The Fremantle Trust

Lent Rise House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Lent Rise House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Fifty one people were living at the home at the time of our visit.

We previously inspected the service on 13 December 2017 and looked at the 'safe' and 'well-led' domains. This was in response to concerning information about allegations people had sustained avoidable harm, that medicines were not properly managed, that people had experienced abuse or neglect and that there was ineffective management of the service.

At that time we found multiple breaches of the regulations related to medicines practice, safeguarding people from abuse or harm, acting in an open and transparent way (duty of candour), assessing and mitigating risks to people's health and safety, recruitment of staff, providing person-centred care and effective governance of the service.

The overall rating for the service was assessed as 'Inadequate' and the service was placed in 'special measures'. We took urgent enforcement action following our last inspection and required the provider to send us a report each week of the actions they were taking to improve the service. We also imposed conditions on the provider's registration to prevent any admissions to the home.

This inspection took place on 31 January and 01 February 2018. It was an unannounced responsive inspection to follow up on our previous findings. We returned on this occasion to check whether people were safe and that the provider was taking the necessary action to improve the quality of care and reducing the risks to people.

The service did not have a registered manager in post for over a year. 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. At the time of our inspection, a manager was appointed who intended to apply for registration.

The overall rating for the service from this inspection is 'Inadequate' and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

People continued to be placed at risk of harm. We found continued breaches of the regulations. Where improvements had been made, it was too early to see that these were sustained and that regulations were fully met.

The provider was taking action and had put in extra staffing resources to make improvements at the home. However, progress was slow in a number of areas such as updating people's care plans and improving fire safety. Improvements were being made to ensure people were assisted to move safely and had the right equipment in place.

The majority of people we spoke with told us they felt listened to and were involved in their care. They said staff were kind and caring. Their comments included "So far no problems. Staff are very attentive," "They look after me very well," "Very nice, kind, compassionate" and "Very kind, running backwards and forwards, always willing."

People and relatives told us about the impact of staff changes and high use of agency staff. Comments included "Used to be very good, was perfect initially couldn't fault anything. Now staff change so much, new people don't get enough training and don't stay for any length of time." Another person said "There are a new series of staff, lots of younger people, (we) have to tell them what you want." A relative told us "There are many agency staff who don't know the residents. All the experienced staff have been suspended. (This) can be quite challenging to the residents."

Improvements had been made to the storage and recording of people's medicines. However, we found a discrepancy in the disposal records of one controlled medicine which we asked the provider to look into. They did this and attributed the discrepancy to a recording error.

The home had been visited by the environmental health officer since our last inspection. They served hygiene improvement notices in response to their findings. We found the home was making improvements to food hygiene measures and the chef managers were keen to put matters right.

Governance systems and processes were not robust enough to ensure there was a co-ordinated approach to implementing improvements. There were inconsistent checks to ensure staff completed work delegated to them. This meant some actions in the provider's improvement plan were marked as completed when they were still not implemented.

People were placed at risk of harm and inconsistent care by the standard of record-keeping at the home. For example, staff had not followed good practice in the management of injuries and pressure wounds. Other important records such as recruitment files did not contain all required checks.

We found continued breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found a continued breach of the Care Quality Commission (Registration) Regulations 2009.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of being supported by unsuitable workers as the home had not ensured all required recruitment checks were carried out.

People were not adequately protected from the risk of fire.

Improvement had been made to the storage of people's medicines and to recording of when medicines had been administered.

People were not sufficiently protected from the risk of abuse, injury or harm.

Is the service well-led?

Inadequate

The service was not well-led.

The home did not have a registered manager, as required by the conditions of registration.

People's care and treatment was not sufficiently monitored to ensure their needs were met safely and consistently.

Improvements were being made to transparency when things went wrong and to notifying us of these events.

The provider was working with external agencies to improve people's care. However, progress in implementing their action plan was slow and lacked effective co-ordination.

Lent Rise 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 January and 01 February 2018 and was unannounced.

The inspection was carried out by two adult social care inspectors on the first day. They were joined by two medicines inspectors on the second day. An expert by experience was part of the inspection team for both days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not ask the provider to complete a Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted community professionals prior to this visit. This included the environmental health officer and care homes pharmacist from the clinical commissioning group. We were also in regular contact with the local authority safeguarding team for updates about on-going investigations.

