Care Quality Commission

Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected the service on 30 October 2014. This was an unannounced inspection.

Southfield Care Home provides accommodation and personal care for older people living with dementia. In the weeks prior to our visit a new ground floor extension with 12 additional bedrooms opened. The service can now accommodate up to 54 people. Accommodation is provided in single bedrooms, most with en-suite bathrooms. There is the ability for double rooms to be provided should there be a request for this. The service is situated in Great Horton on the outskirts of Bradford.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We had previously inspected the service on 12 February 2013 and identified that the systems in place to assess and monitor the quality of care were ineffective. We asked the provider to make improvements and returned to the service on 7 June 2013. We found that improvements had been made to the auditing and quality assurance systems.

During this visit we found the provider had not ensured that these improvements were sustained. We found the service was not well led and the systems in place to assess and monitor the quality of care were inadequate. This meant issues and areas for improvement were not identified and acted upon. Incidents and accidents were not appropriately reported, managed and analysed. There were not effective systems in place to ensure people were regularly asked for their feedback about the quality of care provided and how the service should be run.

People we spoke with told us they felt safe living at the service. However, we found the provider had not taken appropriate action to ensure the care people received was safe. They had not appropriately protected people from the risks associated with unsafe or unsuitable premises. They had also not taken appropriate steps to ensure people were protected from the risk of abuse. The systems in place to manage people's medicines did not ensure people received their medicines in a safe way.

The service was not always responsive. There was a complaints procedure in place. However, the records kept could not always demonstrate that appropriate action had been taken to resolve issues.

Care records were clearly written and regularly reviewed. They also incorporated advice and recommendations given by healthcare professionals. However, there was no formal and structured care review process to ensure the support delivered met people's current needs.

There were adequate numbers of staff to care for people. Care staff had a good working knowledge about the people they cared for. They were caring and treated people with respect and showed an awareness of the importance of maintaining people's privacy and dignity. However, staff did not receive sufficient training and support to ensure they provided safe and effective care.

We saw staff took time to engage people in social activities. However, the activities programme was not formalised and staff were not given dedicated time to engage people in activities.

Systems were in place to monitor and manage situations where people's freedom may have been restricted in order to keep them safe. However, care staff would have benefitted from additional training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA) to ensure they were fully aware of their duties in protecting the rights of people with limited mental capacity.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take to address these issues at the back of the full version of the report.

We also found evidence that the CQC was not being notified of some incidents which had occurred at the service, such as safeguarding incidents. We wrote to the provider and the registered manager and reminded them of their duty to ensure they notified the CQC of certain incidents. We explained that if we found evidence they had failed to notify the CQC of these incidents in the future this could result in enforcement action being taken against them.

Summary of findings

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. The provider had not appropriately protected people from the risks associated with unsafe or unsuitable premises.

The provider and registered manager were not taking appropriate steps to ensure people were protected from the risk of abuse.

There were not appropriate arrangements in place to ensure people received their medicines in a safe way and were protected against the risks associated with medicines.

There were adequate numbers of staff to ensure people were kept safe. People and their relatives told us they felt safe living at the service.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive sufficient training and support to ensure they could provide people with safe and effective care.

We saw most people received appropriate support from care staff to ensure they consumed sufficient quantities of food and drink. However, food and fluid charts were not always clearly and consistently completed.

Our discussions with care staff, people and observed documentation demonstrated that consent was sought and was appropriately used to deliver care.

Records showed that arrangements were in place that made sure people's general health needs were met.

Is the service caring?

Good

We found the service was caring. Care staff knew people well and had established meaningful relationships and worked to create a homely and relaxed atmosphere at the home. Staff treated people with respect and showed an awareness of the importance of maintaining people's privacy and dignity.

Care plans were easy to follow and provided staff with information about people's individual preferences, how they wanted their care to be provided and how they could encourage people to maintain their independence. We saw evidence of care staff actively trying to promote people to retain their independence wherever possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. There was a complaints procedure in place. However, the records kept could not always demonstrate that appropriate action had been taken to try to resolve issues.

