# Ablecare (Philiphaugh) Ltd

# Philiphaugh Manor

**Inspection report**

Station Road
St Columb,
Cornwall,
TR9 6BX
Tel: 01637880520
Website: www.philiphaughmanor.co.uk

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## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This unannounced inspection took place on 22 and 24 September 2015. The service was purchased by the current provider in the summer of 2014 and has not been inspected since this change of ownership.

Philiphaugh Manor provides accommodation and personal care for up to 30 people who do not require nursing care. At the time of this inspection there were 19 people living at the service. Some people were living with dementia.

The service uses a detached house located within it's own gardens. Accommodation is available on two floors. At the time of our inspection only the ground floor rooms were in use as the first floor area was in the process of being refurbished.

The service had a registered manager. However, the registered manager had not been present in the service for an extended period and the provider had formally notified us of this period of absence. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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.

People told us they felt safe and comfortable at Philiphaugh Manor. People's comments included; "I have continuous care day and night. If I need anything else I just use my call bell and they come running" and, "they care for me, nothing is too much trouble." While staff told us; "We put the clients before ourselves, so they are safe" and, "the residents are all lovely and I give 100% to look after them."

We found the service was short staffed, with only two of the planned four carers on duty at the beginning of our inspection. Staff told us they were tired and reported that they found the service's 13 hour shifts difficult. The service's staff roster showed some staff had worked excessive numbers of hours with insufficient rest periods. The provider recognised that staff rosters were inappropriate and took immediate action to address this area of concern. By the second day of our inspection a new staff roster had been introduced and staff told us the new roster was an improvement.

Staff cared for the people they supported and understood their individual care needs. People living in the service appeared comfortable, appropriately dressed and well cared for. Staff reacted promptly to call bells and other requests for support throughout our inspection.

Where staff identified concerns about individuals well-being they took prompt appropriate action to ensure the person's care needs were met. People regularly received visits from external health and social care professionals and staff routinely sought guidance from professionals to ensure people's needs were met.

Recruitment procedures were safe. However, new members of staff had not received formal induction training before providing care and the service had failed to ensure staff training needs were met. The provider had recognised this failure and at the time of inspection was in the process of making arrangements for the provision of additional staff training.

Staff and managers were not clear on the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. We identified that some individuals had care plans that were potentially restrictive, and the service had not applied for the appropriate authorisations.

The service provided tasty home cooked meals and people told us; "It's better food than I used to eat at home." We noted however, that menu choices were limited as there was only one hot option available at lunch time.

People's care plans did not provide staff with enough specific guidance to enable them to meet people's care needs. Care plans contained numerous general phrases many of which were inaccurate. We discussed these inaccuracies with the provider who told us the service's care plans had recently been reviewed and updated by staff who did not know the people who used the service well.

Staff told us they did not think there were enough activities for people to do at Philiphaugh Manor. Staff comments included; "I think activities should be done every day but we just don't have the time". The provider told us they valued activities within the service and were currently advertising for a full time activities coordinator.

The registered manager had been away for an extended period before the inspection. The provider had notified the commission of the extended period of absence but had failed to make appropriate arrangements for the management of the service. The provider had made arrangements for a deputy manager from another service to provide management support. However, this support had not happened and staff told us; "We could have done with more support while the registered manager was away".

During the registered manager's absence the relationship between the staff team and the provider had declined. Regular staff meetings had not occurred and information about significant changes to staff terms and conditions had not been effectively communicated to the staff team. Staff described how recent high workloads and changes to their pay and conditions had impacted on their morale.

In response to our initial feedback provided at the end of our first inspection day immediate action was taken to

# Summary of findings

address some of our concerns. In addition the registered manager returned to the service on the second inspection day and intended to begin a phased return to work during the week following our inspection.

We identified breaches of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014. You can see what action we told the provider to take to address these breaches at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe. The service was short staffed and staff told us they were tired. Staffing rosters showed that some staff had worked an excessive number of hours without appropriate rest periods.

The risk assessment documents were inaccurate and when incidents had occurred these had not been appropriately recorded or investigated.

The services recruitment procedures were safe.

**Requires improvement**

**Is the service effective?**

The service was not effective. New staff had not received induction training and the service had not provided existing staff with appropriate refresher training.

