Thurlestone Court Limited

Willow House

Inspection report

Hillside
South Brent
TQ10 9AY
Tel: 0136473267
Website: willow@seamoorcare.co.uk

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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?	
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3, 4 and 5 March 2015. Breaches of legal requirements were found in relation to regulations 9, 13, 23, 20 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations 9, 12, 18, 17 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to people not receiving person centred care, people not receiving safe care and treatment, staff not being appropriately supervised and appraised, people's records were not always being kept securely or located promptly and staff not always being trained in using suitable equipment.

After the comprehensive inspection, we asked the provider to write to us to say what they would do to meet legal requirements in relation to the breaches. The provider did not write to us but did take some steps to respond to the breaches.

After that inspection we received concerns relating to people's care needs not being met, people's safety with regard to bed rails and sensor mats, staff behaviours which did not show respect for people, people not always receiving their medicines as prescribed by their doctor, and people not drinking enough to maintain good health.

Summary of findings

As a result we undertook this focused inspection to look into the concerns raised and to check the providers had taken sufficient action to meet their legal requirements. The report covers our findings in relation to those topics and those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willow House on our website at www.cqc.org.uk

Willow House is a care home which provides accommodation and personal care for up to 30 older people. Some of which may have care needs related to their dementia. People who live at the home receive nursing care through the local community health teams. The home had not had a registered manager in post for six months but a manager had been appointed and was in the process of applying to be registered. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 26 November 2015 and was unannounced. At the time of our inspection there were 28 people using the service. People had a range of needs, with some people being independent and others requiring more support with their mobility and care needs. A significant amount of people who lived in the home were living with dementia.

During this inspection we found action had not been taken by the provider to meet all their legal requirements. Some legal requirements breached at our previous inspection in March 2015 had been met but some had not. We also found new breaches of regulation and areas that required improvement.

People who lived at the home were not always safe. Sufficient action had not been taken to ensure legal requirements were met in relation to the management of medicines. We found inaccurate recording meant effective medicines audits could not be completed by staff. It was therefore not possible for staff to ensure people had received their medicines as prescribed by their doctor.

People were at risk of dehydration and sufficient steps had not been taken to prevent or rectify this. For example, one person had very low fluid intake and on two occasions only drank 250mls in a day. This person had not been referred to their doctor in relation to this low fluid intake and accurate records of their intake were not always kept. This meant staff were not able to accurately assess the person's fluid intake or know how best to respond to it.

Risks to people had not always been identified and responded to. For example, one person had lost 19kg in one month and 2.5kg the following month. This person had not been referred to a doctor or a nutritionist. Their care plan and risk assessments had not been updated to reflect the weight loss or to direct staff on how to respond to it. Records of this person's food intake were not regularly kept which meant staff were not able to accurately report on what they were eating and how to encourage them to eat more. The provider did not have a thorough understanding of the Mental Capacity Act 2005 (MCA) which meant they did not always follow the legal requirements with regards to gaining people's consent or follow best interest guidelines. People were having their movements restricted unlawfully. Deprivation of Liberty Safeguards (DoLS) are applications to legally deprive people of their liberty under the MCA. In order to deprive people of their liberties, such as not being able to leave premises unescorted, it is necessary to have the legal authority to do so. The provider had applied for DoLS for every person living in Willow House. This included people who had full mental capacity and for whom the MCA did not apply. The manager told us that should a person who lived in Willow House and who had full mental capacity ask to leave unescorted this would be refused because they were fearful of their safety. It was explained to the manager that this was unlawful and they told us they would acquire further knowledge in this area.

Willow House did not have an environment which was adapted for people with dementia. This environment did not make it easy for people to find their way to their bedrooms or around the home. This did not show understanding for people's diversities and the home's environment did not suit people's needs. The manager had not sought guidance around providing environments that were supportive of people living with dementia and the best practice to follow.

Summary of findings

We have made a recommendation for the provider to research and implement guidance for supporting people with dementia in an enabling environment.