Summary of findings

There was no formal and structured care review process to ensure the support delivered met people's current needs.

Care staff took time to engage people in social activities. However, the activities programme was not formalised and staff were not given dedicated time to engage people in activities.

Care records were clearly written and regularly reviewed. They also incorporated advice and recommendations given by healthcare professionals.

Is the service well-led?

Inadequate

The service was not well led. Inadequate systems were in place to assess and monitor the quality of care provided. This meant issues and areas for improvement were not identified and acted upon.

Incidents and accidents were not appropriately reported, managed and analysed.

There were not effective systems in place to ensure people were regularly asked for their feedback about the quality of care provided and how the service should be run.

Southfield Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 October 2014 and was unannounced. The inspection team included two inspectors and one pharmacist inspector.

Before the inspection, we reviewed the information we held about the provider. We contacted the local authority commissioning team and local Healthwatch to ask them for their views on the service and if they had any concerns. We also sent a request for 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. However, a completed PIR was not sent back to the CQC prior to our inspection. The inspectors asked the registered manager about this because they were also the nominated individual for the provider. The registered manager had not supplied the CQC with their new email address and had therefore not received the PIR request. Following this inspection the registered manager submitted a change request to ensure the CQC had an up to date email address for them.

During the inspection we used a number of different methods to help us understand the experiences of people who used the service. We spoke with three people who lived at the home and two visitors. We spent time observing care and support being delivered. We looked at four people's care records, eight medicines administration Records (MAR) and other records which related to the management of the service such as training records, policies and procedures. We spoke with the registered manager, deputy manager, three members of care staff, the owner of the home and domestic staff. We also spoke with a visiting healthcare professional and the visiting pharmacist.

After the inspection we spoke with a fire safety officer to raise concerns about what we had found during our visit. They said they would visit the service to check it met with fire safety regulations. After this inspection we asked the registered manager to send us an action plan to detail the action they would take to address the breaches of regulations. An action plan was sent to us on 6 November 2014.

Inadequate

Is the service safe?

Our findings

During our visit the registered manager showed us around the service. We found areas of potential risk to people which had not been appropriately managed. There were no measures in place to ensure people accessed the three staircases safely. The registered manager told us most people lived with dementia. From our review of care records we found some people were at risk of falling and should have been supervised when moving around the home. Due to the location of the staircases staff could not have ensured they observed people using the stairs at all times. The registered manager explained they recognised there was a risk and had considered putting keypads on the staircase doors in the past. However, they did not want to prevent the people who were safe to use the stairs independently from moving around the home. However, there was no risk assessment or alternative safety measures in place to help reduce the risk to people with mobility problems.

When we visited the home on 12 February 2013 we raised concerns that people could access the laundry located in the basement of the home. During this inspection we saw the stairs to the laundry had been boxed in and a door had been fitted. However, we found the door was unlocked meaning people could still access the laundry. The registered manager was unable to evidence that this work met the appropriate requirements of the Regulatory Reform (Fire Safety) Order 2005. Following our inspection we made a referral to the West Yorkshire Fire Protection Department. They told us they would conduct an inspection of the premises and would report their findings back to CQC once their visit was completed.

We saw a number of areas which were not appropriately maintained and could have posed potential hazards to people as they moved around the home. This included raised and worn carpets in the upstairs corridors and the stairs on a fire escape route. We also found the downstairs sluice room did not have a lock fitted and the vinyl flooring inside was cracked and raised. We saw the glass was cracked in a window on an upstairs corridor which was accessible to people who lived at the service. The registered manager told us they were not aware the window was cracked but agreed the glass needed replacing to ensure people were not put at risk of injury. The provider told us they were aware the window was cracked but due to the shape of the window they had been unable to find replacement glass. They said they were looking at alternative ways of making the window safe.