Staff did not understand the requirements of the Mental Capacity Act 2005. Some individuals had restrictive care plans without the appropriate authorisations having been requested.

The service worked effectively with Health and Social Care professionals to ensure people's care needs were met.

**Requires improvement**

**Is the service caring?**

The service was caring but staff did not consistently respect people's privacy and dignity.

Staff endeavoured to meet people's care needs and promptly responded to people's requests for support

**Requires improvement**

**Is the service responsive?**

The service was not responsive. People's care plans did not accurately reflect their individual care needs.

Activities were limited and staff told us they did not have enough time to support people to do meaningful activities.

**Requires improvement**

**Is the service well-led?**

The service was not well led. The provider had failed to ensure adequate management support was available during the registered manager's absence.

Communications between staff and the provider had not been effective and staff reported that issues and concerns they had raised had not been resolved.

**Requires improvement**

# Philiphaugh Manor

**Detailed findings**

## Background to this inspection

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

This inspection took place on 22 and 24 September 2015 and was unannounced. The inspection team consisted of two inspectors and one expert by experience. Philiphaugh Manor provides accommodation and personal care for up to 30 people who do not require nursing care. At the time of our inspection there were 19 people using the service.

Philiphaugh Manor was purchased by the current provider in the summer of 2014 and we have not inspected this service since it's change of ownership. Prior to the inspection we reviewed all of the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

The date of our inspection had been moved forward as a result of concerning information reported to the commission. As a result a Provider Information Record (PIR) was not available prior to our inspection. The PIR 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. During the inspection we were given a copy of the service's completed PIR and we reviewed this as part of our inspection process.

During the inspection we met and spoke with eight people who used the service, two relatives who were visiting, eight members of care staff, the registered manager, provider's nominated individuals and a director. A nominated individual is a person who has been appointed to represent the views of a service provider. We also spoke with one health and social care professional who regularly visited the service.

In addition, we observed; staff supporting people throughout the service, during the lunchtime meal and we visited three people who were being cared for in bed. We also inspected a range of records. These included five care plans, four staff files, training records, staff duty rotas, meeting minutes and the service's policies and procedures.

Requires improvement

# Is the service safe?

## Our findings

All of the people we spoke with told us they felt safe at Philiphaugh Manor. People said; "I have continuous care day and night. If I need anything else I just use my call bell and they come running" and "It's very nicely run and I have an alarm mat in my room to keep me safe." Staff told us; "People are safe, none of [the staff] would hurt anyone", "In my opinion people are safe" and, "We put the clients before ourselves so they are safe."

Philiphaugh Manor was short staffed. When we arrived, two and a half hours into the day shift, only two of the planned four care staff were on duty, supported by a team leader who was covering for the absent registered manager. Following our arrival the team leader was able to make arrangements for additional staff to come to the service.

We found that staff normally worked 13 hour day shifts within the service. The nominated individual told us that when this system had been introduced the intention was for full time staff to work three of these shifts one week and four shifts the following week. We reviewed the services staff roster for September 2015. We found staff were scheduled to work excessive hours and had not received appropriate rest periods. Two staff had been expected to complete 20 shifts each within the month. Staff told us they were tired and raised concerns that this may impact on the quality of care they provided. In addition we found there was no break room available to staff and staff reported that they were regularly disturbed during their break periods to respond to people's care needs. Staff told us; "We need more staff", "I don't think we have enough staff" and, "One day the deputy manager was cooking, doing meds and answering the phone, it was manic."

We raised our concerns about the staff roster and working hours during feedback at the end of the first day of inspection. The nominated individual reviewed the service's staff roster and recognised some staff were working excessively and not receiving appropriate rest periods. The provider took immediate action to address this issue and by the second day of our inspection a new staff roster had been developed. Staff told us the new roster was an improvement and that significant changes had been made to the numbers of shifts people were expected to complete.

