Bluewater Care Homes Limited

# Bluewater Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We carried out a comprehensive inspection of this service on 27 and 28 October 2015 and found the provider was not meeting the legal requirements in relation to standards of care and welfare for people who use the service. Care and treatment was not designed to meet people's needs or preferences. There was a failure to ensure systems and processes were in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people, or to improve the quality and safety of services provided.

After this comprehensive inspection three warning notices were served on the registered provider on 23 December 2015 requiring them to be compliant with the Regulations by 23 January 2016. The service was placed into special measures. The registered provider sent us an action plan in December 2015 and an operational improvement plan in January 2016 to tell us the actions they would take to be compliant with the Regulations.

On the 6, 7 and 14 April 2016 we carried out an unannounced comprehensive inspection of the service to check they had met the legal requirements. We found the registered provider had failed to meet the required legal requirements in relation to standards of care and welfare for people who use the service. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Bluewater Nursing Home is registered to provide accommodation and nursing care for up to 60 older people. The home is a large, converted property and accommodation is arranged over four floors, the ground floor offering dining, recreational and reception facilities, with the additional three floors of accommodation which also contained some smaller recreational areas. Two lifts are in place to assist people to move between the four floors. Most rooms are for single occupancy and have en-suite facilities. There were 20 people living over the first and second floor of the home at the time of our inspection. At the time of our inspection nursing care was not being provided.

A registered manager had not been appointed for the service since November 2014. 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. The provider had employed a number of managers since November 2014 however these had not become registered with the Commission before employment with the provider ceased.

Whilst people felt safe at the home and relatives had no concerns about the safety of people, risk assessments had not always been completed to ensure people received safe and effective care in the home. A new electronic system for recording plans of care and the risks associated with this had been implemented in the home and required further embedding in the service. People's preferences and needs were not always included in these records.

Staff at the home had not been guided by the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked the capacity to make decisions. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Three people who lived at the home were subject to a DoLS. Whilst all appropriate actions had been taken to support these people, staff lacked knowledge and understanding of the MCA and DoLS.

People were not always protected by staff that had a good understanding of the risk of abuse against vulnerable people. Whilst staff felt confident to report any concerns they may have through the appropriate channels, they had not received appropriate training in this area. The provider had not identified areas of concern in relation to the safeguarding of people which required further action.

There were not sufficient staff available to meet the needs of people. The provider did not have robust recruitment processes in place to ensure people were cared for by staff who had the right skills to meet their needs.

People had access to health and social care professionals as they were required, though staff were not always vigilant in following up appointments.

Whilst people found staff to be caring and supportive we observed some staff act in a way which was not caring and did not respect the dignity of people. Staff knew people at the home well.

There was a lack of stimulation in the home to encourage people to participate in activities, although there were extensive facilities available in the home for people to use. People were not encouraged to use these facilities independently.

People were provided with opportunities to express their views on the service through meetings and in discussion with the provider and nominated individual for the service.

There was no system of quality assurance by which the provider could monitor the safety and welfare of people in the service. The provider and nominated individual did not have a good understanding of the requirements of the Regulations and their responsibility with this. There was a lack of sustained leadership in the home.

Staff who worked and people who lived at the home felt able to express any concerns they may have and have these responded to promptly.

The provider had failed to adequately display the ratings for this service on their website in line with requirements.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks associated with the care people required had not always been assessed. Assessments had not been completed to ensure people received care in an environment which was safe.

Whilst medicines were stored safely, the provider did not have effective systems in place for the safe management of all medicines.

Whilst staff understood systems in place to report concerns of abuse they had not all received training in the safeguarding of people. The provider did not have a good understanding of their responsibilities in relation to the safeguarding of people.

There was not sufficient numbers of care staff to meet the needs of people.

Training and recruitment processes in place were not robust to ensure people with the right skills were employed in the home.

### Is the service effective?

**Inadequate**

The service was not effective.

Where people lacked capacity to make decisions about the care they received, the provider and care staff had not always applied the principles of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had not received the training they required to support their role and meet the needs of people.

Whilst the food people received was nutritious people were not always aware of or offered the choices to meet their preferences.

People had access to health and social care professionals to make sure they received effective care and treatment

### Is the service caring?

**Requires Improvement**

The service was not always caring.

The provider had not taken all actions required to ensure people's dignity was respected through the use of closed circuit televisions in the home.

Whilst staff knew people well, interactions between people and staff were not always caring.

People had opportunities to express their views on the service.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Care plans in place did not always reflect the needs and wishes of people. Care provided was not always in line with that which had been planned.

Whilst there was a wide range of activities potentially available in the home these were not utilised and people were at risk of being isolated.

People felt able to raise any concerns they may have about the service and were sure they would be dealt with promptly. The home's complaints policy was visible for people to use.

## Is the service well-led?

**Inadequate**

The service was not well led.

The provider did not have an effective system in place to monitor and assess the number of staff required to meet the needs of people in the home.

The provider was unable to sustain leadership in the service to ensure stability for staff and a management structure to support the running of the home and there had been no registered manager since November 2014

The provider did not have a programme of audit and review in place to ensure the safety and welfare of people.

Whilst people and staff told us the provider and nominated individual were approachable and managed the service well, this was not reflected in our findings.

The provider had failed to adequately display the previous CQC rating on their website.

# Bluewater Nursing 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 was 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 6, 7 and 14 April 2016 and was unannounced. Three inspectors and an expert by experience in the care of older people visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and service improvement plans. We reviewed notifications of incidents the manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with nine people who lived at the home and four relatives or visitors to the service, to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home. We spoke with the nominated individual for the registered provider, the sole director of the registered provider (referred to as the provider throughout the report) and a consultant who was working in the service as the Care Director. We spoke with six members of staff including domestic and care staff. We spoke with three health and social care professionals who supported people who lived at Bluewater Nursing Home to obtain their views of the home.

