Bcs Medical (Shackleton) Ltd

Shackleton Medical Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Shackleton Medical Centre on 5, 6 and 10 April 2018. The inspection was prompted by a safeguarding concern raised with the local authority.

Shackleton Medical Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Shackleton Medical Centre can provide accommodation and nursing care for up to 26 people with general nursing needs and end of life care.

We last inspected Shackleton Medical Centre on 6 and 12 December 2016 and rated the location as Good.

At the time of the inspection there was a registered manager at the home. The registered manager was also a company director. 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

People using the service and staff felt that at times there were not enough staff to provide the level of support people required. Rotas indicated the number of staff allocated per shift often did not meet the numbers the provider had identified as necessary to provide care. The provider did not ensure there were always registered nurses on shifts to provide nursing care. They had allocated senior care workers, who had trained as nurses in their home country but were not registered in the UK, to cover nursing shifts at the home. After the inspection we asked the provider to immediately address this matter, and they sent us duty rosters to confirm they planned to have registered nurses on duty at all times in the home.

The provider's medicines policy and procedures were not always followed which resulted in appropriate guidance not being in place for staff and checks were not carried out to ensure medicines management was carried out safely.

Management plans to mitigate risks identified during people's needs assessment were not in place to provide care workers guidance on how to reduce these risks and ensure people's safety.

Personal Emergency Evacuation Plans did not provide sufficient and up to date information to enable people to be evacuated safely from the home in case of an emergency. The provider had a process for the recording of incidents and accidents but information was not recorded in relation to the actions taken to reduce the risk of reoccurrence

Processes were not in place to ensure the risk of infection was reduced for people using the service. Cleaning and other chemicals were not stored in a safe way to reduce possible risks to people.

People told us they felt safe when they received care at the home but we saw processes for the investigation and review of safeguarding concerns had not been followed. The provider did not have a process to record financial transactions to reduce the risk of possible misuse or misappropriation of money belonging to a person.

The provider had a procedure for the recruitment of care workers but this was not being followed, as the provider did not ensure that appropriate employment references were in place as part of the assessment of applicants' suitability for the role.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, the policies and systems in the service did not support this practice.

The provider had an induction process, training and supervision but this did not always provide staff with the support and up to date knowledge they required to provide suitable care.

The environment of the building was not designed or maintained to ensure people were kept safe.

People told us they would like more choice for their meals and staff did not adequately monitor people's food and fluid intake by keeping good records about what they ate and drank to identify if a person was at risk of malnutrition or dehydration.

Staff were individually kind and caring when providing support for people using the service but the provider overall did not demonstrate the service was caring because they did not ensure people received a good enough standard of care and were not placed at risk of harm.

Pre-admission assessments identified the person's religious and cultural needs but this information was not always reflected in the person's care plans so staff were clear how to meet these needs.

People had access to a GP and other healthcare professionals but where changes to a person's care had been identified, the advice and information from the visit had not been transferred to the relevant care plan. There was therefore a risk the person might not receive the care they needed.

People's care plans were not written in a way that identified the person's wishes as to how they wanted their care provided. Records did not provide up to date information relating to people's care. There were no structured activities planned that met people's interests and were meaningful to them.

Complaints were not reviewed to understand any learning which could be used to improve the service.

The provider did not ensure the service was well-led and provided to an appropriate standard and that people received safe care and treatment. They had audits and some systems to monitor the quality of the service and to ensure the safety of the people using the service but these did not identify areas where improvements were required or where these were identified, little or no action was taken to address these.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to person-centred care (Regulation 9), need for consent (Regulation 11), safe care and treatment of people using the service (Regulation 12), safeguarding service users (regulation 13), meeting nutritional and hydration needs (Regulation 14), premises and equipment (Regulation 15), receiving and acting on complaints (Regulation 16), good governance of the service (Regulation 17), staffing

(Regulation 18), fit and proper person employed (Regulation 19) and requirement to display performance assessments (Regulation 20A). There was also a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 relating to failure to send notifications to the CQC.

After the inspection we wrote to the provider to ask them about the action they had taken to address the most serious concerns we had identified. They provided us with an action plan and some evidence of the action taken to address the concerns raised which showed some of the risks identified at time of inspection had been mitigated. We considered this information when deciding what action we took against the provider. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The 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.

The providers medicines policy and procedure was not always followed as appropriate guidance was not provided for staff.

Risk management plans were not in place to provide care workers with the information to enable them to mitigate risks when providing care.

Personal Emergency Evacuation Plans did not provide sufficient and up to date information to enable people to be evacuated safely from the home in care of an emergency.

Information about incidents and accidents was not recorded and analysed in a consistent and systematic way in relation to the actions taken to reduce the risk of reoccurrence.

Processes were not in place to ensure the risk of infection was reduced for people using the service. Cleaning and other chemicals were not stored in a safe way.

The provider's processes for the investigation and review of safeguarding concerns had not been followed appropriately.

The recruitment process was not robust as appropriate references were not always in place before assessing applicants' suitability for the role.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, the policies and systems in the service did not support this practice.

The provider had an induction process, training and supervision for staff but this did not always provide them with the support and up to date knowledge they required to provide suitable care.

The environment of the building was not designed or maintained to ensure people were kept safe.

People told us they would like more choices about their meals and records did not provide enough information to enable staff to monitor food and fluid intake if a person was identified at risk of malnutrition or dehydration.

People had access to a GP and other healthcare professionals but where changes to a person's care had been identified the information from the visit had not been transferred to the relevant care plan.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Pre-admission assessments identified the person's religious and cultural needs but this information was not always reflected in the person's care plans.

Staff were individually kind and caring when providing support for people using the service but the provider had not ensured the service was caring for people by making sure people received a good enough quality of care and were protected from identified risks.

Where possible people were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not written in a way that identified the person's wishes as to how they wanted their care provided.

Records did not provide up to date information relating to people's care.

There were no structured activities planned that met people's interests and were meaningful to them.

People knew how to raise a complaint but information was not reviewed to identify any learning which could be taken from the outcome of the investigation to improve how services were provided.

Is the service well-led?

Inadequate

The service was not well-led.

The provider has audits and other checks in place but these had not had an impact on the quality of service provided because they were ineffective and had not identified areas where improvement was required.

