Mr & Mrs M Ellis

Woodthorpe View Care Home

Inspection report

53 Woodthorpe Drive
Woodthorpe
Nottingham
Nottinghamshire
NG5 4GY

Tel: 01159624556

Date of inspection visit:
06 February 2017
01 March 2017
08 March 2017

Date of publication:
30 May 2017

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**

Summary of findings

Overall summary

Woodthorpe View Care Home provides accommodation for up to 28 people who require personal care. At the time of our inspection 19 people were living at the home and one person was in hospital. A number of people were living with dementia.

The home was last inspected in June 2016 and was rated 'Good'. Due to concerns raised by the local authority safeguarding team in relation to the management of falls within the home, this inspection was brought forward.

This inspection took place on 6 February, 1 and 8 March 2017. The first inspection visit was unannounced, with the second announced to ensure the provider had sufficient time to meet with us. The third visit was unannounced to check whether actions the provider assured us they would take after our second visit had been taken. Due to the seriousness of concerns found during our first visit we held a meeting with the provider. During the meeting we shared our concerns with them and requested that immediate actions were taken to ensure people's safety. At the time of our third visit some of the actions they had assured us they would take had not been completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had a registered manager (who is also the provider) in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We will refer to this person as the 'provider' throughout the report.

The provider did not have sufficient systems and processes in place to assure themselves that people received safe and good quality care that met their needs. We found risks associated with people's care were not always identified and managed well to make sure people were protected from the risk of harm. Learning was not taken from previous incidents to reduce the risk of similar incidents from occurring again and actions were not taken to drive improvement at the home.

Assessments of people's care and support needs were not always undertaken prior to people coming to live at the home. People's care records were not always detailed and personalised to give staff guidance on how people preferred to receive their care and how they care needs were to be met. We could not be sure that the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care. People were not always supported to maintain good health as referrals to healthcare services were not always made when people's needs changed. For example, we saw that referrals had not been made to GPs or the Falls Team when people had fallen.

Medicines were not managed and administered safely in line with current guidance.

The provider and staff did not understand the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were not undertaken for people who might need them and people were restricted of their freedom without the necessary legal authority to do so. However, people who were able to were supported to make decisions about their care and support.

People were supported by individual care workers who had undertaken training to have the skills needed to provide safe care and support, however processes to ensure people received care that met their care needs were not in place. People were supported to maintain their nutrition and had a choice at meal times.

People who were able to express their wishes lived in a home where staff listened to them. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting. People were supported to participate in activities they enjoyed.

People were involved in giving their views on how the service was run however we could not determine how this information was used to drive improvement at the home.

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.

Risks associated with people care were not identified and managed well. Measures to reduce the risk of people falling were not in place and this resulted in people experiencing repeated falls. Medicines were not managed or administered correctly which meant we could not be sure people received their medicines are prescribed. Overall, people told us that staff were available at the times they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not understand the principles of the Mental Capacity Act 2005 therefore decisions may not always be made in people's best interests. People's liberty was restricted without the necessary legal authority.

People were supported by staff who received training and supervision. People were not always supported to maintain good health as referrals to healthcare services were not always made when people's needs changed. People were supported to maintain their nutrition and had a choice at meal times.

Is the service caring?

Good

The service was caring.

People lived in a home where staff listened to them and cared for them. People told us they were able to make day to day choices. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting. Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always responsive to people's needs.

People's needs were not adequately assessed prior to moving into the home; therefore the provider could not be assured they could provide the support people required. Information contained within people's care records was not always personalised and the level of information recorded was inconsistent. The system in place to manage complaints about the service was not effective and the provider did not follow their own policy. People were supported to take part in activities which they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. The provider failed to learn from incidents which meant people continued to be at risk of harm. Actions were not taken to drive improvement at the home. Principles of the Data Protection Act were not adhered to and people's confidential personal information was not protected.

Woodthorpe View 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.