We looked at the care plans and associated records for five people. We looked at a range of records relating to the management of the service including; records of complaints, accidents and incidents, quality assurance documents, nine staff recruitment files and policies and procedures.

Inadequate

# Is the service safe?

## Our findings

People told us whilst they felt safe in the home there were not always enough staff to meet their needs. One person said, "Oh yes the place is very nice and safe, but the staff are very busy and I don't like to disturb them." Another told us they were happy in the home and that there was enough staff but added, "They just about cope with the work." One person was heard telling a visitor, "It is scary and bewildering," when they spoke of the home and how they felt during one activity. Relatives we spoke with felt their loved ones were safe in the home.

At our inspection in October 2015 we found the risks associated with the care people received had not always been identified, assessed and managed to ensure their safety and welfare. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider on 23 December 2015 requiring them to be compliant with this Regulation by 23 January 2016. At this inspection whilst we found some improvements had been made in the assessment of risk associated with people's care we found this legal requirement had not been met.

The provider had introduced a new electronic care records system which required further embedding in the service. These records contained a large number of risk assessments for people including those to identify the risks of falls, poor mobility, poor nutrition and loss of skin integrity. The use of multiple risk assessments in the electronic records to identify the risks associated with people's care meant risks were not always being identified and appropriate plans of care put in place to ensure the safety and welfare of people.

For example, the electronic care records for one person held a nutritional risk assessment which showed they were at high risk of poor nutrition and identified the actions required to mitigate this risk including the use of supplements and clear recording of daily dietary intake. There was also a Malnutrition Universal Screening Tool (MUST) score in place for this person in their electronic records. A MUST score helps to identify adults who are malnourished or at risk of malnutrition. This score identified the same person as being at medium risk of malnutrition and staff should observe the person. The conflicting information from these risk assessments did not inform the plans of care for this person. When we spoke with staff they were not aware of this risk.

Another person was at high risk of falls and had received a serious injury from a fall in the home in November 2015. We asked a member of care staff what risks were associated with the care of this person who regularly stayed in their room alone with the door closed. The member of staff was not aware of the risk of falls for this person, although they had a falls risk assessment in place.

Assessments were not always in place to identify the risks associated with specific health conditions. For example, for one person who lived with diabetes, the risks associated with this condition had not been identified and did not inform their plans of care. However, for another person who lived with a long term breathing condition and required oxygen therapy, risk assessments and plans of care were in place to identify and support the risks associated with this need.

Risks associated with the premises had not been identified, assessed and systems put in place to mitigate the risks. For example, risk assessments associated with the environment were not in place including doors and lifts which were locked preventing people who did not have the codes for these from accessing communal areas. There were sharp tools in the corridor displays of the home which were not secured and could cause injury to people.

We had received concerns which identified the poor use of wooden door wedges to hold fire doors permanently open. We noted a number of fire doors around the home were wedged open with a wooden block at all times including a main access door to another floor of the home and two doors to access a room in which oxygen was stored. When we raised this concern, the provider did not agree this was a risk to the safety and welfare of people. They said a fire risk assessment had been completed and agreed with local fire safety officers. They told us they did not have a copy of this risk assessment although a copy was with the fire safety officer. They said they had agreed with the fire safety officer that fire doors in the home could be propped open as a state of the art sprinkler system was in place in the event of fire. We referred this information to the relevant authorities' for further review to ensure the safety and welfare of people.

Following this inspection we received a copy of Bluewater's fire risk assessment dated 2013 which stated that "Wedges and items of furniture are not acceptable and should not be used". In addition information from the external fire safety service was received which demonstrated a fire safety audit had been completed in the home. This identified that improvements were required to prevent doors being wedged open. The fire safety officer visited the service following our inspection and advised us the provider had taken steps to address the concerns we had raised.

Each person had a personal emergency evacuation plan in place which was kept at the reception desk for use by emergency services. Copies of these documents were also held in people's care record files. Staff were aware the home had an efficient fire safety system which meant people should remain in their rooms or be evacuated to a safe place behind identified fire doors. Records showed only six of 16 current care staff had received fire safety training. Following our inspection the provider sent us information to show how they would ensure staff had received appropriate training in fire safety.

At our inspection in October 2015 we found a lack of safe and effective systems in place to administer and manage medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider on 23 December 2015 requiring them to be compliant with this Regulation by 23 January 2016. At this inspection we found this legal requirement had not been met.

Risks associated with the administration of medicines had not always been identified. For example, one person was taking a medicine which thinned the blood. The risks associated with this medicine could include excessive bleeding following injury, illness due to blood clotting quickly and bruising. There were no risk assessments or care plans in place to identify these risks and how staff could monitor for and reduce these. Regular blood tests were required to monitor and manage this medicine. Staff had not ensured these had been completed. The lack of assessments and appropriate actions to reduce the risks associated with this medicine meant his person was at risk of inappropriate treatment and care to support their safety and welfare.

The provider did not have a policy in place regarding the management of the administration of "as required" (PRN) medicines. For eleven of sixteen medicine administration records (MAR) we reviewed, there were no protocols in place regarding the administration of these medicines. A separate "PRN chart" and "Patient Notes" document were used by staff to show when these medicine were or were not administered. These

were not consistently used by staff when documenting the administration of these medicines. There was no information in place to identify how or in what circumstances as required medicines should be administered. For example, for one person who was prescribed a medicine for agitation, their MAR stated, "take one tablet twice a day when required." There was no protocol in place to identify in what circumstances this medicine should be given, how to monitor for effectiveness and what staff should do if this medicine was ineffective. There were no plans of care in place which identified when this medicine may be required and any other actions staff may be required to take before the administration of this medicine.

For a second person who was prescribed two different medicines for pain relief to be given as required, there were no protocols in place for each of these medicines. Records showed staff had given this person one medicine for pain and the second medicine had not been required as the pain was not severe. However, there was no guidance available to staff to support the administration of these two medicines or assess the pain for this person.

