Hafod Care Organisation Limited

Hafod Nursing Home

Inspection report

9-11 Anchorage Road
Sutton Coldfield
West Midlands
B74 2PR

Tel: 01213545607

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 May 2018 and was unannounced. At the last inspection completed 30 June 2016 we rated the service as good. At this inspection we found the service was no longer good. We found there were breaches of regulation, you can see what action we told the provider to take the end of this report.

Hafod Nursing Home 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.

Hafod Nursing Home accommodates up to 29 people. At the time of the inspection there were 26 people using the service.

The registered manager had recently left their post prior to the inspection. The provider told us a new manager would be registering with us. 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's medicines were not always administered in line with guidance. Risks to people were not clearly understood by staff and guidance was no always followed.

People did not always have their rights protected and the principles of the Mental Capacity Act 2005 were not always followed.

The systems in place to monitor people's care delivery were not consistently effective and we could not be assured the systems were sustainable.

People were not always supported by suitably deployed staff. Staff were sometimes unable to provide dignified care due to being task orientated. Staff training was not up to date and competency was not always checked.

The building was not always designed to meet people's needs; in particular people with dementia. Some decoration, adaptations and furnishings also required updating. Infection control required improvements to ensure furnishings were replaced promptly.

People's care plans were not always up to date and held conflicting information. Care plans did not have much personalised information. People were not always receiving support to be stimulated with activities and to follow their interests.

If people required their health conditions monitoring following guidance being provided, this was not always being done. Records of care delivered were not always completed as required as stated in people's care plans. People were not always receiving consistent care and support.

People had their needs assessed but further improvements were needed to how this informed people's care plans. People were supported by knowledgeable staff, however further improvements were required in supporting people living with dementia. Improvements were needed to the environment to ensure it was suitable for people living with dementia.

People were safeguarded from potential abuse. People were supported in a way that met their wishes and effectively at the end of their life.

People received support from staff that were caring and people were involved in decisions and had their choices respected by staff. People understood how to make a complaint.

Notifications were submitted as required and the provider understood their responsibilities for notifying us of specific incidents which had occurred at the service. We found people, their relatives and staff felt supported by the provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not consistently have their medicine administered as prescribed.

People were not always supported to manage risks to their safety.

People did not consistently receive support from safely deployed staff.

Issues which may lead to the spread of infection were not always managed in a timely manner.

The provider did not have systems in place to learn when things went wrong.

People were safeguarded from potential abuse.

People received support from staff that had been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always protected by staff.

People's needs were assessed and planned for, but improvements were needed to ensure these reflected up to date information.

People were supported by staff that did not always have the knowledge and skills to meet their needs.

The environment was not assessed to see if it met the needs of people living with dementia.

People's nutrition and hydration needs were not always monitored effectively.

People did not always receive support to monitor their health.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by caring staff, however some interactions were rushed and people did not receive caring support.

People's privacy and dignity was not always maintained.

People were involved in making decisions and choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always able to follow their interests or spend time doing activities they enjoyed.

People's preferences were understood by staff however this was not consistently used to develop care plans.

People received a response to their complaints.

People received effective support with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor care delivery were not consistently effective.

People and staff felt supported by the provider.

The manager notified us of incidents.

Hafod Nursing 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 unannounced inspection took place on 14 and 15 May 2018. The inspection team consisted of two inspectors, a specialist registered nurse advisor to look at nursing practices, 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.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service.

During the inspection, we spoke with four people who used the service and five visitors. We also spoke with the provider, the deputy, the newly appointed clinical lead, one nurse and six staff.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of six people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, staff handover documents, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 30 June 2016 we found the provider was good. At this inspection we found the provider needed to make improvements.

People were not always supported to take their prescribed medicines safely. Some people were prescribed transdermal patch medicines. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. We found there were no patch rotation charts within the Medicine Administration Records (MARS). Patch sites should be rotated to minimise skin irritation in a particular area. Without an application form staff did not know if they were applying the patches to the same area. This meant the person was at risk of having side effects from their medicine as staff did not have the correct guidance to administer this safely. The clinical lead advised the guidance would be implemented and confirmed staff understood how to safely rotate the location of the patch and avoid unwanted side effects.