We spoke with the home's manager and 20 staff members. This included duty managers, the regional manager, the provider's HR business partner, the chef managers, housekeeping staff, registered nurses and care workers, the clinical lead for the provider, and the director of quality and governance.

We checked some of the required records. These included 13 people's care plans, 14 people's medicines administration records, staff recruitment files including agency staff profiles and records which showed maintenance of the premises. Other documents included records of complaints, staffing rotas, call bell records and training records.

We spoke with nine people who lived at the home and seven relatives.

Some people were unable to tell us about their experiences of living at Lent Rise House because of their dementia. We therefore 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.

Inadequate

Is the service safe?

Our findings

At our last inspection on 13 December 2017, we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had sustained abuse or neglect and appropriate actions were not taken to ensure their safety. We used our urgent enforcement powers to impose conditions on the provider's registration. This included no new admissions or re-admissions to the service, and weekly reports of actions to be submitted to us.

We found that people continued to be at risk of harm. There were multiple reports of injuries, such as unexplained bruising. Staff were more vigilant about reporting injuries but these were not always managed in a consistent way. For example, there were inconsistencies in the use of 'body maps' to show where an injury had occurred and photographs. This meant the service could not be assured that further unexplained harm would not occur to people. We also found the service was unable to provide an accurate figure of how many safeguarding investigations were underway by the local authority, as they had not kept an accurate record of this.

Since our last inspection, the number of staff under investigation with regard to allegations of harm had increased. Investigations had not passed the initial fact-finding stage. For registered nurses, four referrals were made to the Nursing and Midwifery Council (NMC). The provider's staff told us another three referrals were made to the NMC. However, the provider was unable to show us any proof that formal referrals had occurred.

At our last inspection, we found that staff did not attend regular safeguarding training. Only a few staff had completed training since then; five had done an on-line course. The provider told us further training was scheduled. This meant people remained at risk of abuse and neglect because inadequate numbers of staff had refreshed their knowledge and skills in safeguarding.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation.

This was a continued breach of Regulation 13 of the Health and Social Care Act (2008) Regulated Activities 2014.

The local authority and the service had set up 'clinics' for staff and relatives to discuss people's care, concerns and complaints or other issues. We also saw posters throughout the premises regarding reporting abuse or neglect. Various agencies' telephone numbers were listed on the posters. We noted the contact details for the local authority safeguarding team were incorrect.

At our last inspection on 13 December 2017, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people failed to receive safe care and treatment. We used our urgent enforcement powers following the prior inspection, in order to protect people from harm.

We spoke with a visiting social care professional about the care of people. They told us their visit was prompted by an incident of a person being restrained against their will. The person had been resistant to personal care being carried out. Four care staff had then been deployed to ensure the care was completed. The social care professional said the service was asked to complete an urgent Deprivation of Liberty Safeguards authorisation, and forward the referral immediately to the local authority. As the service had not done this, the social care professional was there to ensure the person's welfare.

At our last inspection, we found unacceptable risks related to fire safety at Lent Rise House. On this occasion, we found that equipment related to fire management was suitably checked and fully operational. This included fire extinguishers, emergency lighting and emergency call points. Records indicated these were regularly checked by the provider's maintenance staff and inspected by external contractors.

The home's fire risk assessment had not been kept up to date. We found personal emergency evacuation plans (PEEPs) were not located easily by staff. They had not always been kept under review; some were outdated and others related to people who no longer lived at the home. We noted there had not been any fire training or fire drills for staff since our last inspection. The service held a fire drill in the afternoon of the second day of our inspection. We have passed our intelligence information about fire safety to the local fire inspectorate.

We checked how people who used the service were protected from other risks associated with the premises and grounds. We found that appropriate risk assessments and maintenance were completed in relation to areas such as gas, electrical and water safety.

Staff were not able to readily identify people with the highest risks, when asked. For example, we were initially unable to obtain information about the number of people who had diabetes, received artificial feeding or that had skin integrity issues. Staff were able to find this information by visiting the units and reviewing care records.

We found risk assessments and care plans remained inadequate. We saw the management of people's wounds was not satisfactorily documented by registered nurses. Staff were inconsistent in use of 'body maps' and photographs to show wound healing. Records of wound dressings were also inconsistent.

A focus was being made to ensure people at high risk were assisted to move safely. They were being reassessed and new moving and handling risk assessments were put in place. People were also re-assessed for the type of equipment they needed such as hoists and chairs. Equipment had started to arrive at the home and more was being delivered. Managers had also carried out a night time check of moving and handling and found correct procedures were used.

