Georgians (Boston) Limited(The)

The Georgians (Boston) Limited - 50 Wide Bargate Boston

Inspection report

50 Wide Bargate
Boston
Lincolnshire
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Tel: 01205364111

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 March 2016 and was unannounced.

The Georgians provides accommodation for 40 older people, people living with a dementia, sensory impairment or physical disability. The home provides both residential and nursing care. There were 40 people living at the home on the day of our inspection.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider was not identifying risks to people and ensuring that people received safe care. Staff had not received appropriate supervision or support to ensure they were competent to care for people. People were not always treated with dignity and respect. Systems to monitor the quality of care received and ensure feedback from people living at the home was used to drive improvements were not effective. You can see what action we told the registered persons to take at the back of the full version of this report. We have also made a recommendation about supporting people to receive person centred care.

The registered manager had failed to create a culture where staff were encouraged to provide high quality care or to raise concerns when care was not safe or meeting people's needs. Feedback from people living at the home was gathered through the use of questionnaires and meetings. However there was little evidence that change was implemented and embedded to drive improvements in the care people received.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are used to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The registered manager had not assessed people to ensure they were not being deprived of their liberty. Care plans recorded how people should be supported to make decisions and who they wanted to be included in the decision making process.

Staff were not always kind and considerate to people receiving care and were focused on completing tasks instead of ensuring care met people's individual needs. Care plans did not always fully support staff to provide person centred care, to identity the risks to people and to provide safe care. In addition staff did not embed their training into the care they provided to reduce the risks for people.

Staff received an induction to the home which included appropriate training and shadowing. However, the provider did not fully support staff to access training to maintain and improve their skills. Staff were not supported with supervision from their line manager and consequently did not always provide acceptable

care.

People who were able to access communal areas told us that the activities available helped to keep them entertained. However, where people chose to stay in their rooms it was less clear what support they had to ensure they were engaged and entertained.

Medicines were managed safely and people were supported to access their medicine when needed. Systems were in place to ensure medicines were ordered in a timely way and that they were always available for people. People were supported to make choices about their meals and appropriate advice was sought when people were unable to maintain a healthy weight or eat and drink safely. When needed people were able to access healthcare professionals to support them to stay healthy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not fully identified and staff did not work to minimise risks. Staff knew how to raise safeguarding concerns with their line manager.

People did not received timely care and the registered manager did not effectively monitor staffing levels.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not ensure staff were supported to maintain and develop their skills and staff did not receive supervision to assist them to provide high quality care.

The manager had not ensured people were assessed to see if they were at risk of being deprived of their liberty. However, systems were in place to ensure decision were made in people's best interests.

People were supported to eat and drink enough to stay healthy and were able to access health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff were not always caring and did not involve people in their care.

Care staff were not always discreet or respectful when providing care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was planned and delivered to meet people's basic needs but the attention to detail to ensure care met individual needs was missing.

Activities were available for people who could access the communal areas.

The provider investigated and responded to complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager and provider had not developed a culture where staff strived to provide good care and were encouraged to raise concerns about poor care.

People's feedback was not used to drive improvements in care.

Systems to monitor the quality of the care were not always effective.

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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 care, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 17 March 2016 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with five people who lived at the home, four visitors to the home and spent time observing care. We spoke with the registered manager, a nurse, three care staff, a cook and the activity coordinator.

We looked at six care plans and other records which recorded the care people received. We also looked at management records including how the quality of the care provided was monitored.

Requires Improvement

Is the service safe?

Our findings

The provider did not ensure people were fully protected against the risks associated with receiving care. Some risks had been identified and care records included some information on how to keep people safe. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. However, care plans did not contain sufficient information to ensure that care was given safely. For example, there was no recording of what type of pressure relieving equipment people needed or what equipment should be used to hoist people.

