Karma Health Ltd

Freckleton Lodge

Inspection report

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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

This inspection took place on 09 March 2016 and was unannounced.

This was the first inspection of Freckleton Lodge. The service was registered in September 2015. Freckleton Lodge is a newly refurbished care home for older adults. The home provides personal care for up to 28 adults. Nursing care is not available at this location. The home is situated in a rural area close to the towns of Preston and Kirkham.

All the bedrooms have en-suite facilities. There is a large dining room and communal areas, available for people living at the home. The grounds are well maintained with seating and patio areas. These are accessible for those who use wheelchairs. Public transport links are available and ample car parking spaces are provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included; Regulation 9- person centred care, Regulation 11 – Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 (5) Safeguarding, Regulation 17-Good governance, Regulation 18- Care Quality Commission (Registration) regulations 2009- Notifications of other incidents.

You can see what action we have taken at the end of this report.

The registered manager was present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

At the time of this inspection there were 11 people who lived at Freckleton Lodge. We spoke with six people living at the home. We spent time observing care delivery and spoke with people who visited the service. People told us that they felt safe.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found that some staff had received training in safeguarding adults and demonstrated a good understanding about what abuse meant.

We found there was no formal recording of safeguarding incidents. The provider was recording accidents and incidents however it was not clear what support people were getting after experiencing multiple falls. We found evidence staff sought advice from ambulance services in some instances however this was not consistent.

We found people's medication was being managed safely however this was not consistent. Staff had received appropriate medication training. We found no building fire risk assessment on the premises on the

day of our inspection; the provider however sent us a copy two days after our inspection visit.

Residents did not have personal emergency evacuation plans to enable safe evacuation in case of emergency.

There was no formal staff dependency tool however we found no concerns over staffing levels.

We saw evidence of safe recruitment practices.

We found no evidence of staff disciplinary warnings being recorded.

The service was not always following the Mental Capacity Act, 2005 for people who lacked capacity to make particular decisions. For example, the provider had not ensured that people's rights were actively assessed under the Mental Capacity Act or Deprivation of Liberty Safeguards, even though their liberties were being restricted.

Although some people told us they felt safe and their privacy and dignity was respected, we found people's privacy and dignity had been compromised by installation of CCTV in communal areas without their consent or sufficient consultation with their loved ones.

We found that people's health care needs were not effectively assessed on admission to the service.

Consent was not always sought from people.
The home did not consistently involve people in decisions made around the care they received. Care plans did not evidence involvement.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people living at the service from risk.

Staff were provided with effective support, induction, supervision, appraisal and/ training.

We found people's medicines were safely managed.

We found the service had effective systems to deal with complaints about care and treatment. And found that the manager had kept robust records to show how complaints were resolved.

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

People were not always safeguard after experiencing falls.

People did not have personal evacuation plans.

We found sufficient staffing levels met the needs of people who lived at the service.

We found minor shortfalls in medicines management.

Robust systems were in place for recruitment of staff.

Is the service effective?

Requires Improvement

People were not supported in line with the Mental Capacity Act 2005 to ensure that their ability to consent was appropriately assessed prior to decisions being made on their behalf.

People were constantly monitored without relevant authorisation.

There were effective systems in place to ensure that people received nutrition and hydration appropriate to their needs.

Staff were receiving training.

Supervisions were not used frequently.

Is the service caring?

Requires Improvement

There was positive engagement between staff and people who lived at the service.

The systems and procedures operated at the home were designed to enable people to live their lives in the way they choose, so that they can be as independent as possible.

People's dignity and respect was compromised.

The standard of personal care people received was found to be satisfactory.

Is the service responsive?

Requires Improvement

Care planning was not consistently person centred.

There were a variety of meaningful day time activities and people's independence was promoted.

Social Inclusion was widely promoted.

Concerns and complaints were being acted on.

Transition between services was not adequately facilitated.

The service responded to peoples changing needs by ensuring amended plans of care were put in place and liaison with other health care professionals at times of deterioration in health status.

