Millfield Lodge Care Home Limited

Millfield Lodge Care Home Limited

Inspection report

Mill Hill
Potton Road, Gamlingay
Sandy
Bedfordshire
SG19 3LW

Tel: 01767650734
Website: www.millfieldlodgecarehome.co.uk

Date of inspection visit:
12 April 2017
20 April 2017

Date of publication:
01 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Millfield Lodge Care Home Limited is registered to provide accommodation for up to 31 people who require nursing or personal care. The service is a single storey premises located near the village of Gamlingay. All of the rooms have en-suite facilities. At the time of our night time inspection on 12 April 2017 there were 28 people using the service. On our second day of inspection carried out on 20 April 2017 there were 27 people.

This unannounced inspection was undertaken on 12 April and 20 April 2017. At the last inspection on 5 July 2016 the service was rated as 'Good'.

There was not a registered manager in post at the time of this inspection. There had been four managers who had managed the service since the registered manager left in June 2014, however only one of these had applied to be registered prior to our previous inspection in July 2016. This meant that since January 2016 there had not been a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff were knowledgeable about how to recognise, and protect people from harm. However, we found that where incidents had occurred, these had not always been acted upon or reported to the appropriate authorities. This limited the organisations whose responsibility it was to investigate safeguarding concerns to act promptly, as required.

Staff did not always follow the guidelines on how the risks should be reduced. Reviews of individuals' risk assessments following an incident did not always consider all events of a risk of harm to the person. This put people at an increased risk of harm.

People's care plans did not always contain accurate or up-to-date information. This meant that staff were not always aware of the care needs of the people living at the home. We could not be confident that people always received the care and support that they needed.

Staff enabled people to access health care support when this was required.

People were supported to have choice and control of their lives. People's ability to make day-to-day and more complex decisions about their care and welfare were assessed by staff. Some restrictions on people's liberty had however not always been determined as being in their best interests or in the least restrictive way possible. Some staff did not have a good understanding about the application of the Mental Capacity Act 2005. This put people at risk of being deprived of their liberty unlawfully.

Staff were provided with supervision and guidance to carry out their role. However, they were not always held to account when they hadn't followed the correct procedures.

The manager and provider had not always notified the CQC about important events that, by law, they are required to do.

People, their relatives and staff were involved and enabled to make suggestions to improve how the service was run. A range of audits and quality assurance systems were in place to assess, monitor and improve the service. However, these had failed to bring about the expected improvements as identified by other agencies involved in the home.

Staff were trained and deemed competent to administer people their prescribed medicines. This meant that medicines were administered and managed safely.

There was a sufficient number of suitably qualified staff to help meet people's needs. Following the successful completion of various checks, staff were recruited and once deemed suitable were employed. This helped ensure that staff were suitable to work with people who used the service.

People were looked after with respect for their dignity. Staff provided care that was compassionate and in consideration of each person that was cared for.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Procedures had not always been followed when people had suffered harm. This put people at risk of harm.

People were exposed to avoidable risks because staff did not always follow the guidelines in risk assessments.

Staff were recruited through a robust process to ensure they were safe to work with people using the service.

People's medicines were safely managed and administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training on the Mental Capacity Act 2005 but they lacked an understanding of the Act's code of practice. This put people at risk of receiving care that was not always in their best interests.

People did not always get the support they required with eating and drinking.

People were enabled to access health care support when needed.

Is the service caring?

Good

The service was caring.

People were supported by staff with kindness and compassion.

People were made to feel they mattered by staff who showed concern for people's well-being.

People were free to be visited by relatives/friends at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always contain accurate and up-to-date information. This put people at risk of receiving care that was not appropriate.

A range of social stimulation was provided to help prevent people at risk of social isolation.

A system was in place for people to raise comments, concerns and complaints and staff supported people to access this.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in place. The lack of consistent management limited the provider's ability to sustain improvements.

Audits and checks for the quality of people's care were not always effective. Staff were not always held accountable for their work. This put people at risk of having care that was inappropriate.

The provider had not always notified the CQC about events that they are required to do so.

Millfield Lodge Care Home Limited

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 12 and 20 April 2017, was unannounced and was undertaken by an inspection manager and two inspectors. Part of the reason for our inspection was due to concerns reported to us. These concerns were about people's safety, support and the leadership of the service.