**The failure to ensure there were sufficient numbers of staff available to meet people's care needs is a breach of Regulation 18(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

Posters about the local authorities safeguarding procedures were displayed on the service's notice board. However, when asked staff did not understand local procedures for the safeguarding of vulnerable adults. The nominated individual told us the provider's policy was for staff to complete safeguarding training each year. The service's training matrix recorded that only 10 of 24 staff had received annual safeguarding training. This contributed to the breach of regulation 11 detailed in the Effective domain of this report

There were no procedures in place for the documentation and investigation of significant incidents within the service. For example, we identified a significant incident recorded in the service's daily report book involving two people who used the service. This incident had not been documented in the individual's daily care records and had not been investigated by the service's management. We found similar incidents had been documented on other occasions within the daily care records but again found no evidence to show these incidents had been investigated by managers, or that appropriate referrals had been made to ensure people's safety.

People's care plans included risk assessment documentation. However, these assessments had not been fully completed and contained numerous gaps. Where assessments had identified risks, staff had not been provided with appropriate guidance on how to protect the person and themselves from the identified risks. For example one person's assessment said, "I am unable to readjust my sleeping position independently" but did not provide staff with guidance on how and when to support this person to change position.

**The failure to provide appropriate guidance on the management of identified risks and failure to adequately investigated incidents that had occurred represents a breach of regulation 12(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

Requires improvement

# Is the service safe?

Philiphaugh Manor's recruitment practices were safe. Necessary disclosure and baring service checks had been completed and people's references were reviewed before new members of staff were employed.

Medicines were stored appropriately and detailed records kept of the support each person had received in relation to the management of their medicines. Medicines Administration Record (MAR) charts were fully completed but where hand written additions had been made to the MAR these had not been countersigned in accordance with best practice. Senior care staff had all been provided with specific training on how to support people with their medicines. All medicines that require stricter controls by law were stored securely and accurately documented.

During our review of care planning documentation we found that one person's medicine was being mixed with their tea. Their care plan did not record whether or not the person had consented to receiving their medicine in this way and no specific risk assessments for providing medicine covertly had been completed.

During our inspection we observed staff using appropriate manual handling techniques to support people to mobilise around the service and staff told us, "I always make sure I'm using the right equipment." However, some of the lifting equipment used by staff had not been appropriately serviced to ensure its safe operation. Where accidents had occurred, we found these had been recorded in the services accident book. Where staff were concerned that a person may have been injured appropriate support had been requested form health professionals. Firefighting equipment had been regularly serviced and appropriate fire safety checks had been completed. Staff told us, **"**We do three or four fire drills each year."

Requires improvement

# Is the service effective?

## Our findings

Recently appointed members of staff had not received appropriate induction training. Staff told us their induction had consisted of a tour of the building and a fire awareness briefing prior to providing care to people who used the service. Training records showed recently appointed staff had not completed either the Common Induction Standards or Care Certificate training during their initial period of employment. The Care Certificate training is designed to ensure staff new to care work are provided with sufficient training to enable them to provide compassionate, safe and high quality care and support.

The service's training matrix showed that staff had not received regular training updates in subjects including, safeguarding vulnerable adults, manual handling, health and safety, first aid, and fire awareness. The provider had recognised that the service's current arrangements for ensuring staff received appropriate training were ineffective. Additional manual handling training courses were planned for the week of our inspection and the provider was in the process of arranging a number of additional training coursed with the service's external training provider.

**The failure to provide staff with an appropriate induction and regular training represents a breach of Regulation 18(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

Records showed staff had recently received supervision from managers. Records of these supervision meetings showed they had been beneficial for both staff and managers. However, staff records showed annual performance appraisals had not been completed.

Staff and the provider's nominated individual were not clear on the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting, and making decisions, on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they have an impairment that affects their decision making. Where necessary, the service had not used appropriate systems to assess people's capacity to make choices. For example one person's care plan recorded that they had a diagnosis of dementia. This person's care plan stated "I have full mental capacity to make decisions for myself". We discussed this person's capacity to make decisions with staff. Staff described how the person had capacity to make some decisions about their daily life but described a number of recent incidents where they had taken actions contrary to the persons wish's to ensure their safety. Another person's care plan said, "I have no capacity to make decisions for myself apart from if I say no." This person's capacity had not been appropriately assessed and their care plan did not provide staff with specific guidance in relation to the types of choices this person had capacity to make.

