Morleigh Limited

Tregertha Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Tregertha Court is a care home that provides personal care for up to 38 older people, some of whom have a diagnosis of dementia. The service is part of the Morleigh group of care homes. On the day of the inspection there were 23 people living in the service.

The service is required to have a registered manager and there was one in place. A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

We carried out this unannounced comprehensive inspection of Tregertha Court on 23 November 2016. At this inspection we checked to see if the service had made the required improvements identified at the inspection of 6 April 2016.

In April 2016 we found concerns in relation to recruitment, the heating and hot water system, a faulty stair lift and a lack of assessments to identify any risks to people using the stair lift. There were also concerns that food and fluid charts were inconsistently completed.

At this inspection we found the stair lift, identified as faulty at the inspection in April 2016, had been replaced and was working. However, one of the stair lifts to the top floor was not working. The registered manager had taken appropriate action to ensure people could still come downstairs. However, the provider had not taken any action to arrange for this lift to be repaired.

We also found three bathrooms with baths and sinks that had water with a temperature of 59 degrees Centigrade coming from the hot taps. Three toilets and seven bedrooms also had sinks where hot taps had a water temperature of 59 degrees Centigrade. This included the sinks in the two bathrooms identified at the inspection in April 2016. Hot water at this temperature is a scalding risk, as the recommended water temperature for older people is a maximum of 44 degrees Centigrade.

The registered manager told us that the heating and hot water system worked in such a way that the temperature of the heating and the hot water could not be regulated separately. The heating had been turned up during the week beginning 7 November 2016 because the radiators in some parts of the service were not warm enough for people. It was after the temperature had been increased on the boiler, that the registered manager became aware, two days before our visit, that one bedroom had very hot water. However, an audit of the entire building had not been carried out to check if any other rooms were affected, which was the case when we checked at the inspection. We had not received any assurances from the provider that action was going to be taken to address this serious concern. This meant people were not protected from the risk of water that was too hot or living in a building that was inadequately heated.

Recruitment systems were not robust. At the inspection in April 2016 we found a new member of staff was

working unsupervised, even though their Disclosure and Barring Service (DBS) check had not been received. At this inspection records for three new staff, recruited in September and October 2016, showed that they had started to work before their DBS checks had been completed. Staff we spoke with confirmed they had shadowed for a maximum of two shifts before working unsupervised and they had started to work before they received a copy of their DBS check. This was despite the provider telling us after the inspection in April 2016 that recruitment systems had been improved and staff would not start to work unsupervised until their DBS check had been received. The failure to complete necessary checks, before allowing staff to provide care, exposed people to unnecessary risk and did not protect people from the potential risk of harm from being supported by staff who were not suitable for the role.

Where people were identified as being at risk of losing weight staff monitored people's food and fluid daily intake to ensure they had enough to eat and drink. However, we found there were some inconsistencies in the way this information was recorded. Medicines were mostly safely managed, however, there were gaps in recording that meant it was not clear if one person had received their medicines as prescribed.

People told us they were happy living at Tregertha Court and with the staff who supported them. Comments from people included, "It's OK living here" and "I like living here. I have my own buggy and I can go out when I want to." A relative said, "Very happy with Mum's care."

Staff had good knowledge of the people they cared for and made appropriate referrals to healthcare professionals when people needed it. Staff worked with GPs and community nurses to ensure health conditions, such as diabetes, were well managed. Visitors told us staff always kept them informed if their relative was unwell or a doctor was called.

Care records were up to date, had been regularly reviewed, and accurately reflected people's care and support needs. Details of how people wished to be supported were personalised to the individual and provided clear information to enable staff to provide appropriate and effective support.

Where people did not have the capacity to make certain decisions the service acted in accordance with legal requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People and their families were given information about how to complain. Where complaints had been received these had been dealt with appropriately and resolved to the complainant's satisfaction.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Tregertha Court and has been rated as Requires Improvement since the first rated inspection carried out in March 2015. This inspection was the third inspection the Care Quality Commission has carried out since March 2015. At each inspection there have been breaches of the regulations. Concerns found at this inspection about hot water, with a scalding risk for people, and inadequate recruitment practices, were also raised at the inspection in April 2016.