These issues showed us the provider had not appropriately protected people from the risks associated with unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed training records and found the provider had not ensured all care staff received appropriate safeguarding training. We saw eight out of 33 care staff had received training in safeguarding adults in October 2013. The registered manager was unable to provide us with evidence that the remaining staff had received recent training in safeguarding. We spoke with two members of care staff about how they would keep people safe. They were both unable to competently demonstrate awareness of how they would report concerns about peoples' welfare and safety and what action they would take to safeguard people from the risk of abuse. They were also not aware of the whistleblowing procedures and who they could contact outside of the organisation if they had concerns.

We also found that where safeguarding incidents occurred, complete records of the actions taken in response to the incidents were not always maintained. A safeguarding incident is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. This meant the registered manager was unable to demonstrate that appropriate preventative action had been taken to keep people safe and reduce the risk of future incidents. We found evidence this resulted in some incidents escalating. For example, an incident occurred in May 2014. It was recorded that one person alleged that another person came into their room and grabbed them by the neck. There was no information recorded on the incident form other than that both people were supported to move to separate areas of the home and the incident was reported to the senior on duty. There was no information to demonstrate the immediate actions taken to manage this relationship and reduce the risk of further incidents. On the same day, six hours after the initial incident occurred, another incident occurred between the same two people, which resulted in both people sustaining injuries.

Inadequate

Is the service safe?

This showed us the provider and registered manager were not taking appropriate steps to protect people from abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the systems in place for managing medicines. We were unable to account for a number of medicines as some records were incomplete. This was because senior care workers had not always accurately recorded the quantity of each medicine received into the home, or how much had been brought forward from the previous month. As we could not work out how much medicine should be present, we were unable to determine whether or not these medicines had been administered correctly.

We found seven different medicines in the trolley which were not recorded on people's Medicines Administration Records (MARs). The registered manager explained that these medicines were still currently prescribed, but had been "missed off" the current MARs. This placed people at risk of not being given the medicines they needed as there was no information available to care workers telling them that they needed to be administered.

We looked at how medicines were ordered and stored. The ordering system was generally effective and there were adequate supplies of people's medicines available. However, we found there was a risk people may have been given medicines that were out of date and unfit for use. Some of the injections stored in the medicines trolley were out of date. There were no records of the temperature of the medication fridge. Many creams and external preparations were kept in people's en-suite bathrooms. There were no risk assessments to determine whether this was safe and no records of the temperature at which they were stored. Medicines may spoil if they are not kept at the correct temperature.

From our review of MARs it appeared that most people were given their medicines correctly. However, we saw care workers did not always follow the detailed instructions on medicines labels. Some medicines needed to be given an hour before food or on an empty stomach in order to be absorbed properly, whilst others needed to be given with or after food to avoid unwanted side effects. We saw medicines to be taken before food were given at the same time as those that should be taken after food. From our discussions with care staff we found there were no systems in place to ensure that medicines were given at the correct time with regard to food and drink.

Many people living in the home were prescribed medicines to be taken only 'when required', such as painkillers, laxatives and medicines for anxiety. There was no clear information available for care workers to follow to enable them to support people to take these medicines correctly and consistently. Some of the records directed care workers to give the medicines at specific times; this increased the risk that people would not be given their medicines safely and when people needed them. For example, we found some of the timings suggested on the MARs could lead to doses of Paracetamol being given less than four hours apart. Paracetamol can cause serious side effects if doses are given too close together. Failing to administer medicines safely and in a way that meets individual needs placed the health and wellbeing of people who lived at the service at risk of harm.

The registered manager told us they carried out regular checks to see how well medicines were handled. However, they told us they had not done any checks recently so were unable to show us documentation to evidence these checks were effective. It is essential to have a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home.

This showed us that people were not protected against the risks associated with medicines because there were not appropriate arrangements in place to manage medicines safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care staff had a good awareness of what to do in the event of an emergency situation such as a fire or a medical emergency. Signage was displayed throughout the home to guide people about the correct procedures to follow in the event of a fire. However, there was no procedure on display detailing what to do if medical issues arose in the home and who the out of hours emergency contacts were. This risked that care staff would not consistently follow the correct procedure in the event of a medical emergency. This was raised with the registered manager who said they would work with their community matron to develop a procedure and ensure this was addressed as an immediate priority.

