brought to the manager's attention on the 26 September 2017. We also found that there was a gap in the reviewing of the incidents recorded from 8 September 2017 to 27 September 2017. People were not protected from the risk of accidents and incidents because systems were not in place to ensure the provider monitored and implemented learning from them.

Staff we spoke with reported low staff morale because of the high turn-over of managers. One member of staff told us, "We just get used to doing things one way, then the manager leaves and a new manager comes in and changes everything. It's very demoralising." Another member of staff explained they hoped this manager would stay so they would feel more settled. Staff told us there had been a period of instability for the last three years with consistently changing managers and mixed messages to staff. All the staff we spoke with shared concerns about insufficient staff to ensure people remained safe and expressed a wish that the new management team would listen to them and take action. Staff told us they had meetings with the management team and one to one meetings. However the new manager had been in post for two and half weeks at the time of our inspection therefore improvements would take time to establish.

This was a breach in Regulation 17 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective arrangements in place to monitor and improve the quality and safety and welfare of people using the service.

People we spoke with were not clear who the manager was. One person told us they had met them however other people had yet to meet the new manager. People we spoke with living on the Malvern unit were happy living at the home. However people we spoke with on Cedar unit not consistently happy living at the home. The manager explained they were arranging more formal introductions and would welcome any feedback from people living at 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were safe guarded abuse and improper treatment.

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 The provider did not have effective arrangements in place to monitor and improve the quality and safety and welfare of people using the service.