People's complaints were dealt with effectively.

Is the service well-led?

Requires Improvement

There was a positive staff culture

We found management structure had awareness of people's needs.

Management were transparent and open.

There were no robust audit and monitoring systems in place.

The service was not sending all statutory notifications to CQC.

Freckleton Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 09 March 2016, and was unannounced.
The inspection team consisted of two adult social care inspectors. Before the inspection we reviewed information from our own systems, which included notifications from the provider and safeguarding alerts.

We gained feedback from external health and social care professionals who visited the home. As part of this we were provided with an organisational safeguarding report completed by Lancashire County Council Safeguarding Enquiries Team in January 2016 and had received regular updates from other associated professionals at the local authority.

We spent time talking with people who lived at the home and where possible their relatives, reviewed records and management systems and also undertook observations of care delivery. We spoke with six relatives, six people who used the service, the provider, manager, pharmacist and four care staff. We looked at six people's care records, staff duty rosters, four recruitment files, accident and incident reports book, handover sheets, management audits, medication records and service maintenance records.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at the home whether they felt safe. People told us they felt safe living in the service. One person we spoke to told us, "I feel safe and content".
One relative told us "Mum is definitely safe here, as safe as she can be, safer than hospital or home".

Staff knew how to keep people safe and how to recognise safeguarding concerns. They had a clear understanding of the process or procedure to raise any safeguarding concerns for people. This meant people could be assured that staff would raise safeguarding concerns if they noticed someone being ill-treated. We found staff had received training in safeguarding adults from abuse. Three staff spoken with during the inspection demonstrated an understanding of safeguarding procedures and their roles within both provider and national safeguarding procedures. This meant the provider had provided staff with necessary training.

People were at risk of harm because the provider did not always have effective processes for reporting or recording accidents or incidents and therefore could not monitor, respond to issues and reduce the risk of reoccurrence. Accidents and incidents were recorded however some people did not always receive safe care when they experienced a fall. For example one person who lived at the home suffered up to six falls in one day. Although the ambulance was called it was not evident what the provider did to manage this risk from occurring again or whether a risk assessment had been updated to inform staff how to manage and reduce the risks. Records did not show what observations were being carried out after the falls. We found another person had experienced falls and had refused medical attention. Staff had respected this person's wishes however we found no evidence of a mental capacity assessment to support this person was aware of the consequences of refusing medical care.

In another person's file we found their falls risk assessment had not been recorded to reflect their current risks and how they were being managed. This person had suffered up to eight falls in four days and their falls risk assessment had remained medium risk. We spoke to the provider and they informed us this person was no longer living at the home. We did not find evidence that the provider had referred this person to specialist services such as the falls clinic. We spoke to the provider who informed us they had sought support from the falls team. However there was no evidence this had been done.
Therefore people were placed at risk as they could not be assured that they would receive appropriate care if they were injured.

Risks to people from receiving care were managed. We found people's needs were being assessed and staff recorded care being provided. Where risk assessments had been carried out and actions recorded to mitigate the risk these actions had been carried out and staff reviewed the care plans on a regular basis. For example, we found one person had been assessed as presenting with unsafe behaviours towards others. The service had reviewed and referred this person to specialist services and plans were in place to ensure this person was moved to an appropriate service. This meant that the service had measures in place to assess people's changing needs and recognise where people's needs could not be met safely.

We found the provider had not sought required authorisations to ensure people's care did not result in unlawful restrictions. The provider was using pressure mats during the night to monitor two people's movements. However we checked these people's care files and found no assessment as to why these people needed to be constantly monitored in the night. The people concerned had not been involved in the decision and they had not consented to the monitoring. We found there were no mental capacity assessments in place and no evidence that best interest decisions had been made through specific meetings and discussions between all those involved in these people's care. The provider told us they had put these mats in place to ensure one person did not go in other people's bedrooms during the night. Following our visit the provider contacted us and informed us that they had removed the mats and were supporting these people in other ways that did not involve constant monitoring.

