Mayhaven Healthcare Limited

Down House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 9 and 11 December 2015. Breaches of legal requirements were found in respect of people's assessments in relation to the Mental Capacity Act 2005 (MCA), people's care and treatment not being safe and how the service was being managed and governed. After the comprehensive inspection, we served warning notices on the provider and told them they had to put this right by 4 March 2016. Warning notices are part of our enforcement policy and told the provider they were not complying with requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We undertook this focused inspection on the 19 and 20 April 2016 to check they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Down House on our website at www.cqc.org.uk

Down House is registered to provide residential and nursing care to up to 49 younger and older adults. People may be living with dementia, have a learning disability or autistic spectrum disorder or be physically disabled. They may also be living with a sensory impairment. Twenty-five people were living at the service during this inspection. Another person was in hospital at the time of our visit.

A registered manager was not in place to manage the service. The previous registered manager left on the 9 August 2015. 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. There was a manager in place to manage the service. The provider stated they were aiming for this manager to apply to become registered with us.

People's care records were not personalised and did not always evidence whether people were involved in planning their own needs. The records of people's care were incomplete and lacked essential details to ensure care given was appropriate and as desired by the person. People's medicines were not always managed and administered safely.

People were not being assessed in line with the Mental Capacity Act 2005 (MCA) as required. No person's records held an assessment of their capacity to consent to their own care and treatment. Staff did not understand the link between assessing someone in line with the MCA and ensuring they were not depriving someone of their liberty. However, applications to deprive a person of their liberty to keep them safe had been submitted and were awaiting authorisation.

People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People were not involved in planning how to mitigate the risks they faced while living at the service. People did not have risk assessments for individual health needs in place to inform staff how to recognise

and meet this need should people become unwell. A risk assessment to mitigate environmental risks to people's safety had not been completed to assess the inside and the outside of the service. This meant potential risks were not identified and people kept safer as a result.

People were not assured a quality service as robust quality assurance processes were not in place which identified the issues or concerns. Where audits had been put in place they lacked any analysis of the data and action plan to improve the service as a whole for everyone.

Resuscitation equipment had been serviced and was ready if required. The resuscitation policy required review to ensure staff understood their responsibilities.

Infection control measures had improved to ensure people were kept safe from infection. A risk assessment was to be developed to identify areas of potential risk. For example, the laundry had the clean and dirty areas in the same part of the room and this had not been identified by the provider as a specific area that needed reviewing.

People were protected by staff being clear about their own responsibilities. Staff understood the limits of their roles and felt the service was now better at ensuring there were clear lines of accountability.

We found continued breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report. The Commission is currently giving consideration to what enforcement action to take. We will report on this later.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found action had not been taken fully to improve safety.

People's medicines were not always managed and administered safely.

People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People were not involved in planning how to mitigate the risks they faced while living at the service. People did not have risk assessments for individual health needs in place.

A risk assessment to mitigate environmental risks to people's safety had not as yet been completed.

Resuscitation equipment had been serviced and was ready if required. The resuscitation policy was to be reviewed to ensure staff understood their responsibilities.

Infection control measures had improved to ensure people were kept safe from infection.

Is the service effective?

Requires Improvement

We found action had not been taken to improve effectiveness.

People were not being assessed in line the Mental Capacity Act 2005 (MCA) as required. Applications to deprive a person of their liberty had been submitted and were awaiting authorisation without MCA assessments being in place.

Is the service responsive?

Requires Improvement

We found action had not been fully taken to improve responsiveness.

People's care records were not personalised and did not always evidence whether people were involved in planning their own needs.

The records of people's care remained incomplete and lacked

essential details to ensure care given was appropriate and as desired by the person.

Is the service well-led?

Requires Improvement

We found some action had been taken to improve well-led. The service did not have a registered manager. The provider had taken steps to address this.

Robust quality assurance processes were not in place to identify issues and concerns and improve the service for all people living at the service.

People were protected by staff being clear about their own responsibilities. Staff understood the limits of their roles and felt the service was now better at ensuring there were clear lines of accountability.

Down House

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.

We undertook an unannounced, focused inspection of Down House on the 19 and 20 April 2016. This inspection was done to check improvements to meet legal requirements after our comprehensive inspection on the 9 and 11 December 2015 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well-led?