At times care plans were not specific about the level of care people needed. For example, we saw one person's care plan stated that at times they could be transferred with two members of staff but that it needs to be assessed at each transfer taking account of the time of day and the person's mood and equipment used if needed. We saw that when staff transferred this person they did not assess the person and did not use any equipment. We saw this put the person at risk of injury as staff stood on either side of the person and put their arms under the person's armpits and lifted them up. They turned the person to put them in the chair and while the person's chest and torso moved with the care staff their legs did not. In addition, one member of staff lost their grip and the person started to fall before fully over their chair.

We observed two people hoisting a person in the downstairs lounge. We saw that they did not engage with the person or talk them through the process. They failed use safe moving and handling techniques. We also observed staff hoisting a person in the upstairs lounge and again staff failed to use safe moving and handling techniques and moved the person into the toilet area while suspended on the hoist. Other people were hoisted in the privacy of the toilet. However, staff told us that they would have normally hoisted everyone in the lounge which meant that staff were increasing the risk of people being injured while using the hoist.

Some accidents and incidents were recorded and appropriate action had been taken. However, care plan reviews did not always identify appropriate action following an incident. A visitor told us that their relative had climbed over their bed rails and had a fall and injured themselves. Their care plan had been reviewed following their return from hospital but no changes in care were recorded to stop the person climbing over the bed rails again. The relatives said, "He climbed out of bed a month ago over the sides and hurt his arm. He was sent to hospital but it was just tissue damage and bruising." They added, "He has still got the bed sides that they put up."

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

There were not always enough staff to meet people's needs in a timely fashion. People living at the home and their relatives told us that sometimes they had concerns that staffing levels did not support people to receive person centred care. One family member told us, "I've concerns about night time care as there is only a few staff on and it's a big place to monitor them all." Another relative said, "It can take ages when they're short for him to be hoisted into his wheelchair or into his lounge chair. Some days he has lunch in the

lounge as there's no time to get him into his wheelchair for the dining room."

People told us that response times to call bell were varied and that staff would cancel a call bell and tell the person how long it will be before their turn. One person living at the home said, "Sometimes I'm in a queue and may have to wait." Another person told us, "It's not very quick, it can be half an hour or they just don't come. Night time is the worst." In addition one relative explained how staff having their breaks at the same time was a problem. They said, "The worst time to find staff is their coffee time as they both go off together so there's no-one on the [ground] floor between 3pm to 3.30pm."

Staff told us that at times staffing levels impacted on the care people received. They told us that on a good day it would be midday before everyone was up. We discussed this with the registered manager who was surprised as that was not what they had though was happening in their home. Staff also told us that at times they struggled to get people to bed at their preferred time. One member of staff told us that at times people have asked to go to be but said, "They can be sat there an hour later." Another member of staff said, "You don't feel that you can meet their [people living at the home] needs and take your time with them."

The registered manager told us that they had not used a tool to help them identify appropriate staffing levels. They said that they would monitor what was happening out on the floor and if it did not feel right they would look to increase staffing levels. However, we saw at times the registered manager was unaware of the level of care people were receiving and were not confident that they would recognise when staffing levels needed increasing. Both the registered manager and staff told us that staff sickness impacted on the care they were able to provide and the registered manager has introduced systems to monitor and manage sickness.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. However, we saw that not all the required checks had been completed to ensure that staff were safe to work with the people who live at the home. We found that disclosure and baring service checks had been completed to see if a person had a criminal record, but references had not always been appropriately obtained.

People told us that they felt safe living in the home and in their bedroom. One person said, "Oh yes, I'm safe here." Another person, who had an upstairs bedroom told us, "I feel very safe up here."

Staff told us they had received training in keeping people safe as part of their induction to the home. They understood the different kinds of harm which may occur and were clear that they would report them to their line manager. However, while the nurse and the registered manager knew how to raise concerns externally, care staff did not know how to raise concerns directly with the local authority safeguarding team.

Medicines were well managed and available to people when needed. Where people had the ability they were supported to be independent and manage their own medicines. One person living at the home said, "They never leave me and wait till I've taken my pills. They tell me about them and monitor my medicine for me." While another person told us, "I have to take it while she's there." This showed that medicines were managed in a person centred way for each individual.

