Amberbrook Limited

Cherry Garden

Inspection report

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Date of inspection visit:
26 July 2016
28 July 2016
29 July 2016

Date of publication:
05 October 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

Cherry Garden is the only location the provider is currently registered for. The service provides nursing and residential care for up to 36 people. Cherry Garden is situated in the village of Littlewick Green, close to the town of Maidenhead. It is set in beautiful grounds surrounded by countryside. People who use the service live over two floors; the second floor accessed by a passenger lift. There are 28 bedrooms, two lounges which look onto the gardens and a single dining room. The extensive garden has been designed to incorporate a sensory garden and wild life patio.

At the time of the inspection, there was a registered manager. 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.

Since registration under the Health and Social Care Act 2008 on 23 November 2010, Cherry Garden has experienced fluctuating compliance with the required regulations. Prior to this inspection, we had completed five inspections since the registration of the service under the Act. The most recent inspection was a desk-based review in September 2014, following outstanding non-compliance from a prior inspection on 5 June 2014. A desk-based review meant the inspector had assessed it was not necessary to perform a site visit, and instead reviewed documentation and other evidence sent by the provider. A full history of the service's inspections and reports is available on our website. This is the first inspection and rating of the location under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected against abuse and neglect. However, we found people's safety was at risk for other reasons. We found that moving and handling of people was dangerous and exposed them to the risk of an injury. A robust system of recruitment was required to ensure fit and proper staff provided care to people. Staffing deployment was unsatisfactory and we saw that staff were pressured and rushed. This meant people's safe care was placed at risk. Maintenance of the premises was completed but major risks already identified were not acted upon by the provider. Infection prevention and control was below the required standard.

Staff did not receive effective training, support and appraisal. This meant they cared for people without the best knowledge and skills. The service had not complied with the Mental Capacity Act 2005. This was evidenced by a lack of staff understanding of mental capacity, best interest decision making and deprivation of liberty. People were provided with adequate nutrition and hydration. However at times people were placed at risk because the staff did not follow health professionals' advice about how to change fluid consistency for people at risk of choking. We made a recommendation about staff training in malnutrition and thickening fluids. Refurbishment and redecoration of the service was required to make the premises more suitable and pleasant for people to reside in.

People told us staff were caring, although we did not always observe this during the inspection. Some staff

demonstrated genuine kindness and compassion when assisting people. We observed other staff were focused on tasks and did not engage with the person they were caring for. There was a lack of people's and relatives' involvement in care planning and review. People's privacy was protected, but not their dignity. Staff demonstrated inappropriate behaviour throughout the inspection which disrespected people that lived at Cherry Garden.

Risk assessments and care plans were in place for most people's needs. Some risk assessments were missing for particular people and some care plans did not document the care in a personalised way. People did have the ability to voice their concerns and compliments, and were invited to 'residents and relatives' meetings. However, a better complaints system was needed so people could easily understand how to make a complaint if they needed to. We made a recommendation about improving the complaints process awareness of the service.

People and relatives that we spoke with provided positive feedback about the registered manager. Staff felt the workplace culture could improve and that they were not always listened to when they voiced their opinions and ideas. There was a lack of staff engagement, although the registered manager had attempted to improve this. The quality management process was fragmented, although risks and areas for care improvement were identified. The registered manager had commenced an action plan although it was neither comprehensive nor realistically achievable at the time of our inspection. The provider did not act promptly when the service had identified risks and issues which required prompt resolution. The service had not complied with the duty of candour requirements set by the applicable regulation.

We determined there were nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 sufficiently protected against abuse or neglect.

Risks to people were not adequately assessed, mitigated or resolved.

People's care was unsatisfactory due to unsafe staff deployment.

People were at risk because of unsafe medicines storage and management.

People were unsafe due to unsatisfactory prevention and control of infection risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff who cared for people did not receive satisfactory training, supervision and support.

The service did not comply with the requirements of the Mental Capacity Act 2005.

People received suitable food and fluids, but some risks regarding eating and drinking required action by the service.

People had access to appropriate external healthcare support.

The decoration and design of the service was inappropriate and put people at risk.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive kind and compassionate care from staff.

People's dignity was not respected and often ignored.

Is the service responsive?

Requires Improvement

The service was not responsive.

People lacked participation in the care planning and review process.

People had a range of risk assessments and care plans place.

People's personal care needs were not always appropriately documented.

People told us they knew how to make a complaint. However, the service did not promote their complaints process enough.

People had the opportunity to have their say via 'residents' meetings.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People said the registered manager was approachable.

Staff felt a better workplace culture was required.

Care risks were assessed and documented, but not always acted upon.

The provider's increased presence was required to improve the overall quality of the service.

Cherry Garden

Detailed findings

Background to this inspection

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

This inspection took place on 26 July 2016, 28 July 2016 and 29 July 2016 and was unannounced.

The inspection team comprised two adult social care inspectors and one specialist advisor. The specialist advisor was an occupational therapist with expertise in manual handling. An Expert by Experience spoke with people who used the service, relatives and staff. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In planning the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Before the inspection, the provider completed 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. The provider returned this and we took note of the content. We also asked for a list of the service's contacts so we could talk with stakeholders outside the service who had involvement with people who lived there. This was not returned to us by the provider.

In order to gain further information about the service, we spoke with seven people who used the service and three relatives or visitors. We spoke with the provider's registered manager, deputy manager, a support home manager, maintenance person, chef and activities coordinator. We also spoke with 10 other staff who provide care to people. We contacted the local authority, Health and Safety Executive, Healthwatch, the fire authority and clinical commissioning group (CCG) for feedback prior to the inspection.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection. We reviewed 10 people's care records and the care that seven of them received. We looked at people's medicine administration records (MAR) and the medicine room. We reviewed records relating to the running of the service such as staffing information, documents associated with staff training and quality

monitoring audits.