Risks were assessed, however some plans lacked detail required to ensure staff understood the risks and how to mitigate them. For example, two people were assessed as being at risk of choking and requiring a soft diet. Staff understood what the person should eat but there was no guidance in the plan for staff to explain in detail the food types the person should avoid. Some staff we spoke with were also unaware of why the people concerned had the special dietary requirements. The provider told us people had been seen by a specialist; however there were no records to support this and no guidance for staff to follow. This meant staff may not be aware that other food types posed a choking risk to these people and people were at risk of harm.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples care records were not consistently updated to show they had received support required to minimise risks. One person was being treated for a sore area of skin. The person had a treatment plan in place from a specialist nurse which required staff to reposition the person every two hours. Records were not always completed to show staff had followed the treatment plan. This meant the provider could not be assured the staff had given the care needed. We spoke to the provider about this and they told us they would make the paperwork clearer. Following the inspection the provider was able to send us evidence from the health care professional involved with the person's care that the person had received the treatment and their pressure areas were improving. This demonstrates improvements were needed to ensure records of peoples support were maintained.

People and their relatives had mixed views about whether there were enough staff. One person said, "If I need anything I just ask one of the staff and they always come straight away and when I am in my room I have a buzzer which is answered quickly. The staff do their best but there could always be more of them. I suppose they can be a bit short staffed at times but it certainly doesn't affect my care". A visitor told us, "They do respond to people but it can be dependent on the time of day. During busy times there can be a bit

of a wait". Another visitor told us that whilst staff were there to offer support they did not make time to sit and talk to people. Staff told us there were times during the day when there were not sufficient staff and people sometimes had to wait for short periods to have their needs met. We saw there were times during the day when people would have benefited from having more staff. For example, one person was observed throwing their drinks on to the floor on two occasions through the inspection. Staff were not available to people in the lounge and therefore could not monitor if the person was drinking. This meant staff could not be sure the person had taken the given fluids. We spoke to staff about this and they said they were aware the person did this so they offered fluids more frequently. In another example, we found people had to wait to have support with their meal. One person waited 15 minutes to have help with their lunch. This meant the person was given food which was cold. We spoke to the provider about this and they told us there had been some issues with staff skill mix and deployment on the day of the inspection. They had taken action to prevent staff from changing their on-duty rotas to ensure the right set of skills were available at each shift, and this may have impacted on what we saw during the inspection. They told us they did review staffing levels and had a disaster management plan for more staff if required. We will check the effectiveness of this at our next inspection. This meant there were improvements needed to how staff were deployed.

Medicines were stored safely. We found medicines were stored in lockable facilities, refrigeration was available and temperatures were checked. MAR charts were completed by staff administering medicines and there was guidance to inform staff when people should have medicine which had been prescribed on an 'as required' basis. Where people needed to have their medicines in food or drink there was guidance on how to do this safely. However, we found one medicine was being used for three people. There was no guidance with the medicine to show how it should be given to individuals and this was stored on the work surface in a kitchen area, not in a locked cabinet. We spoke to staff about this and they told us the medicine was in use for three people. This medicine should be allocated on an individual basis and have individual prescriber instructions. We spoke to the nurse and provider about this and they explained the medicine was delivered in bulk and was prescribed for all three people. They told us they would ensure individual medicines would be used going forward with clear prescribing instructions. We found medicines rounds were completed in a without interruption and staff explained to people what their medicines were for and sought consent.

We found improvements were needed to how the risk of infection was minimised. People were sleeping on mattresses that had been identified during an audit by the provider as needing replacement. At the time of the inspection these had not yet been replaced, the provider has since notified us all mattresses have been replaced. We found there was domestic support in place however there were no cleaning schedule to ensure the home was clean and free from infection. The clinical lead said these were being developed and they were identifying a lead nurse for infection control. We saw slings were in use with manual handing equipment that were stained and we observed staff using the same sling for two different people. We found staff were using communal slings, which were not stored and used for one person, this meant there was a risk of cross contamination. The provider told us people should have their own labelled sling; however this had not been implemented by the provider. However, we did see staff using protective gloves and aprons when supporting people and they understood procedures to reduce the risk of infection. This meant there were improvements needed to minimise the risk of infection.