The inspection team was one inspector for the Adult Social Care Directorate, one specialist nurse with experience of the care of older people, a pharmacist inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the previous inspection report and the warning notices we had served on the provider. Warning notices are part of our enforcement policy and told the provider they were not complying with requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We also received updates from the local authority who had been involved in supporting and reviewing the service.

During the inspection we spoke with 15 people and seven relatives. We looked at the care of six people in detail to review if they were receiving their care as planned. We spoke with these people where we could to gain their opinion. We observed how staff interacted with people in the lounge and dining room.

We spoke with nine staff and reviewed the records the provider had about the service which were specifically related to the issues we were reviewing. This included audits and records which demonstrated they were reviewing the quality of the service.

During the inspection we sought the opinion of one health care practitioner and a GP.

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Requires Improvement

Is the service safe?

Our findings

During our last inspection on the 9 and 11 December 2015 we found people's medicines were not safely managed and administered; risks associated with people's care were not complete or updated to reflect people's needs; the inside and the outside of the service was not risk assessed to keep people safe; call bells were often out of people's reach placing them at risk of falls; people's falls were not reviewed to see if changes could be made to keep everyone safer; nursing staff were delegating care without checking this was safe; resuscitation equipment and first aid kits were not maintained and the provider was not ensuring safe infection control practices were followed.

During our last inspection, we saw people's medicines were not always clearly recorded. During this inspection, we saw the current medicine administration record (MAR) charts and those from the previous month contained gaps, meaning that it was not possible to check whether people were receiving their medicines as prescribed. If people declined to take their medicines, the date, time and reason for this were not always recorded. This means it was not always possible to identify a reason why someone may not wish to take their medicines. Some MAR charts had handwritten additions, for example when medicines had been received during the month. Staff making the addition had not always signed the MAR and changes were not always checked by a second staff member to make sure they were accurate. This means that the MAR charts may not have the correct information which could lead to a medicines error.

Some people were prescribed pain relieving patches, which were applied once a week. Records showing where the patch had been applied were not always completed. One person having patches applied did not have a MAR chart to record their application. This meant staff did not know when or where the patch had been administered or when it should be changed. Applying the patch to the same area of the body more than once every three to four weeks is not safe as more of the medicine may be absorbed than expected. This can potentially lead to overdose.

During our last inspection, we saw homely remedies (medicines that can be administered without being prescribed) were used in accordance with a signed and dated homely remedies list, but that some were administered from an unlabelled bottle of tablets. During this inspection, correctly labelled medicines were available but there was no evidence of a homely remedies list. Although medicines administered without being prescribed were recorded in a homely remedies book, staff did not always record the name of the person who received the medicine, the reason for giving it or the outcome. One of the medicines was the pain killer paracetamol. This meant people may have this medicine administered again by staff that did not know it had already been administered, so placing people at risk of potential overdose.

People taking high risk medicines (such as Warfarin that thins the blood) had additional written information from the GP with their MAR charts detailing what dose should be taken based on blood test results. However, one person had information to show they had a blood test on 10 March 2016 but the results sheet had not been updated and still showed the previous test results from 14 January 2016. Not keeping this record sheet up to date means that the wrong dose of a high risk medicine could be given. Another person's records contained a results and dose sheet for the high risk medicine even though this had been

discontinued and replaced with a new medicine which the staff were administering. Keeping discontinued medicine records alongside present records may confuse the staff leading to a risk that incorrect medicines are administered

During our last inspection, we found care staff were not keeping consistent records of the application of prescribed creams. At this inspection, creams and other external medicines applied by care staff were recorded on a form kept in people's rooms, but there were no records to show which external medicines had been applied to which areas of the body or the quantity required or applied. This means that external medicines could be applied at the wrong amount on the wrong area of the body. Staff did not record the application of external medicines on people's MAR charts and we saw one person was having cosmetic creams applied rather than those prescribed for their specific skin condition. This may lead to a worsening of the people's skin condition. The person was unable to consent to the change from the prescription and no record was made to describe the change.

People's care plans and risk assessments did not contain detailed information about their medicines needs. Staff described how one person living with dementia was declining to take their medicines more frequently; including a medicine used to control seizures. The person was encouraged to take their tablets and given those deemed most important first in case they declined them. On the day of the inspection their tablet, given to control seizures, was signed as administered, but the manager told us later that it was found in her lap. There was no assessment under the Mental Capacity Act 2005 and no record of any conversation with the GP about reviewing medicines to ensure this person received the medicine as necessary.