Systems were in place to ensure that medicine was ordered in a timely manner and stored safely. We saw the nurse supported people to take their medicines in a safe manner and information on the Medicine Administration Records (MAR) had been fully completed and provided a clear record of when people had

taken their medicine. There was clear recording when doses of medicines like warfarin changed and systems in place to record when patch medicine had been applied and removed.

Requires Improvement

Is the service effective?

Our findings

Staff were not fully supported to have the skills needed to provide safe care. People told us they felt some care staff had the skills needed to provide safe care which met their needs. One person told us, "The older ones are ok, but not the younger ones."

Staff told us that they had received an induction when they first started working for the home. This consisted of time spent receiving training and time spend shadowing a more experienced member of staff. However, training was not embedded into the care provided. For example, we saw some poor moving and handling during our inspection. We discussed this with one member of staff who we saw inappropriately moving a person. They told us that they had not been trained to support people to this way. They had not raised concerns with the registered manager that moving and handling was not being completed in line with training. When we asked why they had not identified this as a concerns they said, "It's the way we have always done it." This showed that the training was not effective and the provider was not checking the competency of staff following training.

Staff told us they had not received a recent supervision. This is time spent with their line manager to discuss their standard of work and any ongoing training needs. We saw that this had been identified as an issue during a recent local authority visit. We discussed this with the registered manager who confirmed that supervisions had not recently been completed due to pressures of work.

The provider had not supported staff to feel empowered to access training to maintain and improve their skills and abilities to care for people properly. Staff told us that if they needed to attend updates on mandatory training, they had to do this in their own time, unpaid. The registered manager confirmed this and for this reason was reluctant to enforce it.

This was a breach of Regulation 18(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that they had not submitted any requests for people to be assessed under the DoLS. They were aware that this

was an area which they needed to review to ensure that people's rights were protected. We saw there were some people living at the home who were not able to make decisions about where they lived and would needs a DoLS assessment.

People's ability to make decisions were recorded in their care records and they also contained information on who the person wanted to be consulted when decisions were made on their behalf. Some care plans recorded that people had arranged for others to make decisions on their behalf. However, there was no evidence in the care plan that the appropriate legal process had been completed.

Most people told us that they were able to make choices about what to do, what to wear and what to eat. One person told us, "I have to wait for them to come in and get me up. I choose my clothes when they dress me." While a relative said, "She's reliant on the carers [staff] to do everything and decide for her."

People were satisfied about the meals they received and said they received appropriate support from staff. One person told us, "They make lovely porridge. Food is usually hot enough and they cut it up small for me to swallow." While a relative said, "I can't complain about it. He's on a pureed diet now and eating well. I feed him in the dining room, or lounge if they can't get time to hoist him." People were offered a choice of meal and could always request an alternative if they did not want anything that was offered. One person told us, "It's just ok. They'll do me egg, chips and beans on Fridays instead of fish and chips, or a jacket potato." We saw that when people needed support to eat the interaction with the care staff did not support them to be engaged and involved with their meal. For example, there was just basic conversation about trying another mouthful and two members of staff on adjoining tables chatted to one another for much of the time whilst supporting people.

People had access to hot and cold drinks throughout the day and where needed people's fluid intake was monitored to ensure they drank enough to stay well. One person told us, "They monitor what I drink as I'm supposed to drink plenty." A family member told us that staff reminded their relative to drink plenty.

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Their food was modified to increase their calorie intake. Where necessary people had been supported with prescribed high calorie supplements. When people were unable to eat safely they had been referred for an assessment, and guidance about the type and consistency of food it was safe for them to eat was followed. For example, we saw some people had their drinks thickened and their food blended smooth. Where people required enteral feeding appropriate information on the amount and timing of feeds were recorded and advice from dieticians and other healthcare professionals was sought and recommendations were put in place. Enteral feeding is when people receive their nutrition via a tube in their stomach.

