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Tree Tops Residential Home

Inspection report

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Tel: 0151 426 4861

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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection, carried out over two days. We inspected the service on 16 and 19 of February 2015.

Tree Tops care home is registered to provide care for 43 older people who do not need nursing care. There are two separate buildings within the home. One building accommodates 30 older people who are physically frail, the other building accommodates 13 older people living with dementia. There is parking to the side of the building. Tree Tops is located in a residential area of Rainhill within walking distance of a train station.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We observed care and support in communal areas, spoke to people in private, and looked at care and management records.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the safe management of medication, quality assurance, consent, managing risks, assessing, planning and monitoring care needs and staff training to meet specific needs. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

People told us that they felt safe in this home and they did not have to wait long for staff to assist them. We observed that people were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. However we found that people's safety was compromised because the provider did not analyse accidents and incidents in order to address the risks.

The provider did not always following the Mental Capacity Act 2005 for people who had fluctuating capacity to make particular decisions. For example, the provider had not undertaken a capacity assessment or best interests meeting for a person that was given their medication without their permission or knowledge.

We found that people's health care needs were not always assessed, planned and delivered consistently. In some cases, this either put people at risk of not having their individual care needs appropriately met.

Staff were not always trained for the job role they undertook, for example none of the night staff had received any training in administration of medication. This meant that people may not get their medication as needed.

Some of the systems used to assess the quality of the service had not identified the issues that we found during the inspection. This meant the quality monitoring processes were not effective as they had not ensured that people received safe care that met their needs.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

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

The staff were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home.

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.

People in the service were placed at risk because medication was not managed safely.

Some incidents that had resulted in unexplained bruising to people living in the service had not been investigated in order to identify a potential cause in order to protect people from harm.

There were suitable arrangements in place to make sure that sufficient staff were available to meet people's needs.

Staff in the home knew how to recognise and report abuse and this included making appropriate referrals to external agencies such as social services.

Requires improvement

Is the service effective?
The service was not effective.

People's rights were not protected because the Mental Capacity Act 2005 Code of Practice was not followed.

Arrangements were in place to request the support of health professionals to help people stay well. People were given support to eat and drink where this was needed in a manner that met their individual needs.

Requires improvement

Is the service caring?
The service was caring.

It was clear in observations that staff and people had a good rapport. Staff were observed to support people in a manner that was respectful maintained their dignity and meet their needs.

We saw people's privacy and dignity was respected by staff and staff were able to give examples of how they achieved this.

People told us they were happy with the care and that their physical needs were met.

Good

Is the service responsive?
The service was not responsive.

Complaints and concerns were not always recognised and appropriate action taken..

Assessment of needs and plans for how to meet people's needs were not always in place.

Requires improvement

Summary of findings

People and their relatives told us there were insufficient activities to meet all individual needs.

Family members and friends continued to play an important role and people spent time with them. Visitors were encouraged and supported to visit the service as and when they wished.

Is the service well-led?

Requires improvement

This service is not well led.

There were no systems in place to update policies and procedures used to assist staff to provide care and support. Policies in place did not reflect the practice of the service.

Surveys were sent to family members. However their views in response had not been investigated or actioned by the provider.

The provider had not notified us of incidents that occurred as required.

The registered manager and deputy manager were well respected by people living in the service, relatives and staff.

Tree Tops Residential 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 inspection took place over two days on 16 and 19 February. Our first day was unannounced and the inspection team consisted of an inspector, an expert by experience (this is a person who has personal experience of using or caring for someone who uses this type of service) and a specialist advisor. On the first day of our inspection of the service we focused on speaking with people who lived there and visitors, speaking with staff and observing how people were cared for. The inspector returned to the service to look in more detail at some areas and to speak specifically with staff and review records related to the running of the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR, reviewed all the information we already held on the service and contacted the local authority and who funded the care for some of the people living there. We also contacted the Local Healthwatch. Healthwatch is the new independent consumer champion created to gather and represent the views of the public.

During our inspection we observed how the staff interacted with the people who used the service and looked at how people were supported during their lunch and throughout the day. We reviewed seven people's care records, three staff files, staff training records and records relating to the management of the service such as audits and policies and procedures. During the inspection we spoke with 14 people who lived in the home, 10 visitors (two were medical professionals), nine staff, the deputy manager and the registered manager.

Requires improvement

Is the service safe?