Many people lived with dementia so were unable to tell us whether they felt safe. However, one person who could speak with us said, "Yes it's lovely here; I am always warm

Inadequate

Is the service safe?

and comfortable." Another person smiled and nodded their head when we asked if they felt safe. We spoke with two people who visited their relative. They both spoke positively about the care their relative received and said, "We can both go home knowing that our [relative] is being well cared for and is in a safe secure environment."

There were risk assessments in place in care plans which identified the risks for the individual and how these could be reduced or managed. We saw risk assessments relating to mobilisation, tissue viability and nutrition. Discussions with care staff indicated to us that they were fully aware of the benefits of robust risk assessments in delivering safe care and monitoring people's wellbeing.

Safe recruitment procedures were in place to ensure staff were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check and two written references before staff commenced work.

From our review of records, observations and conversations with people we saw that there was adequate staff to meet people's needs, for example in supervising communal areas, answering call bells and attending to people when they needed assistance. The deputy manager confirmed that the dependency of each person was taken into account for calculation the staffing requirements for each shift. We were also told that extra staffing was used if a particular person's care needs increased. Care staff we spoke with confirmed this and provided an example where this had been the case in the week prior to our visit.

We spoke with the registered manager and provider about the plan to increase occupancy at the home in line with the newly opened extension. They told us that the increased occupancy would be dependency assessed and matched with adequate numbers of suitably qualified care staff to ensure a safe environment. We were also reassured by the provider that adequate managerial and administrative support would be allocated to ensure the effective and safe running of the service.

Requires Improvement

Is the service effective?

Our findings

Care staff did not receive effective training and support. We reviewed training records. We found most staff had not completed received recent training in key areas. For example, eight out of 33 care staff had received recent first aid training and dignity awareness training. We saw evidence this directly impacted on people. Our observations during lunch showed that some care staff did not demonstrate a good awareness of how to support people with dignity and respect. We saw some care staff assisted people to eat from a standing position, did not offer choices or options and removed table cloths whilst people were still eating at the table. We also saw that staff who were not primarily employed to deliver care provided some support during mealtimes. Their interactions with people were not always appropriate. For example, we observed they did not always offer choices and explain the support being provided to people. When we spoke with care staff they did not demonstrate a good awareness about key topics such as safeguarding and the Mental Capacity Act 2005. This further demonstrated that care staff would benefit from additional training to ensure they consistently provided people with appropriate care and support.

We saw that the registered manager would have benefitted from additional training to assist them in the completion of their duties. For example, they told us they were not confident in using a computer or sending emails. This meant it was difficult for them to complete administrative tasks such as sending adult protection alert forms.

The registered manager told us they did not conduct formal supervision or appraisals of care staff. This meant there was no evidence that management had discussed individual training and personal development needs with staff members. Supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern. This also meant there was no formal opportunity for management to discuss and deal with any performance issues and ensure a reflective approach to care.

This showed us staff did not receive the appropriate training, supervision and support to enable them to deliver safe and effective care. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From our review of care records we saw that nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. We saw that where people were at risk of dehydration care staff recorded people's fluid intake and output. However, these records were not always consistently completed and in some cases it was not clear why fluid charts were being kept as there was no apparent risk. We found that when nutritional assessments indicated that people's weight needed to be monitored, people were being weighed in accordance with the plan.