Observations, where they took place, were from general observations. The provider was asked to send information to us after the inspection and we received and reviewed this as part of the evidence we considered.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Cherry Garden. We asked five people who used the service and three relatives their opinion about safety. One person told us, "Yes for what I've seen, I feel safe and I'm happy here". Another person stated, "Yes I feel very safe. There's nurses all around here and there's doctors that come in." Relatives had a different view about safe care compared to people who used the service. One relative said, "I have great concerns about my mother. She can converse with people, but she's left alone on her own." Another relative told us, "I've been trying to get the bedroom changed in case there's a fire and I think the good staff know what they're doing. At the weekends there's always a lot of agency staff in here and they don't know what they're doing and if I didn't come in here I would really worry." The feedback from people and relatives indicated safety at the service was in question prior to our inspection.

Staff feedback about safety was similar to that of relatives. Staff questioned why basic safety concerns were not taken seriously by the management and provider. One staff member told us, "My honest opinion is I feel that the home is falling down around me. I think it's not safe here. I came in three weeks ago and the lift was broken. I felt very sad because it was very hot weather and I felt there wasn't enough staff to keep a check on the residents in their rooms to give drinks to them upstairs." Another staff member explained that through a lack of maintenance work, risks around the premises were mounting and either ignored by the provider or delayed. Another staff member told us that on one day of the inspection, a single staff member was expected to do both the laundry and the cleaning, which resulted in less time spent on either task.

We looked at the prevention of abuse and neglect. The service had a 'safeguarding adults and preventing abuse' policy dated March 2016. Although recently implemented, the policy was not in line with processes required for safeguarding vulnerable adults. The policy cited out-of-date guidance documents and made no reference to the Berkshire area procedures for safeguarding. There were no contact details for local safeguarding stakeholders and no clear instructions for managers or staff to follow in the event of allegations of abuse or neglect. This meant that there was a risk that in the event of a safeguarding matter, current good practice guidelines would not be followed to ensure a person's safety or protection.

We saw the staff training information pertaining to the topic of safeguarding. Out of all of the staff, just two had completed safeguarding training in either 2015 or 2016. The remainder of staff had last completed safeguarding training in 2014 or before. This meant their knowledge of types of abuse, how to report it, and safeguarding process were not up to date. When we asked three staff what safeguarding meant they were unsure and we had to prompt them with the fact it referred to abuse or neglect. All three staff told us they would report this to the registered manager. None of the staff we spoke with were familiar with whistleblowing or how they would do this for the purpose of protecting people at the service. The Provider Information Return (PIR) we requested prior to the inspection provided no information about how people are protected from abuse or neglect by way of safeguarding. The service did not know how to find the Berkshire safeguarding procedures online. These provide a step by step guide for reporting and managing abuse or neglect. This puts people at risk of not being protected correctly.

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

2014.

We looked at people's risk assessments, care plans and reviews to check whether planned care was safe. We also checked the people whose care plans we viewed to determine whether the care they received was in line with the care delivered to them. We found one person had a sacral wound. We saw in the care plan the last dressing change prior to the inspection was documented as 9 July 2016. There was no clear evidence that the wound dressing was changed since then as it was not documented. We also found the wound chart did not give any information about when the dressing needed to be changed. Necessary information related to the stage of the wound or how the wound occurred were not recorded. We saw the person had a position change chart in place and that the person was turned in accordance with the plan. The person was on an air mattress, however we could not see evidence that checks were carried out to ensure correct functioning of the device. Failure to check and document the mattress function regularly meant the person was at risk of further skin damage if the device was not operating correctly.

In another care plan, we saw a person who had a diagnosis of epilepsy. We found there was a form that staff used to record when the person had experienced a seizure. The last entry by staff on the form was dated 13 July 2016. The information documented stated 'generalised fit'. There was no documentation that the person was monitored following the seizure and there was no information of events leading up to the seizure. For example, the person may have had known triggers for their epilepsy and it was unclear whether the service had considered them or determined whether the person had experienced this beforehand. We could not see evidence of any involvement with the person or any family members in relation to the care plan and subsequent reviews. This included referral to the GP or a neurologist. This meant the person was not safe because necessary risks regarding their epilepsy were not reviewed and recorded by the service.

The same person also had a urinary catheter in place. However, the care plan did not have any information how often the catheter was to be changed. We saw the catheter was last replaced in April 2016. The found the person had frequent urine infections and had a fluid balance chart in place to ensure they receive adequate fluids to reduce the risk of further infections. However, the last entry in the notes about this was 25 July 2016. The care plan did not confirm how much fluid the person should have throughout the day. We spoke to the deputy manager about this and they told us the person was independent and consumed adequate fluids without staff having to prompt them. The person was at risk of further infections because an appropriate care plan to prevent future urinary tract infections.

Prior to the inspection, we received information that people may not be safe when they were assisted by staff to change position. People were not protected by safe moving and handling processes. We found several risks to people pertaining to manual handling which placed them at risk of an injury. We watched the transfers of people on 18 occasions, observed 7 staff during the manoeuvres and spoke with 6 of the staff. We checked four people's records related to manual handling and looked at staff training for two care workers.

Manual handling protocols were found to not be up to date and contained inaccuracies that could have caused injury to people if agency or new staff had followed the written procedure. After discussion with the registered manager and examination of the care records, we found there was inadequate training on how to complete manual handling assessments. We observed that staff started people's transfers but did not explain the process to them until after they commenced. There were long periods of sitting for some people, with no movement or hoisting, which increased their risk of skin breakdown and pressure ulcers. We found little input from relevant health professionals, like therapists, on postural support for people. There was significant use of access slings without clear and clinical reasoning or assessment for use. We also saw that there was poor maintenance of slings, fraying of straps on slings, and use of the same slings between

different people.

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

There is a varied history of compliance at the location pertaining to premises risks to people, staff and visitors. In September 2013 and June 2014 we considered that health and safety risks arising from the premises were non-compliant and took appropriate steps to ensure people's safety. In July 2014, we inspected the service again and found that the provider had taken action to obtain compliance with the applicable regulation at the time. We checked whether health and safety risks at this inspection were assessed, mitigated and documented to ensure people were safe from harm. We again found that people's safety was compromised by the failure to ensure issues related to the premises were resolved promptly and effectively. The maintenance person worked three part-time days per week. With this amount of hours, the one staff member was expected to perform repairs, engage and liaise with third party maintenance contractors, perform redecoration (as needed) and be on-call for maintenance emergencies. In addition, the maintenance person was required to keep all of the compliance documentation related to buildings and equipment. We found that due to a lack of hours, and an ever-increasing demand in the upkeep of the building, risks stemming from the building were not handled promptly.