Our findings

People who used the service told us they felt safe. Their comments included: "Oh, I'm happy here, all in all. I've been looked after really well. I've got arthritis in the knees, I'm on tablets all the time. They sort it all out, I couldn't. My arm is aching a bit at the moment, I do a lot of knitting. If I asked for something [i.e. pain relief] they'd get it for me"; "I have Alzheimer's and I come in for respite care. I've lost count of the number of times I've been here, but I keep coming back, that's a good sign - so I must like it!"; "That's the bottom line, I'm safe and protected - you're at home. What's important to me is that you've got company. You need other people around you. There's no disharmony, everyone gets on well together."

Families spoken with told us "[person's name] is absolutely safe, there is always someone with them" and "There's only two staff on at night, so it's difficult keeping an eye on her 24 hours a day". Another relative told us, "I'm full of praise for this place. She's safe and well looked after."

One relative explained to us that whilst they were generally happy with the care their relative had had a number of falls particularly overnight.

Two separate relatives explained to us that they were concerned about falls that their relative had had. We looked at the care records and could not find any assessment of the risks to the people or what the provider was doing to manage these risks. One person had sustained an injury following a fall that had resulted in a hospital admission. We were unable to find out from their records or in discussion with the staff and manager what actions had been taken to reduce the person's risk of harm. Equipement had been put into place for another person but there was no assessment in place as to whether this was suitable and was reducing the risks of harm to the person. We informed the manager of the views of the families. The manager stated that she had not been made aware of these views.

We also looked at how the service dealt with accidents and incidents. Accidents were recorded but there was no explanation as to what actions had been taken to investigate the cause or reduce the risks. We saw that the service recorded instances of bruising but there were no records of any actions to determine the potential cause to reduce the risk of harm. The registered manager agreed that in the case of unexplained bruising a body map was completed to show that the bruise had occurred but no exploration had taken place to determine the potential cause.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Suitable arrangements to identify, assess and manage risks relating safety of people using the service were not in place.

We spoke with people about how they received their medication. All the people we spoke with told us that staff managed all of their medications. We looked at how the provider made sure people received their medications appropriately. We saw that people did not always receive their medications in a manner that was safe or met their needs. We saw that on at least two occasions people had not received the prescribed dose of medication placing their health and welfare at risk.

There was no information available to inform staff as to when to give 'when needed' medication. As an example two people required pain relief when needed. We reviewed their care records and the medication records in order to find the instructions for staff as to when to give this. No records were available that informed staff when or in what circumstances to give when needed medication.

We looked at how staff managed external preparations such as creams. There were no instructions to show how and when staff where to apply a cream. There were also no records of when staff had applied a prescribed cream. As a result it was not possible for the provider to monitor that the cream was being used or that the treatment was effective.

We saw that medication that needed to be given at certain times, such as before food, was not recorded as being given at the correct times. We spoke to the registered manager who confirmed that medication that should be given before food in accordance with the manufacturer's instructions had not been given at these times. This placed people at risk of not receiving a medication that was effective as the service was not following the manufactures instructions.

The Medication Administration Records only recorded an indication of the period of time that medication was given such as morning or afternoon as examples. As such the actual time that medication was given was not recorded.

Requires improvement

Is the service safe?

This was particularly important for medication that must have a four hour gap between doses. This meant that the staff member giving a later dose would not know if four hours had elapsed and it was safe to give the medication.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's medication was not managed safely, which placed them at risk of harm.

The downstairs communal areas in the dementia care unit were all newly refurbished and all areas were clean. All four relatives spoken with commented on the cleanliness of the home. We observed that the home looked very clean and well presented. Both units presented as homely, welcoming and there were no unpleasant smells in any area of the service.

We looked at the most recent recruitment of staff. We saw that staff had been appropriately recruited before they started working in the service in order to maintain people's safety.

The staff we spoke with told us that they had completed training to support people safely, knew how to recognise and report abuse, and knew the actions to take if they were concerned that a person was at risk of harm. all expressed confidence that the management of the service would react to any concerns they had and resolve their concerns.

All of the staff we spoke with said there were enough staff to provide people with the support they needed and to keep them safe. We saw that people were given support as needed over the meal times and that there was sufficient staff to make sure that this support meet their needs.

We saw that in an emergency staff appropriately contacted external medical support. This included advice from the persons doctor or an ambulance to hospital if needed.

Requires improvement

Is the service effective?

Our findings

When we asked people about the food in the service they told us "It's all decent, there's not really a choice - not that I know of anyway - it's well cooked."; "I'm not a choosy person about food. So long as it's good and nourishing I'm quite happy. I get enough. I wouldn't say you get a lot of choice. I've never had reason to complain", "I enjoy it, but they could make it a bit more interesting. I always eat my food - some people don't. I don't get a choice."; "Sometimes it's very good, sometimes it's a bit ordinary. It's adequate - there's no choice. I've no special dietary requirement."

