Hexon Limited

# Rosegarth Residential

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Rosegarth Residential 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. The home is registered to provide personal care and accommodation for up to 26 older people, including those with dementia related conditions. It is located in the seaside town of Bridlington, in East Yorkshire. At the time of our inspection there were 19 people living at the home.

This inspection took place on the 3 and 14 May 2018. Both days were unannounced. The inspection was responsive in part due to a matter being investigated by the local authority safeguarding team.

The overall rating for this service is 'Inadequate' and the service is therefore 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 not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and 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.

The service is required to have a registered manager in post. A registered manager is a person who has registered with CQC 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 the inspection there was a manager in place but they had not registered with the CQC.

Measures required to reduce the risk of harm to people were not always in place. This included exposing people to environmental risks around the building and its grounds. Infection control measures were not

sufficient to prevent the risk to people of infections spreading.

Medicine procedures and systems were in place however some improvement was required to ensure that medicine practices were safe. Staff had a basic understanding of how to safeguard people from abuse.

Recruitment processes were in place but these needed to be more robust.

Staff aimed to deliver a good standard of care that was caring. Some staff demonstrated knowledge of people and this helped them to provide some person-centred care. However, staff were not sufficiently trained or supported to meet the needs of the people they were supporting.

Communication between staff and people using the service was not always appropriate or in line with best practice.

Care plans demonstrated that the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied. Monitoring of DoLS applications need to be more robust. People's wider needs were not being met by meaningful activities.

We were unable to clearly establish if people's nutrition and hydration needs were catered for as record keeping in this area was poor. The provider needed to make changes to the meal time experience to ensure that this was pleasant and followed best practice.

The manager had used a variety of methods to assess and monitor the quality of care. However, the governance systems had not picked up all the shortfalls identified during the inspection. Where shortfalls had been identified, action to address these was not timely.

Relatives we spoke with gave positive feedback about the service and the staff. Professionals praised the current manager for their commitment to building professional working relationships between agencies.

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.

Some areas of the service posed a risk of infection.

People were exposed to environmental risks within the service.

Medication processes were not robust.

Some risk management plans were in place but the use of bedrails and specialist mattresses were not risk assessed.

Recruitment processes in place needed to be more robust.

### Is the service effective?

**Inadequate**

The service was not effective.

Improvements were needed to the premises to maximise the suitability for people living with dementia.

Staff had not been provided with regular supervision or a thorough induction and training to support them to understand their role.

People's mealtime experience required improvement to follow best practice.

Staff sought consent from people before providing support. However, people with capacity were not always asked to provide written consent to care.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Some staff showed knowledge and understanding of people's needs. However, communication with people needed to be improved.

Interaction with people was task focused with little observation of person centred care.

Staff could only provide limited examples of how they promoted people's dignity.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People had care plans in place that described their individual support needs but these were not always reviewed and daily recording did not reflect the care described in the plans.

The service failed to provide meaningful activities to meet the wider needs of people.

There was a complaints policy and procedure in place.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Some governance systems for assessing and monitoring the quality of the service were in place. However, they were not robust enough to identify all concerns or address actions in a timely manner.

There was a manager in post who had not commenced the registration process with CQC.

Relatives spoke positively about the manager in place.

Professionals praised the manager for building professional relationships.

# Rosegarth Residential

**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 was a comprehensive inspection that took place on 3 and 14 May 2018. Both days were unannounced. The inspection team consisted of one adult social care inspector and one specialist advisor on the first day. The second day consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. We spoke with two people who lived at the service, two senior carers, three care assistants, one chef, five family members/visitors, the manager, the general manager and two visiting professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people, such as medication administration records (MARs) for six people and monitoring charts for food, fluid intake, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005.

We looked at a selection of documentation relating to the management and running of the service. This included six staff recruitment files, training records, the staff rota, minutes of meetings, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

After the inspection, we contacted two healthcare professionals to seek their views and opinions, both provided feedback.

Inadequate

# Is the service safe?

## Our findings

We found that the service was not safe.