The provider was not always acting on information to make improvements to the service. For example, they had identified the issues with mattresses requiring replacement but action had not been taken to replace the mattresses. However, falls were monitored and action was taken to prevent future occurrences and keep people safe and the provider had made changes to staff rota systems to ensure the correct skill mix of staff were in place.

People told us they felt safe using the service. One person said, "I have no worries here at all, and I have my own room. I do feel safe living here". A visitor told us, "I do feel my relative is safe here. They seem much more settled than they used to be before they came here". Staff were able to describe the signs of potential abuse and tell us what action they would take if they believed someone was experiencing abuse. We saw staff had received training in how to safeguard people from abuse. We found where incidents had been reported and these had been investigated and reported to the local safeguarding authority. This meant people were safeguarded from potential abuse.

People received support from safely recruited staff. We saw the provider ensured checks had been carried out before new staff started work, which included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the service was effective. At this inspection we found the service was not always effective and improvements were needed.

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 and visitors told us staff asked for their consent prior to giving care and support. One visitor said, "People are treated with respect and they ask for their consent". Staff were able to describe how they sought consent from people, however they lacked understanding of how decisions would be made in people's best interests if they were unable to consent. We saw staff had to support people that were unable to consent to their care, and we found that although this was done with understanding and patience, staff had no knowledge of any discussions about decisions being made in people's best interests. We checked to see if people had their capacity assessed and found this was not decision specific and, these had not always led to documented decisions being taken in the people's best interests. We also found there were some people who appeared to lack capacity and no assessment had been done. This meant there was a risk that people's rights were not being protected.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found applications had been made to the local authority where people had been deprived of their liberty. There were no approved DoLS in place at the time of the inspection. However, we found people had not always had a capacity assessment prior to the application being made. Staff were unaware of which people had a DoLS application and what this meant for their care. We found the information about DoLS was stored on a computer and there was no reference to the restrictions or how to minimise these in peoples care plans. This meant the principles of the MCA were not followed and people were at risk of having their liberty restricted.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their needs assessed and care plans were in place to meet their needs. People and relatives told us they were involved in the assessments and care plans. One visitor told us, "Every step of the way our views have been sought and [person's name] care discussed with us". Some staff told us they were not familiar with the assessments and care plans as they had little time to review them. We found care plans sometimes had conflicting and out of date information in them. This meant it was not always clear from the documents what people's needs were. However, staff could describe the care they gave to keep people safe, but this was not consistent. Care plans needed to be updated and staff needed time to become

familiar with people's assessed needs. The provider told us there had been a recent audit of care plans and they were putting in place a plan to review and update the plans. We will check this has been completed at our next inspection.

Staff had not consistently received training or had their competency checked. We found staff were not able to describe the principles of the Mental Capacity Act (MCA) and were unaware what a Deprivation of Liberty Safeguard (DoLS) was or if anyone was subject to restrictions. We observed some people were living with dementia. Plans were in place to meet people's needs, however staff were unfamiliar with the plans and sometimes lacked knowledge to offer effective support to these people. This showed staff training required updating. The clinical lead told us they had identified gaps in staff knowledge and work was underway to address this. They told us staff were going to have a personal development plan, training would be provided and then competency would be assessed, we will check this at our next inspection.

People and their relatives told us they had a good choice of meals and plenty to drink. One person told us, "The food here is lovely". One visitor told us, the food is more than adequate here and [person's name] was an avid cook and loves their food. They talk about their meals with enthusiasm when we visit so it must be good". We found people's preferences for meals were identified in their assessments and staff understood these. People had their needs assessed and where they were at risk plans were put in place. For example, one person was at risk of malnutrition, staff could describe the actions they took to prevent this and we confirmed this was documented in the person's care plan. We found staff ensured people's food and fluid intake was monitored when required, however there were some occasions when entries had been missed. However, we were able to confirm from other records what people had received. This meant improvements were needed to how people's monitoring information was recorded. The provider told us they were going to consolidate monitoring records to ensure all information was captured in one place. We will check this at our next inspection.