The number of registered nurses who provided direct nursing care had increased since our last inspection. This was on a temporary basis to ensure better oversight at the home and until vacant posts could be filled. Staff numbers were increased on both day and night shifts. We saw fluctuations in the number of staff who worked on the units. For example, on one day shift of a weekend there were four registered nurses and 16 care workers across the entire service. However, on another day shift on a weekday there were four registered nurses and 23 care workers. There was no consistency to the number of staff rostered or deployed.

We received mixed responses from people about whether they thought there were enough staff to support them. One person told us the home "Used to be very good, was perfect initially couldn't fault anything. Now staff change so much, new people don't get enough training and don't stay for any length of time." Another

person said "There are a new series of staff, lots of younger people, have to tell them what you want." A relative told us "There are many agency staff who don't know the residents. All the experienced staff have been suspended. Can be quite challenging to the residents." Another relative told us "Staffing levels are not good. They have had problems since November. Most of the good staff are gone." Other people's comments included "As far as I can tell there are no problems whatsoever. Not noticed any difference. Staff are all very good here," "There are enough staff for me," "If they get the right staff it's easy. (They) seem consistent. If you want something it's there." A relative said "I think so anyway. They are all lovely here, great."

The majority of people said they did not have any concerns about where they lived and how staff supported them. However, one person told us "Staff only engage if they have to. I am not getting the care I would expect." A relative told us "There are too many agency staff who don't get to know the residents." Another relative said "I come every day. (There are) so many different people. (It) can be confusing for her. They don't all know her needs." A further relative told us "(The) quality of personal care is going down. It has taken them nine months to get her an appropriate chair, it should be here tomorrow. They have agency staff who are not dementia trained."

We observed sufficient staff deployed within the units during both days of our inspection. Call bells were consistently answered by staff within five minutes, according to computer records. This included both day and night shifts. People said call bells were answered within reasonable times when they used them. Comments included "They respond fairly quickly," "(The call bell) is by my bed and I have a pendant in my bag. They are usually quite good" and "Sometimes you have to wait, it depends on who needs them. Not too long."

It was unclear why one person was supposed to receive one to one care. It was mentioned in their care plan but the hours and arrangements were not recorded. When we observed the person they were alone on four occasions with no staff member present. The provider's clinical lead told us they would follow up on the funding arrangements and ensure a formal document was put in place for the additional staffing.

At our last inspection, we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service's recruitment checks were not robust. We again found that the personnel files did not contain the information required. We allowed time for the provider to obtain the necessary documents and information that were not within the personnel files when we examined them. This was not provided and we were told that the necessary checks were not carried out.

Due to the large number of workers from external agencies, we requested to see the profile sheets from the external employers. We examined the profile sheets for nine workers and found these did not contain the required information. In addition, some staff had not completed fire safety training or food hygiene training. This placed people at risk because the provider did not ensure that staff were fit and proper, suitably trained or experienced enough to work with the people who used the service.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation.

This was a continued breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the building was kept clean. Comments included "It's very clean and tidy," "Everything is cleaned very well," "It's always spotless" and "Seems to be kept very clean." The service was clean and odour-free throughout our inspection. Each unit was tidy and we saw housekeeping staff busy throughout

each day. They were knowledge about the national code for cleaning, stored high risk chemicals correctly, and completed accurate, detailed documentation of their work. The home's laundry was in good order and we saw soiled linen and clothing was kept separate from other washing, to prevent the spread of infection.

At our last inspection, the service's Food Standards Agency (FSA) August 2017 rating for food hygiene was one out of five (where zero is the lowest and five is the highest score). We found food hygiene in the units and the main kitchen was inadequate. Following our inspection in December 2017 we reported our findings to the district council environmental health department. This prompted a council environmental health officer (EHO) to visit the service in December 2017 and January 2018. The FSA score was changed from one to zero (the lowest possible score) by the EHO, and three food hygiene improvement notices were served. The service was given a short time scale to make improvements.