We inspected the service on 6 February, 1 and 8 March 2017. The inspection was unannounced. The inspection team consisted of two inspectors, an inspection manager and a specialist professional advisor who was nurse with specialist knowledge in falls prevention.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received from the Local Authority and statutory notifications. A notification is information about important events which the provider is required to send us by law.

We sought feedback from health and social care professionals who had been involved in the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with eight people who lived at the home and one visiting relative to understand their views of the home.

We also spoke with four members of staff, the deputy manager, the provider and their consultant. This person had been appointed in a primary role to deliver training to staff but also provided additional support to the provider in relation to running of home. We looked at the care records of seven people, medicines records, staff training records, as well as a range of records relating to the running of the service including audits carried out by the provider.

Inadequate

Is the service safe?

Our findings

We found people were not protected from avoidable harm. Prior to this inspection the local authority had recently undertaken a safeguarding investigation and substantiated avoidable harm as adequate steps had not been taking to reduce the risk of a person falling. They told us they were concerned with how falls were managed in the home.

During the inspection we found the provider had recorded 54 falls in an eight month period which identified that 20 people had sustained a fall, five of which had more than one fall. We reviewed the care plans of those five people. We saw that the provider did not adequately assess the risk of people falling when they were admitted to the home. For example, we found that two of the five people's pre-admission assessments did not record the person's risk of falls, therefore the provider was not able to demonstrate that they had assessed the risk to people's health and wellbeing and were able to keep them safe prior to them moving in to the home.

We saw where people had been assessed at risk of falls, appropriate and timely action had not been taken to reduce the risk and reoccurrence of further falls. For example, we saw one person had fallen five times in four months. Their pre-admission assessment identified they were at high risk of falls, however the falls risk assessment showed they were at medium risk. There was no explanation for the difference in the level of risk. The person's care plan showed that a referral to the falls team was not completed until three weeks after the person had fallen the fifth time.

We saw that a request was made to the provider's alarm company for a PIR (Passive Infrared Sensor) alarm to be fitted in the person's room where they spent all of their time. We assessed the type and suitability of the alarm. We found it was not a falls prevention alarm which would indicate when the person left the bed or chair but a standard burglar type PIR room sensor. The result was that it was over sensitive to any movement within the room, including movement within the bed and chair such as arms being raised and turning over, which resulted in too many false alarms. Therefore the provider was unable to effectively monitor when the person was moving about and may need assistance. The provider had not sought professional advice about the type of falls sensor required and as a result inappropriate equipment had been obtained. Therefore opportunities to identify and reduce risks between the person's falls had been missed.

We found that one person had been assessed at risk of falls prior to moving into the home and they used a three-wheeled frame to walk with. On the day they moved into the home the person fell and sustained a fractured collarbone. The person fell again 10 days later. We saw that the provider had not made any referrals to external health professionals or sought advice to determine if the equipment continued to be suitable for the person, given their injury. We also found the person's risk assessment or care plan had not been updated to reflect whether there was any additional support required or new risks associated with this person's care.

Another person's care plan identified that they were at low risk of falls. However we found the person had

fallen three times and their risk assessment had not been updated to reflect this. We found the provider had not made any referrals to external healthcare professionals such as the GP or falls team for advice or support. We asked the provider to make a referral for this person on the first day of the visit, however when we returned on the second day, this had not been done and the provider was unable to give an explanation.

We saw that another person had fallen eight times. Following a fall on 31 January 2017 the G.P had made a referral to the Falls Team. Pending the assessment by the Falls Team the person's care plan was updated. It recommended they should not mobilise unsupervised and should have 30 minute checks when in their room. We found staff were not following this advice, and on the first day of our visit we saw the person mobilise on their own on several occasions. On the second day of the visit, we observed this person had fallen in the main corridor of home and at the time of the fall, they were unsupervised. Therefore, staff were not following instructions in the person's care plan which placed them at risk of harm.

The falls risk assessment tool used by the provider was not based on national recommended guidance and did not automatically lead staff to a risk level through an agreed risk score. Staff we spoke with told us they were unaware of any policy or procedure on the management of falls. We spoke with the provider who confirmed no policy was in place. Therefore, staff did not know how to assess the risk to people and know what action that they should take to keep people safe.