People did not always receive consistent care. One relative told us, "There have been a lot of changes [to staff] lately". We saw handover meetings were held at the start of a shift, and staff were given a record of these meetings. However some of the information on the sheet was out of date and key information was not included. For example, one person required regular repositioning and was being cared for in bed, this was not included in the handover information for staff. Staff told us they felt there was not a clear routine and this meant they were rushed and could not give people time. We found health advice was sought for people and this was included in people's plans, but staff were not consistently following the advice. For example, advice from a dietician had been sought about food intake, plans were in place and whilst staff could describe these to us, the person's daily records were not consistently completed. This meant we could not be assured the advice had been consistently followed. The provider told us they were making changes which would include checks on daily records to ensure people's care was documented. We will check to see how well this has worked at the next inspection.

People and visitors told us support was available to help with people's health needs; however this professional advice was not always followed by staff. One visitor said, "[Person's name] had an off day yesterday and the staff couldn't have done more. They checked [person's name] out thoroughly, undertook some tests and let me know. They are good with things like hospital appointments, and calling in the GP or anyone else that they may need". We found people had received support from specialists and other health professionals. Staff could describe how they sought support from the nurse and how other professionals would be called to come in if needed. We saw records which showed people were supported to access health professionals. However, where people had specific conditions which required monitoring this was not always done in line with best practice. For example, one person was living with diabetes; they needed regular daily checks on their blood sugars. The blood tests should have been completed before the person

had their breakfast to get an accurate reading. We found on a number of occasions this was done after food, which meant the reading may not be accurate. This meant they were not always being supported effectively to monitor their health condition, which could put them at risk of experiencing symptoms and becoming unwell. We spoke to the nurse about this and they said it was sometimes done after food due to time restrictions; however they said they would look at alternatives to ensure the tests were done consistently. This meant improvements were needed to how people's health needs were monitored.

People and their visitors told us they were happy with the environment. One visitor told us, "The decor of a home is irrelevant, it needs to feel like home and this does". The homes decoration required updating; the paint was chipped and looked tired. The provider told us there were plans in place to make some changes and we saw some decorating had begun on day two of our inspection. However we found items of furniture which were in people's bedrooms and in a poor state of repair. We spoke to the provider about this and they told us they would make arrangements for a repair or replacement. We saw some outside doors which could be accessed by people that had steps to get outside; the provider told us they would look at ensuring people could not access the doors where there was no ramp in place.
Some people at the service were living with dementia. We found the environment had not been assessed to meet these people's needs. Signage was not in place for key areas such as toilets. We found there were clocks which had the wrong time and boards which showed the wrong date. This meant it would be difficult for people to orientate time and place. The clinical lead told us they planned to carry out some work to consider best practice guidance in relation to adapting the environment further to meet people's needs. We will look for improvements at our next inspection.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found the service was good. At this inspection we found improvements were needed.

People and their relatives told us they felt people were treated with dignity and respect. A visitor told us, "[Person's name] is treated with respect by staff and their privacy and dignity is considered". We found most staff observed people's privacy and treated people with respect in their interactions, giving explanations. People were observed being spoken to respectfully and with consideration. For example, one staff member was observed supporting a person to their bedroom to assist them with readjusting their dentures. However, this was not consistent; we saw one person have an apron put on at lunch time, staff did not ask or engage with the person or explain what they were doing and why. We also observed two people were being supported by one member of staff to eat their meal at lunch time. This meant the staff member could not easily engage in conversation and make the experience pleasurable for people. We also saw one staff member apply treatment to a person in the lounge area. The person had their clothing lifted up to receive this and no privacy screen was used. The person was not offered the opportunity to go to a private area. This meant people's privacy and dignity were not consistently considered and protected.