We found that medicine management systems were in place however they were not robust. For example, we found staff were trained to administer medication safely and we observed them doing so. However, we found people's medications records did not have photographs to identify them and guide staff to ensure they were giving medication to the right person.

We found there were no care plans for "as and when medication". For example, one person who was prescribed paracetamol did not have a care plan to reflect when and how this medication should be administered. However we observed staff were offering this medication to people appropriately which meant the impact of this shortfall was not significant. Another person had a hand written medicine administration record (MAR) which was not double signed to show that it had been checked to see if it was the same as the prescription. This record had no name or date to say who wrote it and when it was written.

We looked at how the service was supporting people to manage their own medication safely. In the medications records, Inspectors found one person who managed their own medication had not been assessed to ensure they could safely manage the medication. This meant the provider could not ascertain if people were taking their medication safely.

We found people were at risk of receiving unsafe care when moving between services. People's care plans did not contain important information they needed if they were being transferred to hospital or other services. Regulations state that people's details such as their health and social care needs, allergies and medication are recorded and ready for when they need to be shared with other professionals. For example we found one person's file stated they were allergic to penicillin and aspirin. However their hospital transfer record had no information regarding these allergies or this person's current health conditions and medication they were prescribed. In another person's file we found hospital transfer documents did not mention the person's diagnosis, medication they took and the fact that the home was actively monitoring this person's behaviours to avoid harm to others. Lack of these important details had a potential of adverse impact on people. This meant these people were at risk of not being effectively supported if they were to be transferred to another service or hospital.

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

We looked at whether the service had sufficient staff to meet people's needs. On the day of inspection we found there were sufficient numbers of staff. Some people told us there was sufficient staff to meet their needs. One person said, "They always come on time." However one relative told us sometimes staff were stretched, especially in the kitchen. A relative we spoke to told us "I think they need more staff" And "Sometimes when I come there doesn't seem to be any staff to talk to".
We found the home did not have a formal system to assess when more staff were needed. We spoke with the

provider regarding the system they used to determine staffing levels. They were unable to demonstrate to us how they formally determined staffing needs. We found the service was using regular staff and there were no agency staff used. The registered manager informed us this has helped the service to maintain consistency.

The service followed safe recruitment practices. We checked staff files and we found they were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider followed safe recruitment procedures that helped to protect vulnerable adults.

We looked at how people would be supported in the event of emergencies. People did not have plans in place for staff to follow should there be an emergency. We found all six people whose care we looked at did not have Personal Emergency Evacuation Plans (PEEPs). The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise. For example, in the case of fire or flood. The absence of PEEPs meant that staff had not assessed how people would be supported in the case of emergencies in the home therefore putting people at risk. We spoke to three members of staff who had knowledge of how they would support people in the case of an emergency. However they were not aware of what PEEPS were. The provider completed these following our inspection and showed us the evidence.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the service if they felt staff were competent and suitably trained to meet their needs. One relative told us "They are great" and "They look after people really well." Another relative told us, "The owner is good he went to assess my relative in hospital twice to make sure he remembered what they were planning to do with him". And "They are skilful".

We asked a visiting professional for feedback. One professional told us, "There have been some improvements with the recording and they are taking advice on board."

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 make 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 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. We found the provider was not working in line with the key principles of MCA. This included inability to recognise when to apply for a DoLS. For example, there were people without mental capacity to make such decisions who were not free to leave the home and could not come and go as they wish. We found the home operated a locked door which was operated by key pad. Some people were unable to operate this key pad and did not have the code, which meant they were unable to leave the service freely if they wished to do so. These people were also subjected to continuous supervision and control. These people lacked mental capacity to consent to being restricted and monitored. Where people are restricted in this way the law requires the provider to apply for authorisation from the local authority to ensure the restrictions are lawful.

In another example we found the Registered Manager did not follow the principles of the Code of Practice for MCA and DoLS when they installed CCTV within the home. We found CCTV was recording people constantly in the dining room, all lounges and all corridors. People's mental capacity to consent to being monitored had not been considered. We found no consent had been sought from people who lived at the home. A number of people living at the care home had mental capacity to consent to this monitoring but had not been consulted.

