Healthcare Homes Group Limited

Overbury House Nursing and Residential Home

Inspection report

Overbury House
9 Staitheway Road, Wroxham
Norwich
Norfolk
NR12 8TH

Tel: 01603782985
Website: www.healthcarehomes.co.uk

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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

This inspection took place on 4 and 7 September 2017, it was unannounced.

Overbury House Nursing and Residential Home provides residential and nursing care to a maximum of 61 older people, some of whom may have dementia. At the time of our inspection there were 34 people living in the home, 16 of whom were receiving nursing care.

At the time of our inspection visit a registered manager was not in post. 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. However, a manager had been appointed and had been working in the home since May 2017. They told us they intended to make an application for registration.

We last inspected this service on 11 and 12 January 2017 and found the provider was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices in respect of these breaches. Following our inspection in January 2017, the provider sent us an action plan to tell us about the actions they were going to take to meet these regulations.

We carried out this September 2017 inspection to check if the improvements had been made in order to achieve compliance with the regulations. At this inspection we found insufficient improvements had been made and governance arrangements in the home were not effective enough to rectify the breaches found at the previous inspection. The provider was still in breach of regulations for: safe care and treatment, management of nutrition and hydration, dignity, and good governance. We found that there had been deterioration in the quality of care in other areas, which meant the provider was in breach of a further two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that risks to people's welfare had increased.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found people were not being provided with safe care. Risks to people's health and safety were not always identified. We found in cases where risks had been identified, that insufficient action had been taken to manage and mitigate the risk of any further harm. In addition we identified concerns relating to the cleanliness of the home and practices which put people at risk of the infection spread by cross contamination Medicines were not always managed safely. People did not always receive their medicines as prescribed. The service remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional and hydration needs were not always met. People did not always receive adequate

support to access fluids. Meals were not provided in a way that ensured people's nutritional needs or preferences were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not fully adhere to the mental capacity act which meant people's rights to provide consent were not always appropriately protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care provided did not to take in to account people's individual needs and preferences. Recommendations made by health and social care professionals were not implemented and followed in order to make sure the care provided was appropriate and met individual needs. Care plans did not always contain sufficient information or guidance, including on how people wanted to be cared for. The activities on offer did not always meet people's individual needs and interests.. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were occasions when staff were not mindful of people's dignity; this included a lack of attention to meeting people's continence needs which placed people in undignified situations. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had contributed to some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. Necessary improvements to the service had not been made. Not all the staff in the home were clear about their responsibilities or took appropriate actions suitable to their roles. The provider had not always taken action to ensure staff understood their roles and responsibilities, and held them to account. The service remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were sufficient staff numbers on duty staff were not always deployed effectively so as to meet people's needs in a timely manner, for example over the lunchtime period, in order to ensure people had a pleasurable lunch time experience.

Staff received training and support; however the number of concerns identified regarding the care and support provided throughout our inspection meant we could not be confident that the training provided was effective, took in to account best practice, and was imbedded in staff practice.

The provider worked collaboratively with the appropriate authorities to respond to safeguarding concerns. However, not all safeguarding incidents had been identified and reported as required, which meant we could not be confident all staff understood how to identify and report such incidents.

There were opportunities for people, relatives, and staff to provide feedback and be informed about the running of the service. People and relatives felt comfortable and able to raise any concerns or complaints they had. The provider took action to address any concerns raised.

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.

Risks to people's wellbeing and safety were not always identified and actions to minimise risks were not always taken.

Medicines were not always managed safely and in a manner that mitigated the risk of misadministration.

The cleanliness of the home and associated practices put people at risk of the spread of infection by cross contamination.

Is the service effective?

Inadequate

The service was not consistently effective.

The home was not working within the requirements of the MCA.

People were not adequately supported with their nutritional and hydration needs.

Staff did not always implement or follow recommendations made by health and social care professionals in relation to people's care.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always ensure people's dignity was protected; this included the management of people's continence needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care provided did not always meet people's individual needs and preferences, including the provision of activities.

Care records did not provide sufficient guidance to staff to help ensure the care provided was person centred.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread and significant shortfalls in the way that the service
was being managed.