People told us they were able to access advice and support from other healthcare professionals as needed. One person told us, "I've had the doctor out twice but they don't come that quickly. I saw the optician here about 6 months ago." A relative told us, "The home is good at calling out the doctor if needed." We also saw that people were supported to understand their illnesses. For example, we saw that a nurse had spent time and explained the findings of some blood tests with a person. They were supported to consider booking a GP appointment with their relative to discuss their concerns.

Individual care plans included all the information needed to support people's day-to-day health needs. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed. While the home provided nursing care for some people, when extra support was needed people were referred to specialist care for help and advice, For example, we saw one

person had been referred to the tissue viability nurse for support with managing ongoing wounds.

Requires Improvement

Is the service caring?

Our findings

Care staff care staff did not always manage people's needs in a way that respected their dignity. For example, we saw two members of staff take a person into the lounge. The care staff discussed with each other were they would sit the person and a third member of staff shouted from the other side of the lounge, "Stick him in the end one." They did not engage with the person and did not offer them a choice. We saw that this person was capable of communicating their needs. When staff had decided where the person was going to sit there was then 10 minutes of trying to arrange the person's enteral feed before they were ready to assist the person to move position by using a hoist. The process was disorganised and did not support the person's dignity or emotional well-being.

Staff were not discreet when asking people if they wanted to go to the toilet or asking other staff who wanted to go. One member of staff told us they were aware that it was not polite to shout about people's continence needs across the room but had not raised any concerns about doing so. Care staff were focused on completing the task of ensuring people were taken to the toilet to the extent that they forgot to ensure the care met people's individual needs. For example, we saw staff had worked out an order in which people would be taken to the toilet. They did not pay attention when one person said that they needed to go quickly and consequently they supported a number of other people before taking this person to the toilet. This increased the risk of the person being unable to manage their continence and maintain their dignity.

We saw the people in the upstairs lounge had been invited to go downstairs to join in an activity in the afternoon. We saw that staff did not engage the people and ask them if they wanted to go downstairs, instead they asked other member of staff. When they did ask someone if they were going down, they did not wait for a reply before repeating the question to a member of staff. On several occasions we saw staff asked people, "Shall we go to lounge now?" or "Let's move you into this chair shall we?" whilst already moving the person. Similarly, staff were putting on protective tabards at lunch saying, "Let's just put this on to keep you clean." While it was politely done there was no choice offered to people.

We recommend that the service seek advice and guidance from a reputable source about supporting people to receive person centred care.

While some people were complimentary about the care staff other people told us that some of them were not so good. One person told us, "The older ones are better. It's just a job to some." While a relative said, "Some are better than others. You can tell they have their favourites too." However, all the people we spoke with told us staff did not spend quality time with people. One person living at the home told us, "They've no time to sit." While another person said, "You're joking! They only talk if work is being done." We saw one member of the care staff was dismissive to a lady and they walked away from the lady while they were still talking.

People living at the home and their relatives told us that staff were respectful of people's privacy and they felt that they were treated with dignity when they provided personal care. Staff explained how they would ensure curtains and doors were closed and a room divider used shared rooms. One person told us, "They

close my door and curtains every time." While another person said, "They always knock loudly. I like being on my own up here sometimes and being private."

However, we saw that people who were cared for in their room had their monitoring charts left in the corridor outside of their bedroom where anyone could look through them. In addition, one member of staff told us how some staff would not always support people to access clean clothes on a daily basis but would just offer them what they had been wearing the day before.

While people living at the home could not always remember if they had been included in the developing their care plans relatives we spoke with were clear that they had been involved in the process. One relative told us, "I'm involved with it and they talk to me about options and her care." Another relative said, "I'm their contact. We had a review meeting recently and have done two meetings since he came."

Requires Improvement

Is the service responsive?

Our findings

Care plans contained enough information to provide basic care but did not contain enough detail to support staff to provide care which was tailored to individual needs. In addition, it was not always clear in the care plan when people's needs had changed and one relative raised concerns that changes in care had not been handed over to all staff. However, people told us that staff knew about their preferred care and routine and that they were encouraged to be independent if possible.