One person's records showed a medicines review on 11 March 2016 by a GP where a new medicine had been started and the dose of an existing medicine changed. The GP had requested a follow up blood test in two weeks. Notes in the person's care plan on 29 March 2016 showed a telephone call had been made to the GP requesting a district nurse visit to take the blood test. There were no further notes to show if the blood test was done or the outcome. This meant it was not possible to tell if the medicines were safe to use at the prescribed dose.

One person administered their own medicines from a dosette box made up each week by a relative. No risk assessment had been completed to ensure this could be achieved safely. Pre-admission information in the care plan about this person stated that they sometimes needed prompting by staff to take medicines. However, staff were not checking whether they had taken their medicines.

People were asked if they needed medicines that were prescribed to be taken when required, for example pain killers, although there were no protocols to give more information about what the medicines might be needed for, the frequency of administration or the dose. This information should be available to staff so they can ensure that the right medicine is used for the each condition at the right dose and that the GP can be contacted if the person's condition changes.

Medicines that require storage in a fridge should be kept between 2-8°C. During our last inspection, we found the temperature of the fridge used for storing medicines was recorded as 20°C. The record of medicines for disposal showed large quantities of medicines were disposed of on 22 March 2016 with the reason recorded as "fridge faulty". We found the fridge temperature log showed the fridge continued to be recorded as above 21°C. Storing medicines at the wrong temperature may mean they do not work effectively.

Only nurses administered medicines at Down House. We looked at the training records for two nurses and found medicines training did not form part of the provider's annual mandatory training review. New staff did

not have completed competency assessments regarding their ability to administer medicines. This meant it was not possible to ensure staff remained competent to administer medicines.

The manager advised a new medicines policy was being developed. At the time of inspection, there was no medicines policy in use. This meant staff had nothing to refer to in the home in respect of the safe administration of medicines.

Not ensuring the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection, we saw that staff left the room before observing if people had taken their medicines. During this inspection staff observed people taking their medicines. There was a process for ordering medicines that meant the service had enough medicines in stock. Staff checked medicines received into the home to ensure they matched the prescription request. The manager explained they were working with staff to encourage medicine error reporting to improve safety. They stated there had been no incidents to report since our last inspection.

Medicines that required additional controls were stored safely. Stock checks were completed and there were no discrepancies between the record and stock. Two staff administered and witnessed the medicine being given and recorded this.

At the last inspection people's individual falls were being reviewed however, there was no service wide falls audit to ensure any trends across the home or for individuals were being addressed. Accident records were collated but there was no review of these to see if there was any service wide learning required to keep people safer. For example, when people had fallen in their bedrooms there was no check to see if these were at certain times of the day or related to staffing levels. On this inspection we found no action had been taken in respect of this.

On this inspection, we found people had call bells out of reach and others with no call bell. At the last inspection the manager told us some people could not use a call bell and there was no system in place to check if people who could not use call bells required assistance or support. The manager said staff were to write in the daily records they had been to see people who could not use call bells. We found staff had not done this. Risk assessments and reviewing people who could not use a call bell had not been put in place. For example, on this inspection we identified one person living with dementia had a call bell however, they had not been risk assessed as to whether they could use the call bell. We observed the person to be extremely restless and agitated and called for staff to come and support the person as they were on the edge of their chair and at risk of falling. This person's records identified they were at a high risk of falls and spoke about their "memory problems" in respect of other aspects of their care. No assessment had been made about their ability to remember how to use the call bell.

Not ensuring people's risks were fully assessed and mitigated is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the service. One person said, "I always feel safe, because there's always somebody around to call if I need help" and another told us, "I spilt some tea on myself and had to use my call bell. The staff came quickly". Other people felt that staff were responding quicker to their calls for support since the previous inspection.

At our previous inspection, infection control procedures did not always ensure people were protected from

the possibility of cross infection. On this inspection we found this had been improved.

All staff were now trained to meet the infection control responsibilities related to their role. Action had been taken to improve infection control practices. For example, all manual sluices were now fixed and staff were clear on how to use these. Systems had been put in place to identify risks in respect of legionella. An infection control audit had been completed however, there was no current risk assessment in place to identify control measures for high risk areas such as the laundry which had clean and dirty areas in the same vicinity.