We checked the provider's CCTV policy and found they had not followed their own policy and CQC guidance on the use of surveillance. We therefore asked the provider to turn off the CCTV until they had sought consent from people living at the service. We requested to see evidence of this. This meant that the registered manager did not take consideration of whether people were capable of making their own decisions or not.

This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014

Records showed that arrangements to obtain consent from people who lived at the home were inconsistent. Staff did not obtain valid consent from people who lived at the home. We viewed care plans of four people and noted consent for all aspects of their care had been signed by the registered manager only and no indication who else was involved in the decision making process.

In another example we found in these four people's pre-admission documents, consent forms were not signed and no evidence people were in agreement. We found these people were capable of consenting or withdrawing consent.

We looked at training records and found staff and the Registered Manager had completed online training to help them understand the principles of the Mental Capacity Act, 2005. Staff showed a good awareness of people's rights however this was not sufficiently evidenced through record keeping. We spoke to the provider who informed us they were arranging further face to face training for all staff and will ensure all people's files will have consent signed before admission.

We found the registered person had not ensured people's rights were always protected, because consent had not been obtained through best interest decision making processes prior to the provision of specific areas of care. For example we found in 2 people's care records the registered manager had installed pressure mats to monitor people when they get out of bed, however we could not find evidence to show these two people had agreed to this or their relatives where people lacked capacity.

This was a breach of regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014- Need for consent.

Staff did not receive supervision regularly. The provider's policy stated that staff should receive supervision every three months. However, we found staff who had been with the service for five months had not received supervision. We found staff meetings were undertaken monthly and staff told us they found these helpful in understanding where the service was going.

We found training had been undertaken for key areas of the service, for example moving and handling training, safeguarding, mental capacity, managing nutrition and first aid training. We however found the majority of the training was being done on computers (online). We spoke to the provider and the registered manager who assured they would make arrangements for face to face training.

We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. We found snacks and drinks were readily available throughout the home and people were helping themselves. Nutritional care records we looked at showed people's dietary intake was being recorded regularly, however we also found staff were recording everyone's dietary and fluid intake with no justification as to why they needed their intake recorded. We did not find evidence of nutritional assessments and risk assessments that identified the need to record every individual's food and hydration intake. We spoke to the Registered Manager regarding this and made a recommendation.

We observed people eating during lunch time. We saw people were offered choice and encouraged to eat. The atmosphere was relaxed and people seemed to enjoy their meals. People's views on meals were positive. One person told us "We get two choices at all meals". A relative told us "The food is great, we get

offered the food and we like it".

The menu was displayed in the home and people could choose what they wanted to eat.

We also recommended the provider to follow National Institute of Clinical Excellence guidelines on recording people's dietary and hydration.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us, "I find them great" and "They are wonderful really". Another person said "They are caring and we cannot complain" and "Yes I think they are all very nice". Another person told us that although they found the care staff to be kind and helpful, they often appeared to be rushing.

We received information from other organisations that there were some members of staff who had been accused of not providing adequate care during the night, destroying and falsifying care documents. We spoke to the provider and they informed us these members of staff did not pass their probationary period and therefore were not offered employment contracts and that they had measures in place to protect care documents from being destroyed by staff. We did not find evidence this was still happening.

People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. We observed this and found this to be true. Plans of care we saw outlined the importance of respecting people's privacy and dignity and promoting their independence. A staff member we spoke to told us how they would respect people's dignity. They told us "I knock on doors". However, other people we spoke to found they were having disturbed nights due to two hourly checks that staff were doing during the night. We discussed this with the provider and advised they assess people's night time needs and seek consent whether people wanted this as part of their care. This would ensure that only those who agreed to night checks would receive them.

We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance. People were referred to by their preferred names.

We saw evidence people were asked about their views regarding meals. The provider was carrying out surveys regularly to ask people for their suggestions.