People were not always treated with kindness and respect. During our inspection we observed several negative interactions between staff and people. For example, one person was told to "sit down there and drink your coffee" in a tone that resembled telling off a child. One person said "Sometimes they can be a bit sharp because they're overworked but in general they are very good to me". The manager displayed kindness towards people and was working on ways to make people's care plans reflect their personalities more. The provider had taken steps to ensure the culture at the home improved. There had been discussions with staff about culture during supervisions and staff meetings. There had also been a ban on staff taking cigarette breaks together. Further training had been sought in relation to culture and each member of staff had been provided with a staff handbook which highlighted culture.

At our previous inspection in March 2015 we found the provider was breaching their legal requirements in relation to unsafe techniques being used to move people. At this inspection we found appropriate techniques were being used and the provider had ensured all staff had received retraining in moving people safely.The provider had made changes to their quality assurance systems but these had failed to identify some of the concerns we found during this inspection. The provider had also failed to respond appropriately to some of the concerns and legal requirements identified during our inspection in March 2015. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to people not always being treated with dignity and respect, people not being protected from the unsafe management of medicines, risks to people not always being identified or responded to, legal requirements under the Mental Capacity Act 2005 not always being followed, records not always being accurate or up to date and quality assurance processes failing to effectively mitigate risks to people.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not protected from risks associated with medicines.

Risks to people's health and safety had not always been identified or acted on appropriately.

People were at risk of dehydration.

Action had been taken to improve safety with regards to assisting people to move safely.

Requires improvement

Is the service effective?
The service was not always effective.

The environment had not been adapted for people living with dementia to support their independence.

Staff had not followed the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions.

The manager did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS) and this lead to the possibility of people's movements being restricted unlawfully.

Staff received appropriate supervision and appraisal.

Requires improvement

Is the service caring?
The service was not always caring.

People were sometimes treated in ways that were not respectful but some staff treated people with kindness and respect.

The manager was implementing new documents which focused on people's wellbeing.

Requires improvement

Is the service responsive?

Is the service well-led?
The service was not always well-led.

Records were not accurate and kept up to date.

Requires improvement

Summary of findings

A number of issues requiring improvement had not been identified by the provider's quality assurance process.

Adequate action had not been taken to respond to legal requirements and concerns raised during our inspection in March 2015.

Action had been taken to address the culture issues at the home and steps had been taken to ensure staff understood the home's philosophy of care.

Willow 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 checked whether the provider was 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 focussed inspection of Willow House on 26 November 2015. This inspection was carried out to check that improvements to meet legal requirements identified during our comprehensive inspection on 3, 4 and 5 March 2015 had been made. We inspected the service against four of the five questions we ask services: is the service safe, effective, caring and well led. This is because the service was not meeting some legal requirements.

The inspection was undertaken by one adult social care inspector. During our inspection we spoke with three people who lived in Willow House. We also spoke with the manager of the service, a senior manager and one member of staff. Following the inspection we spoke with one healthcare professional.

We looked in detail at the care provided to five people, including looking at their care files and other records such as policies and audits. We also looked at records we hold about the service such as notifications the provider is required to send us by law.

Requires improvement

Is the service safe?

Our findings

At our previous inspection on 3, 4 and 5 March 2015 we identified a number of breaches in the regulations care homes must adhere to. These referred to people's medicines not always being administered, managed or disposed of safely, and safe techniques not always being used when helping people to move and risks to people's health and safety not being adequately assessed. These breaches placed people at unnecessary risk of harm. At this inspection we found the provider was continuing to breach their legal requirements in relation to the management of medicines and risks to people's health and safety not being adequately assessed. At our previous inspection we also identified concerns relating to people not always drinking enough to maintain good health. At this inspection we identified this as still being a concern. However, we found the provider had made improvements to ensure people were supported to change position safely.

Following our inspection in March 2015 we received concerns relating to people's medicines not being managed properly, people not receiving enough to drink and people being exposed to an unhygienic environment. During our inspection we found the provider had a comprehensive cleaning schedule and the environment was hygienic.