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 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 put at risk of harm because the premises and equipment were not properly maintained.

Recruitment practices were not safe. Relevant employment checks, to ensure staff were suitable to work with vulnerable people, were not carried out before new staff started to provide care for people.

While medicines were mostly safely managed, there were gaps in recording.

Is the service effective?

Requires Improvement

The service was mostly effective. Staff had a good knowledge of each person and how to meet their needs.

Staff received on-going training and informal support so they had the skills and knowledge to provide effective care to people. It was not clear from records if staff received regular formal supervisions and appraisals.

People had access to external healthcare professionals as they needed. Monitoring of people's food and fluid intake was inconsistently recorded.

Management and staff understood the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

People and their families were involved in their care and were asked about their preferences and choices. Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

Staff supported people to take part in social activities of their choice.

People and their families told us if they had a complaint they would be happy to speak with the manager and were confident they would be listened to.

Is the service well-led?

Inadequate

The service was not well-led. The provider had not adequately assessed, monitored and mitigated the risks to people living in the service.

When areas of the premises were identified as needing to be repaired, these were not always responded to in a timely manner.

Audit processes were not effective as these had failed to identify shortfalls in relation to the premises and recruitment practices.

Records relating to the monitoring of people's care were not consistently maintained.

Tregertha Court Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 23 November 2016. The inspection team consisted of two inspectors.

We reviewed the Provider Information Record (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed information we held about the home including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with four people who were able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. However, we observed care practices during the inspection. We also conducted a complete tour of the premises.

We spoke with two care staff, two kitchen staff, one domestic and the registered manager. We also spoke with two relatives and a visiting healthcare professional. We looked at four records relating to the care of individuals, medicines records, staff training records and records relating to the running of the home.

Inadequate

Is the service safe?

Our findings

In April 2016 we found the premises and equipment were not properly maintained. The stair lift on the main staircase broke down on the day of that inspection. This prevented people in upstairs rooms, who were not independently mobile, from going up or down stairs as this was the only method available.

We found there had been on-going problems with the heating and hot water in some areas of the building. Two bathrooms had sinks with a hot water temperature recorded at 50 degrees Centigrade, which was too hot to be safely used by people living at the service. Hot water at this temperature is a scalding risk, as the recommended maximum water temperature for older people is 44 degrees Centigrade.

At this inspection we found the stair lift had been replaced and was working. However, one of the stair lifts to the top floor had stopped working a few days before our visit. The two people who were reliant on this lift to go down to the next floor, and then to the ground floor to use the lounge and dining room, had been moved to other rooms on the middle floor. This meant they were able to go downstairs should they wish to. The registered manager told us they had reported the breakdown of the stair lift to the provider. However, the provider had not taken any action to arrange for this lift to be repaired.

At this inspection we found three bathrooms with baths and sinks that had water with a temperature of 59 degrees Centigrade coming from the hot taps. Three toilets and seven bedrooms also had sinks where hot taps had a water temperature of 59 degrees Centigrade. This included the two bathrooms identified at the inspection in April 2016. One of the bedrooms had been identified as having extremely hot water, by the registered manager, two days before our visit. There was a notice displayed in the person's room to warn them and staff not to use it. The registered manager carried out monthly checks of water temperatures. The last audit dated 3 November 2016 showed that water temperatures were within the acceptable range.

On the day of the inspection the registered manager turned down the temperature setting on the boiler to try and bring down the water temperatures in the rooms identified. However, the water temperatures had not come down by the time we finished the inspection. The registered manager told us that the heating and hot water systems worked in such a way that the temperature of the heating and the hot water could not be regulated separately. The heating had been turned up during the week beginning 7 November 2016 because the radiators in some parts of the service were not warm enough for people. It was after the temperature had been increased on the boiler, to ensure the service was warm enough, that the registered manager became aware of the one bedroom with very hot water. However, an audit of the entire building had not been carried out to check if any other rooms were affected, which was the case when we checked at the inspection.