Prior to the inspection, we received notification from the local fire authority that at a routine planned inspection of the service in July 2016, seven deficiencies of the Regulatory Reform (Fire Safety) Order 2005 were detected by the inspector. These included failure to have an updated fire risk assessment, failure to routinely check the fire panel was operating correctly and inadequate training of staff in fire evacuations. The fire authority served a notice to the provider and required that each of the issues was resolved by 7 September 2016. At the time of our inspection, the service had commenced taking action to resolve the deficiencies reported by the fire authority. We will check with the fire authority after 7 September 2016 regarding the provider's actions and related compliance with the relevant legislation.

Staff recorded basic repairs in a book and the maintenance person would perform reasonable tasks to correct the issues identified by staff. Some issues with the building were unknown to staff and therefore not recorded in the repairs book. Assessment and management of more complex building risks, for example Legionella and the routine inspection of lifting equipment, was fragmented and not coordinated at the service level. The service was not aware when certain risks required re-assessment, what to do when remedial actions were required from the risk assessments, and how to document that risks were mitigated. A majority of information from third party maintenance reports went to the provider and were not communicated to the service. Therefore, when we asked to see specific information about building risks during the inspection, some was unavailable. We wrote to the provider following the inspection and they sent us further documents for examination.

An example of risk to people that was not well-coordinated was the management of lifting equipment. The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) requires six month period testing of hoists and passenger lifts. There were a number of hoists including ceiling hoists in bedrooms and one passenger lift. Although the provider submitted LOLER testing certificates, these were not available for all of the equipment and the timeframes between testing sometimes exceeded six month intervals. For the passenger lift, the third party contractor reported defects to the passenger lift in October 2015 and April 2016. No action was taken by the provider between the LOLER inspections to remedy the problems. We saw a repair company had attended the lift on multiple call outs because it was malfunctioning or had entirely broken down. The repair company had even recorded that the lift required replacement on their most recent call out record. When the lift was not functioning, people on the first floor who used wheelchairs were

confined to their rooms as there was no other way to the ground floor. At the time of the inspection, the service could not demonstrate that people were safe from falls or injuries associated with lifting apparatuses.

There were a number of other risks related to the premises. These included the radiator system bursting on the first floor and flooding two people's bedrooms on the ground floor. This necessitated the people having to immediately move care homes temporarily whilst repairs were made. In addition, five radiators in people's rooms were absent because of problems with them that required their removal. They were not replaced at the time of the inspection. In a hallway outside people's bedrooms, a radiator could not be turned off so that in the warmer summer weather, the hallway was overheated. The registered manager and maintenance person had written to the provider regarding the radiators and heating system in June 2016. At the point of the inspection, there was no action by the provider to take definitive action to resolve the underlying problems. A number of staff expressed their frustration with the issues from the poor state of the building and felt people were at risk if issues were ignored when they had reported them to management.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection, there were 27 people who used the service. During a typical day shift, we found staffing for people's care comprised a registered nurse, a second registered nurse for part of the day, and six care workers. Agency registered nurses and care workers were used occasionally to fill ad hoc shifts in the event of other staff calling in sick. Other ancillary staff such as kitchen, laundry and cleaning staff also worked during the day. The registered manager worked Monday to Friday office based hours along with a part-time administrator. An activities coordinator provided social stimulation for people and organised events.

We also checked staffing for night shifts. On one day of the inspection, we arrived at the service before the day staff commenced. This was to check whether people were safe at night. We found one registered nurse and two carers had completed the shift. Staff expressed their concerns regarding night time deployment. They stated that one person who had challenging behaviour often got out of bed and needed almost constant supervision to prevent harm. This took considerable time away from one staff member. The remaining two staff were then responsible for 26 other people over two floors. If a person required turning in their bed or personal hygiene, the remaining two staff were busy with the care leading to no staff being able to respond promptly to any other person's call for help. This was an unsafe practice and we reported this to the local authority so they could review the night time care of the person with challenging behaviour.

We found people's safety was compromised by a lack of logical decision-making regarding staff hours. Although dependency assessments of people's needs were found, these were once-offs, not reviewed and did not change with improvement or deterioration of people's conditions. Staffing levels were stationary and not aligned with the needs of people. We found evidence of this when we reviewed care outcomes and risks to people. Unsafe care practices and insufficient staff resulted in serious risk to people's health and serious injury to people.

We checked staffing deployment of the service during day shifts to determine whether people received safe personal and nursing care. There was an unsatisfactory level of staff who provided care to people. During the first day of the inspection we observed that the clinical leadership of the care team was not visible to care workers. Registered nurses were often not available to care workers and performing tasks like administration of medicines. This was often on the first floor for people who did not leave their room. This meant care workers were required to make decisions amongst themselves without the input from a

registered nurse. On occasion, we could see that some care workers did not know and understand what was expected of them. One example of this was when a member of staff had to ask other members of staff what should they 'do with a person'. The care worker demonstrated they were not knowledgeable about the care of the person. In another example, we heard a staff member say they required the other staff member 'quickly' as someone wanted to go to the toilet and needed to be hoisted out of a chair. However, the other staff member was already busy with another person and could not leave what they were doing to assist. Staff appeared rushed and there was no clear member of staff taking responsibility for the operation of the shift.

We observed people sitting in lounge rooms and the dining room for long periods of time for no apparent reason. People with decreased mobility were seated in wheelchairs and often did not move out of them for extended periods of time. We observed that staff were not often supervising people in the lounge room or outside and that people were alone. We also saw that apart from personal care, people who stayed in their bedrooms were left on their own for large parts of a shift. This was because the shift was understaffed and only personal care needs could be attended to by staff. Our findings were supported by relatives' feedback that people on the first floor in particular, were left alone and without social interaction by staff members.