We saw at times that care did not always meet people's needs. For example, we saw that following a person being hoisted into a chair the person was sitting leaning to one side and staff would have left the person like this. It was only when the person's relative asked for them to ensure they were sitting properly did staff help make some effort for the person to be more comfortable. However, the relative still did not think the person looked settled and attempted to move them to a more comfortable position without support from staff.

One member of staff told us that people were supported to have a bath or shower once a week. However, they said that people did not always get their preferred method of bathing as sometimes staff gave people a shower even if they wanted a bath as showering was quicker and easier. Several people told us that they had a weekly bath slot and that if they were ill or asleep when it was their time, they could miss it and have to wait another week. A relative told us, "They only get one shower a week in a time slot. She has to have bed baths the other days and they'll wash her hair in bed."

People were not always supported to be able to call for help when needed. When we walked around the home we saw that a number of people had been left without the call bell being accessible to them. Some of these people were unable to get up and reach the bell independently and therefore would have been unable to call for support.

Care staff did not always identify when a person needed support. Staff told us that person formed attachments to people of the opposite sex and that this was sometimes a problem. We saw a member of the opposite sex was sitting next to the person and staff did not monitor the situation. The person was putting food into the other person's mouth and that may have been a choking risk. Two members of staff were in the room at the time and while one asked the person to stop they did not and staff did not intervene. One member of staff spoke about how the behaviour of other staff did not support person centred care for the person. For example, they said that some staff did not always provide the amount of attention that was needed and that made the person distressed.

Where people needed nursing care this was provided to meet their needs. For example, where people had ongoing wounds that needed care we saw that there was clear recording and photographs on the size and appearance of the wound, what dressing had been used and what the outcome was. This allowed the nurses and other health care professionals to assess the healing progress and make any amendments to care if needed. Additionally when people had an accident or felt unwell appropriate support and monitoring from the nurses was available. For example, we saw observations around pulse and blood pressure had been completed when a person felt dizzy and appropriate tests had been completed when there were

concerns around infections.

We saw and people told us that the nurses responded appropriately to emergencies. We saw that one person started coughing and choking when talking their medicine, the nurse calmly supported the person and patted their back until they coughed the tablet back. We saw the nurse sat with the person while they calmed down and came back later to check on them and to discuss the incident. The nurse and the person both discussed the incident and agreed a safer way for the person to be offered their medicine in the future. One relative told us where staff the registered manager and the nursing staff had responded well in an emergency. They said, "Mum was choking in the dining room one day – straight away the matron [registered manager] and two nurses were there. They then laid her out in bed and managed to remove the lodged food, they were marvellous to save her."

There was an activities coordinator who worked for five hours a day five days a week. They had completed a training course on planning activities for people living in a care home. A weekly activity plan was produced and displayed. Activities generally took place after lunch in the ground floor lounge and included including musical movement, visiting singers or musicians, bingo and a monthly church service. Easter, Halloween, Christmas were celebrated with parties, entertainment and crafts. Outings were also arranged, these included walks into town or the minibus to a park, garden centre or seaside.

People told us that they were encouraged to join in the activities but their wishes were respected if they chose not to take part. One person told us, "I went down to the church service last week but that's all. I don't get bored up here really." Another person said, "I play in the dominoes group every day if I feel well enough, for a couple of hours. I like the bingo and Countdown too and they take me into town sometimes."

While staff told us that where people chose to stay in their rooms the activities coordinator visited them, relatives were not aware of them receiving one to one support in their bedrooms. One relative told us, "I've not seen anyone spend time with him up here." While another relative said, "She doesn't go to anything as she couldn't join in. I've not seen anyone spending time with her in here either."

No one we spoke with had made an official complaint. However, one family did tell us that they had, "Moaned about staffing" and two people living at the home told us that they had raised a concern with the registered manager about people entering their people's bedrooms during the night-time. They were confident that the registered manger would take action and that they had been taken seriously.