As we identified people were at risk of harm, on the first day of the visit, we asked the provider to produce an action plan in relation to the five people we identified who had fallen two or more times. This was so they could tell us what action they would take to keep them safe and reduce the risk of any further incidents. When we returned on the second day of the inspection, this had not been done. During the second day of the inspection visit we saw one of those people had a further fall. Therefore we could not be assured that people were protected from harm and kept safe.

This was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administration of medicines was not managed safely and people did not always receive the medicines prescribed to them when they should. People did not administer their own medicine and relied on staff to do this for them.

We checked a sample of five medicine administration records (MARs). On the first day of the visit we found that morning medicines were not given to three people. One person was prescribed a medicine to reduce the risk of serious blood clots and another person was prescribed a medicine to help get rid of excess fluid in their body. The medicine was not given at the time prescribed and a member of staff told us the people didn't want to take them, there were no notes to confirm this. Rather than recording the dose as 'refused' the staff member decided to try and give the medicine later, however they did not check with the person's GP or Pharmacist whether there was a risk to the person's health by not receiving the medicine when they should and whether administering a dose later would impact on the person.

Medicines were not administered safely in line with current guidance. We saw a member of staff prepare people's medicine in the office and sign the MARs to confirm people had taken their medicine prior to it being offered to them. This meant there was a risk staff had signed to say people had taken their medicine when people might decline to take it or if staff had to respond to an emergency it would be difficult to establish who still needed their medicine. We brought this to the attention of the staff member who told us, "I know who will take their medicine and who won't." The staff member then proceeded to administer the

medicine in the correct way.

This was a breach of regulation 12(2)(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's medicines were stored securely. Despite the concerns we identified in relation to the management of risks associated with people's care, people we spoke with told us they felt safe living at the home. One person told us, "I feel safe as I have always got someone to talk to if I have a problem." Another person commented, "I feel safe as there are always staff around and they make me feel safe."

Staff had received training in protecting people from the risk of abuse and staff we spoke with demonstrated good knowledge of how to recognise the signs and to escalate concerns to the provider or to external organisations such as the local authority or the police. One member of staff told us, "If I suspected someone was being abused, I would report it to management and they would take action."

The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider carried out checks to determine if staff were of good character and requested police checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

People told us they received the care and support they needed from staff in a timely way. One person we spoke with told us there was always a member of staff available if they needed support. The relative we spoke with also felt there was enough staff working in the home to give their relation the care and support they needed.

The provider told us they did not have a system in place to assess how many staff was needed to support people. One staff member told us, "It's usually always the same amount of carers; it doesn't change if we get more people or if people become unwell." We discussed this with the provider who told us that staffing levels would be increased when needed and that they were in process of recruiting an additional care worker.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider did not understand their responsibilities under the Act and the principles of the Act had not been followed. A number of people were living with dementia and assessments to determine what decisions people had the capacity to make, and which decisions needed to be made in their best interests had not been undertaken.

For example, we saw plans which instructed staff to frequently check two people to ensure they were safe and well. However, we could not see people had consented to these checks. Staff we spoke with told us, "It is in their best interests as they are at risk of falling." The provider had not undertaken capacity assessments to check whether people could decide for themselves and if not, it was in their best interests. This meant the provider had not followed the principles of the MCA.

This is a breach of regulation 11(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

The door to the home was locked via a keypad which required a code to open and this prevented people from leaving when they wished. Staff told us it was because people would be unsafe to go out on their own.

We saw on the second day of our visit that a person had expressed a wish to leave and said, "Where am I? I want to go home," and staff prevented the person from leaving. The provider had not undertaken a capacity assessment to establish whether the person had capacity to decide whether they wanted to leave or not. As this person was deprived of their liberty, the provider must apply for a DoLS, however this was not done. We explained the process how care homes apply for DoLS as the provider was unaware how to do this. The provider assured us that they would submit an urgent DoLS application. When we returned on third day of the visit, this still had not been completed. Therefore the person's liberty had continued to be restricted without the legal authorisation to do so.