Before the inspection, the provider completed 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 looked at this and other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

Prior to the inspection we made contact with the service's local GP practice, local authorities who commission people's care, including social workers. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

We spoke with four people and five relatives. We also spoke with the nominated individual (this is the person who has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the services provided), the manager (on the first day of our inspection), two nurses, one senior care staff, two care staff, the training provider, chef, activities coordinator and a visiting health care professional.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records, six people's medicines' administration records and three records in relation to the management of the service and the management of staff. We also looked at audit records and records of the management of the service.

Requires Improvement

Is the service safe?

Our findings

We found that where accidents and incidents occurred, these had not always been included in people's risk assessments to help reduce the risk of further incidents, including falls.

Staff were able to tell us, as a result of their safeguarding training, what measures were to be taken to reduce people's risk of increased anxiety. However, guidance for staff in people's care plans about how to manage these risks was limited. We found that there were no recorded details of what support was to be given to reduce people's anxieties or what individual calming measures worked for people.

Risk assessments were not always in place for people that needed special diets. The manager told us that one person was having their food liquidised as they were experiencing problems eating food of a normal consistency. However, there was no risk assessment in place identifying the risks to the person or how they should be reduced.

We found that although risk assessments were in place regarding maintaining people's skin integrity; staff were not always following the guidance. This placed people at risk of not being safely supported.

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

A range of information was provided to people, their visitors and staff on who they could contact if any person was at risk of harm or poor care. This information included the local authority's contact details. Staff had received training on safeguarding people from harm. However, we found that where incidents of harm had occurred these had not been reported to the appropriate authorities.

Where people could have behaviours which challenged others, we saw that incidents of harm that had occurred had not been acted upon as the support from the local safeguarding authority had not been sought. This was not in line with the provider's policies and procedures. In addition, where incidents had occurred these had not been always reported to the local safeguarding authority. This lack of reporting also included the requirement to notify the CQC.

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

People told us they felt safe because staff were there when they needed them. Information in care plans asked people, "Is there anything you are frightened or worried about?" One person said, "I have my call bell right by my side and they [staff] come within a few minutes." Another person said, "I need a walking frame with me and the girls [staff] make sure it is near me and that I use it." One relative told us, "There are always staff around when I visit." Another relative told us, "I call in very regularly and if ever my [family member] needs or asks for anything they [staff] are reasonably quick to respond."

We found that staff had been recruited in a safe way. One staff member told us, "I had to provide my driving licence, proof of my address, two references and one from my most recent employer." Records confirmed that staff had been subject to a check for any criminal records with the Disclosure and Barring Service. Another staff member said, "I had to sign to say that I was fit and healthy to care for people." The manager told us that they had kept their registration with the NMC up to date. People could be assured that they were cared for by staff who were suitable to work at the service.

The records showed and discussion with the nominated individual confirmed that people's dependency needs and the staff required to meet these were reviewed regularly. This was to help ensure that there was sufficient staff to safely meet people's needs. We found during our inspection that there were sufficient staff to meet people's needs. One person said, "I need two of them [staff] to help me up, have a bath or shower. There are always two and they are very careful with me."

We found and staff told us that there were sufficient staff to meet people's assessed needs. One staff member told us, "If staff call in sick or are on leave we can cover this with off duty staff, overtime or the use of regular agency staff." A relative told us, "They [staff] are busy but never so busy that they don't have time for a chat or a cuppa." During the inspection we saw that staff were available when people needed them. However, there was some confusion over which staff were responsible for supporting which people. For example, staff gave us differing accounts of which staff were responsible for which people.

Nurses were responsible for the administration of medicines and they had had their competency assessed to ensure that they administered medicines safely. One person told us "They [staff] always make sure I take all my tablets and they apply my creams." A relative said, "[Family member] would soon tell me if they had not had all their medicines. Medicines were stored securely, disposed of safely and records we viewed showed that people had been administered their medicines as prescribed. Systems were in place for people who required support with their 'as and when needed' (prn) medicines, such as those for pain relief and the frequency people could have these if required. People could be assured that they would be administered medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. Although staff had been trained on the MCA and its code of practice, we found that some staff lacked an embedded knowledge of this code. For example, where people lacked the ability to safely consent to the use of bed rails. Although staff told us they had discounted other options such as a sensor matt, there was no record if these bed rails were in people's best interests; or if bed rails were the least restrictive option to safeguard people. We found that where people had capacity this was not accurately reflected in their care plan. This was because where people lacked capacity;contradictory records had been made where the person had agreed to things that they lacked capacity to understand their decision. This was identified in two out of the five records we looked at. This created a risk of people being provided with care that they had not agreed to.