This was a breach of Regulation 18 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

We looked at the personnel files of four staff. We found that the service had completed the necessary checks for new staff and had saved copies of most of the documents in the personnel files. Contents of personnel files included proof of identity, checks of prior conduct in similar roles, job histories and reasons for leaving prior jobs. We saw the provider performed criminal history checks of new staff using the Disclosure and Barring Service (DBS). We found that in three of the four files, staff did not have complete employment histories documented and that there were unexplained gaps in the work history. We pointed this out to the registered manager and were satisfied that they took note of our advice regarding the wording of the applicable regulation.

During our inspection we looked at the systems in place for managing medicines. We spoke with staff involved in the administration and governance of medicines, observed medicines administration, examines people's medicines administration records (MARs). Overall, we found people were placed at risk of medicines-related errors. We have referred our findings to the pharmacist at the local clinical commissioning group (CCG) and recommended that they contact the service to assess and mitigate the medicines risks.

We saw the registered nurses dispensed medication into containers and proceeded to take each person's medicine individually to their rooms. This is the key activity in the medication use process and it is the point at which there are many opportunities for error. Activities such as identification of the person, selection of the medication, administration of the medicine and the recording that the medication has been administered could not be achieved. However, the building is not purpose-built and the corridors were narrow and it may have been difficult to manoeuvre a drugs trolley safely.

We looked at how sedatives were used in the home. We saw that one person had been prescribed lorazepam for agitation 'as prescribed'. The person was given this medicine occasionally. However, there was no corresponding specific chart to assess the person's level of agitation or any information to confirm if the medication had been beneficial. This meant the person was at risk that sedative medicine may be administered when it was not necessary.

We checked stock of controlled drugs and regular medication. Controlled drugs are medicines, such as morphine, that are by law locked away by legislative requirements. The majority of medicine had not been 'booked in'. For example, we checked the stock of boxed lorazepam. The previous supply had not been counted in to the medicines cabinet. We could therefore not been assured if people were given their medicine as prescribed by the GP. People's antibiotics were also not counted and this would make it difficult to check if people had received their prescribed medication for acute infections. We spoke to the deputy manager and they told us, "I started to complete a form which was kept in the drug folder with the running balance of medication. However, someone came in to complete a medication inspection and they told me to discontinue this practice." We spoke with the registered manager about this during our feedback. We asked them to find out who the person was who carried out the medication inspection and gave this advice.

We also noted the controlled drugs cupboard contained other medicines that were not controlled. For example boxes of paracetamol. We spoke with the deputy manager about this and they said, "We do not have anywhere else to store them".

We found the medication room exceeded the correct temperature for safe storage of medication. For over two weeks, the room exceeded the temperature that was advised by the manufacturer which must be below 25° centigrade. We saw temperature readings were above this range over a period of time. People depend on vital medicines and drugs that are safe to use with no loss of their potency and efficacy. If drug quality is compromised it may raise serious issues of people's safety. Staff had continuously recorded the high temperatures and had not acted upon this. We spoke to the deputy manager and registered manager about this and they told us, "We have reported it to the owner of the home on several occasions". People were at risk from medicines affected by being stored in a room which was beyond the recommended temperature.

We saw MARs had several missing signatures. We also noted one drug chart did not have the name of the person on it. We pointed this out to the deputy manager and registered manager during our feedback.

Variable doses of medicines were recorded. No one at the service received covert medicines. We found refusal of medicine forms were not completed. In addition, people's pain management charts were incorrectly completed. For example, the chart had a specific scale numbered from 1 to10 which indicated a person's pain. We found this was not completed and the only entry was that a person was given pain relief. The effect of the medicine given was not recorded. For example, we questioned if the medication was sufficient to relieve the person's pain or if the person continued to experience pain. It was not clear in the notes whether the person needed the GP to review them. We found the management of people's analgesia was unsafe and poorly documented.

Medicines audits completed from January 2016 to July 2016 showed that each month there were several missing signatures. However, there was no action plan in place to address this. The British National Formulary (BNF) medicines handbook edition at the service was noted to be over one year old. We also found that there was no evidence of six monthly medication reviews for people over the age of 75 who are taking four or more medications. This is an action advised by the National Service Framework for Older People.

This was a breach of Regulation 12 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

The fundamental standards require services to use the Code of Practice on the prevention and control of infections and related guidance 2015, published by the Department of Health. The code contains mandatory

criteria for adult social care locations. We looked at infection prevention and control systems at the service to check if people were safe. People were at risk of infections from poor practices across the service. The risks arose from the premises not able to be cleaned effectively, the lack of appropriate clean and dirty utility rooms, and staff practice.

We spoke with two cleaners and observed their practices. We found management of chemicals was in place by cleaning staff. Cleaners had satisfactory access to the safety data sheets for chemicals. These would be used if chemical accidents occurred. Although cleaners performed a satisfactory rushed job of routine cleaning, deep cleaning, for example dusting of high surfaces, did not occur. We pointed this out to the cleaners in the two lounge rooms. Some records for what cleaners attended to were maintained, but these were basic and did not contain enough detail about specific locations cleaned and frequencies of cleaning.

Although the national code of cleaning was adopted at the service, the storage and handling of dirty cloths, mops and buckets was not in accordance with the code requirements. This meant people were at risk because cross contamination of cleaning materials and surfaces could occur. The laundry was unkempt and did not lend itself to keeping people's personal clothing, linen or cleaning materials free from infection. One cleaner's storage area was so crowded that the cleaner was unable to actually enter the space. We observed one cleaner dispose of dirty water from a mop bucket into a person's bedroom sink as there was no other option of where to discard the contents.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People did not receive effective care because staff were not trained with the knowledge and skills they needed to carry out their respective roles. In addition, staff did not have a regular schedule of supervision with their managers or effective performance planning and appraisal. We spoke with staff during the inspection and they expressed discontent with this lack of investment in their knowledge and development. Since taking up their post, the registered manager had made slight progress in turning around the failure to train and supervise staff. This was confirmed by the staff training records and supervision documents that we reviewed.