There was no care plan in place for this person and their pre-admission assessment did not assess whether the person had capacity to consent to living at the home. We spoke to the provider who told us that the person's 'next of kin' had placed the person at home. However decisions by friends and relatives can only be made when they have the relevant Power of Attorney (POA). The provider told us that they had not seen the

POA and therefore they could not be assured that the next of kin had the legal authority to make this decision. As we were concerned about the care and treatment of this person, we made a safeguarding referral to the local authority during our visit.

This is a breach of regulation 13(4)(b)(5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to maintain good health as referrals to healthcare services were not always made when people's needs changed. For example, we saw referrals had not been made to GPs or the Falls Team when people had fallen.

However, we saw people were supported with their day to day general healthcare. We saw people were supported to attend regular appointments to get their health checked and arrangements were in place for local GPs and nurses to attend the home when needed when people became unwell.

People were cared for by staff who were trained to support them. We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately, for example with moving and handling techniques.

Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support people. We saw records which showed staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control.

Staff received an induction and were supported to gain the skills and knowledge they needed when they first started working in the home. Staff we spoke with told us they had been supported to undertake recognised qualifications in care. The provider told us any new staff would complete the Care Certificate. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. Staff we spoke with were knowledgeable about the systems and processes in the home.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the provider and they were given feedback on their performance. We saw records which confirmed this.

People were supported to eat and drink and had a choice of food at mealtimes. We spoke with people about the food and they told us they had enough to eat and we observed people had access to food when they wanted to eat. One person told us, "If I want it, I'll have it. There is a choice on the menu."

People's nutritional needs were assessed regularly and there was information in people's care plans detailing this. We saw plans were in place to support a person to select healthier food choices in order to manage their diabetes.

Good

Is the service caring?

Our findings

People told us individual staff members were caring and they were happy living at the home. One person told us, "Everyone is friendly, staff make me comfortable." A visiting relative said, "All the carers are good and I can't fault them. Staff have a lovely relationship with people." We observed positive interactions between staff and people. For example, we saw staff were kind and caring to people when they were supporting them. People looked relaxed and comfortable with staff and one person who had recently moved in told us, "In the mornings, staff come in and bring me a cup of tea." Staff we spoke with told us they enjoyed working at the home and one member of staff said, "They (the people) are like my family." Observations and discussions with staff showed that staff clearly knew people.

People we spoke with told us they got to make choices for example about when and where they ate, how they spent their time and what activities they participated in. We observed people's choices were respected on the day of our visit. We saw people chose where and how they spent their time. One person told us, "It was my choice to live here and I chose my own room. I like it in my room; I don't go downstairs at all. I have everything I need, my TV, phone and own bathroom. It is nice and peaceful upstairs."

We saw activities and food menus were chosen by the people and records showed that people were encouraged to speak up if they wanted any changes to be made.

We saw people and their significant others had been supported to develop a plan for when they reached the end of their life. A visiting relative told us that, "[Carer's name] stayed behind after their 12 hour shift to hold a person's hand whilst they passed away." This showed that staff were caring and they knew it was important to provide comfort to people.

People had opportunities to follow their religious beliefs. The provider told us no one was currently practicing their faith but gave example of where in the past they had arranged for a local priest to regularly visit the home and provided a service for people. We spoke with staff about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. Staff told us no one in the home was using this service but information was available for them should this be required.

People were supported to be independent. One person told us, "I wash most of my body myself but the staff help me from the knees down as I can't bend." The person explained it was important to them to do as much as they could for themselves. Another person told us that following a recent operation they were using a walking frame but they were told by the hospital, "I can start to walk with stick."

People were supported to have their privacy and were treated with dignity. One person we spoke with told us they felt staff were respectful. We observed people were treated as individuals and staff were respectful of people's needs. Staff were mindful not to have discussions about people in front of other people and they spoke to people with respect. This showed that staff respected people's privacy. Staff told us they were given training in privacy and dignity values. Staff we spoke with demonstrated they understood the values in

relation to respecting privacy and dignity. For example, we saw that staff knocked on people's doors and ask permission before entering.