Records showed that there had been three complaints raised since our last inspection and all had been responded to in line with the provider's complaints policy. We saw there was a notice telling people how to complain in the main entrance. However, staff said they did not know how to support a person if they wanted to make a complaint. Therefore complaints may not always been raised with the registered manager.

Requires Improvement

Is the service well-led?

Our findings

We found the home was not always well led and provider and the registered manager had not created a culture where staff were committed to providing good care, took responsibility for their actions and raised concerns. For example, one member of staff told us that people who were unable to verbally communicate their needs got poorer care than people who were able to say what they needed. While another member of staff told us that at times some staff did not behave appropriately. Neither member of staff had raised these concerns with the provider or registered manager.

We also saw that some staff did not respect rules which had been put into place to safeguard the people living at the home and themselves. For example, there were two students completing work experience at the home. One member of staff requested a student to help them move a person from their wheelchair, when the student had not received appropriate training and was not allowed to provide hands on care. The student politely declined to help.

Staff told us that they attended staff meetings every six months which allowed the provider and registered manager to keep them up to date with changes in the home and for them to raise concerns. However, some staff felt unable to raise concerns with the management. One member of staff told us that they did not feel able to approach the registered manager with concerns. In addition, while the deputy manager was more accessible to them when working weekends they did not have confidence in reporting concerns to them.

People had been supported to give their views about the quality of care they received. People told us about attending residents' meetings. However, they felt that these were not useful as they were not informed of any outcomes and they failed to drive any sustainable changes in the home. One person living at the home told us, "I go along but don't say anything. I've no idea if anything changes." A relative said, "We have our say and it's usually staffing or lost property they raise. Nothing really changes after though."

People living at the home and their relatives had also completed surveys about the care they received. One relative told us, "We had a survey just last week but the tick box type." We reviewed the latest survey and saw that at times people did not always feel safe and that staff did not always notice if people were upset. We saw that the results were displayed on the notice board for people living at the home, relatives and visitors to see. The registered manger told us they were working on an action plan.

Over the last year the provider had been short of trained nurses and the registered manager had been providing clinical care for people on a regular basis. This meant that they had not had the time to complete all the tasks related to the management of the home and this was apparent in our findings and observations during the inspection. For example, staff supervision had not been completed and staff were working in a manner to make their job easier as they had not been held to account for poor care.

While staff were aware that at times the level of care people received was not good enough, the registered manager had not identified these concerns. Additionally while poor moving and handling practices appeared common place within the home the registered manager had not known this was an issue. The

registered manager had not ensured all audits and checks had been completed on the care provided or the environment. For example, we saw that pressure cushions on chairs in the upstairs lounge were old, split and torn, and the cover would not protect the cushion from liquid spills or continence issues. No recent medicines audit had been completed. However, some audits had been used. For example, a falls audit was in place and an infection control audit had been started. The provider visited the home on a weekly basis to review the care provided to people, however given our findings the reviews were not effective at driving improvements.

This was a breach of Regulation 17(2)(a)(b)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

People told us that the registered manger was often seen around the home and they were well liked. One person living at the home told us, "She [registered manager] often comes to say hello."

We saw that the furniture in the home was old and some of the rooms were in need of decoration. We raised this with the manager who explained that there was an ongoing programme of decoration and furniture replacement in place. In addition any ongoing maintenance was recorded in the maintenance book which the maintenance people checked on a daily basis.

The registered manager explained that they were working to ensure they kept up to date with changes in the way people should receive their care. They had signed up to access a website which provides information, tools, case studies and further resources for facilitating research in care homes. The registered manager was also working with a consultant at the local hospital to develop a falls risk tool. Guidance on best practice was also accessed through the local college and the provider supported students on a health and social care course to get work experience.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected against the risks associated with care and risks were not fully mitigated. Regulation 12(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality of care provided. The provider did not assess, monitor and mitigate the risks to people living at the home. The provider did not act on feedback to drive and embed improvements in care. Regulation 17(2) (a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive adequate supervision. Regulation 18(2)