There was training in role-related subjects for staff who worked with people. Topics for example included emergency first aid, food hygiene, health and safety and safeguarding vulnerable adults. We witnessed one new care worker during the inspection undertaking their induction. They sat with a laptop computer and headphones and completed e-learning that included watching DVDs. After watching the DVD, the new staff members completed a quiz to test their knowledge. A small portion of staff training overall was completed using other styles of learning, like classroom-based teaching. We did find that the practical part of moving and handling was completed by externally contracted trainers. However, there were flaws in the training. We saw from records that staff completed the theoretical component using e-learning. We found there were delays in the practical part of manual handling training attendance and competency checks by the external training organisation. This meant new staff potentially undertook moving and handling of people without the practical skills needed to perform this safely.

Six registered nurses who appeared on the service's training records had no dates recorded for any subjects. For other staff, the training records showed infrequent training, learning that had occurred too long in the past and training for complex specialised skills like syringe drivers that had not happened. The fire authority informed us on 7 July 2016 they had notified the provider of a deficiency in fire safety training when they inspected the service. They found too few staff had completed training and this placed people at risk if there was an emergency involving fire or evacuation.

The registered manager provided us with information about staff supervision and performance planning and appraisal. A 'supervision' list showed which staff members were supervised by others. However the list did not contain all of the staff who were employed at the service. This meant that staff did not have someone who met with them regularly to review performance and assess progress towards their objectives. For staff who appeared on the 'supervision list' the registered manager was responsible for a large number of staff supervision sessions. This was not equally shared amongst staff, for example registered nurses who could perform supervision sessions with care workers. Staff who were supervisors had not received training about how to conduct supervision sessions, and this meant they were left to devise supervision sessions without the knowledge of their purpose, aim or outcome. A one-page document was available for the recording of a supervision session. The topics on the individual supervision record were task-related and not performance-related.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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

People can only be deprived of their liberty to receive care and treatment when this 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.

We spoke with the registered manager regarding standard DoLS authorisations. We were told that there 27 people who used the service at the time of this inspection. Of these, two were subject to a standard DoLS authorisation. In the folder presented to us by the registered manager, there was evidence of one DoLS authorisation. In the week prior to the inspection, one DoLS authorisation was granted and the paperwork was not received by the service at the time. The local authority supplied us with a list of DoLS cases for the service which confirmed these authorisations. However, enough DoLS authorisation applications were made by the service.

The Mental Capacity Act 2005 Code of Practice defines 'mental capacity' as the ability to make a decision. In the case of an application for a standard DoLS authorisation by the service the decision is whether the person has capacity to decide whether or not they should be accommodated in the care home for the purpose of being given care or treatment. During the inspection we interacted with people who were unlikely to be able to make the decision to stay in the care home due to a impaired mental capacity. This meant a mental capacity assessment should have been completed by the service. The mental capacity assessment would be time and decision-specific. When we reviewed people's care documentation, there was a lack of mental capacity assessments for this purpose. This had resulted in a lack of appropriate DoLS applications to local authorities for the purpose of a standard authorisation. People were deprived of their liberty by the service without the correct authorisations in place.

Where the relevant person is properly assessed to lack mental capacity to make a particular decision on their own, a 'best interest decision' is formulated. We spoke with the registered manager and requested to see evidence of any best interest decision-making. They told us they have not completed any care plans that involve a person's best interest decision-making. There was a lack of access to independent advocates for people who might request one for decision-making purposes. The service had also failed to establish whether 'relevant others' might be able to legally make decisions for a person who used the service. This would be by way of a lasting power of attorney (LPA) or a Court of Protection appointed deputy (for financial decisions only). There was no evidence the service had checked whether people had an LPA or CoP deputy and if they did, that the relevant evidence was checked and copied to the person's care file.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's nutrition and hydration. The service used the 'malnutrition universal screening tool' (MUST) to assess people's risk of malnutrition. We found care records for people were not clear and logically presented. All weight and MUST charts in people's care plans were not in the same section in each folder.

This meant staff could not easily look at all of the weight management evidence for each person. Care records showed that most people were weighed monthly. However, there were unexplained gaps in some people's weight charts. It was not recorded why people's weights were not documented by staff on these occasions.

Some people had thickening agents added to fluids to change the texture of the drink so that it could be safely consumed. Care plans we looked at did not have thickening agents or nutritional supplements as part of the assessment of need. However, we saw that staff used thickening agents during the lunch time meal in people's drinks. When asked how much thickener should be used in a person's fluid we found staff were not clear of the quantity that was to be used. This meant the person receiving the drink was at risk of choking if the consistency was incorrect as advised by a speech and language therapist.

We found that a kitchen worker thickened people's drinks using the thickening agents. A list was attached to the side of a trolley where the drinks were made. However, the kitchen worker was unaware of people's different needs and referred to the list on the trolley. We checked whether two people had the right consistency for their drinks after the drinks were served. We found one person who was at risk of choking was given a drink that was not thickened at all. Another person was given a drink which was not thickened to the correct texture. This put both people at risk of choking with their drink incorrectly prepared. We referenced what we found with people's care plans and found the information on the list the kitchen worker used was also incorrect for a third person. We pointed this out to the registered manager so prompt action could be taken to decrease people's risk of choking.

People told us they were satisfied with the food and drinks that were provided. One person stated, "Food here is very good; good choice and they cut it up and I eat everything and if I need anything at night I use the call bell." Another person commented, "The food is very good and I get two or three choices. I like poultry as my favourite and at night, I have juice and I don't get hungry." A relative told us, "The food smells delicious and it looks good. [My relative] gets a good choice and...will eat everything, and yes [they] can always get something to eat or drink at night." People had a choice of meal. The meals we saw looked nutritious and appetising. There was a board in the dining room where staff wrote the menu for the day so people could see it. However, this was not updated until nearly lunchtime on the days we inspected the service When we asked staff members on the morning shift what was for people's lunch, they were unaware and were not informed. This meant people who might not see the board or understand the content were not told what they could have for the day.

We recommend that the staff must undertake further training and be subject to competency assessments pertaining to the management of people's risks of malnutrition and the correct use of fluid thickening agents.