Although people using the service and staff felt the service was well-led our findings showed that there was a failure of leadership and there were no clear structure and system to identify management responsibilities and accountability for the quality of services provided to people.

Shackleton Medical Centre

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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. The person is no longer using the service and the incident is currently under investigation by the local authority safeguarding team; as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls and the review of incidents and accidents to ensure appropriate action was taken. This inspection examined those risks.

The inspection was carried out on the 5, 6 and 10 April 2018 and was unannounced. The inspection team consisted of two inspectors 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 service.

Before the inspection we reviewed safeguarding records and notifications relating to the service. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with the registered manager, clinical lead, the care coordinator and seven members of staff including nurses, care workers and housekeeping staff. The expert by experience and an inspector spoke with seven people using the service.

We also looked at records, including 12 people's care plans and records, four staff records, medicine administration records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We asked people if they felt there were enough staff to help them. Most people told us they felt something needed to be done about staffing levels and their comments included "The staff are always tired, they have too much to do and not enough time to do it", "I am always in bed so can't relate to staff shortage. However more can be done", "Some days it seems there is enough but more can be done on staffing issues" and "I feel there is adequate staff available for the job that the carers do, with a good smile on their face."

Staff told us they felt there were not enough staff allocated to work each shift. They said "No, even with four carers we need a person to do the kitchen and housekeeping. If there are three then we cannot manage, but we do. The nurse in charge will help and the clinical lead and care coordinator." Staff also told us that they carried out a range of non-care duties. The morning care workers prepared and served all the breakfasts and most people ate in their rooms. They had to prepare and serve the suppers, topping up stocks of pads, wipes, gloves and aprons and doing the laundry. Nurses, in addition to managing all medicines and pharmacy requests were responsible for carrying out all the daily and weekly health and safety checks in the home, answering any telephone calls to the home and minor maintenance work for example changing the batteries in the dorguard door release system.

We asked the registered manager about staffing levels and he told us they aimed for a staff to person ratio of one to five and it was not based on people's levels of needs. He also told us that he felt the home was overstaffed at the time of the inspection.

During the inspection we found that the provider did not always ensure that there were registered nurses on each shift to deliver nursing care to people. The registered manager and clinical lead and the staffing rota confirmed senior care workers were used to cover the nurse's role in the home on some shifts. The senior care workers had trained as nurses in their home countries but were not registered as nurses in the UK. The tasks undertaken by senior care workers when acting as a nurse at the home included administering medicines (including controlled drugs), management of tracheostomies and PEG tubes, wound care and dealing with any medical emergencies. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe. A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

We looked at the rota for 12 March 2018 to 8 April 2018 and we saw senior care workers were scheduled to work as nurses. The time sheets for four senior care workers during this period showed one had worked two shifts as a nurse, a second had completed five shifts, a third had completed 14 shifts and a fourth had completed three shifts as a nurse.

On each of the inspection days we saw one care worker was unable to work as identified on the rota. The nurse on duty explained they did not use an agency for care staff and nurses and if they required additional staff they would contact staff either on later shifts to see if they can start work earlier or if they can come in on a day off. Staff would also be transferred from another local care home operated by the same owners to

cover any shortfall in staffing numbers. During the inspection we saw one care worker scheduled to work at 2pm came in at 11.30 am, one care worker came from the other home and on another day an off duty staff member came in to work an afternoon shift. This meant there were periods of time which the home was short staffed until cover could be arranged if possible.

Where there were staff shortages and attempts to get staff from the other care home or to get staff who were off duty failed, the provider did not ensure there were adequate staffing levels to meet people's needs. The registered manager confirmed there should be one nurse and four care workers on duty between 8am and 8pm with one nurse and two care workers from 8pm to 8am. The rotas we saw indicated there were regularly only three care workers on duty during the day and one care worker at night. For example during the week of the 26 March 2018 there were three care workers allocated for the day shift on 26, 27, 28 and 31 March 2008. On the 29 March there were four care workers allocated from 8am to 2pm but this dropped to two care workers between 2pm and 8pm. On the rota the night shift on 31 March and 1 April 2018 there was only one care worker scheduled to work. This meant the number of care workers identified as appropriate by the provider were not always available on each shift.

We also saw one care worker was scheduled to work a night shift from 8pm to 8am and was then shown on the rota as working as a housekeeper at another home from 8am to 2pm. On another day of the same week we saw the care worker was scheduled to work as a housekeeper between 8am and 2pm and was allocated a night shift from 8pm to 8am the same day. This meant the care worker might not have had enough rest between shifts.

The evidence contained in the above paragraphs meant people were at risk of receiving inappropriate and unsafe care because the provider did not ensure they deployed sufficient numbers of suitably qualified staff to meet the support and care needs of people using the service.

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a medicines policy and procedure in place but we found this was not always followed robustly to ensure medicines were managed safely in the home.

In the nurses office we found wall cupboards were used to store spare medicines including warfarin and other equipment for tracheostomy management, urine testing sticks and dressings. The cupboards were not locked and the staff confirmed the nurses office was not usually locked so was easily accessible. We raised this with the clinical lead and arrangements were made for the locks to be replaced on all the cupboards on the same day, but on the second day of the inspection we found the cupboards were unlocked and the keys left in the locks.

In one of the cupboards we found a box of needles and syringes including a blood collection set with an expiry date of December 2014. We asked the clinical lead about them and they confirmed they were left over from the care of people no longer living at the home so were no longer used. The clinical lead then removed the box to sort out the contents.

A plastic box containing glucose monitoring equipment was stored in the cupboard and we found the inside of the lid of the box was dirty and unwrapped gauze swabs were stored in the box. For one person their blood glucose monitoring form showed the tests had been carried out on the 2, 3, 4 and 6 April 2018. When we asked the nurse, they explained blood glucose monitoring for diabetics was carried out twice a week, however the frequency for testing was not recorded on the record form.

On the second day of the inspection we found a pestle and mortar on top of a medicine trolley which contained a white powder. We asked the nurse on duty if this was used to crush tablets to be administered via a PEG tube but she was unable to explain why this had been used. We located one pill crushing device which was stored in a cupboard but we were unable to identify why the pestle and motor had been used and for whom and we were not assured these were adequately cleaned between its use to crush medicines.