Not having systems in place to fully identify the risks associated with infection control is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found all the first aid kit contents were out of date. On this inspection we found all first aid kits had been restocked and there was an audit in place to check these remained stocked in relation to current guidance.

At the last inspection suction equipment we found for the purpose of resuscitation was not kept ready for use. Staff were also confused about whether they should resuscitate people or not. On this inspection we found one suction machine was ready for use and the correct, sterile attachments were available should they be required. The provider told us a second suction machine was being kept back for a different area of the home which was currently being developed. After discussion, the provider agreed to ensure this was cleaned and placed with the other machine alongside the oxygen so there was an identified area of the home where resuscitation equipment was available. The manager advised staff had been briefed in respect of their role regarding resuscitation and the policy of resuscitation had been shared with all staff. A relative told us, "My relative had a bad turn while I was here two weeks ago and within 30 seconds four staff members came in to sort it out. They were wonderful".

The resuscitation policy however was not comprehensive. For example, it did not identify how the equipment would be looked after and which staff could use it. The policy also did not identify who could give chest compressions as part of first aid and what staff should do in the event the person had chosen not to be resuscitated. Staff identified this would be addressed.

At the last inspection we identified staff were carrying out roles for which they had not been trained. We found a nurse had delegated a task which they had not ensured the staff member was trained and competent to complete. We discussed the current situation with the manager on this inspection who advised all nurses had been advised no nursing tasks were to be delegated to care staff.

Requires Improvement

Is the service effective?

Our findings

During our last inspection on the 9 and 11 December 2015 we found the service was not meeting its full requirements to be effective. People were not being assessed to ensure they could consent to their own care and treatment in line with the Mental Capacity Act (MCA) 2005 and assessments had not been sought to ensure people were not being deprived on their liberty under the Deprivations of Liberty Safeguards (DoLS).

The 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.

At this inspection we again checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found no assessment on any record had been completed to assess whether people could consent when a condition, such as dementia, suggested they may not be able to or have limited ability to consent. The manager identified 14 people who required an assessment in relation to the MCA. There were no capacity assessments in place on the 14 records to ensure people's right to consent was being respected.

When we spoke with the manager and staff they did not understand the importance of the MCA in respect of people who could no longer consent to their care and treatment in part of as a whole. Where people lacked capacity to make decisions themselves, staff could not demonstrate they were acting in people's best interest. Records did not demonstrate who had been involved in any decision making in respect of people's care and treatment for people who had no or reduced capacity to consent.

People who lack mental capacity can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager did not also understand the link between the MCA and DoLS and had made six applications for DoLS assessments despite no MCA assessment being in place. At the last inspection we were concerned one person was treated as though they had a DoLS in place when actually it had been turned down as they were deemed to have capacity. In December 2015 they had told us they wanted to go home. We reviewed this person's records on this inspection and found no further action had been taken regarding this request. The person told us they still wanted to go home but recognised they would need support to keep them safe.

Not acting in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff always sought their consent before starting personal care. We observed staff always requested people's consent before commencing interactions such as using a hoist to move people from their chair to a wheelchair. Staff waited for people to respond in their own time.

Comments we received in respect of the staff included, "They have the best carers you could ever want", "The staff put themselves out to look after me; they're exceptional", "You couldn't get better girls, they're wonderful" and, "Everybody is very kind and nobody shouts".

Relatives told us, "The staff have been wonderful. Even the laundry lady to the cleaner pop in and have a talk to my relative" and, "The girls that deal with my mum are excellent".

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on the 9 and 11 December 2015 we found the service was not meeting its full requirements for being responsive. Records in respect of people's care were sometimes incomplete with gaps in recordings and monitoring of people's needs not being completed. Care records did not contain the details of how people would want their care carried out.

At the last inspection, people's admission forms were often incomplete and lacked information staff required ensuring care delivered met the person's immediate needs when they first started living in the home. We found no improvement had been made since our last inspection. People's records admitted since the last inspection contained insufficient detail to build an interim care plan to meet people's needs whilst a more comprehensive care plan could be developed. This meant staff did not have the essential details to provide care as the person needed. The interim care plan stated it should run for seven days before a fuller care plan was put in place. People's interim care plan was undated so it was not clear when the care plan had been completed and how long this care plan had been in place.