People received satisfactory healthcare within the service from external professionals. These included the GPs, dieticians, speech and language therapists and podiatrists. People had access, via staff, to a multidisciplinary health team. This meant where specialist health advice was necessary, the service ensured that people received it.

People's individual needs were not met by the effective adaptation, design and decoration of the service. We observed that the environment did not support the people who used the service to increase or maintain their independence. The provider had made little effort to make the building suitable for people with dementia. This was despite the fact that people had a diagnosis of one of the types of dementia. We saw a lack of colour co-ordination for personal hygiene facilities for example, where toilet seats and grab rails were present. On all three days of the inspection, we observed an external glass door that had a 'push bar' for

access to the garden. Pushing the door was heavy and cumbersome, especially for people who used wheelchairs. More than one person in a wheelchair used the door to go outside, but this involved them placing themselves at risk or always requiring a staff member to open it for them.

During the inspection there were several times when the front door was open. This meant a risk for people who could abscond because they did not know they could exit to an unsafe place. The front door was also able to be opened by simply turning a handle. This meant a mobile person who may still not have the capacity to understand leaving the building could have placed themselves at danger if they decided to leave. We found carpets that were rucked, which presented falls risks and poor lighting on the first floor which added to the risk of falls. The building was not suitable in some parts for people who used wheelchairs. On the first floor, there were narrow corridors which made moving a wheelchair or hoist difficult. In the car park, there was a sign for people with a physical disability who wished to park their car. However, the ground was covered with shingle so that even if the disabled bay was used, a person in a wheelchair would have difficulty pushing or moving the wheelchair. At the inspection we asked to see what investment the provider planned for the refurbishment and redecoration of the service. This was not provided to us. We wrote to the provider after the inspection and requested a plan for capital expenditure of the premises. We received the information, but it contained little information other than calendar months and basic information of what was planned for the particular month.

There was insufficient storage of hoists and other mobility equipment. These were instead placed in communal areas and other inappropriate places. This increased the risk that people could trip or fall over the equipment. It also meant that in communal spaces, hallways and people's bedrooms, equipment was stored there instead of in another suitable location. We examined the amount of mobility equipment within the service with the registered manager and found there was an oversupply of wheelchairs and that some mobility equipment was used communally between people.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We asked relatives their opinion about whether the service was caring. Their opinion was that the service was not always caring. One relative told us, "I feel that my mother has lost her mobility since she's been in here. She could walk when she first came in here and now they have put here into a wheelchair and just let her watch TV." We also observed the interaction between staff and people who used the service. People sat around for long periods or on their own doing nothing with little engagement from staff. There was varied behaviour between the staff members. Some staff members were seen to be genuine and had formed a compassionate relationship with the people they cared for. However other staff we observed treated people with the assumption that only tasks were required. The care was task-focussed rather than person-centred. When we observed this, there was little or no communication between the staff members and the person. This meant the person did not understand what staff members were aiming to do in terms of their assistance with care. This particularly happened when people had to be moved or hoisted from chairs in communal spaces. We observed on several occasions that staff approached people, started to get them ready to move and the person was confused with no prior explanation from staff involved.

At times, there was evidence of a lack of dignity for people. Our observations during the lunch time meal demonstrated staff were chaotic and disorganised. Staff appeared to be rushing around with no clear guidance on what they were supposed to be doing. We heard one member of staff speaking loudly, almost shouting to another member of staff on the other side of the room whilst the person they were supporting was in a wheelchair. The staff member yelled, "What shall I do with [the person]?" The other staff member shouted back, "Why don't you ask them?" This was undignified for the person and for other people who were in the immediate area.

Another incident we saw was when a person who was unsteady on their feet and was meant to mobilise with a walking frame. They fell heavily against a metal frame on the wall in the dining room. They screamed out in pain and were clearly upset. Staff attended and assisted the person to a chair. However, later on that day we were aware the person appeared agitated and in discomfort. We asked the registered manager if the person needed some analgesia. It appeared the person was not observed following the fall or offered any pain relief.

Little observation of people's needs was displayed by some care workers. During a different observation, we saw a person was asleep at the dining table with their soup in front of them. This was a significant time after the soup had been served to them. We asked a member of staff to assist the person, as their food would have gone cold. This demonstrated staff were task focused and did not think of people as individuals.

We heard constant shouting out from a person in a downstairs bedroom. We asked staff if the person needed assistance. They staff member told us, "They always do that". From our observations we were not aware that staff checked the person's well-being but rather ignored them and continued on with care of other people.

The dining room was cluttered with wheelchairs and hoists which put people at risk of falls. We also noted

one person's bedroom had been used to store a hoist and a hoover. We pointed this out to the registered manager who said they did not know why staff had put these items in the person's room.

We were aware staff did not spend meaningful time with people and were task orientated. One person remained in their chair throughout the day which was in excess of nine hours. We asked the deputy manager why this was and they told us they usually retired to their room in the afternoon.

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

The majority of people remained in their wheelchairs throughout the entire day. Some people were escorted to the garden area to partake in activities. On the days that the activities coordinator was present, there was a positive environment. We saw their presence made people smile, laugh, sing and not be inside their bedroom or communal lounges for the majority of the day. Relatives who arrived also sat outside with people and watched or participated in the activities. On the day that the activities coordinator was not present, no other staff such as the registered nurses or care workers provided any type of social stimulation for people.

Requires Improvement

Is the service responsive?

Our findings

We looked at whether people and relatives were involved in the care planning and review process. From the care documents we reviewed, we could see little involvement of people in making the decisions about their care. Where people were unable to communicate with staff as part of the care planning process, their relatives or friends were not invited to participate to help ensure the care was personalised. We found no attempts to involve people in the care planning and review process were made, and the service had taken no steps in an attempt to increase people's participation. Care plans were reviewed monthly and sometimes on an ad hoc basis. We looked for evidence people were involved or consulted with regarding changes in their care plans. Instead, we found care plans and care plan reviews often contained statements and information like "no changes." This did not indicate people had an active involvement in making decisions about their care, treatment and support.