The controlled drugs were stored in a metal cupboard which was accessible by using a small set of steps as a person standing would not be able to reach it as it was located relatively high on the wall. We saw the controlled drugs were entered into the controlled drugs book and stock checks were carried out and recorded twice daily at handover. We did identify that ampules of morphine sulphate with different batch numbers which had been administered for one person had been stored in the same box. Each batch had different use by dates of August 2018, June 2019 and April 2020. This meant medicines were not being stored safely in their original boxes to reduce the likelihood of errors with medicines.

We found 14 ampoules of morphine sulphate had been prescribed for another person and the records showed that 14 ampoules were in stock, however we saw that one had broken in the packaging and the liquid had evaporated. This meant there were only 13 ampoules that could be used and the broken one had not been noticed during stock checks and the stock had not been appropriately adjusted.

A bottle of morphine sulphate solution that had been provided by the pharmacy at the end of March 2018 had been opened but the date of opening had not been recorded. The nurse on duty confirmed they would check the controlled drug book to identify the date and record it on the bottle.

Where people had been prescribed medicines to be taken as and when required (PRN), for example for pain control or allergies there were no protocols in place for staff as to when the medicines should be administered. We were then shown two copies of a generic protocol for paracetamol but these were not named or personalised to the individuals. This meant the provider could not ensure people were receiving their medicines as required by them. Following the inspection we received an example of the provider's updated PRN document.

There was a stock of two medicines that the nurse explained were given as 'household remedies'. The GP had signed a document with reasons for administration and permission for five medicines to be given as household remedies and the form was dated more than two years. We discussed this with the nurse who said they would get the form updated and discuss it with the GP, to ensure the information was up to date and only covered those medicines in use as household remedies.

For one person who was prescribed twice weekly treatment for constipation, there was no care plan for elimination in place. For another person prescribed three treatments for skin conditions the instructions on the MAR stated 'to apply emollients as prescribed by GP'. There was no GP instructions that were included on the MAR or in the care plans. For someone prescribed cream to be applied '3-4 times a day as directed' we saw that over a period of 11 days the cream had been signed mainly once a day and at most twice a day, so the instructions were not being followed. For one person there was a gap in signing for a laxative on one day and it was not possible to ascertain if this had been administered.

During the inspection we saw risk assessments were completed in relation to falls, window restrictors, nutrition, skin integrity and moving and handling. Where risks had been identified at the pre admission assessment and in information provided by placing agencies, risk management plans had not always been developed to help protect people from the risk of harm. These risks included diabetes, Chronic Obstructive Pulmonary Disease (COPD), epilepsy, use of specialised dressings for pressure ulcers and mental health

conditions. In addition clear guidance including care plans, risk assessments or policies were not provided in relation to the management of tracheostomies, laryngectomies and PEG tubes. This meant staff were not provided with enough information as to how to mitigate any associated risks in relation to the above.

The records for one person who had moved to the home six weeks before the inspection did not include any risk assessments, care plans or risk management plans even though the pre admission assessment indicated the person was living with diabetes. This meant staff had not been provided with information about possible risks when providing care for this person and how to respond to them.

People using the service could access the lift and stairwells as there were no restrictions or key codes on doors leading to these. People using the service had variable levels of mobility including using electric mobility equipment and tripod walking sticks and could have been at risk of falls down the stairs. There were no risk assessments in place in relation to people using the lifts or stairs unsupervised and how to reduce possible risks.

At the bottom of the stairwell on the ground floor people could walk into a large cupboard which contained electrical panels and cleaning materials which was not locked. As this was located away from the areas regularly visited by staff there was the possibility that a person could access the cupboard which was a falls risk.

In a corridor on the first floor unit we saw a ceiling tile was missing outside a bedroom which exposed electrical wires and pipe work. In the second floor lounge there a light fitting had been removed from the ceiling and wires were exposed and left hanging from the ceiling. The registered manager explained the maintenance company had been in recently and had removed some lights but had not completed the job.

We saw the bathroom near the nurses station was unlocked and being used as a store room for a wheelchair and other items including suction machines requiring repair and tracheostomy care equipment. The door was unlocked and could be accessed by people using the service who were able to be mobilise without staff support.

These issues were not identified as risks to people using the service through a health and safety risk assessment.

The provider had a process for the recording of incidents and accidents but information was not recorded in relation to the actions taken to reduce the risk of reoccurrence. Care plans and risk assessments were not updated to reflect the incident and accident and to identify a possible change in the person's support needs. For example we saw one record following an unwitnessed fall in a person's bedroom but there was no review of the person's fall risk assessment or mobility care plan. Incidents and accidents were not being monitored to ensure appropriate action was taken to identify trends and patterns so these could be prevented where possible.

When we asked staff if there was any learning identified following any incidents and accidents they told us "In handover we will discuss any issues or events so all staff are informed" and "If there are any problems we inform management and they will come and discuss it with us." But there was no mention of how information was used to learn from any incidents and accidents to prevent them happening again.

The Personal Emergency Evacuation Plans (PEEPs) in place did not provide suitable information to enable people using the service to be evacuated safely from the home in case of an emergency. The PEEP included information regarding the room the person was in and if they were able to walk without support or required

a wheelchair and how many staff were needed to provide support. The information was not up to date and it included the details of people who no longer lived at the home. In addition the information did not identify any other issues that might impact on a possible evacuation for example if the person had a tracheostomy and required additional equipment when they were moved.

Processes were not in place to ensure the risk of infection was reduced for people using the service. One person was receiving specialised treatment for pressure ulcers which involved the use of a specific type of dressing. During the inspection the person informed us that the dressing had fallen off the day before and had not yet been replaced. We raised this with the clinical lead and the nurse explained they had not had an opportunity to replace the dressing as they had been so busy. The dressing was then replaced. This represented a significant risk to the person and to the treatment of their pressure ulcer.

There was a sink located in the first floor unit and there were no hand towels accessible on or around the worktop for staff to use. The top of the under sink cupboard used to open it had not been cleaned and was visibly dirty which meant there was a risk of the spread of infection.

Records indicated that the drug trolley should be disinfected weekly but the records we saw showed this had not been completed since 28 January 2018.

Suction machines were used as part of the support for people living with a tracheostomy and records indicated these should be sterilised daily but these had not been completed daily to confirm this task had been completed. The sterilisation records for one person had been left blank on 15 days in December 2017, one day in January 2018 and five times in February 2018. The records for another person were blank for 15 days in December 2017 and one day in January 2018. This meant people were not always being protected against the spread of infection.