After the inspection in March 2015 the provider put in place some measures to ensure they were no longer breaching their legal requirements in relation to the management of medicines. All staff who administered medicines had undergone retraining provided by a pharmacist. New monthly focused medicine audits were also introduced to check medicines were given as prescribed and administration records had been fully completed. A member of staff told us staff were instructed to stay with people until they had taken their medicines in order to ensure people took their medicines and to avoid incidents of inaccurate recording. The manager told us they now took returned medicines to the pharmacy in order to ensure these were all collected appropriately. They also told us senior staff had all had their competencies checked in relation to the administration of medicines. However at this inspection we found these measures had not been sufficient to ensure people's medicines were managed safely.

For example, one person was prescribed a specific medicine by their doctor to be taken four times a day. In the two days prior to our inspection this person's records had no entries for three of the eight occasions the medicine should have been administered. According to the recorded stock balance the person had not received this medicine on those occasions. A member of staff confirmed this may be the case. The registered manager told us the person may not have had this medicine on those occasions and they would be speaking with the doctor about this following our inspection. When we looked at this person's specific medicine we found half a tablet loose within the box. This half tablet could not be accounted for and had not been administered or disposed of appropriately. Two weeks after our inspection we spoke with this person's GP. They told us they had not been contacted by the home about this person's missed medicines. They told us that missing this medicine on three occasions could have an impact on the person's mobility and could have made them "a bit stiff". Due to our concerns about this person we referred them to the local safeguarding team. Another person had no record of them receiving their medicine on one day the week prior to our inspection. Staff were unable to confirm whether this person had been administered this medicine or not. The recorded quantities of a third person's medicine did not tally with the quantities in stock and the member of staff was unable to explain why this was the case.

Staff had not been consistently recording the amounts of medicines held in stock at the home and the amounts delivered by the pharmacy each month. There were discrepancies in the stocks of medicines recorded and the actual number in stock. It was not possible for staff to carry our accurate audits or ensure people were receiving their medicines as prescribed.

Records relating to topical creams were confusing and this lead to staff not knowing whether people were having the creams applied or not. For example, one person's care plan stated they had been prescribed three separate creams to be applied to different areas of their skin. This person's medicine administration record (MAR) did not show one of these creams and the other two had lines through the boxes where staff would record their signatures after application. A member of staff told us this meant this person was no longer receiving creams. This member of staff told us when people were receiving creams a body map and recording chart were held within their room. This

enabled staff to know where they were applying creams and record these had been given. We looked in the room of this person and did not find a body map or a recording chart. However, we found a number of creams within this person's room which were in use. These creams corresponded to the creams detailed on the person's MAR sheets. The staff member told us that they did not believe this person was receiving these creams because if they were there would be a chart in place. We spoke with the manager who told us this person's creams had been discontinued but staff still applied them when necessary. This meant it was not possible to determine whether this person was receiving creams, how often, or whether these were as prescribed by their doctor. The member of staff told us no other people who lived in the home were prescribed medicinal creams.

There were photographs of all the people who had lived at the home for longer than two weeks prior to our inspection at the front of their MAR sheets. This assisted staff with identifying the person they were administering medicines to.

Concerns had been identified at our inspection in March 2015, and more recently raised with us, in relation to people not drinking enough. During this inspection we found fluid charts did not show people were being supported to have enough to drink. For example, one person's fluid intake was being monitored by way of fluid charts. This person's fluid charts had not always been completed. Where they had been completed these had not been totalled so staff did not know the exact amounts this person had been drinking each day. They were therefore unable to adequately assess the risks to this person. Staff had recorded each time they had offered the person a drink throughout the day and night and had recorded if the person had refused this or had been asleep.

In the two weeks prior to our inspection records showed this person had drunk as little as 250mls on two occasions. The records regularly showed the person drinking below 500mls a day. This person's urine output was also being monitored and recorded. On the days this person had drunk very little staff had recorded the person had not had any output or very little output. The manager told us they reviewed this person's fluid charts and totalled the amounts they had drunk around once a week. They had not reviewed this person's charts for the two weeks prior to our inspection. The amount of time elapsing between reviews of this person's fluid intake placed them at risk of harm. They told us this person did not drink well and staff were encouraging this person to drink more.