When we spoke with people and relatives, they confirmed they had little involvement in the care planning process at the service. One relative said, "No, never seen my mother's care plan, but I will now." Another relative stated, "No never seen the care plan; only the once since she's [the person's] been here." When we asked a third relative whether they had seen the person's care plan they replied, "I might have done two years ago." We were not able to communicate with all people who used the service. However, when we asked one person about their care plan they said, "No, I have never seen my care plan." People and relatives' involvement in care planning was unsatisfactory.

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

Better attention was required by the service in the documentation of pre-admission assessments. In the examples we viewed, not all of the person-centred information required was completed on the form used by the service. This meant that appropriate information was not captured before the person moved into the care home, and staff could not always identify the person's needs upon their admission. We spoke with a community health professional who stated they could perform their role better if the service documented better information prior to people moving in. The failure to record accurate, detailed information about a person prior to admission placed them at risk. This was because the service might not be able to meet the person's needs but accept them to move into the care home regardless.

We looked at four people's care documentation to check whether care planning was in line with their needs. Care folders were bulky and overloaded with documents that staff had not considered placing into archive. This meant when staff needed to quickly access information, it was slow or difficult to locate. We found there was an appropriate range of risk assessments within the people's care folders. We saw that commonly expected risk assessments were conducted by registered nurses. For example we found falls risk assessments, food and fluid risk assessments, and bed rail risk assessments were completed. Waterlow scores, used to determine people's risk of pressure ulcer development, were also completed.

Not everyone had documentation pertaining to their choice of resuscitation in the event of a cardiac arrest (DNACPR). For people where the documentation was absent, there was no evidence that a discussion about

end of life had occurred with them to determine their decision. In one person's care folder, the care plan informed staff the person had a DNACPR in place. However, we could not find evidence of the DNACPR instructions. We spoke to the deputy manager about this and they told us, "They want to be resuscitated in the event of collapse." We informed the deputy manager the care plan in no way confirmed this. This put the service and staff in a difficult situation in the event of the person collapsing and requiring resuscitation. This was because there would be confusion about whether to initiate life-saving procedures or not. We requested this person's information be clarified as soon as possible to avoid the person's choice not being followed.

People's care plans were not always holistic. We found one person was unable to take anything orally and had a feeding tube in place. When we visited the person, we saw the person's mouth was dry and sore. We checked the care documents for the person to see what plan was in place regarding their feeding regime. The care plan did not have any oral care assessment or instructions. We spoke to the deputy manager about this and they told us, "They do not let us clean their mouth." However, we could not be assured staff attempt to perform oral hygiene or if the GP was aware of the poor condition of the person's mouth. The daily notes did not comment on the possible infection of the person's mouth.

We asked people whether they knew about the service's complaints process and whether they ever raised a complaint. One person told us, "The only time I blew my top is when I wanted to go to the toilet she told me she was too busy and I wet myself." The person chose not to report this or make a complaint to management. Another person told us they knew who they would go to if they needed to complain. They said, "No, never made a complaint and if I needed to it would be to the manager."

There was a complaints process and system, although it was not obvious, well displayed or communicated to people and relatives. There was a lack of signage and information about how to make a complaint, who to make it to and what would happen when the complaint was received. We examined the complaints policy for the service and found that it required review. The policy did not contain information about where people could seek assistance with complaints outside of the service. We found the registered manager had a good understanding of complaints management and showed an example of how a complaint was managed. Not all complaints were recorded though, and we explained this could affect the services' compliance with the applicable regulation. The registered manager explained with support from another manager they were changing their system and process to record more of the concerns, complaints and feedback to keep track of people's experience of care. Staff we spoke with had general knowledge of what to do if a person or relative made a complaint.

We recommend that the service increases awareness of their complaints process to people who use the service, relatives, visitors and staff.

There was a genuine effort by the service to seek people's and relatives' feedback about the care they were receiving. We found this because there was evidence of regular meetings being chaired by the registered manager. We looked at the minutes from two recent meetings. These showed that people and their relatives did provide their feedback and that the registered manager had communicated important information to attendees. Examples of topics discussed included activities and upcoming outings, menus, having a pet at the service and changes in staff. Evidence of the meetings held and planning showed that the service listened and learnt from people's experiences and concerns.

Requires Improvement

Is the service well-led?

Our findings

We asked people, relatives and staff whether they felt the service was well-led. All of the parties we spoke with gave mixed feedback about the service's management. Some people felt that with the current registered manager care had improved care slowly over a period of time as changes were made. Other people suggested that managers and staff of the service turned over too often. Regarding the registered manager, one person stated, "Yes, I think she does a good job and she's approachable." Another person told us, "Yes she's very approachable. Her door is always open and I've known her for a long while before she came here." Another person who used the service commented, "I think she's got an uphill job here, with staff coming and going." People and relatives stated the registered manager was easy to approach and communicate with.

Some staff expressed dissatisfaction with the service and with the provider's workplace culture. They stated that when they approached with their opinion they were listened to, but their feedback was not always acted upon. Some staff members we spoke with were anxious about speaking with us at the service. We spoke with them via telephone instead, to hear their feedback. They told us that the workplace culture was often a negative one and they felt 'stretched' at times. They expressed that on multiple occasions they wanted to resign. One staff member we spoke with had submitted their resignation, and another two staff members stated they were frustrated and were considering handing in their resignation. This tied in with the staff turnover rate which was not aligned with the size of the service. However, there were some staff members who were employed for long periods of time and enjoyed their roles.

An effort was made by the registered manager to engage with staff. We were provided with meeting minutes from two staff meetings; one held in February 2016 and one held in June 2016. There was a previous staff meeting held in October 2015. We saw a significant number of staff attended each meeting. A range of topics were discussed, such as documentation, manual handling, person-centred care and teamwork. The minutes recorded showed that the focus of the discussion was for one of care improvement, and how the service could function better. Confidentiality by staff was a consistent theme in the staff meetings. It was documented that there was a possibility the service breached people's confidentiality, started rumours and some members of staff had perpetuated this. No specific examples were cited in the minutes. No actions were documented from the staff meetings to demonstrate what steps managers would take to address issues, the timeframe for resolving them and who would be responsible. There was no evidence of a staff survey where their opinions could be recorded and tallied to see team strengths and areas for improvement.