Whilst there were some systems in place to monitor the quality of the service, these were not effective.

Not all staff appeared to understand or take action to fulfil their responsibilities.

Overbury House Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 7 September 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor in relation to medicines management, 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. The second day of inspection was carried out by two inspectors.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also spoke with the local authority adult safeguarding team and the local clinical commissioning group for their views on the service.

During our inspection we spoke with five people using the service and five relatives of people using the service. We spoke with the manager, a general support manager; the provider's safeguarding lead, a nurse, and three members of care staff.

Not everyone living at the home was able to speak with us and tell us about their experiences of living in the home. We observed how care and support was provided to people and how people were supported to eat their lunch time meal.

We looked at documents relating to ten people's care records, staff recruitment files and staff training records. We looked at medicine records, quality monitoring documents, accident and incident records, and

other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 11 and 12 January 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always identified and action was not always taken to keep people safe. At this inspection on 4 and 7 September 2017 we found sufficient improvements had not been made and additional concerns were identified.

Risks to people had not always been identified and managed appropriately. For one person we found they were experiencing behaviour that may challenge themselves and others. We found there was no risk assessment or care plan in place regarding this. For another person also experiencing behaviour that may challenge we found that the measures taken to address this risk had not been thoroughly risk assessed. For both people we found that advice from health professionals on the management of this risk had not been followed. For three people we found that technology that had been assessed as required to keep people safe, for example alarmed mats that notified staff that people who were at risk of falls and required staff support were about to mobilise independently, was not in place or working properly. This meant staff had not taken action to sufficiently mitigate these risks.

At our last inspection in January 2017 we found improvements were required regarding the management of wounds and pressure ulcers in the home. At this inspection we found improvements had not been made. We looked at two people who required support with the management of wounds in the home. We found for both, staff had failed to sufficiently monitor their skin condition and the management of their wounds. This included undertaking regular wound assessments in order to identify any increasing risks. For one person we found staff had missed a required dressing change. We were not confident this would have been identified and addressed had we not brought this to the attention of the manager. For a third person the provider's safeguarding lead had conducted an investigation in to a pressure ulcer acquired by one person whilst living in the home. The report showed that there had been failures in the identification and management of this wound.

Our previous inspection had identified concerns that actions were not taken to manage the risk to people from malnutrition. At this inspection we continued to have concerns. We found that staff had identified people at risk from malnutrition and recorded actions required to mitigate and monitor this risk. However, we found these actions, such as recording weekly weights, had not been taken for four of the people we looked at.

At this inspection we found additional concerns that actions to protect and mitigate people identified at risk of choking had not been taken. We found for one person assessed as being at risk their risk assessment stated they should be assisted and monitored at every meal. We observed this did not occur during the lunch time meal. For a second person we found staff had identified them as being at risk of choking on their medicines. Staff had requested a referral for a specialist assessment. However, they had failed to follow this referral up and had not taken any additional action to address this risk whilst waiting for the person to be assessed.

We identified, during this inspection, additional concerns relating to the cleanliness of the home and practices which put people at risk of infection spread by cross contamination. This included waste bins overflowing, debris, and dirt on people's carpets as well as the management of people's continence needs in the home which had resulted in a two people's rooms smelling unpleasant. In addition to the management of cleanliness of the home we also found continuing concerns regarding the management of the premises and associated risks. This was in relation to the management of water and fire safety in the home, as not all required checks were being carried out.

We looked at three staff files and found for one of them safe recruitment practices had not been followed in respect to ensuring the required character and criminal record checks prior to the staff member starting work in the home. This matter was brought to the attention of the service managers. The staff member had subscribed to the Disclosure and Barring Service (DBS) update service. This enabled the provider to promptly establish that no new information had been added to the staff member's records since the previous satisfactory DBS certificate had been issued.

At this inspection we found additional concerns regarding the management and administration of medicines in the home. People did not always receive their medicines as prescribed. One person had a diabetes care plan that specified that a fast acting insulin should be given if their blood sugars reached a certain level. We found that on two occasions the person's medicines records showed their care plan had not been followed and this medicine had not administered. For another two people we found they had not received a prescribed medicine on two concurrent occasions as this medicine had run out and staff had not ensured they had sufficient supplies in stock.