Staff told us this person drank out of a beaker and they had tried to introduce them to other cups to see if this would increase their intake. However, this person's care plan did not reflect this. This person had a nutritional care assessment in their care plan which stated they had good fluid intake. Daily records relating to this person also contained information about their fluid intake recorded by staff. On the two days when they had drunk 250mls staff had written "Good food and fluid intake". The manager told us staff reported to them this person was not drinking enough but were not reflecting this in the daily notes. The manager told us they had referred this person to their GP during the week prior to our inspection due to their low intake of fluids and were awaiting their visit. We spoke with the GP two weeks following our inspection and they told us they had not been contacted by anyone at the home about this person's low fluid intake. They had not been made aware this person was having difficulties drinking and had not been asked to check on this. Due to our concerns about this person's fluid intake we referred them to the local safeguarding team.

A second person had been assessed as being at risk of dehydration and their fluid intake was being monitored. Their fluid intake had been recorded but in the eight days prior to our inspection their fluid charts had not been checked, the amounts of fluid they had drunk had not been totalled and their daily requirement was only present on one day. This meant staff were unable to adequately assess whether this person was drinking enough or if they were at potential risk of dehydration.

Risks to people had not always been adequately assessed and appropriate action had not always been taken to respond to people's needs. For example, one person had lost 19kg between August and September 2015 and a further 2.5kg between September and October 2015. . There was no instruction for staff around how to encourage the person to eat and no advice had been sought from healthcare professionals about this weight loss. The manager told us this person had always had a small appetite and staff had been instructed to offer this person a cup of soup should they refuse a meal. Staff had completed a nutritional risk assessment for this person which had

Requires improvement

Is the service safe?

identified the person had gone from low risk of malnutrition to high risk. Following this, however, no changes had been made to the person's care or records. The person had not been placed on more frequent weigh ins and had not been placed on a specific diet or fortifying foods. Records of this person's food intake were not regularly kept which meant staff were not able to accurately report on what they were eating and how to encourage them to eat more.

This person had also suffered two falls at the beginning of November 2015 which has resulted in a cut to their head. This person's falls risk assessment had not been reviewed following these falls and no body map had been created to document the cut to the head. This person had a moving and assisting risk assessment which did not contain information about the person's weight or height and stated their mobility risk was low. This meant staff were unable to determine the risks to this person and were therefore unable to effectively minimise risks to their safety.

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

During our inspection we observed two members of staff supporting a person to move with the use of a hoist and sling. They moved the person from their wheelchair into an armchair in the living room. Staff used the correct techniques and moved this person safely. A senior manager present during the inspection told us staff had all gone through retraining in relation to moving and handling in order to ensure appropriate techniques were used.

People told us they felt safe at the home. People's comments included "I'm very happy here, I've got a call bell if I want any help" and "I feel very safe. I've never had anything nasty here".

Requires improvement

Is the service effective?

Our findings

At our previous inspection in March 2015 we identified a breach in the regulation relating to staff not receiving adequate supervision and appraisal. At this inspection we found improvements had been made.

Following the inspection in March 2015 the provider had implemented a new supervision format. This new format consisted of direct care observation, feedback from the observation and questions for the staff member based on people's care plans. A senior manager told us this format encouraged staff to refer back to people's care plans and provided staff with opportunities to discuss personal development and additional training. Staff confirmed they had had supervisions. One member of staff said "I have had two supervisions but not an appraisal". The manager told us staff received three supervisions in a year followed by an appraisal. None of the staff had reached their appraisal date yet due to the new format having recently been implemented.

At our previous inspection we identified some concerns relating to people's mental capacity assessments not being located by staff during the inspection. We had therefore been unable to ascertain whether these had been completed appropriately. Staff were not able to review these to ensure they reflected people's current abilities to consent to their care. During this inspection we found concerns relating to the principles of the Mental Capacity Act 2005 (the MCA) not always being followed.

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.

The provider had not followed the principles of the MCA for those people who did not have the capacity to make their own decisions. For example, we looked at the records for one person who was living with dementia and may lack capacity in certain areas. There was information in the person's care plan which suggested that best interest decisions needed to be made in relation to certain decisions for this person, however no best interest decisions had been made. Bed rails had been fitted onto this person's bed which restricted their movements. No assessment had been made in relation to this person's capacity to make this decision and no best interest process had been undertaken. We spoke with the manager about this and they confirmed an assessment and a best interest decision should have taken place prior to installing the bed rails.