People and their relatives told us they felt the staff were kind and caring. One person told us, "I like living here. They are all golden to me every one of them. I like all the staff". Another person told us, "The staff are very friendly and kind to us all. They are all lovely and are good with everyone". One relative said, "The staff are very caring. They are always smiling which really does make a difference. They address my relative by name and always show kindness". Whilst another relative told us, "The staff are all extremely nice and approachable too. I haven't seen them make the time to sit and talk to my relative though." Staff told us they had got to know people; however they told us sometimes they did not feel there was time to talk to them outside of when giving support. Our observations of interactions between people and staff confirmed this. We saw some kind, considerate and compassionate interactions with staff and people. For example, the way staff supported people that were anxious, gently using conversation to distract them which resulted in people calming down. However, we also saw people were, on occasion, not responded to in a caring way. For example, we saw staff walk away from one person when they had not finished speaking, and on another occasion a person tried to speak to a staff member and was not responded to as the staff member was busy trying to do tasks. This meant whilst interactions were mostly positive, staff sometimes became task orientated as they were busy.

People and relatives had mixed views about the level of involvement they had with care plans. One person said, "I can't remember ever discussing my care plan". A visitor told us, "The care plan was reviewed with us last year". Another visitor told us about how they were involved in discussing their relatives care and some changes they had been involved in with the provider to develop a new bedroom area for their relative. People had their communication needs assessed, staff described people's needs and how they were met and we confirmed this was in people's care plans. People and relatives told us people could make choices. One person told us they loved their independence and were able to make choices. They said they chose to spend most days outside and staff supported them with this, staff confirmed the person was very

independent and we saw the person spent most of their time in the garden and their care plan reflected this as a preference. A visitor told us, "They respect [person's name] choices and they can get up and go to bed when they wish". This demonstrated people were supported to live independently and make choices for themselves.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found the service was responsive. At this inspection we found improvements were needed.

People and their relatives told us staff understood what was important to them, offered a personalised service and understood their needs and preferences. One person said, "They know my preferences and how I like my tea". A visitor told us, "Every step of the way our views have been sought and [Person's name] care has been discussed with us". Assessments included consideration of people's diverse needs such as religious beliefs and sexual orientation. We found people's life history was included in the assessment; however this had not consistently been recorded and was not used to inform peoples care plans. Staff could describe the care people required but were not always clear about what was included in care plans. We found some plans had been reviewed but people and relatives were not consistently involved in these reviews. However, one visitor did tell us about how responsive the service had been in supporting their relative to pursue their interests. We spoke to the provider about this and they told us care plans were in the process of being reviewed and this would consider peoples personal histories to inform care plans. We will check this at our next inspection.

People and their relatives told us opportunities for people to be engaged and stimulated were limited. One person told us, "No, I have never been asked to take part in activities or what I like. Some of the men potter about in the garden which is lovely for them". Another person told us, "I love nature. I come into the garden and watch the birds. I love animals. I would love a rabbit to look after but I haven't asked them if I can have one". A relative told us, "[Person's name] seems unstimulated. They used to be in another lounge where was more going on but the staff have moved them to the little lounge now. I have never known them play any music and I do think that would be an improvement for the residents. People respond to music don't they? They do sometimes have parties though". Another visitor told us, "I think that they know they need to develop things on the activity front. [Person's name] loves music but there is nowhere for them to go and listen to this comfortably". Staff told us there was not always time to engage people in activities, often they were short staffed and could not engage people in activity. We observed people on the day of the inspection sitting looking around with no stimulation, we saw staff tried to engage people in some activities on the day of the inspection, however these were not tailored to the person and often people were unaware of what they were expected to do. We did see one person was engaged in activities which were of personal interest to them; they spoke about the support they had to engage from staff. We spoke to the provider about this and they told us they planned to introduce individual activity plans for people and the staff would be receiving some training around activities. We will check to see if improvements have been made at our next inspection.