On the first day of inspection we walked around the premises and looked at communal areas of the service including bedrooms, bathrooms and toilets. We observed a number of infection control concerns. For example, we saw that the laundry area was unclean and unorganised, the flooring and hand washing facilities were dirty. Clean clothes were stored near dirty areas and non-laundry items. As we looked around the service we saw that there were areas of concern regarding cleanliness. Dust and dirty floors were identified throughout. There were a number of malodours that were not managed by the service. Flooring in a shower room was ripped and therefore could not be adequately cleaned and a carpet was found in an en-suite bathroom which had a strong malodour. The provider already had plans in place to address the shower room flooring and this work started during the second day of inspection.

On the first day of inspection we found that the door to the laundry could not close, which provided people access to hazardous substances. Although this concern was highlighted on the first day of inspection and the door was fixed, we found the door was left unlocked all day during the second day of inspection. This posed a risk to people who used the service. An open cupboard in a downstairs bathroom was found to contain hazardous substances and Personal Protective Equipment (PPE). We highlighted this concern to the provider on the first day of inspection and a lock was fitted. However, on return on the second day of inspection we found this cupboard to be left open for the majority of the day. We saw that disposable gloves were easily accessible by people which posed a potential risk of ingestion to people who used the service.

Where people had been identified as at risk of skin pressure damage we saw air mattresses were in use for them. We were unable to check whether these mattresses were set at the correct levels of air to ensure effective pressure relief as this was not recorded anywhere. There were no audit checks to ensure that the correct levels were set. We found one bed was beeping as having a fault on both days of inspection. This impacted on the risk to people's skin integrity. We saw that people had bed rails in place however; no risk assessments were in place to ensure that the risks were managed safely. There were no audit checks in place to record routine checks on bed rails and associated equipment. When we raised these concerns with the provider they told us they would take action to address this.

The manager was unable to locate their most up to date fire risk assessment. This was later provided after the inspection by the general manager. Records showed that there had been large gaps in weekly testing of the fire system, from December 2017 until April 2018 and no emergency lighting or fire door checks had been recorded. When we raised this with the manager they could not explain why the gaps had occurred. We have referred this information to the local fire service. The provider told us after the inspection that a reputable company attended the service to check the fire equipment and complete an annual fire safety check. The fire equipment was in working order.

We found multiple rooms that were used for storage. All of these rooms were unlocked and accessible to people using the service, providing a risk to them due to the items that they could access and a fire safety

risk due to the mixture of electrical equipment and paperwork being stored together.

We looked at the systems in place to manage people's medicines. We found that there were daily gaps in the recording of the application of all prescribed creams for people. This meant that the provider could not ensure that medicated creams had been given as prescribed. There were periods of time that people had run out of their creams. People had medication that required being stored in temperatures no higher than 25 degrees but the provider did not record the temperature of the room where medication was being stored and there was no policy or procedure in place to advise staff of the action to take. On the first day of inspection we found this room was 27 degrees. When we raised this with the provider they advised they would put actions in place to address this. We identified five people who should have been given one medicine before food; however, this was being given after breakfast. On the second day of inspection we found that this medication was now being administered 30 minutes before breakfast. All other checks we completed in relation to the administering of medication were found to be accurate and safe.

The garden area was unmaintained and unsafe. The footpath into the garden had a large hole in it creating an uneven and unsafe surface. We saw people accessing the garden independently during the inspection however; there were no risk assessments in place. We brought this to the urgent attention of the manager and the regional manager, who advised they would take action to address this. The provider told us after the inspection that a gardener had started work.

We looked at the most recent portable appliance testing records which had been completed within the last year. However when looking around the home we found six items that had not been tested since 2015, which is not in line with the services own policy. This meant that we could not be satisfied that the provider could be assured the equipment was safe.

A lack of robust actions to reduce risk is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of risk assessments were in place for people, these included; falls risk, moving and handling, nutritional risk assessment, call bell risk assessment and tissue viability. However, the management of the risk of pressure wounds and nutritional intake could not be properly assessed because of poor record keeping in this area. We are aware the local safeguarding team were investigating some concerns with regards to hydration. These investigations are still on-going.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records in this area were not complete or accurate.