We found the service used a key pad lock system to enable staff and visitors to exit the front door, while keeping people that were not safe to leave the building without support from leaving. We also identified that a number of forms of surveillance and control including pressure alarm mats, bed rails and line of sight observations were routinely used by staff to ensure people's safety. Risk assessments, MCA assessments and best interest decisions had not been completed in relation the use of bed rails or pressure alarm mats. We asked staff what would happen if one specific individual asked to leave the home. Staff told us, "You would have to go with [the person]," as it was not safe for the person to go out on their own. Therefore the staff acknowledged that this person was not free to leave the building without an escort. However there were no current DoLS authorisations for anyone at Philiphaugh Manor to be deprived of their liberty. During our inspection we identified a number of individuals who did not have capacity to make decisions and who were unable to leave the home. We instructed the nominated individual to review the forms of control used by the service and to immediately discuss our concerns with the local authority DoLS team.

**The failures in relation to the requirements of the Mental Capacity Act represent a breach of regulation 11 of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

The service provided tasty home cooked meals and people told us; "It's better food than I used to eat at home" and, "We get drinks, tea and coffee usually every two hours, but they don't always bring a biscuit". People enjoyed their meals and we saw staff providing encouragement and appropriate support to enable people to eat

Requires improvement

# Is the service effective?

independently. The main meal of the day was served at lunch time. However, the lunch menu was limited with only to one hot menu option and a dessert offered. The service's cook told us they were able to provide something else if a person preferred. The service's kitchen had been awarded four stars out of five at its most recent Food Standards Agency inspection for food hygiene. We discussed this result with the cook who explained that damaged flooring in the entrance to the kitchen had impacted on the service's rating.

One person told us, "I've had a doctor visit recently because of an infection" and their care records demonstrated the service made prompt and appropriate referrals to health and social care professionals to ensure people's needs were met. Within people's care plans we found evidence that demonstrated people had been regularly visited by a variety of professionals including, GPs, district nurses, dentist, opticians and chiropodists.

At the time of our inspection the service was in the process of being refurbished. All rooms on the first floor were currently unoccupied and one room was being redecorated during our inspection. We noted that the carpet on the stairs was threadbare and the nominated individual told us this carpet was due to be replaced as part of the current refurbishment process. We discussed the refurbishment process with the nominated individual who explained the provider's intentions to install a lift and replace the carpets as part of the refurbishment.

On the ground floor the service was appropriately decorated and well maintained. The service's defect book showed that all reported issues with the environment on the ground floor had been addressed and resolved promptly. People's bedrooms were clean and had been personalised by the addition of paintings, pictures and other personal items. Maintenance staff told us, "They are improving the place all the time" and care staff commented, "The environment is improving".

Requires improvement

# Is the service caring?

## Our findings

People and their relative's told us staff at Philiphaugh Manor were caring. People's comments included, "Very much so they care for me, nothing is too much trouble" and, "I like to get up early and do things myself, I'm like that and they don't mind." One person's relative said, "Everything is working out well with [my relative]."

Staff knew the people they supported well and understood how to meet people's specific care needs. Where people's care plans lacked detailed information we asked staff how they supported people. All staff were able to provide detailed explanations of people's care needs and describe how they ensured these needs were met. Staff told us, "We have always done good care" and "The residents are all lovely and I give 100% to look after them."

Staff quickly identified any changes to people's care needs and took appropriate actions to ensure their comfort within the service. During our inspection staff identified that one person was feeling unwell and was in pain. We saw that staff reacted promptly to this incident and immediately sought advice from the person's GP, who prescribed additional medicines. Staff quickly confirmed with the local pharmacist that the new medicines were available and made arrangements for their prompt delivery to the service.

People living in Philiphaugh Manor appeared comfortable, appropriately dressed and well cared for. A call bell system was available within the service to enable people to request support from staff in their rooms. We observed that staff responded promptly to call bell alarms and other requests for support.

We spent time in the lounge and dining room observing interactions between staff and people who lived at Philiphaugh Manor. During both mornings we were at the service people tended to spend their time in the lounge. The television was on but most people were not watching it, preferring to sit quietly together. We noted communication between people and staff was often limited to the particular task staff were involved in. Staff were generally busy in the mornings and unable to spend time talking with people in the communal areas. During the afternoon staff had more time to interact with people on an individual basis.