The daily assignments sheet was used by staff to identify the schedule for the day including what time meals and drinks should be served, when records of care should be updated and when staff working a full day shift could take their lunch. The same schedule was used every day. The sheet indicated one of the daily activities was the disinfecting of one person's room on each unit and washing all the hoists and slings and recording in the audit folder. We saw the disinfecting rooms record was last completed on 7 December 2017 and there were no recent records.

Cleaning and other chemicals were not stored in a safe way to reduce possible risks to people. We saw five litre bottles of lemon deodoriser and hand sanitiser were stored in cabinet located in a communal area on the second floor which could not be locked. In the cupboard under the sink on the first floor unit which could not be locked, we found a bottle of disinfectant and a bottle of cleaning liquid. We saw when the home was being cleaned the bleach and other cleaning products were left in communal areas and were easily accessible to others. This meant people were not protected from the risk of accessing dangerous chemicals.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a copy of the pan London safeguarding procedure on safeguarding adults at risk of abuse on file. During the inspection we were unable to locate any records in the home for safeguarding concerns that had been raised either with or by the local authority since the last inspection. The clinical lead provided the records for one safeguarding concern which had been stored at the owners' other nursing home but we saw the records did not indicate if any review of the learning from the investigation had been undertaken. In

addition it was not clear what actions had been taken to reduce the risk of the issue occurring again.

The clinical lead confirmed safeguarding adults was not identified as a mandatory training course by the provider. The records indicated a safeguarding training course had been completed in November 2017 as we were provided with a copy of a certificate for one staff member but the clinical lead was unable to provide a list of all the staff that attended.

People using the service were supported by care workers with their shopping but the provider did not have a process in place to record any financial transactions to ensure they were protected from misuse of their money. During the inspection we found an envelope containing money belonging to a person using the service had been stored in the controlled drugs cupboard. We asked the clinical lead if staff did shopping for people and how this was recorded. The clinical lead explained for the majority of people an invoice would be sent for any shopping or additional costs. If a person asked the staff to go shopping for them they would ask the person for money and then do the shopping. They would give the person the change and receipt and record in the daily records of care provided that they had done shopping for the person. There was no formal record made of the amount of money given to the staff, the change returned and a copy of the receipt to confirm the transaction. This meant there was no robust process in place to reduce the risk of possible misuse or misappropriation of money belonging to the person using the service.

The above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a procedure for the recruitment of staff but this was not always followed. The registered manager explained applicants were asked for five years work history and contact details for two references from recent employers. During the inspection we reviewed the recruitment records for four staff who had been employed since the last inspection. The application form for one staff member identified the contact details of both a current and a recent employer. We saw one of the references identified the relationship with the applicant as employer/partner. This was raised with the care coordinator who confirmed this had not been identified during the recruitment process. In addition the records for this member of staff included a copy of their CV which identified they had worked for another care provider which was not included on their application form. A reference had not been requested from this employer.

The application form for another member of staff showed there was a gap in their employment history for over one year but there was no reason given for this. There were no records of the interview process for any staff member which might have provided additional information including discussions about any issues that were raised during the interview process.

The care coordinator who was responsible for the recruitment of new staff confirmed they did not have any specific training in relation to recruitment.

As the recruitment procedure was not always followed it meant the provider could not ensure applicants were suitable to work with people living at Shackleton Medical Centre.

The above was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Notwithstanding the above, people told us they felt safe when they received support from staff at the home. Their comments included "Yes I do feel safe from harm and abuse. I was told not to go into my toilet without my frame" and "There is no abuse, I think if there was I would have to leave. Although I like some of carers

more than others there is no abuse."

The service used a monitored dosage system and the majority of medicines were supplied in blister packs. We carried out a random sample of four people's morning medicines blister packs and the stocks tallied with the number of doses administered. Medicines for disposal were recorded and collected by the dispensing pharmacist.

Inadequate

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 asked staff what they understood by acting in people's best interests and one staff member told us they had not heard of acting in people's best interest and said, "We will make them safe."

All the care plans we looked at had not been signed by the person using the service to consent to their care being provided. We saw a consent to sharing information form had been agreed by telephone with the daughter of a person using the service who had a DoLS authorisation. There was no record of the relative having a Lasting Power of Attorney to enable them to make decisions on behalf of the person or any evidence of best interests decisions being made.

This meant people's care was not being provided within the principles of the Act.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw a list of applications for DoLS authorisation was displayed on the wall of the nurse's station but this list was out of date and included people who were no longer living at the home. The clinical lead provided an up to date list and we saw applications had been made for seven people during 2017 of which six DoLS authorisations had been received. We looked at the care plan folders for five people who had received DoLS authorisations. The care plans for these people did not indicate that they had DoLS in place and did not address any conditions that might have been in place and did not provide guidance for staff as to how they should support each person. Copies of each person's DoLS authorisation were not available at the home. This meant there was a risk that where people were being deprived of their liberty that conditions to the authorisations were not being followed as required to make the process lawful.

The above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had an induction process and provided some training and supervision but this did not always provide staff with the support and up to date knowledge they required to provide suitable care to people using the service.

New staff completed a three to four day induction programme when they started work. The clinical lead told us the first day was spent shadowing existing staff and then they would complete an induction programme including reviewing the policies of the home, information on people using the service, food and deliveries and housekeeping routines. We saw a record form was completed to identify when each section of the induction had been completed but the date each part had been completed was not recorded so it was not clear when the person had undertaken the training. Each section of the form had a month of completion recorded for example we saw the induction record for one staff member which showed they had completed their induction in November 2017. There was no record of any assessments of the staff member's competency being completed during their shadowing day to demonstrate they had the required skills and knowledge for the role.

The clinical lead confirmed care workers did not complete the Care Certificate as part of their induction. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. The clinical lead told us when new staff joined the home they were asked to provide a list of training they completed with their previous employer and if they had done any of the mandatory training during the previous year they would not have to complete that session until the next annual refresher.