We observed people eating their lunch during our inspection. We saw this was a positive experience for most people with care staff providing appropriate support to encourage people to eat and drink. However, we noted two people's care records indicated they required support from staff during mealtimes. We saw care staff did not provide these two people with appropriate support to ensure they ate and drank sufficient quantities. We discussed these observations with the registered manager. They told us they would address this at the next staff meeting and would follow this up with observations of staff practices during mealtimes to ensure people received appropriate support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that two people were subject to authorised deprivation of liberty and a further application had recently been made. Our review of people's care records demonstrated that all relevant documentation was securely and clearly filed. This information was made available to care staff through people's care records to assist them with complying with any conditions. The registered manager was not aware of their requirements to notify CQC of authorisations to deprive someone of their liberty but said they would review the relevant regulation and ensure that they are familiar with the requirements.

Requires Improvement

Is the service effective?

Our discussions with care staff, people using the service and observed documentation demonstrated that consent was sought and was appropriately used to deliver care. In addition we observed care staff seeking consent to help people with their needs.

Records showed that arrangements were in place that made sure people's general health needs were met. We saw evidence that care staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community mental health nurses, audiologists, chiropodists and dentists.

We saw that where a health care professional had indicated a particular course of treatment or care that this had been attended to. For instance we saw that a discharge from hospital letter had indicated that urgent foot care was needed. We saw that the arrangements had been made and a record of the attendance of the chiropodist indicated this had been completed within an appropriate timeframe.

Good

Is the service caring?

Our findings

Most people who lived at the service were living with dementia so were unable to speak with us about their experiences. To enable us to understand the experiences of people we used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the home. We also spent time informally observing interactions between people and care staff. Overall, we saw people appeared at ease and relaxed in their environment. We saw that people responded positively to staff with smiles when they spoke with them. We observed staff included people in conversations about what they wanted to do and explained any activity or support they provided prior to it taking place. People appeared comfortable and were well dressed and clean which demonstrated care staff took time to assist people with their personal care needs.

The three people we were able to speak with told us the standard of care provided was consistently good. One person said, “They care for me really well here. The staff are angels from heaven who know me and help me live my life as best I can.” The two visitors we spoke with told us they were always made to feel welcome whenever they visited and were encouraged to visit their relative whenever they wanted to.

Care plans were easy to follow and provided care staff with information about people’s individual preferences and how they wanted their care to be provided. We saw they contained information about what the person could do for themselves and identified areas where support was required. This helped provide care staff with information to help encourage people to retain their independence. We saw evidence of care staff actively trying to promote people to retain their independence wherever possible. For example, one person enjoyed washing their own clothes. The registered manager explained this person regularly spent time in the laundry doing their own washing and helping the laundry assistant because they enjoyed doing this.

Care staff were able to tell us about people’s care needs and the support they provided to people. They demonstrated knowledge and understanding of people’s different personalities, preferences, routines, likes and dislikes. This was supported by our observations which showed staff knew people well and how they preferred to be supported. We saw people and staff shared jokes together and there was lots of laughter between them; this showed us staff had built meaningful and appropriate relationships with people which helped to create a relaxed and homely environment.

We noted that staff always knocked on doors prior to entering people’s bedrooms and showed discretion when attending to people’s continence needs. This showed us staff were respectful of people’s need for privacy and dignity. When we looked in people’s bedrooms we saw people had been able to make choices about the decoration and were able to personalise their rooms with their own furniture and personal items if they wished.

Requires Improvement

Is the service responsive?

Our findings

The service had a complaints procedure in place. We looked at the details of the six formal complaints received between June 2013 and October 2014. We found the records kept were not always comprehensive and did not always demonstrate that appropriate action had been taken to try to resolve issues for people.

A complaint was received in March 2014 regarding care staff not appropriately meeting one person's continence needs. From our review of records it was not clear what action had been taken in response to this issue as the records regarding the outcome of the complaint were incomplete. The complaints log indicated two complaints were received in September 2013. However, we were only able to see records relating to one complaint during the month of September 2013. We asked the registered manager about this. They said all records of complaints should be kept within the complaints file. They were unable to show us any further documentation relating to complaints.