We checked the recruitment records for six members of staff. These evidenced that a Disclosure and Barring Service (DBS) check was in place prior to applicants commencing work for only five out of the six files we looked at. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Although the provider ensured that people had references and the correct identification in place all six files failed to record the full employment history for the person applying.

This was a breach of Regulation 19 of the Health and Social Care Act (regulated Activities) Regulations 2014 due to a failure to ensure full employment history was obtained and ensuring people had a DBS in place prior to commencing work.

Safeguarding and whistleblowing (telling someone) policies were in place at the service and some staff we spoke with demonstrated basic knowledge of what to do if they had concerns. This has been considered further in the 'Is the service effective?' section of this report. We found that the manager's log of safeguarding incidents within the service was not up to date.

The registered provider had systems and processes in place to record accidents and incidents. We found people in the service had regular accidents in the service that were not reviewed, investigated or referred to outside agencies in a timely manner. There was a lack of recording to demonstrate any actions taken or any lessons learnt following incidents and accidents. This exposed people within the service to continued or increased risks.

The service used a dependency tool to assess the right levels of staffing needed to meet people's needs. Although the service was staffed according to this tool, the staff's lack of training and support meant that at times the staffing levels were insufficient to meet the needs of people in the service.

Maintenance records showed safety checks and servicing had been completed on the gas supply system, hoists and slings, the passenger lift and the electrical installation. We found there were plans in place to respond to any emergencies that might arise. The provider had devised a continuity plan and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises.

Inadequate

# Is the service effective?

## Our findings

The service was not effective.

We found that the service's premises and equipment were poorly maintained. The garden furniture was broken and unsuitable for people to use. We saw flooring and carpets that needed replacing; some of this was planned for shortly after the inspection based on our feedback. We saw wallpaper that was hanging from walls and dirty marks on paint work.

As we looked around the service it was clear to see that the environment did not support the needs of people living with dementia. The service was split across three floors and the layout was very confusing. This was further exaggerated through the inconsistency in bedroom numbers and the lack of any dementia friendly signage. Disorientation and bewilderment are a common experience for people with dementia. Signs can be very helpful if they are clear, mounted low enough, have words and a picture and contrast with the background. On the second day of inspection we found that the manager had started adding people's names and pictures to their bedroom doors in response to our initial feedback. The provider told us after the inspection that they are painting corridors different colours to aid recognition of different areas around the home and bedroom doors are being painted in bright colours, according to people's choice.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the premises was not maintained and suitable for the purposes for which it was being used.

Staff were not sufficiently trained or supported to carry out their role effectively. Staff had not received training which provided them with the skills to meet the needs of the people. On speaking to staff they had only basic knowledge of safeguarding and limited or no knowledge of mental capacity and deprivation of liberty safeguards. A copy of the services training matrix was provided after the inspection as the manager stated it required updating. Not all staff names were included in the matrix. The matrix confirmed that staff received limited training. Dementia or end of life care training was not provided and attendance was only small on a number of other courses including falls and nutrition. We observed some poor interactions between staff and people in the service.

Records showed that staff supervision meetings had not been held in line with the provider's policy of every two months. Within the last 6 months most staff had received only one supervision. Two staff had not received any. Where supervisions had taken place records showed that these were of poor quality usually covering one topic only. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. There were no records of any annual appraisals. When we raised these concerns with the manager, they advised they had a supervision matrix in place and was recording supervisions and team meetings moving forward. Staff we spoke with told us they felt supported by management. "My supervisions are good. We both talk and if I have any worries or concerns I can speak out." However there was no consistency as to how often staff thought supervisions should take place.