We checked the food hygiene as part of our inspection. It was clear the chefs had taken the EHO findings seriously and they wanted to ensure the food hygiene was safe. Based on the EHO's list of failings, one chef manager explained the steps they had taken to remedy the issues. For example, microwaves were removed from kitchenettes (to prevent reheating food) and better monitoring of food temperatures was implemented. The chef managers had ensured that people's food allergies and intolerances were updated, and we saw these were clearly displayed. We were shown equipment that was replaced or updated. We were also shown that the provider's documentation system for food hygiene standards was in place and consistently completed. Some remedial works were still required at the time of our inspection, but the chef managers were able to show us evidence this was organised. The service was awaiting another visit from the council's EHO, where a new food safety score would be awarded.

When we inspected the service in August 2016, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always stored at safe temperatures. We asked the provider to take action to remedy this. They sent us an action plan which told us they had put more satisfactory arrangements in place. However, when we visited on 13 December 2017 we found improvements had not been made. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this occasion we found improvements had been made to storage of people's medicines. Medicines trolleys were stored in an air conditioned room when not in use. The temperature of the room was monitored to make sure medicines were not exposed to temperatures beyond the manufacturers' instructions. Temperature records showed medicines were now being stored within safe temperature ranges.

At our last inspection, we found medicines were not ordered on time or were often out of stock. This lead to people not receiving them and staff sometimes failed to take action to rectify the issues. We also found errors in medicines records and insufficient information where people received their medicines covertly (when the medicine is disguised in food or drink so the person will take it without rejection). There were gaps to medicines administration records and we found staff had followed unsafe practice by handwriting prescribing instructions on the medicines records without a second person to double check or records of phone orders from the GP.

On this occasion we observed staff members giving medicines to people in the morning and in the afternoon. They were caring and encouraged them to take their medicines. After administering, they signed for each medicine on the medicines administration record (MAR).

At our previous inspection we had found missing signatures in MAR charts. During this inspection, we looked

at MAR charts for 14 people and did not find any gaps. Staff had made hand written changes to dosages of some medicines on the printed MAR charts supplied by the pharmacy. However, the changes were not always signed by the staff. This meant it would be difficult to identify who had made the change if there was an error or a query about the change.

The manager had met with the surgery, pharmacists and the safeguarding lead for the clinical commissioning group in January this year. This was to agree ways for routine ordering of medicines and processes for ordering acute prescriptions. It was also to agree a communication process regarding starting, stopping and changing any medicines. The recommendations were to be implemented by Lent Rise House to improve practice.

Some people were prescribed medicines on a when required basis. Guidance for 'when required' medicines was not always available. This meant that staff may not be able to give these medicines consistently and know the signs a person might display if the medicine was needed and they were unable to ask.

We saw evidence that the provider had taken steps to get people's medicines reviewed by their GP. This meant people were being prescribed appropriate medicines for their condition.
The provider informed us that there were no training records available for staff relating to the handling of medicines. This meant staff employed by the service may not be appropriately trained to handle medicines safely.

We asked people if they received the right support to take their medicines. One person told us "I take quite a bit. Only thing is they will bring my pills in about three quarters of an hour after I get into bed. Just get settled and someone comes in with a pill." Other comments included "They bring my medication. I don't know if it is timely," "Medication is given me by staff. No idea what it's for" and "Nurse comes round with medication at around 8.30. I prefer to take my pills around 10.00 so she has to come back." A relative told us it had taken a while for their family member to start on antibiotics when they had an infection. The provider was looking into this.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the treatment rooms. Staff recorded and disposed of unwanted medicines using appropriate waste medicine bins. However, for one person we could not find disposal records of their unused controlled drugs (medicines which are more liable to misuse and therefore need close monitoring). We asked the provider to investigate this as the missing tablets could potentially be misappropriated. The provider sent us information as requested. Their investigation concluded there had been a recording error by the nurses and the person had likely refused the medicine, part of which was prescribed for use 'as required'. They told us they had referred this to the local authority safeguarding team and had also contacted the community pharmacist, who was willing to come and provide training for the nurses.

External pharmacists had recently carried out medicines audits. However, we did not find an action plan derived from these audits. We found the medicine policy in use had a review date of March 2016. As the medicine policy was out of date, guidance followed by staff on how to manage medicines may not be current.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation. However, we could see some progress was being made but it was not sustained.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 13 December 2017, we found a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009. We had concerns that the home had not informed us of incidents they were required to. The manager had started to ensure incidents were reported as they arose and as historical injuries and events came to light. We asked the provider to take action to improve practice. We had been kept informed about important events since the last inspection such as safeguarding concerns and injuries.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation. However, we could see progress was being made but it was not sustained. This was because we had not been told about thefts from the home which had been reported to the police after our last visit in December 2017.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection on 13 December 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not always take mitigating action where audits, monitoring and assessment systems identified risks related to the health, safety and welfare of people who used the service and others. We used our urgent enforcement powers to impose conditions on the provider's registration. This included no new admissions or re-admissions to the service, and weekly reports of actions to be submitted to us.