We also saw evidence of a recurrent complaint. One person had made a complaint in June 2013 that their relative's clothing drawers were untidy. The same person complained again in September 2013. They stated the same issue was still occurring and that staff had not taken appropriate action to ensure their relative's clothing drawers were kept tidy. This showed us that the issues raised in the initial complaint may not have been addressed and resolved to the complainant's satisfaction.

We saw complaints audits had been completed up until June 2014. However, these were not effective in picking up and addressing the issues identified above and it was therefore not a robust auditing system.

This showed us ensure there was not an effective process in place for identifying, receiving, handling and responding appropriately to complaints. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From our review of care records we saw that people and their relatives had contributed to the initial assessment of people's care needs. However, in the care files we reviewed we did not see evidence of regular ongoing reviews with people, their relatives, advocates, care staff and any relevant healthcare professionals. The registered manager explained that people usually received an annual review with their social worker. However, there were two people who lived at the home at the time of our visit who did not have a designated social worker as their care was not funded by a local authority. The registered manager said they operated an open door policy and encouraged people to come to them if they had concerns or wanted to change the care and support they received. However, without a formal care review process the service was unable to ensure that the care and support being provided remained appropriate and met people's current needs. We raised this with the registered manager, who assured us they would introduce a more formal and structured care review process.

During our visit we saw care staff took time to engage people in reminiscence therapy and life story work. We saw people looking at their old photographs and discussing them with other people. We saw care staff encouraging people to talk about things of the past aided by the service's collection of old household items. People's facial expressions indicated they enjoyed this activity. Reminiscence can improve mood, wellbeing and mental abilities of people living with dementia. The registered manager explained that the service did not operate a formal activities programme. They said activities were led by people depending on what they wanted to do each day. They said care staff organised regular quizzes, games, visiting entertainers and seasonal social events. However, care staff were not allocated designated time for activities and there was no formal activities plan to work to. This risked that care staff prioritised other care tasks ahead of engaging people in social activities.

The registered manager told us an assessment was completed before people moved into the home to make sure staff could meet the person's needs. We saw evidence of this in the care records we reviewed. We found care records to be clearly written and logically filed to enable ease of access of information for care staff. Care plans and risk assessments had been completed in key areas such as; eating and drinking, falls assessments, moving and handling, mobility, cognition and tissue viability. We found these were usually reviewed each month.

We saw evidence that care records had incorporated advice and recommendations given by other healthcare professionals, such as dieticians, to help care staff to meet people's changing healthcare needs. We spoke with a visiting district nurse who provided positive feedback

Requires Improvement

Is the service responsive?

about the quality of care. They told us "I would be quite happy if a relative of mine was to come to live here. It's really homely, the staff and management are approachable, take my advice on board and seem to be pro-active in responding to people's changing healthcare needs".

Staff handovers took place at the beginning of each shift. Care staff explained that during handovers each resident was spoken about and any changes in their care needs were discussed. This ensured staff could provide responsive care.

Inadequate

Is the service well-led?

Our findings

We had previously inspected the service on 12 February 2013 and identified that the systems in place to assess and monitor the quality of care were ineffective. We found that this breached Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A compliance action was set for this breach. We returned to the service on 7 June 2013 and found that improvements had been made to the auditing and quality assurance systems.

During this visit we found the provider and registered manager had not ensured that these improvements were sustained. The systems in place to check the quality of care were inadequate. In the "Safe", "Effective" and "Responsive" sections of this report we identified failings in a number of areas. These included; the medicine management system, management of safeguarding, management of complaints, staff training and support and the safe management of the premises. These issues had not been identified prior to our visit, which demonstrated an absence of robust quality assurance systems.

In the six months prior to our visit the registered manager told us they had been focusing on the development and opening of the new extension to the service. We found this meant management checks had not been completed and there was a lack of effective and consistent leadership.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. There was not a robust system in place to ensure accidents and incidents were consistently reviewed. The registered manager told us they had asked the deputy manager to complete the monthly review of accidents. However, the deputy manager told us they had not had time to complete the analysis since June 2014. This meant we were unable to see evidence that trends and patterns were identified and that appropriate action was being taken to manage risks to people who used the service.