We observed a mealtime on both units on the first day of the inspection. We saw that, where people required assistance to eat, this was provided in a patient and caring manner. The staff serving the meal were friendly and, whilst busy, appeared unrushed. When everybody was served, two of the staff joined people (at different tables) and ate their own meal, whilst interacting pleasantly with them. Comments overheard included: "Watch the plate it's hot"; "I'm just going to put you a bit nearer the table"; "Just eat what you can"; "Is that enough?". We heard one person say that that they didn't want a full meal, and a bowl of soup was brought to them with the comment, "Be careful it's very hot. It's tomato, your favourite, would you like some bread with it?"

On the dementia unit we were told by the staff that, for those people unable to express a choice, the chef speaks with them and their relative on admission and establishes their dietary needs and likes and dislikes. We saw that care records contained dietary likes and dislikes. Copies were available in the kitchen. The cook explained how special diets were catered for but stated that they would find more training of benefit.

We looked at how the service monitored people's nutritional intake. A nutritional risk assessment was in place for each person. We saw that this did not take into account medical conditions such as diabetes. The manager was unsure where the assessment format had come from. The records showed that people generally did not lose weight.

We spoke with care staff about the training that they received they all they had received a range of training which included a training specific to care such as moving and handling training and safeguarding for vulnerable adults as examples. They told us that training was updated and refreshed every year. We saw that information regarding training was available to staff. Staff were offered a choice of three dates. We saw that a training matrix which tracked the training of staff was available and the manager monitored this and made sure that staff attended updated training as appropriate.

However we saw some instances in which staff did not have training in place to enable them to deliver care and treatment to people safely and to an appropriate standard. We saw that staff were administering insulin to two service users. They had not received supervision from a qualified nurse for this in over two years. Department of Health guidance states that non nursing staff should receive supervision at least every four months to carry out activities of this nature. We were also informed by the manager that staff undertook some clinical testing such as blood monitoring and analysis of urine samples. However they had not received training in this. There were no records of any training for these tasks or any assessments of competency in order to ensure that they were carried out safely and to a suitable standard.

We were also informed by the manager that none of the staff on duty overnight had training in medication administration, which meant that if a person required a pain killer, they would not be able to receive this as there were no staff on duty that were competent to give this. The registered manager lives on site and said that staff could ring her and she would get up out of bed and attend the service. Training records confirmed that staff overnight had not received any training in the administration of medication. We also saw that there were no records that staff that gave out medication had been checked for their competency. The manager informed us that staff were checked for their competency on the medication audits. We viewed the medication audits and these did not record any competency assessment for individual staff.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As staff did not have the training or competency to deliver some care and treatment that was safe or to an appropriate standard.

We looked at how the service had regard to the Mental Capacity Act Code of Practice, and the Deprivation of Liberty Safeguards (DoLS). The mental capacity act

Is the service effective?

provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be, and is not, implemented then people are denied rights to which they are legally entitled.

We were informed by the registered manager that all but two of the people who lived on the unit for dementia care needs were subject to Deprivation of Liberty Safeguards standard authorisations (DoLS). We looked at care records and saw that there were no Mental Capacity Act assessments completed, nor best interests decisions documented. We saw that one person received covert medications. This is medication given without their permission or knowledge. There was no assessment of the person's capacity or a best interests meeting. The provider had accepted the doctor's permission without assessing the person's capacity to make this decision and follow this with a best interests meeting if needed.

We also saw that people's relatives had signed for permission on behalf of the person without the provider having any evidence that the relative had the legal right to do so. The legal right to act on the person's behalf is known as Power of Attorney and this can be for financial or health and welfare decisions on behalf of the person. In one care record there was a record that a relative had Power of Attorney. However, it was not specified whether this was financial and\or health and welfare specific. It is important that this is established so that staff do not make invalid decisions that do not protect people's rights.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have suitable arrangements to obtain and act in accordance with people's consent.

We saw that staff had an understanding of how to support people less able to express an opinion or make on-going decisions on daily basis. We saw that staff sought consent in their daily practices. This included people's preference for a daily routine and what kind of clothes they wished to wear. We also saw that staff appropriately supported people with daily activities and discussed with them the choices they would like to make. Records showed that the provider sought people's preferences and made this information available to staff. As a result staff were able to take into account people's personal choices and preferences.

Good

Is the service caring?