One person, who lived with diabetes, required suitably trained staff to monitor their blood sugar levels and support with the administration of their insulin. Records showed, and staff confirmed, a member of staff who had not been suitably recruited to the home, and had no record of appropriate training, had been carrying out an invasive clinical test on the person. We spoke with the provider about this practice. They acknowledge that this had occurred and we were assured this was no longer current practice in the home. They confirmed staff who had received the appropriate training supported this person with this need.

Records showed staff who administered medicines had been suitably trained to administer medicines safely and effectively. Whilst medicines were stored securely staff did not always ensure medicines stored within a fridge or a medicines room, were maintained at the appropriate temperature to ensure the efficacy of medicines was maintained. Daily records of the temperature of the medicines fridge had not been recorded since 15 March 2016. A member of staff told us they did not know why the temperature readings were not recorded daily. However they were aware of the temperature range the fridge should remain within and said they would report any concerns to the manager if the temperatures were not within this range. Following the inspection the provider advised us a prompt had been added to the front of the MAR charts to ensure staff checked and recorded fridge temperatures daily.

An audit of medicines which had been carried out by a manager on 8 January 2016 identified actions to be completed to ensure a monthly audit of the medicines room was completed. There were no audits available to show medicine records and practices had been audited and reviewed since this date.

There was a lack of appropriate risk assessments in place to monitor and manage the risk associated with people's care and treatment. Risks associated with the premises had not been assessed and appropriate actions taken to ensure the safety and welfare of people and there was a lack of safe and effective systems in place to administer and manage medicines and monitor health conditions safely. These demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns which alleged there were insufficient numbers of staff at the home to meet the needs of people. We received mixed feedback about the staffing levels in the home. Staff told us they felt there were enough staff to meet people's needs. A visitor to the service told us they felt there were not enough staff and said the "Girls are very rushed". One person said they felt there was enough staff but added "They just about cope with the work". Our observations reflected there was not always sufficient care staff available to meet the needs of people and ensure their safety and welfare.

We observed staff were very busy and task orientated in their duties due to the limited number of staff available to support people. They did not have time to spend interacting with people in a way which encouraged them to be independent and calm. For example, for one person who frequently called out, staff did not have the time or opportunity to sit with this person who remained calm when we observed people were present with them. One person told us, "They [person] called 'nurse' like that all day yesterday."

For significant periods of time people were left alone without the opportunity or encouragement to interact with staff and others. For example, in one communal area, four or more people sat for periods of 15 minutes or more without a member of staff present and when they required assistance staff were busy in other areas of the home and not readily available to help. One person told us they needed assistance to visit the toilet. We asked if we should call for some help for them and another person said, "You'll be lucky, there's never anyone around when we really need them." We asked people how they called for staff as there was no call system in communal areas. They told us call bells were available by their bedsides. People were unable to call for assistance unless a member of staff was available in the immediate vicinity to hear their request. One person said, "There are lots of people hurrying by, no one helping us."

There were not enough staff to sufficiently engage with people and orientate them to time and place which is particularly important for those who live with dementia. One person told us, "I expect someone to talk to you, tell you where you are." This person had some significant memory loss and had been at the home for some months. They did not understand where they were, the routines of the home or what was expected of them. On 6 April 2016 we only observed staff spend a few minutes with this person throughout the day. Staff did not have time to spend chatting and orientating this person to ensure their safety and welfare.

Another person who said they had been asleep in their room during the morning, mobilised from their room to a communal area of the home independently at lunch time. All care staff members were on the ground floor of the home supporting people to go to lunch and had not been present on this floor for five minutes. The person told us they were unwell and we observed they were unsteady on their feet, falling back towards a table. We supported them to sit in a chair. They told us they wanted to talk to a member of staff. We remained with them until a member of staff returned to this floor a further four minutes later. At this time there were five people on this floor of the home, each in their room. There was insufficient care staff available to meet the needs of these people and several were unable to use the call bell system as they were frail or did not understand how to use this should they require assistance.

People who remained in their rooms were not provided with time to interact and socialise with staff as they were busy supporting other people across two floors of the home. For example, one person who remained in bed for most times in the day had music playing in their room but had no other social interaction with people other than when care was being provided for them. For another person in their room who became agitated easily, interactions with staff were limited to provision of care.

Day care services were provided for two people who attended the home at different times of the week. At the time of our inspection, only one person attended the home for day care. We saw there were no additional staff to support this person and as such carers would be required to support the person receiving day care with any needs they may have, taking the care staff away from those living at the home.

The provider, the nominated individual for the service and the administrator who managed rotas told us three members of staff were required as a minimum at all times to meet the needs of people. The provider and their nominated individual told us two people who lived at the home required support from two members of care staff at all times with their care. Staff told us four or five people required this level of support with personal care and at other times of specific support such as changing their position or moving

to another area of the home. The provider told us a minimum of three members of staff were required at any time to meet the needs of people, and that they and the nominated individual were available at any time to help support people. They told us a manager, who had recently left, had implemented a dependency tool which was used to identify the needs of people and gave guidance on the number of staff required to do this. The provider was unable to access this tool and provide information on how it was used. They were unable to tell us how many staff the dependency tool had required them to provide to support people's needs or if the number of staff allocated on the staff rotas had been sufficient to meet the needs of people since the introduction of the tool.

The provider told us staffing numbers had not dropped since the manager had left on 17 March 2016 and that as people had recently left the home this meant there must be enough staff available to meet people's needs. This identified a lack of understanding as to how the use of a dependency tool would identify the fluctuating needs of people in the service.