People and their relative's complaints were investigated and responded to. One visitor told us, "I am fully aware of the complaints procedure and feel I could approach staff with any concerns." Another visitor told us, "I did raise an issue once and it has been dealt with". We saw complaints were investigated and responded to and the provider told us they used complaints to learn and make changes to the service. This demonstrated people and their relatives understood how to complain and felt their complaints were

responded to.

People had their wishes assessed for care at the end of their life. We found plans were in place which identified where people preferred to receive treatment, consideration for assessment of pain, their personal care needs and their religious needs were considered. Although nobody was currently receiving end of life care, staff described how people with end of life care needs would be supported. This meant people would be supported to have a comfortable and pain free death.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections we found the provider did not have systems in place to monitor the effectiveness of the service and drive improvements. At this inspection we found the provider had not made the required improvements.

The provider's system for assessing staffing levels and deployment was not effective. The provider told us staffing levels were based on people's needs and staff were deployed by seniors on the shift. We observed times when there were insufficient staff and they were not always deployed to areas where people may need support. We found there were times during the day when people had to wait for their care, staff often did not have time to spend with people and they were task focussed. Staff were rushed which meant sometimes the interactions with people were not caring and staff were unable to provide dignified care.

Systems for ensuring medicines were stored, administered and recorded accurately were not always effective. Medicines were not applied in line with manufacturer's guidance. We found the provider's systems for monitoring medicine administration had not identified concerns.

The system in place to ensure people's risks were assessed and guidance for minimising the risk was not always effective. We found risk assessments were not always followed to ensure people were safe, guidance for staff was sometimes unclear and staff did not always understand people's risks. This meant people were sometimes left at risk of harm.

We found audits were not always effective in driving improvement. An audit had identified in March 2018 that mattresses required replacement; action had not been taken at the time of the inspection to replace all of the mattresses. Cleaning schedules were not always effective in ensuring equipment in use was clean and cross infection was avoided. We found hoists and slings were stained and were not used by individuals. Audits on the building were carried out to identify improvements and repairs required however they had not driven improvement to the building and furnishings. This demonstrates systems were not effective in monitoring the quality of the building, equipment and cleanliness.

We found people had not always had a MCA assessment when it was suspected they lacked capacity to make decisions. There were no records which showed how staff made decisions on people's behalf. Where people were having restrictions a DoLs application had been completed; however we could not see how this was used in people's care plans, nor were staff clear on how to support people using the least restrictive option. The systems in place to check the quality of the service people received had not identified these concerns. This demonstrates the quality checks were not effective.

We found people's care plans had conflicting information in them and were not consistently reviewed; this meant people not receive the care they needed. This was mitigated by staff understanding people's needs. However the systems to monitor the effectiveness and accuracy of care plans had not always identified these concerns. We found where people required monitoring in relation to their health conditions, this was not always adequately recorded by staff. Action had not been taken to improve monitoring records. This

demonstrates the systems in place to identify and address these concerns were not effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

People and their relatives told us they felt they could approach the management team and would be listened to. Most were unable to recall any formal meetings or surveys to consider feedback. One visitor told us, "I have not been to any meetings or received a survey but I am fully aware of the complaints procedure and feel I could approach staff with any concerns". Another told us, "I made suggestions for things to try with [person's name] which they have done so they did listen". However, another visitor commented, "I don't know of any meetings or surveys and we haven't discussed the care plan. Should we have?" Staff confirmed they felt listened to by the management team and said they were able to raise any concerns or make suggestions. This showed overall the management team was responsive to people, relatives and staff.

The provider had systems in place to analyse accidents and incidents to help identify changes that could be made to reduce incidents. We found this was effective in ensuring learning from accidents was put in place to help prevent them from reoccurring.

The provider had submitted notifications to CQC in an appropriate and timely manner in line with the law. Services that provide health and social care to people are required to tell us about important events that happen in the service, we use this information to monitor the service and make sure the service is keeping people safe.

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 The principles of the MCA were not being followed. MCA assessments were not always completed to assess people's capacity. DoLS care plans were not in place and best interest decisions were not always recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always administered in line with guidance. Risk assessments were not always understood by staff and followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems were not always effective in identifying concerns and driving timely improvements.