We were advised, the day after the inspection, that because the temperature of the boiler had been lower for over 24 hours, the hot water temperatures in the rooms we identified had reduced. However, all of these rooms still had hot water temperatures of between 48-49 degrees Centigrade. This remained a scalding risk to people living at the service. The registered manager told us they were checking the hot water temperatures twice daily and had carried out risk assessments for each person affected. All staff, and people

who accessed hot water independently, had been made aware of this risk. However, if the boiler was turned down any lower the heating would not work in some or all areas of the building. We had not received any assurances from the provider that action was going to be taken to address this serious concern. This meant people were not protected from the risk of water that was too hot or living in a building that was inadequately heated.

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

Recruitment systems were carried out centrally for the Morleigh group as a whole and these were not robust. At the inspection in April 2016 we found a new member of staff was working unsupervised, even though their Disclosure and Barring Service (DBS) check had not been received. After the inspection we asked the provider to tell us what action they intended to take to improve their recruitment systems. We were advised by the provider that recruitment procedures had been changed and staff would not work unsupervised until a DBS check had been completed.

At this inspection, records for three new staff recruited in September and October 2016, showed that they had started to work before their DBS checks had been completed. The period of time after each new staff member had started to work in the service, before the DBS check had been completed, ranged from three weeks to seven weeks. Staff we spoke with confirmed they had shadowed for a maximum of two shifts before working unsupervised and they had started to work before they received a copy of their DBS check. The registered manager told us that if there were any delays in DBS checks being received then sometimes staff might work unsupervised until the check was completed. This showed that the provider had not made the changes to the recruitment practices, despite telling us they had.

This meant the provider did not have the information required in respect of all employees as specified in Schedule 3(2) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk and did not protect people from the potential risk of harm arising from being supported by staff who were not suitable for the role.

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

Medicines were mostly managed safely at Tregertha Court. All medicines were stored appropriately and Medicines Administration Record (MAR) charts were fully completed. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. Where people were prescribed pain relief by means of a skin patch, 'body maps' were completed to record where and when patches were sited. This helped to ensure that patches were changed safely and the site was rotated as directed. The amount of medicines in stock tallied with the records kept.

A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records demonstrated room and medicine storage temperatures were consistently monitored. This showed medicines were stored correctly and were safe and effective for the people they were prescribed for. Staff had received appropriate training in administrating and managing medicines and weekly audits were completed by the manager.

Records showed one person had not been given their teatime medicines, the day before our inspection. They had attended a hospital appointment that day and had not returned to the service until 7pm. A stock

check, carried out during the inspection, showed the person had received one of their medicines, one had not been given and for two it was not possible to be certain because the medicines were in liquid form and could not be accurately checked. The registered manager told us they thought that the missing medicines may have been given by the hospital. However, there were no records to confirm if this person had been given their medicines by hospital staff. This meant we could not be sure the person had received their medicines as prescribed.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were enough staff on duty to meet people's needs. On the day of the inspection there were three care staff and a senior on duty from 8.00am until 8.00pm. In addition the registered manager worked all day and there were kitchen, and housekeeping staff on duty. An activities coordinator worked for two hours in the afternoon. The staffing levels had been increased by one member of care staff in the afternoon three weeks prior to the inspection to meet the needs of 23 people, the same number as at our last inspection. Staff told us the increase in staffing levels was very helpful. A visiting healthcare professional told us, "I had raised concerns with the service about the staffing levels and I am pleased to see the levels have been increased."

Care records included informative risk assessments. These documents provided staff with guidance and direction on how people should be supported in relation to each specific identified risk. For example, risk assessments for when staff needed to help people mobilise explained how many staff would be needed to carry out the procedure and the type of equipment to be used. People who needed staff to assist them to mobilise, using a hoist, were allocated individual slings. The size of sling used had been assessed to meet each individual person's needs.