Staff rotas showed there were not always three members of care staff available throughout the day, particularly in the afternoon between 14:00hrs and 20:00hrs and only two members of staff were available at night. On the first day of our inspection there were two members of staff on a morning duty of 08:00 till 14:00hrs. An additional member of staff was present on a shadowing shift for their first day at the home. This member of staff left the home at 11:00hrs. Whilst a member of staff came in at 12:00hrs to support this shift there were not enough staff to meet the needs of people on this day. The nominated individual was present in the home and told us that they often provided care for people in addition to the care staff present on duty. The director told us they were available if they were required in the home though they did not provide personal care for people. We saw the administrator provided support and care for people including the administration of medicines; however there was a lack of staff available to meet the care needs of people.

The administrator told us rotas were completed four weeks in advance to ensure there were enough staff to meet the needs of people. We asked to see the rotas and were only provided copies of the previous two weeks and the two weeks of our inspection visit. No future rotas were shown to us. Subsequent to the inspection we were provided with a further four weeks rotas. The provider and administrator told us they were recruiting new members of staff all the time to ensure there were sufficient to meet the needs of people.

The lack of sufficient staff in the home to meet the needs of people and ensure their safety and welfare was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns regarding the recruitment processes at Bluewater Nursing Home. The provider told us the service had very robust recruitment procedures and required high standards of all their employees. Recruitment files held lists of information which should be verified before people started to work at the home. These included; application form and interview questions, complete employment history without gaps, two references and Disclosure and Barring Service (DBS) checks. These checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services.

Recruitment records showed these checks were not always completed prior to staff commencing work in the home. Of eleven recruitment records, five held incomplete information. One staff member only had one reference. A second contained one reference which was dated after they commenced work. This person also had a Disclosure and Barring check that was in another company name and over three months old. A third staff member's DBS was over five months old when they commenced work at the home. For one member of staff, whom the provider told us worked in a voluntary capacity, there were no recruitment checks in place.

Their duties included access to computer systems at the home, administrative front desk duties, completion of documentation for people in relation to the care they received and they had also completed an invasive clinical procedure for one person.

A care director was in the service in a consultancy capacity and shown on the rota as being available in the service. There were no recruitment or safety checks in place for this person. The provider told us this person provided support and guidance in the absence of the manager for the service. They had access to all areas of the home and had access to all care records. We spoke with the provider, nominated individual and administrator about the poor recruitment practice for these two people. They told us they had not completed recruitment checks for these people.

The provider told us a previous manager of the service had been responsible for the poor recruitment practices we had found in records. They said this previous manager had taken several telephone references for people; however they had not documented or evidenced these.

People were not always cared for by people who had been appropriately recruited and checked for their suitability to work with people. The lack of established and effective recruitment processes in the home was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who felt they had an understanding of the types of abuse which they may observe and how to report this; they felt confident any concerns they raised would be dealt with appropriately by the provider and knew how to escalate any concerns they may have to the local authority or CQC. However at our inspection in October 2015 training records showed only six of ten staff had received training in the safeguarding of people. At this inspection training records showed only 3 of 16 staff had received this training, but only one of these remained in date. We were not assured all staff had received appropriate training and guidance on the safeguarding of people.

The provider had failed to provide information of concern to the local authority and the Commission with regard to a serious injury of a person who lived in the home in November 2015. The provider and nominated individual said there were no current safeguarding concerns in the service and said the local authority were very happy with all the work they were doing at the home. We identified one person whose needs we were concerned were not being met by staff at the home and raised this concern with the local authority for further review. The local authority was visiting the service regularly to monitor concerns which had been raised following a serious safeguarding incident in December 2015.

The lack of appropriate systems and training in place to recognise, report and record allegations and investigations into abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

Staff knew people well and told us they understood their needs. People felt the care they received met their needs. One person said, "I am here because I can't live alone any more. The staff will help me when I need it. They are very busy." Another person said, "The girls will help me if I need it." People said they were not always aware of choice in the food they had but that food was well presented and tasty. Health and social care professionals told us people had access to their services as required.

At our inspection in October 2015 we found the provider had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment they received. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider on 23 December 2015 requiring them to be compliant with this Regulation by 23 January 2016. At this inspection we found this legal requirement had not been met.

People had not always consented to the care they received. The provider told us they had implemented a contract and consent form for people who lived at the home to show their agreement to; the use of CCTV in the home, the taking of photographs of people and consent for care records to be in place for them to support their care and treatment. Whilst we saw these records were in place for people these were not always consistent in their completion and were at times signed by people who did not have the legal authority to do so.

Where people had capacity to consent to their treatment, some people had signed consent forms and contracts with the provider to demonstrate this. However, for two people who had signed a consent form relating to their records, care and treatment and the use of CCTV and taking of photographs, a contract with the provider which consented to them taking accommodation at the home had been signed by another person. There was no information to identify this person had the legal authority to sign this contract. The provider told us that they believed this was because at the time the contracts had been signed the person did not have the capacity to sign these, however the person's ability to consent to care had changed and this was why the new consent form had been signed by them. There were no records to support the change in this person's ability to consent to their care.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

For people who lacked capacity to make decisions about their care and safety, steps had been taken to assess their ability to make decisions about the care and treatment they received in line with their wishes or best interests. Some records held information regarding people who had been legally appointed as representatives for the person in making decisions about the care they received; however this was not always the case. Staff were not always guided by the MCA when they supported people who were not able to consent to aspects of their care and treatment. Whilst care records held some information to identify what decisions people could make themselves, best interests' decisions were not evidenced and documentation in place to support people's ability to make decisions about their care and treatment was incomplete and lacked clarity.

For example, for one person who had a power of attorney (POA) in place for property and financial matters we saw the POA had signed the consent forms relating to the records, care and treatment, use of CCTV and photographs. This person did not have the legal authority to complete this consent form as their POA did not cover health and welfare matters. There was no evidence best interests decision had been completed, or who else had been involved in this decision making process.

Care staff had a very poor understanding of the MCA and how to apply this in the day to day care of people. One member of staff told us the MCA was, "about how to help people with their money properly and make tea safely." Staff were able to identify who would need to be involved with people to help them make a decision however they were not clear on how this should be documented.