Where people needed to be deprived of their liberty, including renewals for these, we found that DoLS applications had been sought, authorised and included in people's care plans. However, these applications had not always been made in a timely manner. In one situation an application had not been sought for over six months. The application had been made but only when this was highlighted by the local authority. We also found that when some DoLS authorisations had expired, renewal applications had not been made. These DoLS were about the support people needed with their choices such as where to live and be safe.

People did not always get the support they needed with eating and drinking. The care plans stated that some people required thickener in their drinks to prevent problems when swallowing. However, we saw during the inspection that one person had not been supported to have the thickener in their drink as stated in their care plan. There was confusion amongst the nursing and care staff about whether the person required thickener in their drink or not. This meant that we could not be confident if people had the nutrition they needed.

One person said, "We have a choice of what to do, what to eat and where we spend our time it's up to us." Another person told us about their preferences by saying, "I am always asked if I want to join in with lunch time but I like to eat here in my room." Another relative told us how they took their family member out for lunch.

People told us that they could choose what they ate and that staff encouraged them to do so. One person at lunchtime said, "I love the food, always a choice." We observed that the lunchtime was an occasion where people could enjoy their meals together, in the place they liked to eat and at a pace people preferred. Records and our observations confirmed that people had been offered choices of food and drink including those people who required a vegetarian, soft food or pureed diet and any supplements. One person whilst

showing us their empty plate said, "That was gorgeous." Another told us, "If I want something else I can have it." One relative said, "Snacks and drinks are offered throughout the day."

We found that mealtimes were an occasion where people could socialise as well as eat. People told us, and we could see for ourselves, that they could choose what to eat from a choice of freshly prepared food. We found that a record was kept and monitored for the quantity of food and fluid consumed for each person at an increased risk of weight loss.

A planned programme of staff training was in place to help meet people's assessed needs and preferences. This included support for care staff as well as clinical supervision for nurses. Other training was provided to help maintain staff skills in the preparation of food. Subjects staff had been trained on included first aid, moving and handling, safeguarding, medicines administration, the Mental Capacity Act 2005 (MCA), dementia care and fire safety. This was as well as more in depth training if this was required such as dementia care and diabetes. One staff member told us, "I have regular training from [training provider]. She explains things clearly and in a way I understand. We get frequent updates as well as answers to any questions we may have." However, we are not sure if staff had learnt from the training as there were restrictions on people's liberty which had not been lawfully agreed.

Staff told us that their induction, training and support enabled them to meet people's needs. The training provider told us, "The [nominated individual] has clamped down on staff who don't attend training and I offer different times and dates. Staff complete a workbook to evidence their understanding of the subjects we cover." They also told us that staff's training was tailored to their needs such as by providing e-learning and classroom based training. One relative told us that based upon the training staff had received, "Staff seem to know what they are doing. My [family member] is much better than when they moved in. They are eating better too."

One person told us, "The girls [staff] definitely know what they are doing." A relative said, "I arrange everything for [family member]." This was confirmed by their family member's records. We found that the nominated individual and manager used information from national care and nursing organisations to keep up-to-date on any developments. One staff member told us, "I like having more knowledge and with the support from nurses, the trainer and [name of home owner] I keep my skills up to date." The manager said, "[Nominated individual] does my clinical supervision and helps me if I am not sure about something." A nurse told us that they kept all their knowledge and skills up to current standards and that they had attended a day's training for their revalidation with the Nursing and Midwifery Council. This showed us that staff kept their care and nursing skills up to date.

Referrals to appropriate health professionals were made promptly where the risk to people required external interventions. This included the advice as well as inputs to people's health from a GP, Speech and Language Therapists (SALT) and Tissue Viability Nurse (TVN) to help maintain people's health. We also saw where staff had sought health care support and advice from opticians and chiropodists. One person told us, "I am happy knowing that when I needed a GP they [nurses] called one for me and they came the next day." Records demonstrated that staff were proactive in obtaining advice or support from health professionals when they had concerns about a person's health and wellbeing.

Good

Is the service caring?

Our findings

All of the people and relatives we spoke with were complimentary about the care that was provided. One person told us, "They [staff] are always popping in and asking me if there is anything they can get me." A relative said, "I would recommend the care here as my [family member] seems ever so settled. They [staff] just can't do enough for you." Another told us, "They [staff] are really careful when getting [family member] up out of bed; always take very good care when applying creams." However, we did observe how some staff kept repeating responses to people's questions. This was without exploring other options to settle the person. We saw that the person continued to ask the same questions which staff accepted as being normal. This put people at risk of not always being treated with respect. The nominated individual told us they would revisit staff's dementia training as well as bringing this point up at meetings

Reviews of most people's care involved the person, their relative or appointed representative at each occasion this took place. Information from these reviews was used to help ensure that the care people received was based upon what was important to the person.