Records showed that manual handling equipment, such as hoists and bath seats, had been serviced. There was a system of health and safety risk assessment in place. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills.

Incidents and accidents were recorded in the service. We looked at records of these and found that appropriate action had been taken and where necessary changes made to learn from the events.

Requires Improvement

Is the service effective?

Our findings

Staff told us they felt supported by the registered manager and senior care workers. They told us they had received an annual appraisal to discuss their work and training needs and had regular supervision. However, the matrix showing when staff had received supervision did not correspond to the information in individual staff files. We were not given any information to confirm that annual appraisals had taken place.

Some people were at risk of losing weight due to receiving poor nutrition. Food and fluid monitoring was in place for some people living at the service. We found records in bedrooms where staff had recorded what people ate and drank each day. However, these records had not been totalled and did not state what was the assessed level each person needed to eat and drink. This meant it was not possible for staff to accurately monitor if people were having the correct level of food and fluid intake to meet their needs and to know when further action may need to be taken.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us they had received relevant training for their role and training was regularly updated. The training matrix we looked at confirmed that staff received regular training. New staff completed an induction when they started employment which included training identified as necessary for the service and familiarisation with the service's policies and procedures. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. The service's induction incorporated the Care Certificate. This is designed to help ensure care staff, who are new to care, have a wide theoretical knowledge of good working practice within the care sector.

We observed the support people received during the lunchtime period. Staff asked people where they wanted to eat their lunch and most people chose to eat in the dining room. There was an unrushed and relaxed atmosphere and people talked with each other, and with staff. People were given plates and cutlery suitable for their needs and to enable them to eat independently where possible. One person told us, "It's always good food here. There is enough for me and I can always ask if I want anymore." People were provided with drinks throughout the day of the inspection and at the lunch tables.

Staff had good knowledge of the people they cared for and made appropriate referrals to healthcare professionals when people needed it. Staff worked with GPs and community nurses to ensure health conditions such as diabetes were well managed. A visiting healthcare professional told us, "There is good communication with staff and they always report any concerns about people's needs to us appropriately." Visitors told us staff always kept them informed if their relative was unwell or a doctor was called.

Care records showed that people, or their advocates, had given their consent to their current support arrangements. We observed throughout the inspection that staff asked for people's consent before assisting them with any care or support. People made their own decisions about how they wanted to live their life and spend their time.

The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). 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. At the time of our inspection the registered manager had made DoLS applications for twenty people who lived at the service.

Staff applied the principles of the MCA in the way they cared for people and told us they always assumed people had mental capacity to make their own decisions. Care records detailed whether or not people had the capacity to make specific decisions about their care. Records showed where decisions had been made, on a person's behalf; the decision had been made in their best interest at a meeting involving key professionals and their family.

The environment was clean and odour free. Signage was around the building to help people living with dementia to identify their rooms and toilets and bathrooms.

Good

Is the service caring?

Our findings

On the day of our inspection there was a relaxed atmosphere in the service. We observed people had a good relationship with staff and staff interacted with people in a caring and respectful manner. People told us they were happy living at Tregertha Court and with the staff who supported them. Comments from people included, "It's OK living here" and "I like living here. I have my own buggy and I can go out when I want to." A relative said, "Very happy with Mum's care."

The care we saw provided throughout the inspection was appropriate to people's needs and enhanced people's well-being. Staff were friendly, patient and discreet when providing care for people. They took the time to speak with people as they supported them and we observed many positive interactions that supported people's wellbeing. For example, we saw staff assisting one person to move from an armchair to their wheelchair. Staff were patient and gentle explaining every step of the manoeuvre and talking to them throughout the procedure to prevent them from becoming anxious.

People were prescribed continence aids which met their individual needs. When we looked around the service we saw continence aids were in each person's room and these belonged to them. There was a dedicated continence professional linked to the service who responded to referrals made by the registered manager.