Three people were subject to a DoLS at the time of our inspection. The provider told us these documents were held in care records and were to prevent people leaving the home as it would be unsafe for them to do so. When we asked if these DoLS had been applied to their care records and staff were aware of these and understood the implications of these documents they told us, "I believe so." Whilst records had not always been completed to reflect these documents this work was in progress on the new computerised system. The provider told us this was an area the new manager would be reviewing and ensuring all documentation was completed appropriately.
We had raised concerns in our inspection in October 2015 relating to the use of locked doors and lifts in the home which meant people were restricted and unable to move around the home independently. At this inspection we found this had not changed. There were coded locked doors at each internal floor exit. Lifts situated in the centre of the home were also operated by coded locks. People were not always able to access areas of the home independently and could not leave the upper floors of the home without support from staff. There were no records to identify this had been discussed and agreed with people or their representative. No consideration had been made as to the restrictions this may have been having on people.

The provider told us people were given the codes when they were admitted to the home. However there was no evidence or record made of this. Information regarding the door codes was not present in information given to people as they moved into the home, nor was people's capacity to understand and use this information assessed. The provider told us people who had the capacity to unlock these exits had been given these codes. We spoke to two people who had been newly admitted to the home and had the capacity to understand this information. Both told us they were not given the codes to the exits when they moved into the home; however one told us their relative knew it and as they required assistance from people to mobilise from the home they did not need to know it. Another told us they had never been given these codes; however they had managed to identify what the code was from watching staff when they did it and

used this to independently move between floors using the lift. They did not know the exit codes to stair wells. Following the inspection, the provider sent us information which showed they had discussed the locked doors and codes with one person.

Whilst secure entry to and from the home ensured people's safety, the lack of appropriate information to show people's ability to consent to their care and treatment meant we could not be sure people were not being deprived of their liberty.

There was a lack of consistency in the approach to seek, obtain and document people's consent to their care and treatment. People were at risk of receiving care and treatment to which they had not consented and which was not in line with their wishes. People were at risk of being deprived of their liberty. This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received training they required to meet the needs of people. We asked the provider for copies of certificates or information to demonstrate the training staff had received. They told us this had all been documented in an electronic staff training matrix which had been completed by a manager who had recently left. They forwarded this matrix to us during our inspection. Staff personnel files held minimal records with regard to the training they had received. The administrator told us the previous manager had removed a lot of certificates from these files which they were now unable to locate. The provider told us they had a comprehensive training program available to all staff. They said an induction program was completed by all staff and they believed all records of training were documented in the staff training matrix.

The training matrix showed staff had completed only minimal training since they had commenced employment at the home. This included details of 16 staff members, including the nominated individual and administrator. Two care staff showing on the rota and working at the time of inspection were not included on this matrix. The matrix showed no member of staff had received an induction to the service, 10 care staff, the nominated individual and administrator had received training in moving and handling of people, three care staff had up to date training on the Mental Capacity Act, On staff member had up to date training on the safeguarding of people, two had received training in dignity and respect and two members of staff had received training in infection control. At our inspection in October 2015 the manager told us they had introduced the Care Certificate for all staff. This certificate is an identified set of standards that care staff adhere to in their daily working life and gives people the confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This had not been introduced for staff at this inspection.

Whilst some staff told us they had received training but were not sure where certificates were held, one member of staff had received no training since they commenced employment at the home. They told us they had been employed for one month at the home. They told us they received training in a previous job but were unable to provide certificates for these due to the cost. The provider told us they felt the training this person had received from their previous employer was sufficient for them to work at this home. There were no records of completion of any of this previous training and the provider had not verified these courses with the staff member's previous employer. The provider had no way of ensuring this person had the skills and training required to meet the needs of people prior to their employment and had failed to ensure they received the training required to meet people's needs in this home.

Another member of staff who commenced work on the first day of our inspection was due to be working a shift to shadow staff and had received no induction or training at the home. We observed they were working independently in the home providing personal care and supporting people.

At our inspection in October 2015 a system had been introduced by the previous manager to support staff development through the use of one-to-one sessions of supervision and appraisal; however at this inspection we found this system had not been embedded in the practice at the home. Whilst some staff had received supervision or appraisal this was not regular and lacked consistency. The provider and nominated individual told us they had a very supportive working relationship with all staff who they encouraged to discuss any concerns they may have with them. Staff told us the provider and nominated individual were supportive of their needs when at work.

The lack of complete and thorough induction, training, formal supervision and appraisal was not in line with the registered provider's policy and did not ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns about the lack of nutritious food and drink people received in line with their preferences and needs. We found whilst people enjoyed the food which was provided and always had sufficient to eat and drink, they were not always aware of the choices available to them. Whilst a written menu was available in the ground floor dining room of the home, this area was not accessed until meal times and not at a time when people chose their meals. There was no information available to people on the first or second floor about the choices available each day and no written display to remind people of the food options available to them.

We spoke with the cook who told us they had received training from a highly recommended resource to identify nutritious fresh meals for people and how to ensure these met the varied needs of people. They told us they had proposed new menu plans to the manager who had recently left the home but that these had not yet been approved and printed so that people could view the variety of foods available.

Whilst one person was being supported to mobilise to the dining area they told us they had not been aware of the second option of sausages on that day's menu as they really liked these. A member of staff said, "Well [cook] came up and asked what you wanted today," and dismissed their comment. The person told us later they would have preferred sausages but had fish pie as that's what they had requested apparently.

A second person requested a cooked breakfast every day, however we saw this was not always available as the cook did not commence work till 10:00hrs every day and was not present to make it. We were told if people requested a cooked breakfast then the nominated individual would prepare this for them but that they must request this. There were no visual prompts for people to remind them of this available option.

The cook had an awareness of people's preferences. Special diets were catered for such as soft or diabetic and vegetarian diets and food was presented well in an environment which was clean and fresh. The main dining room provided a calm environment for people to enjoy their main meal. In a dining area on the first floor of the home staff regularly prepared hot drinks for people and breakfast was served from there.