One person said, "I like all the carers [staff]. They are always polite and kind to me." A relative told us, "I can't fault how nice they [staff] are to my [family member]." A visiting healthcare professional said, "This is my first visit but the staff appear helpful and friendly." Another relative told us, "Staff pay attention to [family member] as they know the exact quantity of prunes [family member] prefers." This showed us that the care provided at the home was centred on the person and ensuring people really mattered.

We observed that staff spoke with people in a kind and considerate manner such as encouraging them to do what they wanted and supporting them to do this. This included helping, and supporting people to, rearrange the books on a shelf to the person's liking. Staff encouraged people to be independent. Examples of this were at lunch time where we observed how people were encouraged to eat independently such as cutting up their food but then supporting them to eat it with only the necessary support. We also saw that where people needed support with eating and drinking that staff did this sensitively and in an unhurried way. This reduced the risk of people losing the skills that they still possessed.

We observed that staff sought permission (where the person was able to give it) to enter people's rooms. This was by knocking on a closed or open door and waiting for permission to go in or by introducing themselves with respect to people's privacy. People could be assured that staff would treat them with the care and compassion they deserved. However, the impact on people's privacy as a result of surveillance equipment in the gardens, entrance and parking areas had not been assessed. This had the potential to infringe people's right to a private life. The nominated individual provided us with information following the visit informing us that they had acted on this point.

We found that people could have visits by friends and families when they wanted. One person said, "I love my grandchildren and family visiting." One relative said, "I can and do visit [regularly]. I feel as much at home here as my [family member]. There is always someone [staff] to talk with and that is important for my [family member]." Staff knew about people's families and their visitors as well as what was important to the person.

People's care records were held securely and daily care records were used to record some of the care people had received. This was as well as a staff handover detailing any changes to people's care. This helped staff respect how people had wished or needed to be cared for.

We found that people who required advocates to support them with their care such as a Lasting Power of Attorney had this in place. We saw that information was displayed and provided for any external and independent advocacy. The manager told us that support was provided where people required someone to advocate for them to speak on their behalf.

Requires Improvement

Is the service responsive?

Our findings

We found that prior to using the service people's needs were assessed. Information regarding the assessment of people's needs was obtained from the person, their relatives, health care professionals and others associated with determining what worked best. This was as well as determining if the service could meet people's needs.

We found that people's care plans did not always accurately identify or record the most up-to-date information about the person. For example, where people had behaviours which could challenge others, care plans had not been updated to ensure it gave the staff the information they required. This put people at risk of being supported in a way which was not centred on the person. There was also contradictory information in some people's care plans. One care plan stated that the person ate well and that they did this independently. The care plan also recorded that the person ate a pureed diet due to their health condition and it "remained relevant and to be reviewed monthly". However, the care plan said that this person needed staff to "assist with feeding". And then, "[person] likes (certain foods)". The care plan did not state whether this was pureed or not. This meant that there was a risk of people having a diet that was not appropriate.

Staff told us that another person required a pureed diet. This person's food chart stated on the 16 April 2017 "(what pureed food the person had eaten)." However, the care plan did not state that the person was on a puree diet. There had been five occasions where staff had recorded a normal diet had been provided. The most recent review of this person's nutrition care plan did not include the information that the person was on a pureed diet. Although staff had made the chef aware, the chef produced the required number of meals but the list the chef had about people's dietary requirements was not accurate. This meant that there was a risk of the person having a diet that was not appropriate.

In another person's care plan it stated, "[Person] eats nutritious food; eats independently; continues to eat pureed diet due to swallowing problems. However the person's care plan recorded that they needed staff to "assist with feeding". A nurse said that, "The care plan is wrong [person] has been able to feed themselves for months." The nurse also said that they "did not know why [the person] was on a repositioning chart as they can do it for them self." In a third person's care plan we saw that the person required their drinks with thickener (a powder or gel used to thicken foods for people with a difficulty of swallowing). This was meant to be provided in a beaker (specialised cup to aid with drinking) but we found they had a normal glass with no thickener in the squash or the water in the person's room. Not all staff were aware of this person's needs and one member of staff assisted the person to drink without thickener. There was no guidance for staff on the type, quantity or consistency of the thickener to be used. The most recent reviews of the person's care plan stated, "can manage fluid with thickener." This meant that people with a swallowing disorder were at risk of not having their foods and drinks in an appropriate format for their needs as care plans were contradictory and inaccurate.