We found at this inspection the writing of people's care plans had not changed significantly. Although work had been completed in respect of people's care plans, we found they lacked detail such as how to care for a person with diabetes who was taking a high risk medicine, such as warfarin, that thinned their blood. This meant staff did not have the details to notice if something was wrong. We found people's care plans continued to lack the details to demonstrate care was being planned with them and reflected their personal choice on how they wanted their care delivered. There was an "About me" document on people's files but where this was filled in it was not used to inform people's care plans or inform how their care should be delivered.

One member of staff who delivered care told us, "Sometimes when identifying something like someone might have a urine infection I would tell the nurses and document. It's not always acted on." We saw in a person's records on the 3 April 2016 that a urine infection was suspected but that a member of staff had been unable to take a sample or check the urine. This was not mentioned again in any part of the records so it was not possible to see this need had been met. We spoke with the manager who advised they had not known about this concern and would follow up why this was not passed on in handover.

The same person had a health condition requiring specific staff practice and skill. Concerns were also raised by staff in the daily records on the 23 March 2016 that the area of need was becoming infected. The next entry about this in the daily records was on the 29 March which raised the same issue. The GP was then contacted on the 30 March 2016. The issue was not raised in the same notes again until the 7 April 2016 when the nurse specialist gave specific advice to staff which was also written in the staff diary. It stated the specialist nurse would then review at one week. There was then no further information written in the records until the 16 April 2016 to say the staff were reviewing the area of concern on the person. We raised this with the manager who agreed to follow the issue up to ensure the person's needs were being met.

Another person's records contained errors. For example, it was recorded they had been admitted on either

the 25 January or 2 February 2016. One section of their full care plan was completed on the 2 March 2016. This was entitled "Nutrition". No full care plan had been completed on other needs. This meant staff did not have the full information available to them to meet this person's needs. The nutrition care plan also stated the person had weighed 72.5kg on the 25 January 2016 but weighed 41.0 kg by the 5 March 2016. The manager advised this was more likely a recording error and they thought the person's initial weight should have read 42.5kg. They stated they were aiming to refer the person to a dietician "as they had lost weight" but there was no record indicating why and whether their weight had been taken again to measure this. We were told this would have been added to the MUST record on the computer which was not held with their other records. We discussed with the manager this person's records and how new, existing and agency staff, which the service are currently using at night, would have difficulty following this person's care records. This could then lead to inappropriate or incomplete care being given.

One person's "All about me" stated they should be having pressure stockings used to prevent their legs from swelling. The same form for another person, stated the person was being given a strip wash, "but I'm sure it would be nice for [them] to have a bath or shower". There was no information in their records that either of these comments had been actioned and built into their care. We spoke with the manager about this form, which we saw last time had not been reviewed, and were told they were completed by family since the last inspection. They would seek to ensure these were reviewed when care plans were being rewritten.

Not keeping accurate, complete and contemporaneous records of people's care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff who delivered care told us they knew they could access people's care records which were stored in the nurse's station however no staff were reading the care plans. They told us they were too busy and had no time set aside for them to achieve this. They relied on feedback during shift handovers. The same staff stated they were not involved in the development of the new care plans, which meant they were unable to contribute people's changed condition to the care plan process.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection on the 9 and 11 December 2015 we found the service was not meeting its full requirements to demonstrate they were well-led. We found the provider did not have adequate systems in place to ensure the quality of the service. There was no system in place to ensure the correct number of staff were on duty to meet people's needs safely. Audits were not used to analyse and address practice.

Down House is run by Mayhaven Healthcare Limited. This is this company's only service however, the directors also run three residential services for older people in the Plymouth area. There was a nominated individual (NI) in place who is a person appointed by the provider to be responsible for supervising the management of the service. The NI was one of the directors and was available throughout the inspection to answer questions at the provider level. The service was managed by the provider, an administrator and a manager. The registered manager had left in August 2015. The provider advised they planned for the current manager to seek registration with us.

At this inspection we found there was a lack of quality monitoring of the service as systems and processes were not always in place to ensure good governance.

Some audits had been introduced however, there was a lack of action associated with these audits. For example, the call bell response times were being monitored each month. However, there was no analysis of the information or record of any action taken as a result. For example, for the period of 1 March-31 March 2016 the response to call bells of each room had been collated. However, on one day the average call bell response for one room showed the call bells were answered in 9.31 minutes for the morning shift, 10.27 minutes for the afternoon and 3.51 minutes in the evening. Another room showed an average of 27.01 minutes in the morning, 4.19 minutes in the afternoon and 2.00 minutes in the evening. Both people in these rooms had identified needs which placed them at higher risk of for example, falls. No analysis accompanied these figures or questioned why some people's call bells were not being responded to in a timely manner. On the last inspection we had identified call bell times were not being reviewed against staffing and people's needs. We found no difference on this inspection.