Requires Improvement

Is the service responsive?

Our findings

People's needs and preferences were not always identified and responded to by staff. For example, on the second day of our visit we saw another person had come to live at the home. We checked the records for this person. We found that a comprehensive pre-admission assessment was not undertaken to identify what support the person required in the way they preferred and to identify any risks staff need to be aware of.

Their pre-admission assessment contained only brief information about the person's personal circumstances and assessments of their care and support needs had not been undertaken. Risks associated with the person's care had not been assessed. For example, an assessment of the person's mobility and risk of falls had not been undertaken although we saw the person walked with the use of stick. There was no care plan in place for areas such as personal care, medical history, medicines, like and dislikes. Therefore the provider was unsure whether they could meet this person's needs prior to the person coming to live at the home. The pre-admission assessment identified that the person was living with dementia. However there was no care plan to instruct staff how they should support this person. Staff we spoke with told us that they would ask the person what they wanted. We discussed this with the provider who told us they would ensure a care plan was put in place immediately. When we returned seven days later, there was still no care plan in place. Therefore staff were unable to demonstrate how they could meet the needs and preferences of this person as the information had not been obtained. This meant that the person might have received care that was not responsive to or met their needs.

One person we spoke with told us the provider did not currently have any male care workers so people were not able to express a preference of the gender of their care workers. This meant that some people's preference may not be met.

We saw staff completed a review of each person's care and support every month, however these reviews did not result in information being updated to reflect the changes in people's health and needs. This meant that staff did not have access to accurate and up to date information to enable them to respond to the person's current and changing needs.

In other care plans we looked at, we found some people were involved in planning and making choices about their care and support. We saw in one person's care plan that staff had discussed the person's end of life wishes with them and the person had signed to indicate that they agreed with information.

Other care plans included the information staff needed in order to meet the needs of the individual. They contained information about people's physical and mental health needs and this guided staff in how to support them. For example, one person had diabetes and there was clear detailed information about how staff needed to support the person to maintain their blood sugar levels, what signs and symptoms to look out for which would indicate they were too low and the action they needed to take. This enabled staff to respond to this person's needs.

People were supported to follow their interests and take part in social activities. One person told us they

enjoyed watching a specific programme on TV every day as it gave them enjoyment. We saw the person was watching this programme during our visit and was seen laughing. During our visit we saw people were playing dominoes together and enjoyed each other's company. We saw other people were sat reading the daily newspapers and magazines. One person was keen to show us a story they had read as they had found it interesting.

People were encouraged and supported to develop and maintain relationships that were important to them. One person told us, "My family visits me every afternoon." The provider's statement of purpose which is given to every person states that, "Visitors are welcome at any reasonable time."

Staff were aware of how to respond to complaints and the provider had some systems in place to deal with complaints if they arose. The provider's complaints procedure was on display in the home so that people would know how to escalate their concerns if they needed to.

The deputy manager told us they had not received any complaints in the last 12 months. We reviewed the 'compliments and complaints log' and found that, during this time period the provider had received one complaint from a relative. The complaint was not acknowledged or responded to in line with the provider's complaint procedure. The provider explained there were on-going complexities and it would be inappropriate to respond at this time. However, the provider had not written to the person to explain this. The provider told us in the future they would ensure all complaints were dealt with in line with their policy and procedures.

People knew what to do if they had any concerns. People we spoke with told us they would speak to the provider or to one of the care workers if they had a problem or concern. They told us they felt they would be listened to. One person told us, "If I wasn't happy about something, I would talk to one of the staff or the provider, but I haven't needed to complain." Another person we spoke with said, "I have nothing to complain about."

Inadequate

Is the service well-led?

Our findings

Since registration with the Care Quality Commission, the provider has not consistently been compliant with the regulations at this home. In 2012, under our previous method of inspecting, the provider was not compliant in assessing and monitoring the quality of service and supporting staff; in February 2013 it was not compliant in relation to audits and notifying us of incidents; in October 2013 the provider was not compliant with maintaining people's care and welfare, infection control, medicines and records. In July 2014 the provider again was not compliant in audits; in June 2015 the provider was not compliant with premises and equipment. In June 2016, the home was inspected again and rated as 'Good' in every area.