People had access to external health and social care professionals and services as they were required. For example, old care records showed people had access to the GP, chiropody services, dentistry and community nursing and therapy services. Further work was required with new electronic records to provide clearer information about these visits and to ensure staff understood their responsibilities to ensure people received the care they required.

Staff clearly identified when external health and social care professionals were responsible for the care of people, however this often showed staff identified the responsibility of this care to be the professionals and

not theirs. For example, for one person who required continuous oxygen to be administered to support their breathing, care staff were keen to identify the responsibility for this care was with the community nursing team who monitored the oxygen administration and associated care. Whilst community nurses visited the home regularly care staff did not record these visits in their daily records. Whilst staff said they were monitoring and administering the oxygen administration for this person, daily records did not identify they were meeting the needs of this person in line with their care plan and the instruction of the community nurses.

For another person who required a follow up blood test which the home were required to organise, records did not demonstrate staff had dealt with this request and staff were clear it was because the health care professional had not responded and so the blood test had not occurred. Staff took no responsibility to follow up this care need and document the actions they had taken to ensure the needs of this person were met.

Health and social care professionals told us staff always received them in a welcoming way and knew people well.

Requires Improvement

# Is the service caring?

## Our findings

People said staff were very caring but were always very busy and this meant they were not always available to interact with them. They said staff were kind and understood their needs. One person told us, "They are all lovely and really very caring." Health and social care professionals told us staff knew people well and were always kind and considerate towards people when they visited.

At our inspection in October 2015 we found the provider had not taken all appropriate steps to ensure the privacy of people who lived at the home. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to identify how they would become compliant with this Regulation. At this inspection we found that whilst some improvements had been made to ensure the privacy of people was maintained, further actions were required by the provider to embed this practice in the service.

The registered provider used closed circuit television cameras in communal areas of the home. They had introduced consent forms for people to acknowledge their consent for the use of this equipment in the home. They told us if people did not consent to this requirement then they would not be able to live in the home.

The provider had been made aware of guidance available from CQC about the use of CCTV in care homes and the information required to show compliance with the regulations in line with the use of this equipment. They had not followed all of this guidance. Policies were not in place in line with this guidance. A further copy of this guidance was given to the provider at this inspection and they agreed this information would be reviewed.

Staff knew people well and were aware of their preferences. For example, staff knew how people liked to have their hot drinks and where they preferred to spend time during the day. We saw mixed interactions with people which demonstrated staff were not always caring.

We saw staff take time to speak with a person who was confused and disorientated at breakfast time. Another person was supported kindly and gently during one lunch time when they had become agitated and were requesting staff support.

However, when one member of staff responded to a person who was in bed and had called for assistance, the person requested help to go to the toilet as they were going to wet the bed. The member of staff responded telling them they would be with them soon to help them get up and not to worry as they had a pad on. This lack of understanding and caring approach to a person's needs meant this person did not receive care and support in a way which demonstrated a respect for their needs.

For another person who was sat at a dining room table in a wheelchair, staff proceeded to move their wheelchair without first speaking to them, so that another person could sit next to them. The person appeared startled as they were moved. Staff made no attempt to speak with either person following this

action.

We observed one person who sat at a table in a communal area of the home in a wheelchair. They appeared to be uncomfortable and slumped to one side. Another person said to us, "That [person] has been sat like that for as long as I can remember. If that is care, it makes me scared." Staff did not at any time during a morning observation attempt to move this person or sit them in a position they could participate in any meaningful interaction with others.

For another person who regularly called out in a distressed way, staff told us they always did this and whilst they made attempts to support this person at times, there were periods of over thirty minutes or longer when the person was left alone in a closed room without staff to interact and care for them. This appeared to be an accepted behaviour which staff did not always respond to.

We were not assured people were always treated with the dignity and respect they deserved and this showed a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to personalise their room and one person told us how a family member had helped them to settle in by bringing to the home many items of importance to them to decorate their room. They told us the nominated individual had been very kind and helped to provide a display in their room to make it feel more homely. Relatives and visitors told us staff were always very courteous and kind to them and their relatives.

Some people told us they were aware new care records were being completed and the manager who had recently left had spoken with them at length about their needs. People told us they would tell staff if their care needs changed and felt able to talk to staff about their needs. Two relatives told us they had recently been involved in the planning of care for their loved one. Care records showed people and their representatives were involved in planning care to meet their needs, however the care plans did not always reflect the preferences and needs people had expressed. For example, one person's preference for a cooked breakfast was not included in a care plan and they did not receive this every day.

People and their relatives /representatives were encouraged to communicate with the provider, nominated individual and staff at any time, however this was not recorded in daily records for people. There had been a relatives meeting with the provider, manager, people and their relatives since our last inspection and there were no identified actions from this meeting. A further meeting was planned.

Inadequate

# Is the service responsive?

## Our findings

People felt able to raise any concerns they may have about the service with any member of staff, especially the provider and nominated individual. People and their relatives were able to identify managers in the service and said they were approachable. However people were not always clear how they could participate in the planning of their care and when these plans of care were updated to reflect their changing needs. Relatives had provided information about the care people required and this had not always been followed. Health and social care professionals we spoke with described a service which reacted to people's needs rather than being responsive and alert to needs before they required further intervention.

At our inspection in October 2015 we found the provider had failed to ensure care and treatment was designed and carried out in line with people's wishes and preferences ensuring their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to identify how they would become compliant with this Regulation. At this inspection we found that this legal requirement had not been met.

The provider had very recently introduced a new electronic system of care records to record care plans, risk assessments and other daily records for each person who lived at the home. They told us a manager, or the administrator, recorded plans of care and all the associated assessment documents onto a secure computer. The administrator told us this information was then available to staff, through the use of hand held electronic devices, to inform the care they provided for people; however they told us further training was required for staff to ensure a better understanding of the use of these records. Paper copies of care plans and some assessments were also available. Staff told us they did not use the paper records for people any more. However, two members of staff told us they had not read the care plans for people which were available on the computer or printed out.