New staff completed an induction when they started working at the service which was recorded in an

induction checklist. Completed checklists we saw in staff files detailed a number of topics to be covered in one week. On speaking to staff it was apparent that topics were not always covered in depth. For example when asking whether they had read any people's care plans during their induction we were told, "They told me where the care plans were kept but that's it, I haven't read them." We provided feedback to the manager about these concerns but they were unable to provide a response.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because staff not being sufficiently trained or supported to carry out their role

We looked in people's care plans which showed that people's weight was being checked and that people's weight on the whole, was recorded as being consistent and stable. We also spoke with visiting professionals who advised that they are now attending a 6 weekly meeting with the manager to consider the needs of all people living in the service. However, we were unable to fully assess whether people's nutritional needs were being met due to the inconsistency and lack of recoding in this area.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as record keeping was not accurate.

We observed the dining room experience on both days of inspection. We were told by staff that people were able to choose where they wanted to eat their meal. We observed people eating in the main dining room, both lounges and some people chose to eat in their rooms. People were asked and encouraged to choose what they wanted to eat however, there was no menu displayed and people with dementia were not shown food options. Food options given were the choice of two hot meals, but we saw alternatives such as sandwiches and cheese on toast being offered to those who did not want a hot meal.

Where people required assistance from staff to eat and drink, this was not provided in a way that meets best practice, for example, staff did not have the skills to communicate with people who they were assisting with eating their meal. Staff stood at the side of people instead of taking a seat by their side and encouraging them to eat at their own pace, not rushed. Visual aids, such as pictorial menus, and non-verbal communication skills were not used to support people with dementia make informed choices about their meals. Feedback about this was given after the first day of inspection. On the second day of inspection we observed only limited improvements in this area. We observed one person being offered a clothes protector but this was after food had already stained their clothing. A member of staff told this person they would support them to change after lunch however, on checking later in the afternoon, this had not happened. People had access to drinks throughout the day, however these were regularly placed next to the person and no encouragement throughout the day was given to prompt people to drink. This further demonstrated the lack of training and support for staff.

People who used the service gave positive feedback about the food they received. Their comments included, "Yes, the food is good here." Relatives we spoke to felt the food was good. One told us, "My relative enjoys the meals."

Care plans we reviewed clearly identified people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack 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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that although care plans reflected the principles of the MCA, some areas were not signed by people to provide consent where they had capacity to do so. Monitoring of the DoLS expiry dates for people in the service needed to be robust to ensure that the service was meeting its obligations, as the manager was unable to locate the list for some time. Once the list had been located we identified one out of date application that needed to be actioned immediately.

Records showed a range of healthcare professionals were involved in the care and treatment of people who used the service. We saw contact in care plans relating to dietetics, the community mental health team and speech and language therapists. Health care professionals confirmed they were contacted by the service. Comments from them included, "We are contacted when needed and I have confidence in certain members of staff, but not all, that action will be taken."

Requires Improvement

# Is the service caring?

## Our findings

The service was not always caring.

Overall we observed staff at the service had a desire to 'care' for people. We observed a senior care worker to have good knowledge of some people and how to communicate effectively with them to reassure and provide comfort. For example, when staff were supporting a person with a hoist, this person was becoming quite anxious. The senior care worker advised the care staff to talk to this person about specific topics that they enjoyed to offer a distraction. When that failed to help the senior care worker took over stating, "They are calmer with me." This seemed to calm the person down as the senior had anticipated.

However, our observations were that staff interaction with people was heavily task focused. Staff were observed to be very busy during the inspection and time spent with people was mainly focused around tasks including providing medication, supporting people to move and providing people with food or drinks.

During our inspection we completed a SOFI observation. We observed a group of four people in one communal lounge for a period of 40 minutes. Throughout the duration of the observation there was no interaction with staff at the service. Although one staff member entered the room on one occasion, they did not engage in communication with people in the lounge.

A lack of training in dementia meant that staff lacked knowledge in how to communicate with people they were supporting. We observed staff interaction to be at two very different extremes, either very limited or very loud and jovial. We were unsure whether the people staff were supporting were able to understand the level of 'banter' used by the staff team and felt that this was sometimes inappropriate.