Where people required management of their wounds the dates for wound dressing changes had not always occurred on the identified date. We found that some dressings had been changed two days later than the due date. Two of the three people's records stated that they required to be repositioned every two hours.

However, the records showed that the people had been repositioned every four hours. On the second day of the inspection we asked to look at the repositioning records for three people. We found and staff told us that these records had not been completed. The nominated individual told the staff that this was not acceptable. This showed us that although people's needs had been planned for, staff did not always complete an accurate record. This put people at risk of receiving care that was not based upon their needs. We could not be confident that people were receiving the care that they required.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The activities coordinator gave us many examples of the pastimes, hobbies and interests' people had taken part in and enjoyed. For example, on the second day of our inspection the planned outdoor activity was changed with people's agreement due to cool weather. Some people where appropriate did however go out with family members for lunch. In the afternoon, as an alternative, we saw people engaged in reading, playing hoopla and listening to music. One person who was reading a magazine said, "I love horses and reading about them." Other people were supported in their rooms with one to one support. One relative told us, "They [staff] when bringing a drink or meals always have a chat. They know I'm there but that doesn't stop them paying attention to [family member]."

A range of social stimulation, hobbies and interests were provided. The activities coordinator told us how the exercise sessions they undertook had benefitted people to increase their strength, mobility and independence. One person said, "I am always asked if I want to take part. I prefer to be in my room watching TV or reading as well as having my own peace and quiet." One relative told us, "[Family member] has to have a [specific] diet and they [staff] make sure this is provided." Staff told us and we found that if people needed any cultural or religious support that this was provided.

A number of systems were in place to encourage people to comment about the quality of their care. For example, at the regular contact meetings relatives and people had with their named staff as well as the nominated individual. We saw that a residents and relatives meeting was planned for 22 April 2017 where any concerns could be raised. This was as well as responses by the nominated individual to recent concerns identified by the local authorities. One person said, "I would speak with [name of owner] as she is always around. My concerns are sorted before they become a complaint." One relative told us that they had spoken with the [nominated individual] about concerns their family member had had and that their concerns were being addressed. One staff member said, "If ever anyone is unhappy about something I would try to sort it out if the solution was easy. If not, I would record this and speak with a nurse or [nominated individual]."

We saw that where complaints had been made, actions had been taken to the satisfaction of the complainant. A number of compliments had been made such as, "We sincerely, with the utmost appreciation thank you and you and all the carers and rest of the staff for looking after [family member] with great love and dedication." The nominated individual used complaints as well as compliments to identify what worked well within the service.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider had not always submitted notifications about important events they must tell us about when this had been required. We had not received notifications about several important events such as safeguarding and serious injuries.

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

During this inspection we asked the nominated individual to provide us with information about people who had experienced incidents of harm. We required this information to be sent to us. However, we did not receive this information.

There was a lack of effective quality assurance systems being used to drive improvement. The local authority and Clinical Commissioning Group had carried out reviews of the service provided. They identified that improvements were needed to ensure that records were accurate and a true reflection of the care being provided. During our inspection which took place three months after this had been identified we found similar concerns in relation to the records. This meant that where there were opportunities for improvement, the provider's systems had not identified these.

We found that on two separate days there were no repositioning records completed from midnight until 8.30pm for a person at risk of poor skin integrity. This lack of records had also been identified and fed back to the nominated individual by the local authority. Care plans and recording of the care and treatment received by people were not up to date. One nurse told us that they had changed a person's dressing the previous day but had not recorded it in the relevant chart.

On the second day of our inspection, we found that for two people there was no completed record at all for food, fluids and repositioning. This was for where they had been identified as being at risk. Staff told us the people had been fed and repositioned, although a lack of records meant we could not be sure that this had happened. The nominated individual stated, "I tell staff if it's not written down then there is no evidence it has happened." We also found that where omissions in recording of care had occurred staff who had subsequently recorded people's interventions had not reported the recording omissions. Staff had not been held accountable for omissions in the records.

We asked a nurse and the provider if a person was on a pureed diet. The nominated individual told us, "Yes, pureed and soft but it's probably not in the care plan is it?" The review of the care plan had not identified that it was not accurate. This meant that audits and reviews were not effective in driving improvement and put people at risk of receiving care that was not based upon their needs.