During our time at the service, we saw numerous senior personnel and staff from the provider's headquarters at the service. This included representatives from human resources, finance and estates departments. Four additional staff were at the home to focus on high risk areas of moving and handling and ensuring people were being supported safely and had the right equipment in place.

The provider had sent us their improvement plan each week, as required by the conditions of registration we imposed at our last inspection. This was an extensive document with actions they had taken and intended to take. Whilst we could see that some improvements were being made, we found there was not a co-ordinated approach to implementing the improvements. For example, we were directed toward individual senior staff for access to certain records and to update us on improvements. One of these areas was accident and incident reporting. We looked at a sample of six accident and incident reports and eleven 'body map' records for one person which had been completed in January 2018. Body maps are used to record marks, injuries or bruises that staff observe on people. In the improvement plan sent to us a few days prior to our inspection, it stated "daily management analysis of all reports being undertaken." There was no evidence of any management sign-off of the accident and incident reports we looked at. No analysis had been made of the body maps to see if there were any trends or to explain how the marks may have occurred. When we raised this with the manager, it was their understanding the senior member of staff should be undertaking the analysis.

The improvement plan included an action to "identify and monitor residents with high risk and complex needs." Examples of this were people who had catheters, people at risk of malnutrition, and skin integrity (checking that skin is whole, undamaged and intact). We found senior staff were unable to identify people with the highest needs when we asked them. Information that there was no one with pressure damage was incorrect. This meant people with high risk conditions were not receiving safe care and treatment because their needs were not being identified and managed appropriately.

Records were not consistently well-maintained at the home. Only one of 13 care plan folders we read had been completely revised. In the other care plans, we could see some sections had been reviewed and kept up to date. For example, risk assessments for moving and handling, use of bed rails and risk of malnutrition. However, in two files care plan sections had not been reviewed from the time they were written in 2015 regarding areas such as diet and nutrition, physical health and mental health and emotional well-being. This placed people at risk of inconsistent care or care that did not meet their current needs. We found insufficient information in some areas such as staff recruitment files.

We found improvement was needed to records associated with medicines practice. Individual protocols were needed to provide guidance on the use of 'as required' medicines to ensure consistency of use amongst staff. Staff had not been provided with any guidance about side-effects or warning signs associated with the use of anticoagulant (blood thinning) medicines. We asked the provider to attend to this latter point as a matter of urgency after the inspection and forward copies to us. This was done.

Records could not be located consistently in all cases and we needed to request several documents following our visit. For example, records of any complaints, agency workers' recruitment profiles and records to show upkeep of the premises.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation.

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

At our last inspection on 13 December 2017, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns that people's care and treatment was not appropriate and did not meet their needs. This was because the service failed to implement advice by external community professionals such as healthcare specialists. We asked the provider to take action to improve practice. On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation.

Staff sometimes did not respond promptly to people's health conditions. We saw documentation for a person with unstable diabetes. A podiatrist had reviewed the person's feet, and left instructions for "daily" dressings, "contact GP" (for antibiotics) and refer to the diabetes specialist service "urgent(ly)." When we asked for evidence these actions were completed by staff, no information was provided. This placed the person at high risk of harm due to their pre-existing condition. We passed this information to the provider's clinical lead to ensure the person's requirements were met.

In another person's file, there was a list of 22 requirements regarding risk assessments and care plans that had been left by a visiting social care professional when they came to the home on 11 January 2018.This included changes to plans for the person's diabetes management, continence, skin care, nutrition, weight and mobility. The social care professional had listed that a referral to a speech and language therapist was

required because of the high risk the person was at with their eating and drinking. This referral was not made prior to the time of our inspection. Out of the entire person's care requirements which required intervention by nursing staff, only two were signed off as completed. It was unclear why the remainder of the items, some classed as a high priority, were not completed. This meant the person's care was not person-centred to ensure their needs were met.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 13 December 2017, we found a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns that the provider was not complying with the duty of candour requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

On this visit we were checking to see if progress was being made against the provider's action plan but at this stage the provider was not compliant with this regulation as changes were not sustained. However, we could see progress was being made. For example, we were shown nine examples on the computer of letters sent to relevant persons after things had gone wrong. We read one of these letters which contained an apology and stated an investigation was being carried out.