The provider had a dignity and privacy statement in place which stated, 'This home believes that every resident has the right to live their life with privacy, dignity, independence and choice.' A dignity statement was held in each person's care plan detailing the standards expected within this policy. When speaking with staff they were only able to provide us with limited examples of how they respected people's dignity. Their responses included "Speaking quietly to respect their privacy" and "Be kind with them and listen." We observed staff respected privacy by knocking on resident's doors before entering rooms and closing doors on toilets and bathrooms when residents were in. The training matrix confirmed that staff had not attended any dignity training which was not in line with the provider's dignity and privacy statement.

Written information about people who lived at the service and staff was not always stored securely in locked cupboards to protect people's confidentiality. We found daily records and charts were located in the communal dining room throughout both days on inspection. We also found the lack of a filing and archiving system in the manager's office meant that documents were often hard to locate.

Relatives spoke positively about the staff. Comments included, "Staff are always really nice and approachable. I go to them with questions and they always try and help me understand [person's] needs" and "The staff seem very nice and they have a pleasant chat with me when I come in."

People's friends and relatives were welcome to visit, there were no restrictions to the amount of time they could spend at the service. Relatives we spoke with said, "I am always made to feel welcome" and "I am always welcomed by all staff at the service, even when a few of us visit, we get offered a cup of tea when we arrive."

There was information regarding advocacy services in the building. Advocates provide independent support to help ensure that people's views and preferences are heard. We observed documents confirming at least one person living at the service had support from an advocate at the time of the inspection.

People's cultural and religious needs were considered when care plans were being developed. Information about people's likes and dislikes and their religious beliefs was included within the care plan. The provider had an equality and diversity policy setting out a commitment to equality and diversity principles. One person received visits from a local religious leader and this visitor informed us they were always made to feel welcome and they were encouraged to visit on a regular basis.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive.

A pre admission assessment was completed before people moved into the service. This included a summary of needs for all areas of support the person may require.

We found that the manager had recently updated people's care plans. These plans included information about people's individual needs, such as; communication, pain management, social and religious needs, physical health and medication, continence, personal care and diet and nutrition. We found care plans to be person centred and respected people's ability to make their own choices. However, we found that staff had limited knowledge of what was written within the care plans. Improvements were required to ensure daily care needs were met and recorded. We found staff recording in daily notes to be repetitive and failed to accurately reflect how care was provided in line with the person's care plan.

The provider's expectation was that reviews of care plans would take place monthly. We found significant gaps in this over the last year. When reviews had taken place, this involved a signature to confirm the person's needs remained the same. This was not accurate on all occasions and therefore the review process was failing to identify possible changes in people's needs and support. For instance, we found that one person's care plan stated that they were awaiting information from a GP regarding their mobility. Each review afterwards stated that the care plan 'remained the same' without any record of chasing up this information from the GP or what this GP had advised. Improvements were needed to ensure that the review process was effective in ensuring that the care plan continued to meet the person's needs. The manager failed to provide an explanation for this when we discussed our concerns.

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

The service was failing to meet people's wider needs through the provision of any activities. We were informed that the provider employed one activities coordinator across a number of services but it had been some time since this person had visited the service. A poster was displayed within one of the communal lounges detailing weekly activities to be provided within the home but these were not being provided. Staff told us that the provision of activities needed to be improved. Comments included, "The only thing I would like to see improve is activities, even if just buying some games. It would be nice to sit with people and play dominoes or scrabble" and "I think we could do with more activities, we do what we can now and again, but people could do with more." There were no rummage boxes in communal areas and people did not have access to items which would distract them. A rummage box is a container filled with familiar items as a means of reminiscence.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was failing to meet the needs and preferences of people within the service and consistently deliver person centred care.

The provider had a complaints policy and procedure in place and this was on display within the service. Two complaints had been received and these were recorded on a complaints log. The provider had dealt with both complaints received by conducting an investigation and responding to the complainant with an outcome.

There was the option within people's care plan to record their end of life preferences. In the care plans that we saw it was recorded that people had chosen not to discuss this at this time but that it was important to revisit this with this person at later date. The training matrix showed that only one staff member had received training in end of life care and this was five years ago therefore staff were insufficiently trained to facilitate discussions with people in this area.