One local authority had visited the service in March 2017 and identified a need for one person to have their DoLS reapplied for as it had expired. The DoLS had not been valid since September 2016. This meant that for over six months this person had been unlawfully deprived of their liberty. Although the nominated individual had reapplied for a renewal of the DoLS, the audits and checks that were in place had not identified this

shortfall. Once again, audits had proved to be ineffective in identifying required improvements.

Audits, checks and reviews of people's care had been undertaken and where reportable events had occurred the nominated individual's audits had not identified this omission. This limited the CQC's ability to contact other organisations should they have needed to. This also limited the provider's ability to identify trends such as incidents of harm or potential harm.

The local authority had imposed an embargo on admissions of people funded by them. This was until such time that improvements were made. This was because they were not confident, that following several visits that improvement in the quality of service provided was occurring.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the nominated individual was displaying their previous inspection rating conspicuously in the home and also on their web site. The home did not have a registered manager. The most recent registered manager left in June 2014. Although there had been several managers employed since that date, only one had applied to be registered but withdrew their application in January 2016. This meant that since January 2016 there had not been a registered manager in post to provide stability of management. The manager who was in post on the 12 April 2017 had informed the nominated individual that the role was not for them and they were not present on the 20 April 2017.

People and their relatives knew the manager by name and that they saw them frequently around the home. One person told us, "I know the manager, she's very nice and I would feel comfortable talking to her if I needed to." A relative said, "I would speak to the manager if I had a problem." Staff told us they felt motivated in their roles and every opportunity to improve the quality of people's lives was taken, such as the recruitment of a permanent activities coordinator.

The nominated individual told us that the values of the home were putting people first. They said that staff were regularly reminded at meetings and supervisions of why putting people first was important. This was as well as staff being enabled to have a two way discussion about what support they needed. For example, staff had been reminded to record any care that had been provided. We highlighted that staff had not always done this to the nominated individual and they said that it was not acceptable as staff are regularly reminded that they should record action at the time it is taken and not later during the day. They spoke with staff about this matter during our inspection and added that they were taking back the responsibility to review and update care plans.

Staff we spoke with told us that they were happy and satisfied with the support they received from the nominated individual. For example, working with experienced staff, training, supervision and development. This was by mentoring staff and by using staff who had a passion and skill for caring for people living with dementia and to coach other staff with these skills. One relative told us, "They [staff] always help each other no matter what time of day it is. [Name] is particularly good with my [family member]. All staff have a can do attitude." Another relative told us that their family member received good care because, "Staff are fantastic."

We saw that the nominated individual was in the process of acting upon some improvements required as a result of local authority contracts' monitoring visits. Other changes were planned such as to the kitchen and laundry. The nominated individual told us that they now had quotes for this work.

People were supported to access the community such as with their relatives and staff, with visits from

religious groups, to local cafes and garden centres. The activities coordinator said, "I bring my grandchildren and people love to see them. We also have the school choir come at festive periods."

As a result of the work of the chef and audits of food hygiene the service had received a rating of five from the food standards agency. This demonstrated good food preparation standards. In addition, the training provider was qualified to train people, had qualifications to do this and had experience of working in care. This helped them empathise with how staff worked and the challenges they faced.

All staff told us that if ever they identified or suspected poor care standards they would have no hesitation in whistle blowing (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work). The training provider said, "Staff are given anonymised examples of how to keep people safe and what harm could look like. I am confident that they [staff] would report this. I have even seen staff pull each other up if there was a risk of harm."

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had not always notified us about events that by law they are required to do so.

The enforcement action we took:

We decided to impose a condition on the provider's registration. This was to prevent further admissions. We also imposed a positive condition that the provider must have governance that was fit for purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People who use services and others were not protected against the risks associated with receiving care that was not as individualised as it could have been.

The enforcement action we took:

We decided to impose a condition on the provider's registration. This was to prevent further admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were at risk of receiving care that was not safe. This was because the actions needed to support people safely had not been recorded.

The enforcement action we took:

We decoded to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
	Service users were not always protected from harm as well as they could have been. Safeguards in place had not always been determined as being lawful.

The enforcement action we took:

We decided to impose a condition of no further admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Records were not always accurate. Risks to the quality of people's care was not minimised as audits and governance of the service was not as effective as it could have been.

The enforcement action we took:

We decided to impose a condition on the provider's registration. To prevent further admissions to the service. We also decided to impose a condition on the provider's registration that they must send us governance records and arrangements on the first Monday of every month.