We found that the medicines stock was poorly managed. We looked at the medicines for five people and found they had excess stock of medicines. A staff member told us this was due to oversupply of medicines in the home. Medicines no longer required should be returned to reduce the risk of a medicines error. We also found poor record keeping in relation to medicines administration in the home. For example, one person had medicine allergies noted in their care records but these were not noted on their medicines administration records. This increased the risk that they would be administered a medicine they were allergic to. We found on some people's medicine administration records staff were recording that people had not been given their medicines but had not recorded the reason why this was. This meant that the provider could not determine whether suitable actions had been taken in response.

We observed a staff member undertaking medicines administration in the home. We saw that whilst they were completing this task they were interrupted by another staff member, who wanted them to assist with another task. The disruption and interference of staff whilst administering medicines increases the risk of a medicines error and is not good practice.

The above information meant the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received conflicting and varied feedback regarding staffing levels in the home. One person told us, "We have plenty [of staff], there's always someone around." A relative said, "Staff levels are definitely better, there are several new staff coming in." However, another person told us, "No they're nearly always short staffed, they don't have time [to chat], they would if they could but they don't have time." Whilst a relative told us, "There's generally enough staff at most times, on the odd occasion I would question there aren't enough." They went on to say, "I was concerned that [name] wasn't being got up early enough in the morning, sometimes they were still in bed at lunchtime. [Name] can't express a choice but every day [in bed] wasn't their choice."

During our inspection we observed that although there appeared to be sufficient staff they were not always deployed effectively to ensure people were adequately supported or in a timely fashion. For example, over the lunchtime period or with support getting up in the morning.

Records showed staff had received training in adult safeguarding. Where safeguarding concerns had been raised and identified we saw the provider worked closely with the appropriate authorities to refer and respond to concerns.

There was a high use of agency staff in the home which some people and staff commented on. However, none of the people, relatives, or staff we spoke with raised this as a particular problem. One relative said, "There can be a lot of agency staff, last week there were quite a few. If there's an agency staff gets [name] up there's always a regular member with them." The manager told us they tried to ensure that the same agency staff were used to allow for continuity and familiarity with people. They told us there was an ongoing recruitment plan to address the use of agency in the home and more permanent staff had recently been appointed.

People we spoke with told us they felt safe living in the home. One person said "I don't think there's anyone ever been nasty to me." A relative told us, "I enjoy coming here, I feel [name] is so secure, the staff talk to all the residents."

Inadequate

Is the service effective?

Our findings

At our previous inspection on 11 and 12 January 2017 we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always receive the right level of support to eat or sufficient fluids. At this inspection on 4 and 7 September 2017 we found sufficient improvements had not been made and the provider remained in breach of this regulation.

We observed improvements were still required to ensure people had sufficient access to fluids. On a number of occasions during our inspection visit we observed people sitting in very warm communal areas without access to drinks. During lunchtime we sat with two people and observed during the entire lunchtime period they did not have access to any drinks. One person was offered a flavoured drink which they declined, stating they only drank water. However, no water was subsequently provided.

We also found that meals were not provided in a way that ensured people's nutritional needs or preferences were met. For example, we saw one person had been assessed by a dietician as they were at nutritional risk. The dietician had recommended that in order to ensure the person had sufficient nutritional intake they should be provided with small and frequent meals as well as regular snacks. When we looked at this person's food records we found this was not being followed.

It was not always clear during our inspection how much choice people had regarding their meal options. Whilst we saw most people were offered choices regarding what they wanted to eat, for one person who could only eat soft foods they were not offered any choice. When we spoke with people and relatives it was not always clear from speaking with people they were consistently able to choose their meal options. One person told us, "There's generally a choice of two." Whilst a relative said, "Sometimes they'll show [name] two meals. They gave them the softer option because they knew they'd prefer that."