People told us their care staff respected their privacy and dignity and one person commented, "I like my own company but the girls knock on my door to see if I'm ok." Staff told us they always respected people privacy and that people were able to lock their bedrooms if the wished. One staff member said, "I always close the door and curtains to give people respect and dignity." However, during our inspection we found people's privacy and dignity was not consistently respected. The locking mechanism for the toilet adjacent to the lounge was broken. We observed staff supporting a person to use these facilities. The staff member closed the door to give the person privacy. After a short period the staff member opened the door to check the person. The staff member failed to knock on the door or inform the person that they were about to open the door. This failure meant the person privacy and dignity were not respected. In addition while touring the building we found that people's clothes, including undergarments, had been left on windowsills outside bedrooms for most of the first day of our inspection. Some staff practice was not respecting peoples' privacy and dignity at all times.

Requires improvement

# Is the service responsive?

## Our findings

People's care plans included generic phrases and lacked specific guidance on how to meet people's care and support needs. During our inspection we identified numerous examples where these generic phrases were inaccurate and did not reflect the person's current care needs. For example, one person's care plan said, "I am able to brush my own hair." We asked staff about this person's care needs and were told this information was incorrect. Another person's care plan said, "I have good communication skills". When we visited this person we were unable to communicate effectively with them. We asked staff about this person's ability to communicate and were told, "[the person] does not speak at all."

We discussed the care plans with the nominated individual who explained that during a recent local authority quality assurance visit the quality of people's care plans had been raised as an issue. In order to address this concern all of the service's care plans had been reviewed and updated. However, these reviews had been completed by staff who did not know the individuals well and the nominated individual recognised the new care plans were not sufficiently accurate or detailed to enable new staff to meet people's specific care needs.

The provider had recently introduced a key worker system where named staff were given the responsibility of monitoring and reviewing named people's care plans to ensure they accurately reflected their needs. However, this system had not yet become embedded within the service and staff were unclear what the role of the key worker involved.

People's care plans lacked information about their life history, hobbies and interests. This meant that staff could not support people effectively with activities they enjoyed as they had not been provided with information about people's individual interests. Each person's care plan included a section titled 'My life so far'. This section of the care plan was blank in the care plans we reviewed. In addition, 'My life history books' designed to help staff understand people's backgrounds and interests, were available for some people. Most of these books were also blank and those that did include information had not been read by staff. Staff comments in relation to 'My life history books' included, "We started them about a year ago but have not had the time to do them" and, "I've never seen them before."

During both days of our inspection most people spent time in the lounge area. There was a noticeable lack of activity within the lounge throughout both mornings of our inspection. During the afternoon of our first day we saw two staff reading magazines and discussing photograph albums with people in a quiet area, while a balloon passing game was facilitated by a member of domestic staff. People obviously enjoyed this game and this led to greater communication between people in the lounge.

Staff told us they did not think there were enough activities for people to do at Philiphaugh Manor. Staff comments in relation to activities included; "I think activities should be done every day but we just don't have the time" and, "If it was my parent I would like them to be able to do a little more." We discussed current arrangements for activities with both the nominated individual and director. They explained there was currently a vacancy within the service for a full time activities coordinator. This post had been widely advertised but the service had been unable to fill the vacancy. The director told us they recognised the importance of providing activities within the home and as an interim measure they had asked a member of staff to organise four hours of activities each week in addition to monthly visits by an external fitness instructor.

The services website indicted that a minibus was available to enable people to access local visitor attractions. We asked people and staff how regularly they went out for trips away from the service. People told us they had last used the minibus at Christmas 2014 and one person said, "It would be nice if they could take us out in the minibus more often." Staff commented, "People don't go out" and, "[the minibus] has been used once here." We discussed our concerns in relation to the current lack of activities within the service during feedback at the end of our first inspection day. During our second inspection day we saw the provider's minibus was available at the home.

**The failure to provide appropriate guidance for staff and support to enable people to engage with activities represents a breach of regulation 9(3)(b) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

Requires improvement

# Is the service responsive?

Many of the people who live at Philiphaugh Manor had a diagnosis of dementia or were known to become confused. The home's communal area's were plainly decorated and there was limited signage available to help people's orientation within the service. Although bedroom doors were numbered, neither photographs nor people's names had been used to help people identify their own rooms. This issue combined with the lack of detailed guidance and information within people's care plans meant staff were not consistently able to meet the needs of people living with dementia.