The provider had identified five training courses they considered mandatory for all staff. These were basic life support, moving and handling, fire safety, infection control and health and safety. These training sessions were completed annually and were usually run by the clinical lead during January and February. The clinical lead however did not have a training qualification and they confirmed they had not completed any 'train the trainer' courses to support them to provide the mandatory training and they told us their own training for these subject areas consisted of watching the training DVDs ahead of the session with the staff. For example they told us the fire safety training consisted of the registered manager showing staff around the home locating the fire extinguishers and fire exits and watching a short film on fire safety. The clinical lead confirmed they had not completed any training in relation to running a moving and handling course. We therefore could not be assured that staff were receiving appropriate training that would upskill them in their role.

The mandatory training records for nurses and care workers (including the senior care workers) did not provide accurate information as some of the dates related to people completing the sessions in August and December 2018 which was after the inspection. The records for the moving and handling training indicated two nurses and 10 care workers had not completed the refresher since February 2017. The infection control training for 2018 had only been completed by 10 staff out of a total of 36 staff employed including housekeeping. 12 staff had completed the fire safety training in 2018 and there were no records of staff completing the health and safety training in 2018.

Records indicated a competency assessment had been completed for senior care workers when they joined the home in relation to tracheostomy care, wound care, clinical observations first aid and medicines administration. The forms stated the senior care worker had completed a theoretical assessment successfully but there was no evidence of a practical assessment of their skills by a competent person trained to do the assessment. These assessments had not been repeated regularly to ensure the care workers were aware of any changes in practice and to test that they continue to maintain the appropriate skills to complete these procedures.

The clinical lead also told us they did not carry out any competency checks on nurses in relation to medicines administration, tracheostomy care and PEG management and wound care to check that nurses' knowledge were up to date and were aware of current techniques, practice and guidance in relation to these processes. The clinical lead stated that because the nurses were registered and had completed nursing training, they did not need to be assessed and had already demonstrated their competency. We saw a medicines safety refresher course had been completed in March 2017 which was attended by four senior care workers and three nurses but there were no records to confirm their competency had been assessed and if the other nurses had completed the course.

The training records indicated one nurse had not completed their annual mandatory training with the provider but at another care home provider where they also worked. This meant the content of the training completed including how this compared to the training offered at Shackleton Medical Centre and the nurse's competency and understanding could not be assessed.

The clinical lead provided a list of additional training courses that had been held during 2017 which included end of life care, food hygiene, learning disability and wound care. They could only provide attendance records for a limited number of the courses indicated on the list so we were unable to check records to identify which staff had attended these training sessions. A record also showed that six staff members including the clinical lead had attended dementia awareness training but there was no date to indicate when this was completed.

Records showed and the clinical lead confirmed that staff had one supervision meeting per year at which they completed their appraisal document. This meant staff did not have a regular opportunity to discuss their performance, any concerns, if they felt they required additional training in relation to their role and any possible career progression with the organisation.

The above paragraphs meant the provider could not demonstrate they had ensured staff had received training to keep them up to date with current guidance and good practice. They were also unable to identity which staff had completed the various training sessions throughout the year and they had not ensured that staff were supported to carry out their role in an appropriate and safe manner.

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The environment of the building was not designed or maintained to ensure people were kept safe.

The communal areas were not designed to support people with dementia with appropriate signage and the communal areas did not have a homely feel due to the quality of the decoration which did not take into account the needs of people living with dementia. The lounge and communal areas on the second floor had three armchairs but the remaining seats were more suited to be used in an office environment than a nursing home. The chairs were not suitable for people who found standing difficult as they were light weight and did not provide a secure and stable base for a person to help them stand.

On the ground floor of the building there was a separate dermatology clinic also owned by the provider as well as five bedrooms which were part of the nursing home. The doors used to access the stairwells were located near the treatment rooms and were not restricted. There was a car park in the basement of the building and the lift from this area provided access for the clinic as well as both floors of the home. During the inspection we saw people using the service who wished to go out could leave through a door in the stairwell to the side of the building which was used for out of hours visitors. During the inspection a person

using the service gave us access to the building without knowing who we were. Visitors are required to sign in at the reception on the ground floor but this is not always staffed. We saw record of incidents and accidents where people had invited visitors into the home without the staff knowing and they found them in communal areas or in the person's bedroom. This meant people could access the care home without staff being aware as the lifts opened out the communal areas of the home or they could access the stairwell to all floors of the building.

We saw the bathroom on the first floor was not in use and a staff member told us the bathroom was no longer in use as the bath was broken and needed to be made good. They explained that if a person living in the first floor unit wanted to have a bath and did not want to use their en-suite shower they would be taken to the ground floor or second floor bathroom, but not all bedrooms had an en-suite. There were five bedrooms on the ground floor including one with an en-suite shower, there were 13 bedrooms on the first floor of which 12 had en-suite showers and on the second floor there were eight bedrooms including four with en-suite showers.

The above was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people about the food provided by the home and they told us they felt they did not always have a choice of food they liked. Their comments included "Some days the food is not good all the time. I would prefer for the home to provide some of my choice of meal", "The food is generally very good. We do have an option and choice. They always asked you what you required. They always have soup, ice cream. For days I don't feel like having a meal", "The food is good but I would prefer more of my choice", "The food is not too good for me, I don't like rice and they give me rice most days. More can be done to give me my choice and what I can eat and enjoy. I will like my choice", "Food is pretty good. Don't really get a choice", "Most people have meals in their rooms" and "Yes, we do have choice of our food but the choices I don't like, I prefer my own choice of meal that can be prepared"

Menus were not displayed around the home and staff explained they asked each person the day before for their meal choice for the following day. Staff prepared breakfast and evening meals which included sandwiches and soup in the home.

Food was cooked at the home on a Friday but was prepared and cooked at the provider's other local home and brought over to Shackleton Medical Centre in insulated bags. On the second day of the inspection a staff member confirmed fried fish and chips had been prepared with a vegetarian burger for one person and cheese and onion pasties as an alternative for others. The staff confirmed they used a temperature probe to check the food but during the inspection we were unable to locate any records for the temperature checks of the food and for checks on the temperatures of the fridges.

We saw three people required a very soft diet and we saw staff members using a hand blender to puree the mashed potato, then the fried fish followed by the baked beans. We asked the staff what consistency each person required their food and they were not able to tell us but confirmed they used thickener powder and water to help puree the food more easily. There was no guidance in the kitchen area or in the nutrition care plan to identify the consistency required and no alternatives were offered such as poached fish instead of fried fish having to be pureed. We noted that people did not eat all of their pureed meal when the plates were returned.