At this inspection we found systems and processes to monitor and improve the quality and safety of the service provided to people were not comprehensive or effective. The provider did not analyse incidents and accidents to identify trends. Therefore opportunities to reduce reoccurrence of incidents were missed which resulted in incidents of a similar nature happening again. When incidents and accidents happened in the home and where people sustained a serious injury such as a fracture, these were not always notified to us.

We saw where shortcomings were identified, there was no clear action plan in place to demonstrate how the provider planned to address them and re-evaluate to ensure any action taken had resolved the issues. For example, the provider was notified by the local authority that a safeguarding allegation was substantiated as they failed to take appropriate action to reduce the risk of avoidable harm to a person. We found that learning wasn't taken from the outcome to improve the care and treatment for other people living at the home and similar risks to other people were still present at this inspection.

A number of care records did not contain sufficient detail to support staff in delivering person centred care that was safe and appropriate. We could not be sure people were involved in making decisions in line with the principles of the Mental Capacity Act. The provider's governance arrangements had not identified these issues which resulted in negative impacts for a number of people who lived at the home.

The provider's whistleblowing policy which should provide a clear procedure for staff to raise concerns anonymously about people's care internally and externally was not fit for purpose. The policy only provided information on how staff could raise concerns internally. The policy should also include details how staff can report concerns to external agencies such as to the local authority, us or the police. The policy was dated 2004 and had not been reviewed.

The provider's systems and processes did not protect the confidentiality of people who lived at the home in line with the principles of the Data Protection Act 1998. Confidential personal information was accessible to a consultant that the provider used and a data management agreement was not in place to demonstrate how the provider would retain responsibility for the information. As the provider obtained, managed and processed people's personal data, they are required to be registered with the Information Commissioners Office (ICO). We found the provider was not registered. The provider told us they were unaware of their responsibilities, therefore they failed to ensure people's personal information was protected.

The provider did not adequately assess people's needs prior to admission; therefore they failed to ensure they could meet people's needs and keep them safe prior to living at the home.

This was a breach of Regulation 17(1)(2)(a-f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we notified the local authority commissioners about the serious concerns we had identified related to the safety and quality of care that people received. We spoke with and wrote to the provider to give them the opportunity to provide assurances of the actions taken to ensure the safety of the people. We asked them to submit an action plan to tell us how they were going to mitigate the risks. The provider also told us that they would not admit any new people to home so that they could concentrate on making improvements. We have received information from the provider outlining the actions they have taken to date.

People we spoke with told us they were happy living in the home and the relative we spoke with also commented positively and said they felt their relation was happy there. The relative told us, "It's a fabulous home, I would come and live here myself."

There was a registered manager in post who was also the provider and people we spoke with knew who the provider was. The provider oversaw the running of the home and ensured people were happy with the service being delivered. The provider was a regular visitor to the home and people and staff told us the provider spent time talking with them and checking on how things were going.

People who lived at the home, their relations and other visitors were given the opportunity to have a say about the quality of the service. There were meetings held for people so the provider could capture their views and get their suggestions and choices. Minutes from the last meeting assured us this did happen. . We saw feedback forms were sent to people, their relatives and health professionals every year. The results of these were analysed and shared with people. The results of the last survey were positive and no one had anything negative to say about home.

Staff we spoke with told us they felt the home was well run and said that the provider and deputy manager worked with staff as a team and were approachable. One member of staff told us, "The provider and deputy manager are hands on. They would always be available if we wanted a chat." We saw staff working together well and when care staff were supporting people and others required assistance; the deputy manager would step in.

Staff told us they would speak up if they had any concerns or suggestions and felt they would be listened to. One member of staff gave us an example of when they had asked for the layout of the furniture to change to include tables between the arm chairs so that people had a place to rest their belongings when sitting the lounge.