People were not always supported to make decisions. For example, there was information in one person's care plan which stated they liked being able to make their own decisions. During our inspection we observed one staff member telling this person what to do without asking them for their opinion or giving them options to choose from. We observed another person who was being assisted by staff to move say "I don't want you to" and staff replied "You have to darling". They did not listen to this person, respect their wishes or explain to the person what they were doing and why.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS). The manager had applied for DoLS for every person living in the home. This included people who had full mental capacity and could make decisions for themselves. For example, one person's care plan stated they were able to make simple or complicated decisions but the manager had applied for a deprivation of liberty safeguard authorisation due to their lack of mobility. The manager told us that should a person who had full mental capacity ask to walk out of the home they would stop them from doing so. We explained they had no power to stop people from leaving the premises and the manager stated they would seek further knowledge in the MCA in order to gain a better understanding. The manager had made some appropriate applications where people lacked capacity and were under constant supervision and unable to leave the home unescorted. The majority of the applications had not yet been authorised by the local authority.

Requires improvement

Is the service effective?

The environment was not suitably adapted for people living with dementia. For example, the corridors and furnishings were very bland in colour and there was a highly patterned carpet. This choice of flooring was unhelpful for people with dementia or other health issues that may affect vision or the inner ear as it could increase unsteadiness. This did not show understanding for people's diversities and the home's environment did not suit people's needs. There was some visual signage but this was not bright and did not stand out. People's bedroom doors had pictures of animals on them but the manager told us this did not help people to identify their bedrooms. This made it difficult for people to find their way around and find their bedrooms. We asked one person about their bedroom, they replied "I'm not quite sure where my room is. We're upstairs". This person's bedroom was not upstairs but downstairs. When asked how people with dementia found their way around the home the manager told us people were escorted. The manager told us they had not conducted any research into best practice and how to enhance environments for people living with dementia. A senior manager told us, however, that the provider was looking into ways in which to improve the garden in order to develop a space which enhanced the wellbeing of people with dementia.

We recommend the provider researches and implements guidance for supporting people with dementia in an enabling environment.

Requires improvement

Is the service caring?

Our findings

At our previous inspection in March 2015 we identified concerns in relation to people not always being spoken to with kindness and respect. Since that inspection, we received some concerns relating to people not always being spoken to in a respectful manner. During this inspection we identified people were not spoken to with kindness or respect by some staff.

We spoke with one person who said "It's very good here, they're nice people. They absolutely treat me with respect". However, during our inspection we observed one member of staff speaking to this person in a way that was not respectful or kind. This person had been sitting in the living room but decided to get out of their chair and walk towards the door. As they were doing this a member of staff said "Where are you going? You sit down there and drink your coffee" in a way that resembled telling off a child. The person walked back to their chair and sat down. Once they had sat down the member of staff said "You eat your dinner" in the same tone. This was a very unpleasant interaction which did not display respect or kindness for this person.

We spoke with another person who said "I get on with the staff, sometimes it gets a bit strained" and "Sometimes they can be a bit sharp because they're overworked but in general they are very good to me". We observed one member of staff displaying this 'sharp' attitude during our inspection. Whilst in the living room we observed one person repeatedly asking the staff a question. One member of staff answered the person's question twice and when the person asked the question a third time a second member of staff snapped at them. The member of staff answered the question in a sharp and angry way and the person did not ask again.

We observed one person being assisted by two staff members to move from their wheelchair to an armchair in the living room. During this transfer staff did not explain to the person what they were doing or reassure the person. Staff gave the person orders such as "Put your arm up" and "Move your head up". This was done in an unpleasant fashion which did not show respect for the person being assisted. The person told the staff on several occasions "I don't want to" and "I can't" but staff simply replied "You have to darling".

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some positive interactions between staff and people who lived in Windward House. People seemed very comfortable around the manager and there were some nice exchanges between the manager and people. For example, we saw the manager using terms of endearment towards people and people responded with physical contact and smiles. The manager displayed kindness when speaking with people and gave people physical contact when speaking with them.

The manager was in the process of implementing a new document which would be included in people's care plans. This document was called 'good days and bad days' and gave staff information about who the person was, what was important to them and how best to support them to have a good day. This showed the manager cared about people's daily wellbeing and was implementing ways of improving this.