The records for one person identified they required a pureed diet but during the inspection we saw the person was eating crisps. We spoke with a member of staff who told us they were aware the person was on a

pureed diet but did not know why as they ate rice and curry. As the person was not receiving meals according to their care plans they were not being protected against risks that can arise if they ate food which were not indicated for them.

Individual food intake records indicated what food the person had been given but not the amount eaten. The records for fluids were similar showing the amount of drinks provided but not showing how much the person had drunk. A second food intake record chart was also completed which provided an overview of the food intake for everyone using the service indicating if each person had eaten a full meal, half meal, a quarter meal or had refused food. We saw the second food record chart indicated every person had eaten a full meal every day even though their individual food and fluid records may state they ate less. This meant it was difficult for staff to monitor actual food and fluid intake if a person had been identified as being at risk of malnutrition or dehydration.

The above was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

An assessment was completed before a person moved into the home to identify the person's care and support needs. The registered manager explained the clinical lead and care coordinator would visit the person to confirm the details of the referral information provided by the commissioning agencies and whether the person's needs could be met by the service. We looked at the assessments for two people and saw the pre admission assessment had not been completed in full with information relating to the person's wishes, a body map and potential risks had not always being been identified. This meant that the provider could not have fully ascertained themselves of the needs of the person before offering them a place in the home.

People using the service had access to a GP who visited the home regularly. The clinical lead explained that following a GP visit they would receive a copy of the GP's electronic records of the visit which were placed in the person's care plan folder. We also saw people had access to other healthcare professionals including district nurses, specialist nurses, dieticians and physiotherapists. Information following visits from other healthcare professionals was recorded on the multidisciplinary team form but we saw information relating to any updates in the person's care needs was not always transferred to their care plans so these were updated to reflect people's needs. For example the records for one person included a note following a dietician's visit where they had identified a number of ways the staff could support the person to increase their weight including having a fortified diet but this information had not been transferred to the care plan for nutrition so the information was clearly identified.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service caring?

Our findings

We asked people if they were happy with the care they received and everyone we spoke with told us they were happy. Their comments included "Very happy in here, always happy in here and never lonely" and "Yes they support me."

During the inspection we saw people received support from individual members of staff in a kind and caring manner but the provider had not demonstrated they were always caring because they had not ensured that people consistently received a satisfactory standard of care and they were protected adequately from risks that can arise as part of receiving a service. In the first instance the service was not very caring because the provider had disregarded people's health and welfare by not making sure that there was a trained registered nurse on duty to provide the nursing care they required. There was also a lack of staff deployed within the service which meant they had to focus on the care tasks they were required to complete and they were not able to spend time with people and engaged with them socially. The provider had not demonstrated they were caring because they had not done all that was reasonably practicable to assess risks people faced and taken action to mitigate the risks

People told us "Most of the staff are kind and caring especially the regular staff ", "Most of the familiar carers do their best. I like when the regular staff are around" and "Yes, very much, I have made friends with them. The carers are my family. We live like a family." The staff we spoke with had an understanding of the care needs of the people they were supporting as well as their likes, dislikes and preferences. Staff told us they wanted to spend more time with people other than when they were providing care but did not have the time during their shift.

The pre-admission assessment identified the person's religious and cultural needs but this information was not always included in the person's care plans. Staff we spoke with told us they celebrated religious festivals throughout the year. They said "Every person had their own individual beliefs and we respect that. We celebrate together" and "For Indian people we celebrate the festivals, prepare food, offer to go to the Temple." At the time of the inspection no-one wanted to visit the temple. They also said they celebrated Diwali and Vaisakhi. Staff also told us they took part in "English celebrations" including Easter and Christmas. They also commented that a Roman Catholic priest had visited the home where a person was nearing the end of their lives, but they did not visit routinely.

At the time of the inspection everyone using the service could communicate using English. Staff told us they could speak with people in other languages if required, for example in Hindi. We saw the registered manager speaking with some people in their primary language. Staff also told us they had a folder containing signs and symbols which could be used to communicate with people, if that was required but no one needed this facility at the time of the inspection.

People said staff treated them with dignity and respect when providing care. Their comments included "All of them do, so I will say Yes", "Well most of the staff or care workers do, depending on the staff available", "Some do, others try their best" and "Yes they always do treat me with respect and dignity."

We asked staff how they maintained people's privacy and dignity when they provided support and they told us "I want to make them happy. It is our responsibility to look after them" and "We give them the choice, clothes, food at breakfast and supper, we ask them." Staff also told us they closed windows and doors when providing care and knocking on doors before entering people's bedrooms to help maintain people's privacy and dignity.

We asked people if they had been given a choice to have their care provided by a male or female staff and they confirmed they had been asked their preference. They told us "Yes, I was asked. I don't mind having a male or female carer. A male carer did my nails" and "Yes as long as a good care service is delivered."

People were supported to be as independent as possible including one person who regularly went out to teach music at a school and other people going out with family and friends and visiting local shops. When we asked if people felt they were supported to maintain their independence they said "Yes the carer is supportive to help me to use my zimmer frame more", "Yes, it does due to my mobility problem they do encourage me to walk and get out of my wheelchair at times", "Well I do need support but due to being bedbound more help is needed to meet my needs" and "Yes, I am helped to maintain my independence."

Requires Improvement

Is the service responsive?

Our findings

Each person using the service had a care plan, but the care plans were focused on the care tasks and did not identify how each person wished their support to be provided. A one page care plan for each aspect of care included a brief outline of the actions required to meet this aspect of care. The care plan review list included communication, nutrition, elimination, personal hygiene, personal environmental safety and mobilisation but these care plans were not always in place for people.

When a person first moved to the home a short term care plan was put in place for the first four weeks but the information to describe how the person's care should be provided was limited. For example in the section for personal care one person's short term care plan stated they required the assistance of two staff for personal hygiene but no further information was provided as to how the care should be provided to meet the person's specific needs. We saw one person did not have a full care plan after six weeks living at the home, which meant staff did not have a personalised care plan to follow to meet the person's needs in a consistent way. People's care plans were lacking and did not always provide accurate and consistent information for care workers to identify how they should provide appropriate care for the person.