The organisation structure had changed with regards to management. The previous service structure was one that had a registered manager and regional manager. The regional manager was a support mechanism to the registered manager and also performed some of the auditing and quality assurance processes. The regional manager did not visit the service any longer and this role was not replaced in the same way. The regional manager was not able to continue visiting the location due to travel distance from other services they worked with. The nominated individual came to the service on an ad hoc basis but in relation to business-orientated items only. Most recently, an experienced home manager from another service had commenced attending the service instead a few days a week. This was to support and mentor the registered

manager to make further changes within the service.

A part-time administrator was employed and supported the registered manager with some office-based tasks. However, the role for the registered manager was overwhelming given the size of the service and complexity of the people who lived there. Prior to our inspection, one of the permanent registered nurses was promoted to be the deputy manager and supervised by the registered manager. On the days when we saw the deputy manager, they were working as a clinician and not in the role of a deputy manager. When we enquired about hours that the deputy manager spent not completing clinical work, there was no clear answer about their deployment. The registered manager stated that the deputy manager would be offered supernumerary hours to perform the management role effectively. We were then provided with a copy of the rota for the period 1 August 2016 to 7 August 2016 which showed the deputy manager had 16 hours' supernumerary time planned. The function of the deputy manager and managerial tasks they would undertake was not specified. The organisational structure of management and senior staff was not strategically set-out and established to ensure a well-led service for people.

The provider has a legal duty to inform the CQC about certain changes or events that occur at the care home. Since the registered manager commenced in their post in 2015, statutory notifications have been sent to us as required by the relevant regulations. Examples included events that impacted on the service functioning, police reports and serious injuries. When we received the notifications, we asked the registered manager for further information in some circumstances. This was provided to us promptly and helped us to understand the incident and assess whether people were safe and receiving appropriate care.

A robust system of quality management was not implemented at the service. We reviewed a range of quality audits and processes, but these were fragmented, and not sustained over a long period of time. For example, the provider contracted an external consultant to audit the service using the same key questions we inspect. We examined three reports from the contractor dated February 2015, October 2015 and March 2015. The consultant's audit showed that over time, the same outcomes were reported with little or no change to what was found in previous visits. In the three reports, the auditor had mentioned that cleanliness and the fabric of the building required attention by the provider. Another point repeated in the reports was that regarding accident and incident reports. The reports showed that there was no clear process for reporting them, variations of forms were used and there were no themes or patterns analysed by management. This meant that incidents involving people that were preventable had not been considered and action taken to stop their recurrence.

A range of other audits created and used by the service were viewed by us. Examples included checks on catering, laundry, people's personal finance and valuables, and a pressure ulcer audit. There was an audit titled 'annual quality audit nursing service' which was conducted in July 2016. This reviewed the service's complete spectrum of care and management, from people's leisure to record keeping. The audit showed that some components of the service which were reviewed were rated 'good'. However the majority of subjects which the audit covered were described as requiring improvement. Examples of areas where improvements were required included catering, housekeeping, health and safety and maintenance.

Findings from the various audits up to this point were not always duly noted and then acted upon by management. This was because unsatisfactory outcomes in the audit reports remained on the audit form and were not listed centrally for resolution in a risk-orientated way. Instead, the audits were filed away. However, there was evidence that various management staff had communicated their concerns about certain aspects of the service to the nominated individual and provider. When we asked to see what response was given, this was not readily available for viewing and had to be searched for. In addition, we found once we had asked for evidence of action taken regarding whole of service risks to people, action was

only evident at the point of our inspection, and not prior to our visit. This demonstrated that although risks and requests for action were communicated to the provider, they were not always acted upon in a reasonable fashion. The provider failed to recognise not promptly acting on problems identified by managers could place people at risk of harm or result in injury to them.

A single action plan was shown to us at the inspection. This was created in July 2016 by the registered manager and other home manager who came to support the service. We saw this started to capture the assessed risks and known areas for improvement. For example, the action plan stated that housekeeping was unsatisfactory. There were some gaps in the action plan. At the inspection, the registered manager told us the service had advertised for a housekeeper to supervise and manage cleaners. However, the action plan did not contain this as a point for following up. The action plan was not extensive and did not include all of the information from the recent audits completed up to the date it was created. The action plan content was untenable, as all of the actions were assigned to the registered manager, who could not possibly address all of the items themselves. The provider was not made responsible for any of the items in the action plan where steps were required by them. For example, with regards to refurbishment and redecoration, it was out of the registered manager's role to action this. The action plan needed review and more content to ensure a safe and well-led service.

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

Providers are required to comply with the duty of candour statutory 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. The management was not familiar with the requirements of the duty of candour and were unable to clearly explain their legal obligations in the duty of candour process. The provider did have an occasion where the duty of candour requirement needed to be utilised at this service. However, the steps required of the applicable regulation were not completed. At the time of the inspection, the service also did not have a duty of candour policy.

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

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
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users was not appropriate, meeting their needs and reflecting their preferences. The registered person had not designed care or treatment with a view to achieving service users' preferences and ensuring their needs were met. The registered person had not enabled and supported relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Where service users were unable to give such consent because they lacked capacity to do so, the registered person had not acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Treatment of disease, disorder or injury	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 did not ensure the equipment used by the service provider was safe for its intended purpose and used in a safe way. The registered person did not ensure the proper and safe management of medicines. The registered person did not do all that was reasonably practicable to mitigate risks to service users.

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 form abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the provider were not clean, properly used, properly maintained and appropriately located for the purpose for which they were being used. The registered person, in relation to such premises and equipment, did not maintain standards of hygiene appropriate for the purposes for which they were being used.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not monitor and improve the quality of the services provided in carrying on of the regulated activities (including the quality of the experience of service users in receiving those services). The registered person did not mitigate the risks related to the health, safety and welfare of service users and others

who were at risk which arise from the carrying on of the regulated activities.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered persons did not act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on the regulated activities.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of the regulated activities did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.