People were able to move around the building freely and choose where they spent their time. Some people preferred to remain in their own rooms and these decisions were respected by staff. Staff told us, "People can choose when to go to bed, some people stay up to midnight" People's daily care records showed that people were able to choose when to go to bed.

The service encouraged people's relatives to visit whenever possible. Relative told us they felt welcome within the service and on the day of our inspection we saw staff assisting one person to get ready to go out for lunch with their family.

The service had appropriate procedures in place for managing and investigating complaints. People told us they knew how to make a complaint and commented, "I'd complain to whoever is on duty" and a relative said, "We've had no complaints but if I had to I'd go to the manager."

Requires improvement

# Is the service well-led?

## Our findings

People and staff complimented the registered manager on the care and support she provided. One person said, "The manager is lovely. She's very friendly and always talks to me" while a relative told us, "The management and staff are all very approachable."

The registered manager had been away from the service for an extended period before our inspection. The provider had known this period of absence would be extensive and formally notified the commission of the registered manager's absence. The nominated individual told us they had arranged for a deputy manager from another of the provider's care homes to provide additional leadership and support during the registered manager's absence. Staff told us this manager was "wonderful" but reported that they had not been able to visit the service regularly. One staff member told us, "We could have done with more support while the registered manager was away".

During the registered managers absence there had been a breakdown in communications between the provider and staff team. Regular staff meetings had not occurred and staff had been informed of significant changes to working practices, pay and conditions via notices and memos left in the staff office. We saw some of these messages had been written entirely in block capitals and staff told us they found the tone of these messages was generally negative.

The provider had purchased the service approximately one year before our inspection. The provider's director explained they had observed how the service operated for the initial year and were now making changes in order bring the service in line with their other homes. Staff told us they had not felt supported during this transition period and that concerns they had raised had not been addressed or resolved. Staff said they respected the provider's nominated individual but felt that they had not been adequately supported during this period of change.

Staff described how recent high workloads, increased shift lengths and changes to their pay and conditions had impacted on their morale. One staff member told us, "I do love my job but it would be nice if it (the service) was run properly" while others told us that they had begun looking for other employment.

At the end of the first day of inspection we provided detailed feedback on our initial findings and informed the nominated individual we would be returning later in the week to complete our inspection. On our arrival for the second day of this inspection we found that one of the provider's directors had travelled down from London to provide additional support to the staff team. We discussed our concerns at length with the management team who recognised and accepted our findings. In addition the registered manager returned to the service during our inspection, and was expected to begin a phased return to work in the week following the inspection. Staff welcomed the return of the registered manager and we observed this news had a positive impact on the morale of the staff present.

During our second day of inspection we saw actions had been taken to address concerns we had previously highlighted. For example, we had enquired why over 20 lounge chairs were being stored in the service's garden. These chairs were removed and disposed of by the provider's maintenance staff during the second day of the inspection. The support provided to the service by the director and the actions taken between inspection days demonstrated the provider's commitment to improving the service.

The service's quality assurance processes had not identified many of the areas of concern identified during our inspection. However, a recent audit had identified that their policy and procedure documentation had become outdated. The nominated individual had begun reviewing and updating these documents to ensure they accurately reflected the service's current practices.

**The providers failure to ensure there were appropriate systems in place to effectively manage the home during the registered managers absence represents a breach of regulation 17(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>**Regulation 9(3) of the Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**<br><br>**The service failed to provide staff with sufficient detailed guidance to enable them to meet people's care needs.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>**Regulation 11 of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**<br><br>**The service had failed to act in accordance with the requirements of the Mental Capacity Act 2005 where people lacked the capacity to make decision for themselves.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Regulation 12(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**<br><br>**The provider failed to ensure care and treatment was provided in a safe way. Identified risks had not been appropriately managed and significant incidents had not been adequately investigated.** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Regulation 17(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**<br><br>**The provider had not operated effective system to ensure the service complied with the requirements of the regulations. Quality assurance processes had failed to identify the concerns detailed in this report.** |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**Regulation 18(1) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.**<br><br>**There were not sufficient numbers of suitably skilled staff available to safely meet people's care needs.** |