We observed the lunchtime meal on the first day of our visit and found this to be chaotic and disorganised. This meant not all people present had a pleasurable meal time experience. For example, we saw a number of people had been seated at tables for their meals but ended up waiting a long time before they received these. For one person we observed that they were sat at their table for forty minutes before they received their lunch. For another person we saw they were sat waiting for thirty-five minutes before they received their lunch. We noticed that this was causing them some anxiety. When staff did arrive with the person's lunch they hadn't realised the person had not been given their starter first and we had to intervene to ensure the person was provided with their entire lunch time meal. On other occasions we saw that people were assisted to dining rooms to find that there was nowhere available for them to sit down. They were then taken to another dining area.

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

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 was being met.

At our last inspection in January 2017 we made a recommendation that the provider reviews this legislation and associated guidance to ensure they are acting in accordance with the MCA. At this September 2017 inspection we found the provider had not made the improvements required and they remained in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not acting in accordance with the MCA.

We saw that relatives were being asked to provide consent for people without staff checking that they had the legal authority to do so. For example, we saw relatives were signing for consent to the service sharing information about people.

Whilst the home had carried out some mental capacity assessments for people where they had concerns they couldn't make specific decisions there was no documented best interests decisions. This meant it was not clear what decision had been made in the person's best interests, the reasons why, and who had been consulted. We also found for some decisions, which were restrictive in nature, mental capacity assessments had not been carried out as required.

Applications for DoLS authorisations had been made. However, in one case we were concerned that the measures taken were overly restrictive, as there was little evidence to support the decision made and we could not see how the decision taken had been evidenced to be in the person's best interests and the least restrictive possible.

At this September 2017 inspection we found that people were not always supported to access relevant health and social care professionals. When people did have access to health and social care professionals we found that their advice was not always listened to and implemented. For example, we found for two people with behaviour that may challenge staff had failed to implement strategies and advice given to them by each person's community mental health nurse. For a third person we found staff had failed to ensure they had been seen in a timely manner by a doctor for a particular health condition they suffered from.

The above concerns relating to support from health and social care professionals meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed us staff received a range of training, for example in moving and handling, fire safety, dementia awareness, and medicines management. The records showed staffing training levels in the home overall were at good level. However, we found a number of concerns regarding the care and support provided throughout our inspection which meant we could not be confident that the training provided was effective, took in to account best practice, and was imbedded in staff practice.

Relatives we spoke with told us they felt staff had the skills needed to do their job. One relative said, "Yes I feel they do know what they're doing and they do tell you about their training, one member of staff who normally works nights mentioned their in-service training for medication and told me they're coming in during the day to learn." Whilst a second relative told us, "I think they [staff] know [name's] needs, mainly through experience but also training."

New staff received an induction in the home prior to commencing work. Staff we spoke with confirmed this and told us they received a good induction, this included a four day corporate induction, training, and shadowing other staff members.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 11 and 12 January 2017 we found the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. At this September 2017 inspection we found the provider remained in breach of this regulation.

During our inspection we found staff were not always mindful of people's dignity. For example, we found occasions where staff had not properly ensured people's privacy was protected as doors to rooms where they were receiving assistance with personal care had not been fully secured. For another person we found they were receiving constant one to one support which was provided in a manner that impacted on their autonomy and dignity.

We also found that a lack of attention to people's continence needs had placed people in situations which compromised their dignity. For example, we found some people's rooms had a strong unpleasant odour that was also apparent in the corridor to people passing by. On one occasion we found another person had required assistance with their personal care but this had not been provided in a timely manner which had compromised their dignity.

On the first day of our inspection we found the home's post had been delivered but left unsecured and on top of the visitor's signing in book. This meant people and visitors to the home could have had access to potentially sensitive information.

We received conflicting information from people on how caring and friendly the staff were. One person told us, "We're only a hindrance." We observed this person during our inspection visit and saw they were sat in a communal lounge and appeared to be in a low mood with their head in their hands on a several occasions. We saw that staff did not appear to engage or offer any comfort to this person. A relative said, "The majority of staff are friendly and approachable, note I mention the majority of staff."

We found instances where people's independence was not fully promoted. For example, we saw the whilst people were watching television in the communal lounge they did not have access to the remote control in order to change the channel or adjust the volume. This meant people had to ask staff, or ourselves on one occasion, for assistance.