Our findings

People who lived in the service were complimentary about the care provided. Comments included: “They‘re nice people, my son speaks very highly of them. None of them have upset me so far”; “I like it because there’s company here and I’ve become friends with the residents and the staff. The staff haven’t got a lot of time, they all seem very busy, but I know I could always go to them.”; “They’ve been very good to me. If they need to, or if I ask, they’ll contact my relatives for me.”; “There isn’t anybody to talk to about “can I do such and such?” or “I’d like to find out about something.”

In an office we saw a number of thank you cards, comments included, “wonderful care” and “your understanding.”

Staff were able to demonstrate an understanding of people’s needs and how to anticipate meeting their needs. We saw that people were neatly, appropriately dressed and well groomed. Staff were able was able to give a examples of how they maintained people’s privacy and dignity. We observed that if someone left the lounge\dining room staff did not attempt to stop them, but rather they accompanied them, until they established what the person wanted to do. We saw that staff could readily predict this.

During the morning drinks, we observed a person who had just woken and was still drowsy being handed a cup of tea, with the comment, “be careful, don’t spill your drink.” The staff member then watched over them carefully, making sure they didn’t spill it.

We saw that that visiting was a very relaxed process; people could sit in the lounge with their relatives or go in the dining room, which afforded some privacy

We saw that care records were kept in a locked cabinet on both units that was accessible by the senior care staff on duty. We did see a notice in the treatment room that was visible from the main corridor. This contained confidential details that visitors would have been able to see on walking down the corridor. The manager moved this information during our visit. Staff provided real examples of how they made sure that people’s information was maintained in a confidential manner.

We saw people being encouraged to do as much for themselves as they were able to. Some people used items of equipment to maintain their independence. Staff knew which people needed pieces of equipment to support their independence and ensured this was provided when they needed it.

A relative spoken with regarding to end of life care explained that the staff had provided the supportive and thoughtful care. They were complimentary as to the support both the family and the person had received. Staff described the support that they had given people at the end of their lives. The manager and the deputy manager have undertaken a particular course known as the “six steps”, which is designed to support people at the end of their lives.

Requires improvement

Is the service responsive?

Our findings

People who used the service told us that staff responded to them as individuals. We received mixed views on this. Comments included "There isn't much to do just watching the TV. Nothing else. Sometimes I argue with that bloke [pointing] about what's on". Another told us, "Knitting and crocheting - I don't use patterns because I can't read. No activities really, because we're all old and just sit about." Whilst we were talking with them, a staff member brought a number of balls of different coloured wool and said, "Here you are [name], this'll keep you going for a while". Another person told us, "They had a shop the other day. I bought this cardy (cardigan). It was good to have a rummage around" and "I used to play hoopla and things like that, but it seems to have stopped. They look after us and feed us and then leave us to it."

We asked whether people were given the opportunity to go out. One person said "I wish I never get to go anywhere. Somebody goes out with their relatives every day. The social life could be improved a lot. It'd be nice to be taken out, once a month, say. I like it here. In the summer I like the garden. I like watching the birds. But I can't get out to the garden [from the conservatory where we were sitting]."

We observed that the external door in the conservatory led to a raised patio with a railing around it, which prevented the person from going into the garden. To enter the garden it would be necessary to exit the main door (which was kept locked with a key pad) and walk around the building. Whilst there was a ramp, this was not the most convenient route.

The service did not have a dedicated activities coordinator. Both units had a board displaying a four week programme of events. These were not displayed in an accessible place for people living in the service.

One person had specific needs in relation to their religious beliefs. These were supported and members of the person's church were encouraged to visit and support them.

We observed that activities took place for a short time in the afternoon, which to leave the rest of the day void of any stimulation. We observed that throughout the morning most people sat in their chairs sleeping. In the afternoons we found those that had visitors much more animated and able to respond to stimulation. One relative told us, "I don't know how much activity there is, I know there is an entertainer and my brother loves sing-alongs, but he used to love playing bowls". We spoke with the manager about the suitability of activities. The manager told us that staff had been increased to provide more activities daily but they had not had training in undertaking activities to meet the individual needs of people such as suitable activities for people living with dementia.

We looked at how the service assessed and planned individuals' care and welfare. We looked at care records and saw that were well organised and showed evidence of visits by health care staff, including doctors, nurses, chiropodists, dentists and care managers. We saw that one person had received a doctor's (four days earlier) in which their medication was changed. This visit had not been recorded and the changes in the person's treatment had not been updated in their care records. This meant that there was a risk that the wrong treatment could have been given to the person.

One person, who had been living in the service for three weeks, did not have an assessment or a care plan available and staff relied on verbal instructions to deliver care to the person. This meant that there was a risk of the person not receiving consistent care or care that did not meet their needs.