We looked at whether people were involved in their care planning. We looked at care records for six people and found that people were not involved in the care planning process. We spoke to the Registered Manager about the need to involve people in writing their own plans. They informed us they had sent forms for families to complete however regulations state they should get people to tell their own stories on how they want to be cared for instead of relying on family members. Only where people cannot decide themselves should family members be asked in line with the Mental Capacity Act.

We asked people if they had been given the opportunity to be involved in writing their care plans and one person told us, "I was not asked, I guess it's because I have only been here shortly." A relative of one person told us "I have not been asked to sit down to do the care plan and I would like to do that".

We did not find any evidence of involving people who lived at the service in decisions made about the general running of the home. For example, we had no evidence that the use of surveillance around the home

had been discussed with people who used the service. We spoke to people who lived at the home and also spoke to some relatives who had been visiting regularly and they all told us they had not been involved. This meant the provider could not demonstrate that people's voices were always heard and their opinions used to shape how their care was delivered.

This was a breach of regulation 9(1) (3) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014-Person Centred Care.

We asked the manager if residents' meetings were held and she explained that meetings were scheduled however no one turned up on the last meeting. They advised us they were seeking other ways of sharing information such as newsletters.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to. One person told us "They are excellent really" And, "They listen to you.
One relative told us, "They keep people occupied, there are so many activities". Another person told us, "They know he loves walking, they take him for a walk regularly". However another person told us "I am not sure really as its early days".

We looked at how the service provided person centred care. We observed evidence of person centred care by the way staff were interacting with people during our inspection. Staff treated people as individuals however personal preferences were not always taken into consideration. For example we looked at some care files and found staff were recording and monitoring all people's dietary and fluid intake with no evidence why this was necessary. We also found two hourly night checks were being carried out for all residents regardless of whether they required this. One person told us this was disturbing their sleep pattern. We spoke to the registered manager and they clarified they had been advised to ensure they record this by the local safeguarding team.

We looked at the plans of care to see if they were written in a person centred way. However we found the care records were not consistently person centred. For example one person's file had their personal details missing this included their previous address, who their next of kin was. A number of sections on what this person can do for themselves were left uncompleted which meant that this person's assessment did not reflect on their strengths and guide staff on what they needed help with. We found people's social backgrounds and their personal interests were not sought to ensure staff could enable people to reminisce.

We also looked at how the service assessed people before they were admitted into the home. We found pre-admission assessments had not been completed adequately to reflect people's needs and whether the home was able to meet them. For example we found one person had been admitted as a result of a fall while they lived on their own. However this person's care records and pre-admission did not mention a history of falls nor did they have a risk assessment to manage the risk while they were at the home. We spoke to the registered manager regarding this and they informed us they had challenges obtaining information from hospital staff when they had gone to assess people and this had impacted on their care planning.

We looked at how people were supported to maintain local connections and take part in social activities. We observed that people were provided with stimulating activities to promote their wellbeing or to prevent social isolation. For example, one person told us, "We have a party every month here". Another person told us "I started a choir and everyone joins in now". Another person was offering to help set up the tables at meal times. This person valued the importance of being allowed to do these tasks and felt it was empowering and keeping them active. We found the provider had shown appreciation to this person's contribution to the service.
We observed people taking party in morning exercises with staff. People told us "We have exercise and everyone is encouraged to join in".

We saw the provider had provided a dog which residents interacted with. They told us this was in response to some residents who were pet lovers and were missing their pets. We observed some warm interaction between residents and the dog.

We found records to demonstrate that the service considered people's social stimulation on a frequent basis. The provider told us they did not have a formal activity plan. However evidence from people we spoke to and our observations on inspection showed people had been actively engaged with a variety of activities.

We looked whether people were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. We found people were supported to continue practicing their religious beliefs. Two people told us they were visited by their priests. Another person told us, "I go out with my family." Relatives of people who lived at Freckleton Lodge told us they could visit anytime of the day or week and there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationships in their lives without restriction.