The service promoted people's independence and encouraged them to maintain their skills. We saw examples during lunchtime of staff cutting up people's food and providing plate guards to enable people to eat independently.

People were able to make choices about their daily lives. People's care plans recorded their choices and preferred routines. For example, what time they liked to get up in the morning and go to bed at night. People told us they were able to get up in the morning and go to bed at night when they wanted to. People were able to choose where to spend their time, either in one of the lounges or in their own rooms. We saw staff asked people where they wanted to spend their time and what they wanted to eat and drink.

Some people living at Tregertha Court had a diagnosis of dementia or memory difficulties and their ability to make daily decisions could fluctuate. Staff had a good understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible. Care plans recorded details of people's life histories and known likes and dislikes

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

Staff supported people to maintain contact with friends and family. Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in one of the lounges or in

their own room.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs because staff were aware of the needs of people who lived at Tregertha Court. Staff spoke knowledgeably about how people liked to be supported and what was important to them.

Care records were up to date, had been regularly reviewed and accurately reflected people's care and support needs. Details of how people wished to be supported with their care needs were personalised to the individual and provided clear information to enable staff to provide appropriate and effective support. These were reviewed monthly or as people's needs changed. Care plans gave direction and guidance for staff to follow to meet people's needs and wishes.

Staff were provided with information about how to support people who could sometimes display behaviour that was challenging for staff to manage. For example, for one person their care plan explained that the person could sometimes be verbally aggressive when staff provided them with personal care. The person's care plan instructed staff to, "Staff to take the time to talk to [person's name] and explain what is happening. Ensure they have the radio or television on as this calms them."
People, who were able to, were involved in planning and reviewing their care. Where people lacked the capacity to make a decision for themselves, staff involved family members in writing and reviewing care plans.

Staff told us care plans were informative and gave them the guidance they needed to care for people. Daily records detailed the care and support provided each day and how they had spent their time. Staff were encouraged to give feedback about people's changing needs to help ensure information was available to update care plans and communicate at handovers.

People had access to activities of their choice. Care plans reflected people's individual choices and preferences and how they liked to spend their time. An activities coordinator worked between 2pm and 4pm every afternoon from Monday to Friday. On the day of the inspection we saw some people taking part in a singing session. Other activities included, craft work, quizzes and baking. There was a replica of an old style sweet stall in the dining room with fruit and snacks, including diabetic snacks, available for people to eat as they wished.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. We looked at the records of a recent complaint from a relative who was concerned that the person was not having regular baths. The registered manager had invited the relative into the service each week to assist staff when the person had a bath to see if the person may respond more positively to a family member being present. This had proved to be successful and after a few weeks the person was happy for staff to give them a bath without their relative being there.

Inadequate

Is the service well-led?

Our findings

At the inspection in April 2016 we had concerns about the suitably of the environment and the maintenance of the premises. The provider had not taken sufficient action to repair or replace a faulty stair lift. There was hot water in two bathrooms, with a scalding risk to people, and the heating system intermittently broke down and some areas of the premises were not warm enough for people. Despite audit systems being in place these had not identified that food and fluid charts were not being consistently recorded. Recruitment systems were not robust and people were at risk of receiving care from staff who were not suitable to work with vulnerable people.

At this inspection we found the water temperatures in the two bathrooms, identified in April 2016, still had water with a high temperature. In addition we found another bathroom, three toilets and seven bedrooms where the water temperature was too high. This was despite monthly checks of all water temperatures. The registered manager told us that the heating and hot water system worked in such a way that the temperature of the heating and the hot water could not be regulated separately. This meant the provider did not have effective systems to maintain the premises or have adequate oversight to ensure there was a suitable and safe environment for people to live in. The provider had failed to recognise the risk to people by the service having a boiler that could not safely regulate water temperatures and heat the service to an acceptable level.