This was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had no registered manager for over a year. A condition of the location's registration with us is that a manager must be registered. A home manager was in post during most of 2017 however they left the service. Interim management arrangements were then put in place by the provider. An experienced manager was recruited to work at the service. It was their intention to apply for registration. They were being supported by a peripatetic (roving) manager and other managers and senior staff who worked for the provider. They were familiar with processes and systems within the organisation. Two of these managers were working as 'duty managers' to cover the home seven days a week.

Improvements were made to how staff communicated in the home. A daily meeting was convened at or around 11:00 a.m. with managers and a nurse from each unit in attendance. A check was made to see if there had been any accidents, incidents, sickness, safeguarding concerns or injuries to people. There was a check to see if any appointments or birthdays were due, what activities were taking place and who was the 'resident of the day' on each unit. This person would have their care plan updated and their room deep-cleaned. Any other information was also shared such as training, maintenance issues, any complaints and what was for lunch.

We asked people if they knew how to raise concerns about their care. Comments included "Yes, I would approach staff first and if not happy would take it further," "Would ask to see the boss, I would have no hesitation," "They listen but don't react. I don't know the management" and "Not been asked if I have any concerns." Relatives told us "The office is always too busy" and "I have no real concerns. If there is an issue they will inform me on entry."

Complaints and concerns were recorded on appropriate forms by the management team. We examined the content of a small sample received since our last inspection. We noted brief details were recorded of the complaints or concerns. However, the resolution notes recorded on the forms were not comprehensive and failed to reflect all the steps the service would take, or took, to prevent recurrence of the same matter. In addition, the service had not acted in accordance with the provider's own policy of acknowledging complaints in writing, completing a formal investigation and writing to the complainant with the outcome. This meant the complainant may not have received a satisfactory response to their initial concern and could remain unsure whether the issue was resolved to their satisfaction.

Meetings had been held to provide feedback to staff and relatives about the home. Minutes of these showed people had been made aware of the main areas of concern following our last inspection. The local authority's head of safeguarding had attended the relatives' meeting. These meetings gave people the opportunity to ask questions about what was happening with the home and to hear about improvements that would be made to people's care.

People told us what they liked about the service. Comments included "In general it's nice to be somewhere where there are lots of people. I don't have to think about anything," "We have a laugh and a joke," "We're left on our own, do as we please. There are people around to help when needed" and "I'm being cared for. Some of the staff are lovely." A relative told us "Today everything is fine. They appear to be trying to make a difference. It has taken a while."

Half of the people we spoke with said there was nothing they did not like or they were not happy with. Other people's comments included "I would prefer to know what's going on. Mostly they look after us very well. New ones (staff) are not as nice. Too many agency staff. Some just stand around" and "I don't like it much here. Not much going on. They start something but don't finish." A relative told us "(They) can't find staff. It was so good last year, not so good now."

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of the incidents specified in this Regulation which occurred whilst services were being provided in the carrying on of the regulated activity, or as a consequence of the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate, did not meet their needs and did not reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person failed to satisfactorily assess the risks to the health and safety of service users of receiving care or treatment; do all that was reasonably practicable to mitigate any such risks; ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely; ensure that there were sufficient quantities of medicines to ensure the safety of service users and to meet their needs and ensure the proper and safe management of

medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment in accordance with this regulation. Systems and processes were not operated effectively to prevent abuse of service users. Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established an effective system to ensure compliance with regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not always take mitigating action where audits, monitoring and assessment systems identified risks relating to the health, safety and welfare of service users and others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed meet the conditions in the Regulation. The registered person had failed to ensure that the following information was available in relation to each such person employed: the information specified in Schedule 3, and such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered persons had not acted in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on the regulated activity. As soon as reasonably practicable after becoming aware that notifiable safety incidents had occurred the registered person had not: provided an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knew about the incidents as at the date of the notifications; advised the relevant persons what further enquiries into the incidents the registered person believed was appropriate; include apologies, and be recorded in a written record which is kept securely by the registered person.