Whilst we saw improvements were required, we also received some positive feedback. For example one relative told us, "Staff are brilliant, consistent in their approach, they're like it all the time, always pleasant." Whilst another said, "The staff are very good, friendly". We saw some friendly and positive interactions during our inspection visit although these appeared limited in their duration as staff appeared to be focused on the tasks at hand.

Requires Improvement

Is the service responsive?

Our findings

At this inspection we found people did not receive personalised care that met their individual needs. For example, we found one person required additional support from staff to regain their independence by walking for short periods. There was no system in place to support this and records did not show this support was being given. We observed during our inspection visits that this person clearly wanted to spend some time walking about the home but this was not facilitated by staff.

The care plans we looked at did not always contain sufficient information or guidance, including on how people wanted to be cared for. People's care plans were often generic in nature with their names written in. When we asked the manager about this they told us staff had been using the provider's templates but appeared not to have recognised the need to change and adapt these so they were relevant to people's individual needs and circumstances. As the care plans were generic in nature this meant we could not be confident that people, or relatives, where appropriate had meaningful input in to the writing and reviewing of people's care plans. It also meant staff did not have sufficient written guidance to meet people's needs. In addition new or agency staff who did not have knowledge of people and their needs would not have sufficient written guidance to meet people's needs in the event that permanent staff were not available.

Where care plans did detail specific actions required in order to meet people's needs we found staff did not always follow these. For example, by failing to ensure that equipment that had been assessed as required to support people was in place. This meant staff had failed to ensure they were providing responsive care that met people's individual needs.

At our previous inspection we found concerns that activities on offer did not always take in to account people's individual needs and interests. At this inspection we found whilst activities were provided these were communal in nature and we could not see that people's individual interests and hobbies were promoted. For example, we saw one person had listed gardening as an interest and hobby when we reviewed their activity records we could not see this person had been supported to engage in this interest.

The above information meant the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people regarding the activities in the home. One relative told us, "[activities coordinator] is excellent, she works very hard, spends time with them, rubs their hands, cuts their nails." Another relative said, "We have a singer once a week on average, last week there were two on consecutive days, bingo, cooking sessions, karaoke." However, a third relative said, "There's only one activities lady, she can only do it for a relatively small number of people."

People and relatives told us they felt listened to by the manager and able to raise concerns if necessary. One person said, "[Manager will] come back and tell me if he's sorted it, he's a busy fella, we've never had one like him who comes round and sees you, it's a lot better now, he's great." A relative told us, "If he's busy [manager] he'll say I'll come and find you, you don't feel doubtful about chatting to him, he listens and tries

to sort things out." Although one relative said, "[Named manager] has been very approachable. I do think sometimes that you're waiting longer than you would think for a matter to be resolved."

We looked at the home's complaints records and saw that the provider had investigated and appropriately responded to concerns they had received.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2017 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. At this inspection carried out on 4 and 7 September 2017, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

Our findings during this inspection showed that the provider had failed to meet the regulations in respect to safe care and treatment, nutritional and hydration needs, dignity and care, consent, person centred care, and good governance. In addition, the provider had consistently failed to sustain and make improvements where non-compliance and breaches of regulations had been identified during previous inspections.

Whilst there were some systems in place in the home to monitor the quality of the service provided via audits on areas such as health and safety, infection control, medicines, and care plans, these were not effective at identifying the areas of concern that we found during this inspection. We found for some audits they did not detail clearly what areas were required for improvement, giving only yes and no answers. Where issues had been identified not all the audits undertaken had resulted in an action plan. This meant that the provider was unable to demonstrate whether any actions had been taken to address the issues raised. In other cases where audits had generated action plans we saw these actions had not been followed up to ensure that the improvements required had been made.

The provider also carried out regular audits of the home, these looked at areas such as, but not limited to, safeguarding, care records, medicines, monthly audits, and staffing. We reviewed the most recent provider audit carried out in June 2017 and found this had also not been fully effective in ensuring actions to make improvements had been made. We found actions that were identified as required in the June audit were still outstanding at the time of our inspection visit in September 2017. This meant we were concerned about the lack of timely action to make improvements identified as necessary. The June audit also stated that identified actions from this audit would be added to the home's action plan. However, when we reviewed the home's action plan we found this had not happened. As a result we were concerned that there was a lack of oversight of the identified and required actions that needed to be taken to make improvements in the home.