We reviewed how the service responded to complaints and found that the manager had kept records to show how complaints were responded to. We found the service encouraged people to make suggestions and raise concerns through the suggestion box. There was a complaints policy and procedure which people were aware of. This meant that the service ensured people were able to complain about their care and treatment.

Requires Improvement

Is the service well-led?

Our findings

We asked people who lived at the service and their relatives if they thought the service was well led relatives told us, "The owner and the manager are very involved" and "They are more hands on". We asked people who lived at the service if they would be able to speak with the manager about any concerns. People told us, "Yes, she is very kind and understanding" and "We know we can talk to her anytime".

We looked at how the service demonstrated good management and leadership. We were told that people had a lot of faith in the manager. One relative told us "I think they are dedicated and lead from the front".

We spoke to staff and some told us they were able to make suggestions to the provider if they found areas for improvement. Staff told us they were using staff meetings to share their views. We found there were staff meetings every month. We found evidence one residents meeting had been arranged however no one turned up. Provider told us they are now developing a newsletter to see if this would help.

We found systems that ensure delivery of high quality care were not adequately implemented. During the inspection we identified some failings in a number of areas. These included person centred care, medicine management, lack of PEEPS, seeking people's consent, assessing people's mental capacity managing risk to people. These issues had not been sufficiently identified or managed by the provider prior to our visit which showed that there was a lack of robust quality assurance systems in place.

We found some audits were being undertaken however these were not consistent. For example the service had carried maintenance audits, catering and cleaning audits in November 2015, Infection control audits had been undertaken in September 2015 and the last review was October 2015. We did not see evidence audits were undertaken regularly in accordance with the provider's own policy.

We found the service did not undertake its own medication audits to ensure they provided oversight on how staff had administered medication and identify errors timely.

We found there were shortcomings in scrutiny and analysis following accidents and falls which meant that the provider had failed to analyse incidents and accidents as they should so they could take action to prevent a reoccurrence. We found inconsistences in the way people received care after experiencing falls.

We also found instances of incidents and accidents that had been reported through management systems however safeguarding processes had not been followed. For example we found evidence in 3 people's files they had experienced significant falls, for one person 6 times per day with ambulance being called twice however, we could not find evidence of the after care and measures put in place to reduce or manage these risks. We discussed this with the provider and they confirmed they knew about these incidents and they had put measures in place however they acknowledged they did not follow the measures that they had put in place themselves. This meant that the provider had failed to follow their own protocols and meant people could not be assured they would receive appropriate care after a falls.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if the registered manager understood their responsibilities. We found the registered manager had some understanding of their responsibilities and the regulations. However they needed more understanding of regulations around consent, mental capacity, and deprivation of liberties and involving people in planning their care.

We found there was adequate management oversight and leadership within the service. The provider was able to acknowledge the shortcomings identified by the inspection and willing to put measures in place to rectify the shortcomings.

We observed a positive culture throughout the service. Staff showed team working ethos and appeared to have established positive relationships with colleagues and people who lived at the service.

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had not fulfilled their regulatory responsibilities and submitted a notification to CQC that two people had suffered significant falls which required medical attention.

We also found the provider had not notified CQC of incidents when allegations of abuse or neglect were raised against their staff. In another incident the provider failed to inform CQC of an incident where staff had falsified care documents and where another member of staff had destroyed a record used during provision of care.
This failure to submit notifications meant that CQC were unable to effectively exercise its regulatory duties.

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

The manager and the provider were transparent in their way of working with us. They provided us with all the information we requested and they acted on the actions that we requested then to put in place without delay. They were willing to work with us and showed a commitment to ensure the home met the required standards.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying the Care Quality Commission of reportable incidents Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not have systems in place to ensure people were included in the planning of their care . Regulation 9(1) (3) (5) -Person-centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that care and treatment was provided in a safe way for people who used the service. Regulation 12

(1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have suitable arrangements in place to ensure that people were effectively safe guarded. Consideration for deprivation of liberty safeguards had not been embedded at the service. Regulation 13 (1) (2) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation 17 (1) (2)