Whilst records in place showed people and their relatives had been involved in the planning of their care, care plans were not always person centred and did not provide the information staff required to provide safe, effective care in line with people's needs.

For one person who had been admitted for a short period of respite their relative told us of information which had been provided to the home had not been used to inform plans of care for this person. There were no plans of care in place for this person. For example, they had requested specific dietary and personal hygiene needs which we saw had not been recorded or followed.

This person also required a regular blood test to be taken to ensure their medicines were at an appropriate level. A relative had advised the staff at the home this was required to be completed on 31 March 2016. This had not been completed by our visit on 7 April 2016. The administrator told us this blood test had been requested of the local GP and nursing service on several occasions however had not been completed. There were no records to show this blood test had been requested by care staff or any actions staff had completed to ensure this test was received to ensure the safety and welfare of this person.

Care records for a second person showed they had lost 7.8kilograms in weight over a period of three weeks. A risk assessment showed the person was at very high risk of poor nutrition and that daily records of dietary intake and weekly weights should be completed. Also that dietary supplements should be given daily and to liaise with the GP and dietician. There was no information in care records to show these actions had been completed. The 'Nutrition /Hydration' care plan in place for this person made no mention of weight loss or the associated actions to be completed to monitor and reduce this risk. Dietary supplements were not being provided and weekly weights were not being recorded. Staff we spoke with were unable to identify this person had had a significant weight loss or what actions they should be taking to support this. Entries in care records were generalised regarding the amount of dietary intake for this person and stated, "Ate most of their food", "Chose a balanced diet", or "ate their main course and pudding." The care plans did not identify the needs and preferences of this person and staff were unaware of these needs.

Daily records of fluid intake, urine output and dietary intake were available on the electronic record system and these were informed by the information care staff entered via an electronic hand held device. However, information added to these records was task orientated and did not provide specific information to inform the care people received.

For example, the care plans for one person identified they lived with kidney disease and recorded that staff should monitor their urine output and report any deterioration in their condition without delay. We asked two members of staff how they monitored the fluid intake of people and they showed us how the entered this information into the computer. However they were unable to identify how they monitored whether this person had taken sufficient fluids during any one day. They told us this was monitored by the manager on the main computer. The manager had not been present in the service for more than three weeks. The provider told us the administrator was monitoring this in the absence of a manager. There was no information in daily care records to show care staff were effectively monitoring the fluid balance and evaluating this need for this person.

The administrator told us staff required further training on the electronic records system to use it effectively. However our findings meant we were not assured the care which people were receiving was effective and in line with their needs and preferences.

The lack of care planning in place to ensure care and treatment was designed and carried out in line with people's wishes and preferences ensuring their needs were met was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a large communal area on the ground floor of the home which contained many areas of interest and resources for people including; hairdresser, sensory room, secure outdoor garden, games, memorabilia, cinema, conservatory and general areas where people could relax. This area was not accessed by people independently through the day. People told us they went to these areas when staff or their visitors were available to take them and we saw this was the case.

The provider's Operational Improvement Plan stated a support coordinator would be employed to encourage and promote the activities available in the home. This action was dated 29 February 2016 or sooner if time allowed. This action had not been completed. There was a lack of information available to people about the wide range of activities the home could support. We asked the provider who managed activities for people and they told us care staff currently supported people with these. The care director told us there was no need for an activities coordinator at the home at this time as there were not sufficient numbers of people living there.

People gathered in a smaller communal area on the first floor of the home. A large television was on most of the day and the volume was loud. People sat around a table, some with their back to the television and there was minimal interaction between people and staff. On the first day of our visit, a member of a local church carried out a service for people who wished to attend. They told us they visited twice per month and would provide a service in the communal area or the chapel area of the home.

We observed an activity during an afternoon where eight people were supported by two members of staff in a card game. A program of activities which was displayed as available was not regularly followed; this program changed during our inspection. Care records showed people were not regularly supported to complete an activity of their choice.

People who remained in their room throughout the day received no stimulation or support to participate in activities in the home. Whilst one person had music on in their room at all times their care plan identified they liked to be engaged in brief conversations. This did not occur during our visit and care records did not reflect this activity took place. For another person whose care plan stated they resisted inclusion in activities, records showed the person liked to have their room door open so that they could see people passing by and staff should put their television on to stimulate them. The room to this person's door was closed for most of the time of our inspection and the television was not on at any time.

The lack of support and provision for people to participate in stimulating activities which met their needs and preferences was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints process in place which was clearly available for people. The provider told us they had received no formal complaints in the service since our last inspection. They told us they took pride in the way in which they dealt with any concerns promptly as they were on the premises of the home at most times. However, any concerns which were raised by people and their relatives were not documented or recorded in daily records for people and so the provider had no way of monitoring any patterns of concern which were raised. People were happy to raise any concerns they had with staff or the management of the home and felt sure their concerns would be dealt with promptly. During our inspection we saw the provider responded to concerns raised by family members.

Inadequate

# Is the service well-led?

## Our findings

People felt the provider and the nominated individual were very nice people. They told us they were always available in the home to speak with them. One person said, "They are very nice to me," and another said "Oh yes I know them both, they are very nice." Staff enjoyed working at the home and told us both the provider and the nominated individual were very nice to them and supported them in their work. Relatives told us the management team were always available to talk to them.

At our inspection in October 2015 we found the provider had failed to ensure appropriate systems were in place to effectively assess, monitor and improve the quality and safety of the service or the risks associated with the health, safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider on 23 December 2015 requiring them to be compliant with this Regulation by 23 January 2016. At this inspection we found this legal requirement had not been met.