We also found the system for ensuring oversight of incidents that occurred in the home was not robust and did not provide an effective overview of these risks to people. It was not clear from the system in place that any analysis of incidents in the home, such as patterns or frequency of incidents, was occurring. We were concerned that the system in place logged a high number of falls for some people in the home but there were no clearly recorded actions or review of these numbers. When we asked the manager about this they told us they there had been no completed falls analysis since July 2017 as they were not trained to do these and the person responsible for this was no longer working at the home.

During our inspection we found that there was a lack of oversight and knowledge of the provision of care and how people's individual needs were being met. The manager did not always appear to know what was happening in terms of the provision of care on the floor. For example, that people's weekly weights were not being undertaken as required. We found in part this was because there was a lack of effective systems to provide this level of oversight. For example, we asked a senior staff member how staff ensured that recommendations from health and social care professionals were followed up and actioned. They told us there was no clear system and the responsibility fell to whoever was on shift and attended the relevant consultation. It was clear this was not effective as we found examples where recommendations from health professionals had not been implemented.

In addition we also found concerns about delegation of responsibility and accountability of staff in the home. For example, we found where the manager had delegated required actions to staff members these had not been undertaken. We also found other examples of actions during the day to day provision of care which had not been undertaken which led us to question staff accountability in the home. Two of the staff we spoke with told us that they felt not all staff were fully capable or motivated in terms of their roles. This meant we had concern about the culture in the home and how the provider ensured staff understood their roles and responsibilities, as well as holding them to account.

At our last inspection in January 2017 we found that the care records we looked at contained information about people's care needs but these were not always sufficient, accurate, and up to date. The care records we looked at during this September 2017 inspection showed this continued to be a concern and action had not been taken to make sufficient improvements. This meant the home did not have in place accurate, complete, and contemporaneous records of people's care including guidance for staff on how to meet people's needs. This was of particular concern given some of the staff working in the home were agency staff.

From talking to the management team, and from information we received prior to our inspection, it was clear that there had been some issues regarding the cohesiveness of the staff group. This had led to some difficulties in action being taken to make and sustain improvements in the home.

At the time of our inspection a registered manager was not in post. However, a manager had been appointed and had been working in the home since May 2017. They told us they intended to make an application to registered shortly. People, relatives, and staff spoke positively of the manager's support and approachability. One person told us, "[Manager] hasn't been here long, he's friendly, has a laugh and a chat with you, it helps." A relative said, "I think [manager is] lovely, he always says that his door's always open, everyone's got his mobile [number], he's not frightened to get stuck in, the other week he had the hoover out." A third relative told us, "[Manager] told us at one of the meetings, 'if you have any problems you can ring me'."

We saw there were also regular meetings for people living in the home and their families, as well as regular staff meetings. We reviewed the minutes for these which showed people, relatives, and staff were provided with opportunities to provide feedback about the home, offer suggestions, and that the provider shared important information regarding the service provided.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: The service did not fully adhere to the mental capacity act which meant people's rights to provide consent were not always appropriately protected. Regulation 11(1)(2)(3)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The care provided did not meet people's individual needs and preferences. This included involving health and social care professionals and ensuring their recommendations relating to people's care needs were implemented. Regulation 9 (1)(a)(b)(c)(3)(b)(c)

The enforcement action we took:

We issued a notice of decision to impose positive conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: people were not always treated with dignity and respect. Regulation 10 (1) (2)(b)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: risks to people were not always assessed and action was not always taken to mitigate against risks. This included the management of risks relating to the premises, infection control, and medicines. People did not always receive their medicines as required. Regulation 12 (1) (2)(a)(b)(d)(f)(g)(h)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: actions were not always taken to ensure people were sufficiently hydrated. People's nutritional needs were not always met. Regulation 14 (1) (4)(a)(c)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. The provider had failed to implement effective systems to assess, monitor and mitigate the risks to people using the service. The provider had failed to ensure there was an accurate, complete, and contemporaneous record in respect to people's care. Regulation 17 (1) (2)(a)(b)(c)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.