At the last inspection we found a medicines audit had been introduced, but had not identified concerns found on the inspection. Also, since the last inspection the community pharmacist and the NHS clinical commissioning groups care home lead pharmacist had both visited the home to discuss service improvement. Because of these visits, on the 7 March 2016 staff had audited medicines. Although some of the issues identified had improved, such as recording of allergy status on MAR charts, other areas had not improved. For example, the MAR chart audit identified that there were gaps in recording and noted an action to remind staff to sign MAR charts. On this inspection we saw there were still gaps on MAR charts. The manager advised they would remind staff of the importance of both completing and alerting if gaps were seen.

Information about people's accidents and falls continued to not be used to identify themes, to help keep the person safe, and prevent it from happening again.

Staffing remained an area which people, staff and relatives commented on. The manager was responsible for devising staff rotas but told us staffing still did not reflect people's dependency or the results of any audit, such as falls or call bell response time. This meant staffing levels were not reviewed at times of high need to check enough staff were employed. Staff told us staffing levels had improved since the last inspection, but that gaps due to regular staff sickness were not always covered. The manager stated they tried to fill shifts but this was not always possible due to existing and agency staff not being available.

None of the people or relatives we spoke with were aware of any processes where they could comment about the service. For example, residents' meetings, questionnaires and speaking to the manager and provider.

Not having adequate systems in place to ensure the quality and the safe running of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person commented, "I always give the staff my own opinion of what is going on in the home." A relative said, "If there was anything medically wrong with my relative I would go to the Matron, otherwise I get things sorted out myself".

Staff told us they felt the culture at Down House was gradually changing. They told us they felt more valued and there was a stronger team spirit with the nurses now "working on the floor" and helping staff with caring duties if they were shorthanded or very busy. However, all staff commented that communication about developments in the service were inconsistent. For example, the results of the last inspection had not been formally addressed with all staff. Staff commented they wanted to have this discussed openly when they could say where they could help put things right. We received a mixed response about whether staff felt the provider and manager were approachable or would treat their information with confidence in line with the whistleblowing policy.

All the staff raised concerns that the rota was not ready to be given to them despite starting in three days' time. Staff told us they felt this was part of why they were feeling negative about the service and led to their taking time off as they had not had time to organise their work and personal commitments.

Comments from staff included, "We feel we are doing a fantastic job. Staff are struggling and working as well and hard as we can; there is a lack of positive feedback", "I do feel [the service] is improving", "[Those in charge] can be hands-off, so we get no leadership", "It's a better place to work than before; I feel much happier about coming into work" and, "I feel important as a member of staff; if I had an issue I would go to the senior carer, [manager] or [provider] as all are approachable".

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	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 11(1)(2)(3) The registered person was not acting in accordance with the MCA 2005 for people who were unable to consent because they lacked mental capacity to make particular decisions for themselves.

The enforcement action we took:

The Commission requested the provider submit written responses to tell us how they were meeting the requirement of the regulations. We carried out a further inspection on the 17 and 19 October 2016. The report from this inspection will be available in due course

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12(1) and (2)(a)(b)(g) The registered person had not assessed risks to ensure the health and safety of people; was not doing all that was reasonably possible to mitigate risks or ensuring the premises were safe and ensure the proper and safe administration of medicines.

The enforcement action we took:

The Commission requested the provider submit written responses to tell us how they were meeting the requirement of the regulations. We carried out a further inspection on the 17 and 19 October 2016. The report from this inspection will be available in due course

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17(1) and (2)(a)(b)(c) Systems and process were not established to

assess, monitor and improve the quality and safety of the service (including the quality of the experience of people receiving the service) and assess, monitor and mitigate the risk to the health, safety and welfare of service users. Records of people's care were not always accurate, complete and contemporaneous.

The enforcement action we took:

The Commission requested the provider submit written responses to tell us how they were meeting the requirement of the regulations. We carried out a further inspection on the 17 and 19 October 2016. The report from this inspection will be available in due course