The provider had failed to improve their centralised recruitment practices despite being required to do so after the last inspection of this service in April 2016. At the inspection in April 2016, and the inspection of another care home owned by Morleigh Limited in January 2016, we found new staff were working before Disclosure and Barring Service (DBS) checks had been completed. As a result of these findings we met with the provider in April 2016 to discuss what action they intended to take to improve the recruitment procedures across all six of their care homes, including this one. Notes from that meeting recorded that the provider told us, "New systems have been out in place and explained to all managers. New staff will not be offered the job until the first part of the DBS check has come through and will not work unsupervised until the full DBS is completed."

Despite these assurances, as detailed in the safe section of the report, records showed that three staff had started to work before Disclosure and Barring Service (DBS) checks had been completed. The registered manager confirmed that staff shadowed other staff for a few shifts before they worked unsupervised and sometimes they may start to work unsupervised before the DBS was completed, if the DBS check was delayed. This showed that the provider was not willing to make the required changes to recruitment practices to comply with the regulations and ensure people were safe.

Requests for maintenance and repairs were not always responded to in a timely and appropriate manner. The main stair lift, identified as being faulty at the inspection in April 2016, had been replaced in September 2016. However, during the period between 6 April 2016 and 26 September 2016, when a new lift was installed, we received several concerns from relatives that the stair lift continued to regularly break down. We contacted the provider each time a concern was raised and asked them what action they intended to

take. On each occasion we were assured that an engineer had been called out and the lift had been repaired. A relative told us at this inspection, "There was a problem with the stair lift, and I can't understand why it took so long to mend it."

At this inspection another stair lift, for people to use who lived on the top floor, was not working. The registered manager arranged for people, who needed to use the stair lift, to move to rooms on the lower floor. However, the provider had not taken any action to ascertain if the lift could be repaired or if it needed to be replaced. The registered manager completed a weekly maintenance report for the provider to action. Records showed that action was not always taken. For example, when an Environmental Health inspection was carried out for the kitchen in September 2016 there was a requirement that repairs were needed to the paintwork on one of the kitchen walls. The request for this work to be completed was recorded on each weekly maintenance list since that inspection. The registered manager told us they had arranged to have this work completed, at their own cost, because the provider had not actioned it. This showed the provider did not have an adequate system in place to ensure necessary repairs and maintenance were carried out to the premises.

The Morleigh group carried out annual surveys to gather the views of people living in each service and their families. When surveys were returned these were collected and collated centrally at the provider's head office. The manager told us surveys were given to people and their families to complete in April 2016. However, they were not aware of any results of these as this information had not been passed to the service. This meant the registered manager was unaware of any concerns highlighted in surveys and therefore was unable to address them. The systems in place to drive improvement within the service were not effective

Some records in the service were not accurately completed. Some people needed to have their food and fluid intake monitored. The associated records did not contain enough information to accurately establish if people were receiving adequate food and drink. There were some gaps in the recording of when people were given their medicines. This meant there was a risk that people may receive inappropriate or inconsistent care because records of the care people received were not accurate.

Records relating to staff supervision and appraisals were incomplete. There were no records of staff having annual appraisals, although the registered manager and staff told us they had taken place. The matrix showing when staff had received supervision did not correspond to the information in individual staff files. This meant the provider did not have accurate information about how staff were being supported in their role.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Tregertha Court and has been rated as Requires Improvement since the first rated inspection carried out in March 2015. This inspection was the third inspection the Care Quality Commission has carried out since March 2015. At each inspection there have been breaches of the regulations. Concerns found at this inspection about hot water, with a scalding risk for people, and inadequate recruitment practices, were also raised at the inspection in April 2016.

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

The service is required to have a registered manager and there was one in post. The registered manager had managed the service since November 2015 and became the registered manager in May 2016. The registered manager had a good knowledge of the needs of people living at Tregertha Court and regularly spoke with people so they were aware of people's views of the service. The registered manager was visible in the service

and had earned the respect of staff in the time they had been the manager.