Is the service responsive?

Our findings

Requires improvement

Is the service well-led?

Our findings

At our previous inspection in March 2015 we identified a breach in the regulation relating to people's records not always containing up to date information and containing conflicting instructions. At this inspection we found sufficient improvements had not been made.

During our previous inspection we identified that action had not always been taken to respond to issues that had been identified. During this inspection we found continuing concerns relating to action not being taken to respond to issues and concerns identified. However, during our previous inspection we also identified concerns relating to staff not being supported to understand the home's philosophy of care. During this inspection we found the provider had taken steps to ensure staff understood the home's philosophy of care.

A senior manager told us care plans were regularly reviewed. Within each person's care plan a document entitled 'my monthly care plan review' stated when a person's care plan had been reviewed and what changes had been made. This record showed people's care plans had been reviewed at least once a month. Where people's needs had changed, however, other documents within their care plan, such as risk assessments, had not been updated to reflect these changes. For example, one person's records showed they had been assessed as being at high risk of falls. Due to this a sensor mat had been placed in their bedroom to alert staff to the person mobilising independently in their bedroom. We found on our inspection, however, that this person no longer had this sensor mat in place. The manager told us this person was no longer at high risk of falls and the mat had therefore been removed. Within the person's care plan we found an incident report from the ambulance service detailing a fall the person had suffered in October 2015. The person's falls risk assessment had not been updated to reflect this fall. This means the documents relating to this person were not up to date or accurate. Staff could not ensure they were providing care which responded to this person's current needs in a safe way. Another person had been unable to mobilise when they moved into the home. With the help of physiotherapists the person was now able to mobilise independently. Within this person's care plan was a personal emergency evacuation plan which stated they were still unable to mobilise. This meant procedures in place to assist this person in an emergency were not accurate and this could pose a risk to this person's safety.

People were not protected from unsafe care because accurate and up-to-date records were not maintained.

Following our previous inspection we asked the provider to send us an action plan detailing how they would ensure they met their legal requirements. We did not receive an action plan from the provider. Following this inspection the provider told us they were unaware they needed to send this plan to us and sent us a document detailing the actions they had taken following the March 2015 inspection. This document included actions taken in relation to the management of medicines, changes to the home's management, changes to do with staff culture relating to group smoking breaks being banned and new quality assurance processes. The provider did not provide us with evidence they had answered concerns raised in the March 2015 inspection with respect to risk assessments not always being completed, people's care needs not always being assessed, people being at risk of dehydration, and issues relating to the Mental Capacity Act 2005 (the MCA). We found these same concerns still present during this inspection. Where issues had been raised to them, the provider had not always taken steps to respond to these and minimise risks to people.

The provider had a quality assurance process in place, which included conducting audits and self-assessments. However, this process was not effective and had failed to identify a number of the concerns we identified at this inspection. For example, the provider had implemented new processes to audit medicines, however we found a number of concerns relating to the administration and disposal of medicines which had not been identified through the audit. Audit systems had been implemented to conduct self-assessments based on the five Care Quality Commission questions (Is the service safe, effective, caring, responsive and well led?). However we found staff were not always caring when assisting people and the environment was not suited to people with dementia.

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

Requires improvement

Is the service well-led?

The provider took steps to respond to concerns relating to staff not being supported to understand the home's culture and the behaviours that were expected of them. The provider had identified that there were concerns relating to the staff culture at the home. They spoke with the staff about professional conduct and approach, they implemented a smoking ban which stopped groups of staff going out together at one time to smoke. They introduced training relating to culture in the care sector and provided each member of staff with a pocket handbook which emphasised culture. The manager had undertaken specific culture training and was sharing their knowledge with staff during supervisions and staff meetings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always being treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not being assessed, care was not being provided in a safe way for people and medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not assess, monitor and mitigate risks or improve the quality of the service provided. Regulation 17 (1)(2)(b)(c).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk and mitigating the risk. 12(2)(a)(b) The registered provider had not protected people from risks associated with the management of medicines. Regulation 12 (2)(g).

The enforcement action we took:
Warning notice