The provider had not had a registered manager in post since November 2014. The provider had been unable to employ and sustain appropriate people in the service to provide leadership and to ensure the service was able to meet the requirements of the Regulations. The provider had employed a registered manager when they registered the service in September 2014. However since November 2014 four different people had been employed into the home manager's role. Three of these managers had applied to be registered manager for the service, however had left the service before completing this registration.

At this inspection a manager had recently left the home after being in post for three months and the provider had appointed a new manager to start on 8 April 2016. The provider told us the manager who had recently left had told them they had completed all the required actions for the service to be compliant with the Regulations. The provider had told us this same information at our inspection in October 2015 when a previous manager had left and a new manager was in place. Following this inspection the provider told us the management structure had changed again and another new person was planning to apply for the post of registered manager at the home. This person had submitted an application to the Commission.

Whilst the provider and nominated individual had a very active role in the home it was not one which ensured the service was able to meet the requirements of the Regulations. The provider and nominated individual demonstrated a lack of knowledge and understanding of the Regulations and their legal responsibility to comply with these. Their awareness of the poor compliance with the Regulations was demonstrated repeatedly throughout the inspection as they were required to provide information in support of compliance with each Regulation.

The provider told us they believed there was a programme of audit and review in place to review the quality and safety of the service being provided for people. They believed this was completed by the manager who had recently left the service .They were unable to tell us what the programme contained or provide information with regards to the audits which had been completed in the home. The provider had not identified the concerns we had raised during our inspection in relation to the risks associated with people's

care, the lack of staff available to support people or the lack of information to support compliance with the regulations.

The provider and nominated individual knew people who lived and worked at the home very well. They were very visible to people, staff and their relatives as they spent extensive hours each week in the home. The provider told us they provided an, "Amazing service for people", and believed the home was safe and met the needs of people. This did not reflect our findings at this inspection

There was a lack of structure to the management of the home. The provider and nominated individual were present at most times. The nominated individual provided cover for care staff including night duties, supported the preparation of food when the cook was not present and completed administrative duties as well as being the nominated individual for the provider. Throughout our inspection there was no member of staff at the front door to the home to respond to incoming telephone calls, answer the main door or general administration tasks associated with these tasks. The provider was seen to support these tasks.

The administrator at the home provided extensive support to both the nominated individual and provider in the use of computerised records and systems to monitor the effectiveness of the service. They were also seen to provide support with the delivery of care for people including meals and medicines. They told us they were responsible for the rotas and would be providing a personal assistant service to the new manager who started on 8 April 2016.

A care director had been engaged in a consultancy role to support the previous manager in the development of care planning and records and provide advice on the quality assurance in the service. They were listed on the rota to provide specific shifts of support however we saw this did not happen. Following the departure of the previous manager the provider told us the care director was "Helping out until the new manager arrives".

There was a lack of structure in place to identify the specific roles staff completed in the home. There were two head of care posts which were shown on staff rotas. The provider told us another senior person was promoted to head of care on the day of our visit. This was not reflected in staff rotas or the duties they completed. Care staff did not have sufficient support and guidance from more senior staff who had a good understanding of the systems and practices in place in the home to ensure the safety and welfare of people. Following the inspection and a request from the Commission for additional information, the provider sent us a staffing structure.

The system in place to monitor all incidents, accidents or safeguarding concerns was inadequate and did not identify trends or patterns in these events. Records we looked at showed incidents had not been recorded or reported in a way which ensured the safety of people.

For example, for one person we saw an incident form had been completed for an unwitnessed fall which occurred in their room. There was no investigation into this incident and this information had not been added to a list of incident and accidents the administrator gave to us. The form did not inform the care records for this person and a member of staff was unaware this person was at risk of falls. We had also been provided with information which suggested two members of staff had injured themselves whilst on duty in separate incidents. The adverse event tracker form recorded one member of staff had been injured however it did not contain any details. There was no other record of this or the other staff members accident. There was no incident and accident book available for use at the time of our inspection. Following our inspection the provider advised that the incident book was found "behind a cabinet."

Whilst new electronic care records were being introduced to the home and staff required time to embed this practice in the home, information available in some care records was not clear, contained conflicting information and was inaccurate. Care plans and records had not been audited and reviewed to ensure they were accurate.

For example, one person had care plans in place dated 1 February 2016 which identified they required full assistance of staff and remained in bed at all times to receive end of life care. Care plans identified they were not taking any food and required all care in bed with two members of care staff for support. This person was not being cared for in bed and was supported to manage meals in the dining area of the home.

Information relating to the fluids, dietary intake for people and continence issues was not always clear and collated in a way which informed the care staff gave to people. For people newly admitted to the home or for short term respite care records had not always been added to the electronic system and information was not always available for staff to inform the care they needed to provide for people.

Records relating to the management of the service were not held securely and appropriately to ensure they could be accessed by the provider when required. Contracts for staff and people who lived at the home were held haphazardly and there was a lack of organisation and awareness of how records should be maintained and provided in line with the Regulations.

The provider had requested people and their relatives completed quality assurance surveys for the service in December 2015 and January 2016. The feedback from these surveys showed people were very happy with the quality of care at the home; however some minor areas for development had been identified such as a change in the menus at the home. The provider told us they were going to, "Put up some pie charts on the wall in the entrance to show people the results. " They told us they had not done this yet nor had they collated the results of the survey to demonstrate any learning or outcomes from the survey. The provider told us the feedback had been excellent and this was the most important thing for them. A failure to promptly analyse feedback gathered and plan actions to drive improvements meant that issues identified by people may not be acted upon.

There was a lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services being provided and the risks associated with the care people received. There was a lack of records to demonstrate the registered provider managed the Regulated Activities at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The public has a right to know how care services are performing. To help them to do this, the Government introduced a requirement from April 2015 for providers to display CQC ratings in the home and on any websites for the home. Clear guidance is given to providers on how this requirement should be met. The provider had failed to appropriately display this information on the website for their home despite further information being provided to them for this requirement. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.