The MAR chart for one person directed staff to the care plan for elimination for guidance on the administration of a laxative but there was no care plan for elimination in the person's care plan folder. There was no other guidance provided for staff in relation to the administration of this medicine.

The records we looked at for people using the service showed staff had supported the person with daily exercises but there was no clear guidance in the care plans from an occupational therapist or physiotherapist. The clinical lead explained the staff carried out stretching exercises with people who were cared for in bed or were less mobile but these were not specific to each person's health needs and had not been directed by the relevant healthcare professional. We also saw records of daily exercises had been completed for people who were independently mobile and did not spend long periods of time in bed. As there was no specific directions for exercises based upon each person's health and care needs it meant that there was no assurance that the exercises were always beneficial to the person.

The care plan for one person indicated they were mobile and used continence aids but following discharge from hospital the person was now cared for in bed and used a catheter. Their care plan had not been updated to reflect this.

The nutrition care plan for one person identified they had type 2 diabetes and food should be provided according the person's dietary requirements but there was no information about the dietary requirements in the care plan folder, so staff were clear about what the person's nutrition should be. The care plans and guidance from the Tissue Viability Nurse stated this person could be supported to move to a chair for up to two hours per day but the person said they had not been out of bed for about two months. Staff we spoke with confirmed they had not supported the person to move to a chair as they did not have enough staff to move the person safely.

We saw some people had a completed do not attempt resuscitation order (DNAR) on their file which had been agreed with their GP and with family members where possible. There was no information provided in their care plans as to the person's end of life wishes and how and where they wanted their care provided. We saw one person had a care plan in relation to dying but the only provided information was focused on a DNAR being in place, palliative care input available and the person's family to have 24 hour access to the home if the person's condition deteriorated. There was no information relating the person's wishes and how they wanted their end of life care provided.

There were clear visiting hours displayed around the home stating people could only be visited between 11.30am and 19.30pm. The signs stated that if people refused to leave the home when asked by staff they would call the police. This meant that people could not be visited at the time they wanted due to the time restrictions and were not being adequately supported to maintain a relationship with their relatives.

During the inspection we saw records of occasional one to one meetings that were held with people using the service and/or their relatives to discuss the person's care needs and any other issues. We saw the information on these forms relating to any changes to how the person or their relatives wanted care to be provided was not transferred to the care plan. There was no record of these meetings in the care plan folder to demonstrate people and/or their relatives had been involved in their care planning. The care coordinator confirmed group meetings for people using the service and their relatives were not held but they had now scheduled monthly meetings during the rest of 2018.

When we asked people their views on the activities some people confirmed they were able to organise their own activities but one person said "They don't involve other people in activities here."

During the inspection we saw where people could undertake activities outside the home they did, but if people required support to go out or were cared for in bed their options for activities were limited. This was because there was no evidence to show that there were structured activities planned that met people's individual areas of interest and were meaningful to them. We saw one person was colouring a picture and we asked if they liked doing that and they said "No". One person commented they did not want to go to the second floor unit as they did appreciate the music being played on the piano by another person. We did see two people chatting, looking out of the window and they then moved to one of their bedrooms where they continued to socialise.

We were told an activity coordinator worked at the home from 8am to 2pm between Monday and Friday. It was later confirmed that this member of staff was also one of the care workers scheduled on the rota for the morning shift and was not a supernumerary position. We saw some people being cared for in bed and who preferred to watch television or listen to music. A staff member told us that they only really spent time with some people who were cared for in their bedrooms when they provided care as they did not have time to sit with people and chat or support them with individual activities.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with told us they knew how to make a complaint if they had any concerns. Their comments included "Yes, my family will do so if there is a need" and "Yes I do know how to make a complaint. I do have issues but have been dealt with properly." A copy of the provider's complaints procedure was kept in the complaints folder. There was information on how to make a complaint included as part of the "Resident's Handbook" given to the person when they moved into the home. We did not see information on how to raise a complaint displayed around the home.

We looked at the complaints folder and found a log sheet which showed the last recorded complaint was received in July 2017 with two complaints received in 2016. The log sheet provided the name of the person who had raised the complaint and the date it was received in 2017 but there was no information on the nature and elements of the complaint, no detail of an investigation, any actions taken and if the complaint had been resolved.

Staff acknowledged that this was not an accurate reflection/log of complaints and said that informal or verbal complaints were not recorded. This meant the provider did not have a robust system to address the management of complaints and information from complaints was not reviewed to identify any learning from the complaints' investigation, to improve how services were provided to people.

The above was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Even though the care plans were not signed by the person using the service when we asked people if they were involved with decisions about their care they confirmed they and their families were involved. Their comments included "Yes, I am involved in my decisions, in all decision making in regard to my care. I am involved in my care plan for example having coffee before getting up", "My family are in all decision making in regard to my care" and "Myself and my family are involved in any decisions relating to my care." This involvement was not recorded on the care plans or in any other document in the care plan folder to demonstrate people's or their relatives' involvement in decision making.

Inadequate

Is the service well-led?

Our findings

There was a range of checks that the provider had identified as part of their quality assurance processes but these were ineffective and did not provide the necessary information to enable improvements to be made to the service provision. These checks were carried out either daily, weekly or monthly but were not always recorded to provide an audit trail on what was checked, the outcomes of the checks and whether any areas for improvement were identified.

The outcome of weekly fire drills was recorded and if issues were identified it was noted that a list was given to management indicating where repairs were required. There was no record of what repair issues had been passed to the management or confirmation they had been resolved. That meant when the checks were carried out the following week there was no record of any issues which needed to be monitored for example, fire doors not closing automatically which had been identified during a previous fire drill.

The record form for the checks on bed rails, beds, dorguards (which release the doors automatically in case of fire) and pressure relieving mattresses indicated these checks should be completed every week. However the arrangements to carry out these checks were not effective because the checks were not carried out robustly and therefore areas for improvements were not identified promptly so these could be addressed. The records available showed the checks had been completed on the 27 February 2018 and 6 March 2018 and there were no other records in the folder relating to 2018 to show these checks had been consistently carried out. In relation to the pressure relieving mattresses the records indicated they were working but there was no information to show whether these were set to the appropriate pressure setting for the person. This meant the mattress may not have been providing the level of support required to reduce the risk of skin damage.