Requires Improvement

# Is the service well-led?

## Our findings

The service was not always well-led.

We found that quality assurance systems were not effective or robust and there was a lack of managerial oversight by the manager and provider.

Record keeping within the service needed to be more robust. The provider and manager were failing to ensure that accurate and complete records of care were being maintained for each person who used the service. Examples included inaccurate and incomplete recording of food and fluid charts. We observed these records did not reflect what the person had actually consumed on the day and totals were not calculated or monitored. This meant the provider was unable to assess whether people's nutritional and hydration needs had been met and whether any risks had been identified or action required.

Measures put in place to ensure people's safety, such as regular night checks or repositioning charts for pressure relief were not sufficiently detailed or consistently recorded to confirm whether checks had been undertaken. The manager and provider were therefore unable to be satisfied that risks to people were being managed in relation to their night time safety and their tissue viability.

Staff notes made in daily records were minimal, repetitive and failed to reflect care as described within people's care plans.

Although the manager had recently completed some audits in the service these had failed to identify most of the concerns that we had found during our inspection. Care plan audits had failed to identify ineffective recording and gaps in monthly reviews. We found an infection control audit had been completed and actions had been identified, however, these actions had not been completed within the set timescale.

We found that although staff felt supported by the manager there had been a lack of consistent supervision and development of the staff team. Plans were being put into place to address this but gaps in knowledge and skills had impacted on the delivery of person centred care that met the needs of the people who used the service.

Safety checks of bed rails and mattress were not in place and the provider lacked knowledge of best practice in this area. Risk assessments were not in place for access to the garden. This meant that the risk to people was not being managed safely.

The provider had no registered manager in post. The manager of the service had been in post since January 2018 and although they expressed an intention to register with CQC their application had yet to be completed.

Feedback on the second day of inspection was provided to the manager and the regional manager. Despite the severity of the concerns we had, limited responses and actions were provided as reassurance that action

would be taken.

A lack of good governance of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we wrote to the provider and requested an action plan to be provided to inform CQC how they intended to address the concerns that we had identified during the inspection. This was returned to CQC in a timely manner.

Relatives we spoke with advised that they had not been invited to any meetings to share their views and feedback about the service or been given surveys to complete. The provider advised us that a relative's survey was due to be distributed the following month. Relatives spoke highly of the manager and comments included, "They are very approachable and professional."

The manager was building positive relationships with visiting professionals. Visiting professionals we spoke with confirmed this. Comments included, "I have confidence in speaking with the manager and knowing that they will get things done. They have shown a real commitment to improving relationships between the services." Another visiting professional stated, "All staff are welcoming when we come in. I have found the manager to be approachable."

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. Following our site visits we were made aware of some intelligence regarding some possible failures to notify CQC. This is being addressed outside of the inspection process.

Previous CQC inspection ratings were displayed within the service; however they were not being displayed on their website as required. This is being addressed outside of the inspection process.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>A lack of activities meant the service failed to meet people's wider needs.<br><br>Care plan reviews failed to capture people's change in needs.<br><br>Although care plans reflected people's preferences staff had limited knowledge of what was written within care plans. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Infection control measures were not in place to prevent the risk of spread of infection. Health and safety checks were not in place to reduce risks. Medication procedures required improvement to ensure people received their medications as prescribed, at the right time and medication is stored at a safe temperature. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The services premises and equipment were poorly maintained. The premises did not effectively meet the needs of the people in the service. |

| Regulated activity | Regulation |
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| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality assurance systems had not picked up on some the shortfalls identified during the inspection and where actions had been identified, these were not completed in a timely manner.<br><br>A lack of robust record keeping meant that the provider could not be assured effective risk management plans were in a place and that people received person centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment procedures were not sufficiently robust to record people's full employment history and to ensure people did not start work before they had a DBS in place. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not been provided with regular supervision, a thorough induction or on-going training to support them to understand their role and meet the needs of people. |