The records of accidents and incidents were inadequate. They did not contain sufficient detail to demonstrate that appropriate investigations and preventative action had been taken to manage and reduce risks to people. For example, we saw an accident report had been completed in August 2014. It documented that a person had fallen out of bed whilst reaching for their buzzer. There was no evidence to show care staff had taken action to reduce the risk of this person falling out of bed again, such as reviewing the location of their buzzer. Both the registered manager and deputy manager were unaware of the actions staff had taken in response to this incident.

We found incident forms which documented that two incidents occurred in March 2014 where the police had been called to the service due to the escalation in behaviours of one person. Neither of these incidents had been referred to the CQC. It was also not clear from reviewing these two incident forms that appropriate action had been taken in response to the incidents, such as reviewing care plans and risk assessments relating to this person's challenging behaviour. These omissions had not been picked up as part of an effective system to identify and manage risks to people's health, welfare and safety.

We found there were not robust systems in place to assess and monitor the quality of care provided. Although some audits of care records had been undertaken in 2014, these were not fit for purpose. We found some people's food and fluid charts were not being correctly and consistently completed. The registered manager did not realise these had been incorrectly completed by care staff. This issue had not been identified and rectified through an effective system to assess and monitor the quality of care records.

The provider told us they visited the home each week and completed regular checks of the premises. These checks were not formally recorded. The registered manager told us they walked around the building each day to check for any issues or problems. These checks were also not recorded. We were unable to see evidence of other audits relating to infection control and medicines. This further showed there was a lack of robust quality assurance systems.

We found the service did not have adequate systems in place to ensure people were regularly asked for their feedback about how the service should be run. The registered manager told us they did not have meetings with people who lived at the service because they had not worked in the past. They said they operated an open door policy where they encouraged people to come to them to raise any concerns or issues they had with the quality of care and support they received. They also told us they conducted annual surveys of people's relatives to ask for their views about the service and how they felt it should be run. However, the last survey was completed in March 2013,

Inadequate

Is the service well-led?

so was not reflective of people's current views. We also saw that the service did not operate their own formal care reviews to ensure that the care and support being provided remained appropriate and met people's current needs.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found safeguarding incidents were not always reported to the local authority Adult Protection Unit and to the Care Quality Commission (CQC). If referrals were not made this meant external agencies were unable to effectively monitor issues and decide if a plan to keep people safe was required. One incident recorded in July 2014 identified that one person who lived at the service "began to punch" another person on the arm. Another incident between two people was recorded in May 2014 and stated there was "punching", "digging nails" and "grabbing by the hair". These are both examples of safeguarding incidents which both the CQC and the local Adult Protection Unit should have been informed of, but were not. We wrote to the provider and the registered manager on 4 December 2014 and reminded them both of their duty to ensure they notified the CQC of certain incidents which occurred at the service. We explained that if we found evidence they had failed to notify the CQC of these incidents in the future this could result in enforcement action being taken against them.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The people, relatives and care staff we spoke with provided positive feedback about the manager. They told us they felt able to raise issues with them and had confidence they would take action to address any concerns they had.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not ensured that people were protected against the risks associated with unsafe or unsuitable premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure that people were safeguarded from the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not ensured people were protected against the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The registered person did not ensure there was an effective process in place for identifying, receiving, handling and responding appropriately to complaints.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure the people they employed were appropriately supported to enable them to deliver care safely and to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected people against the risks of inappropriate or unsafe care and treatment, as it was not regularly assessing and monitoring the quality of services provided, nor identifying, assessing and managing all risks relating to the health, welfare and safety of service users. There was no consistent analysis of incidents that resulted in, or had the potential to result in, harm to a service user. The registered person was not regularly seeking the views of people who used the service and those acting on their behalf.

The enforcement action we took:

We served a warning notice on the registered manager and registered provider stating that they are required to become compliant with this regulation by 24 February 2015.