The records showed the hoist battery should be recharged daily and recorded in the audits folder. We saw the record form had not been completed on six occasions in January 2018, 12 times in February 2018 and 13 times in March 2018. At least nine people at the home required the use of the hoist when being moved so if the battery had not been charged it meant those people could not receive the care they required in an appropriate and safe way.

The provider required the portable defibrillator to be checked daily but we saw the records for these checks were not always recorded. The records for December 2017 showed checks had not been recorded on three occasions and another record did not indicate which month it related to but was not completed on seven occasions.

Staff completed a daily register of people which identified if they were at the home or in hospital. We saw the record for January 2018 had not been completed in full on four days and the record for March 2018 showed it had not been completed in full on six days. The meant an accurate records were not being maintained on how many people were at the home and if any were in hospital.

The clinical lead explained the care plan review which was carried out monthly was seen as a care plan

audit. We saw the review form consisted of a list of 12 standard care plans each person should have in their folder and it was ticked when checked. These included communication, skin, mobilisation and elimination and sleeping. We saw the review form for one person indicated they had all 12 care plans in place but there were only eight included in the person's care plan folder.

The review did identify where the person did not have specific standard care plans in place but where this was indicated action had not been taken to address the deficit and a care plan had not been developed. For example a person who received support with constipation did not have an elimination care plan.

The clinical lead told us a check of the administration of medicines should be completed daily but the nurse on duty and the clinical lead confirmed this had not been completed but they could not confirm when it was last carried out. This meant regular checks were not carried out to ensure medicines were administered in line with the provider's policy and good practice.

The management structure and responsibilities at the home were not clear and staff were sometimes unsure who was in charge and who had oversight for the quality of services provided to people.

When we arrived at the home on the first day of inspection, the nurse on duty and care workers could not confirm who was in charge at the home that day as the clinical lead, who works across both of the owner's homes was off as they had a regular day off on a Thursday. The staff did not also know where the registered manager was. The staff contacted the other home and they contacted the clinical lead and the care coordinator who both came to Shackleton Medical Centre. The registered home manager also arrived at the home but left to return later. We asked him who was in charge of the home that day and he pointed at the nurse in the corridor and said 'she is'. When we had arrived at the home at the start of the inspection when asked the nurse had confirmed to us she was not in charge of the home that day. The registered manager confirmed there was no formal agreement for who was responsible to manage the home on that day. The registered manager explained they could be contacted by telephone and would visit the home during the day but they were not scheduled to be on site when the clinical lead was not on duty.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider did not display the current rating for the location in the premises and on their website as required by law.

The above was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager did not ensure notifications were sent the CQC in relation to Deprivation of Liberty safeguards (DoLS) authorisations when the outcomes of applications were known, and safeguarding alerts that were made to the local authority where there were allegations or suspicions of abuse. During 2017 and 2018 seven DoLS applications were authorised by the local authority but notifications were not sent to the CQC. During 2017 we have identified five safeguarding concerns had been either raised by or with the local authority but notifications were not received by the CQC.

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014

We asked people what they felt about the registered manager and other senior staff and if they felt the home was well-led. People told us they felt the registered manager and senior staff were good and their comments included "The manager and senior staff are fine. There is always someone to talk to in here" and "They are all good." One person we spoke with told us they did not know who the registered manager was.

We asked staff what they felt about the way the home was managed and if they felt supported. They told us "We are all happy about the management, it is the staffing that is the issue." Another staff member said "I am very happy here." They also said they felt they were listened to but other staff members told us they did not feel listened to and the only discussions were at daily handovers. They also said the clinical lead and the care coordinator kept them informed if there were any changes to how they should provide care to people.

The registered manager told us he looked at the CQC website once a month to see if there were any changes to regulation. He also told us he had attended registered manager forum meetings held by the local authority.

When a person moved to the home they received a "Resident's Handbook" which included information on visiting hours, insurance, behaviour towards staff and other people at the home, termination of placement and any additional costs for services. Staff also received a staff handbook which included information on general employment guidance, wages and payment methods, responsibilities and training as well as an overview of other policies.

The care coordinator explained management of the home would be present during staff handover meetings to discuss any issues, reviews and complaints with staff. However they confirmed they did not have regular staff meetings but they have now introduced a schedule of staff meeting to be held every two months during 2018. The minutes of these meetings would then be kept on site for staff to access if required.

The clinical lead explained a questionnaire had been sent at the beginning of 2018 to people using the service and their relatives to obtain feedback on the services provided. At the time of inspection we were not provided with a copy of this questionnaire by the provider and the results were not yet available.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 as where service users were unable to give consent because they lacked capacity to do so, the provider could not demonstrate they followed the best interests process to make decisions for service users. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users were protected from abuse and improper treatment and they did not have systems established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2) (4) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure the premises and equipment used by the service users were secure, suitable for the purpose for which they were being used and properly maintained.

Regulation 15 1 (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not ensure any complaint received was investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs, reflected their preferences and was designed to meet people's needs by following healthcare professional advice.. Regulation 9 (1) (a) (b) (c),(3)(a)(b)

The enforcement action we took:

A Warning Notice was issued requiring the provider to be compliant with the Regulation by 29 June 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users. The risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper and safe management of medicines. The registered person did not assess the risk of, prevent, detect and control the spread of infections. Regulation 12 (1) (2) (a) (b) (g) (h)

The enforcement action we took:

A Warning Notice was issued requiring the provider to be compliant with the Regulation by 29 June 2018.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure service users' nutrition and hydration needs were being met. Regulation 14 (1)

The enforcement action we took:

A Warning Notice was issued requiring the provider to be compliant with the Regulation by 29 June 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity Regulation 17 (1)(2) (a) The provider did not have an effective process to assess the specific risks to the health and safety of services users and do all that was reasonably practicable to mitigate any such risks. Regulation 17 (1)(2) (b)

The enforcement action we took:

A Warning Notice was issued requiring the provider to be compliant with the Regulation by 29 June 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that persons employed in the provision of the regulated activity were deployed in a way to ensure they could meet people's needs. The registered person did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate induction, training, supervision and assessment of their competency to ensure they were able to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:

A Warning Notice was issued requiring the provider to be compliant with the Regulation by 29 June 2018.