We looked at the care plans for people with specific medical conditions such as diabetes. The care plans viewed did not state what the signs and symptoms were if people had low or high blood sugars. The service was undertaking blood sugar monitoring and recording the results. However there were no instructions as to what action to take if the person's blood sugars were out of a normal range.

Daily records for two people showed occasions when they were described as "agitated", "upset" and "hitting out at staff". We looked in these people's care records and could not find any plans regarding assisting people with their behavioural needs. Descriptions of "agitated" are unhelpful as they do not detail the person's actual behaviour and are subjective in nature.

We looked at how the provider monitored people's behavioural needs. We saw that the provider did have useful documentation that could record people's behaviour but this was not in use. In the records we saw that staff had contacted a person's doctor stating that the

Requires improvement

Is the service responsive?

person was “agitated”. However the daily records for two weeks prior to that date did not record that the person had any behavioural concerns at all. Without this record staff relied on their own memories and verbal reports, which created a potential risk of inaccurate reporting and inappropriate treatment prescribed.

Without ensuring that proper arrangements are in place to monitor, assess and determine people at risk of behaviour that challenges staff would be unable to accurately inform medical professionals of the behaviour of an individual or accurately monitor the effectiveness of any treatment put into place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not make sure that proper arrangements were in place to assess, monitor and plan effectively meet the needs of people living in the service.

We looked at how the service dealt with complaints. We were told by people living in the service that if they had any complaints they were confident that the provider would deal with them. We saw that there was a complaints procedure displayed on both units. This was long, complex and had no evidence that it been reviewed or updated for several years.

The Commission had not received any concerns about the service in the previous twelve months. When we looked at the surveys completed by families we saw that there were a number of comments about such things as grey washing, people wearing other people's clothes and the lack of activities. There was no evidence to suggest that action had been taken to resolve these issues. The manager confirmed there was no system in place to monitor complaints received, which meant there was a risk that people's complaints and concerns would not be addressed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not make sure that proper arrangements were in place to recognise and investigate complaints.

People who could speak with us told us that they made choices about their lives and about the support they received. They said the staff in the home listened to them and respected the choices and decisions they made. People told us that the staff in the home knew the support they needed and provided this as they required. We saw examples throughout our inspection that staff responded to people’s needs rapidly and with a good level of understanding of the individual person.

As the service was not large and the majority of staff have worked there for a number of years. All the staff we spoke with were familiar with people’s needs. The staff we spoke with showed that they were knowledgeable about the people in the home and the things that were important to them in their lives.

We saw that visitors were welcomed throughout the day and staff greeted them by name. Visitors and relatives we spoke with told us they could visit at any time and they were always made to feel welcome. Visitors told us they felt they were consulted about the service and relatives’ meetings were held.

Requires improvement

Is the service well-led?

Our findings

People who lived in the service told us: “I’m happy. I’d soon say if I wasn’t. I can highly recommend it". “I’m perfectly satisfied here. I’m lucky to have a place like this”. “[owners name] and [managers name] are quite approachable. They know us quite well. They can’t do enough for us.” Another person told us, “[manager’s name] is approachable” and “I’m never asked for my opinion.”

The home had a registered manager who had worked in the service for over 10 years. She was supported by a deputy manager. Both the registered and deputy manager said that they thought they worked well together and that they were well supported by the provider.

Staff spoken with felt confident that they could approach either the registered manager or the deputy manager and that they would be listened to.

People and their relatives knew the management team well, they saw them often and told us they felt comfortable speaking with them. All people and relatives felt confident that they could go to the registered manager, deputy manager or to any member of the staff and they would be listened to and their views acted on.

Visitors we spoke with confirmed they had been consulted about the quality of service provision and could provide this information anonymously if they wished to. The registered manager said that, where any concerns were identified, they were discussed with people who used the service and their relatives and improvements made.

Staff meetings were held on regular basis and issues of concern noted and addressed. Staff told us they were informed of any changes which occurred within the home through staff meetings, which meant they received up to date information and were kept well informed.

The home had not notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. In particular serious injuries or Deprivation of Liberty safeguarding applications and their outcomes This was discussed with the registered manager at the inspection who agreed that notifications had not been correctly made. The registered manager stated that these would be undertaken in the future.

We looked at a number of policies and procedures for the service, which were undated. The registered manager confirmed that they had not been updated for several years. We saw that the policies and procedures no longer matched best practice, the practice in the service or changes in legislation. For example the medication policy did not include information as to how to manage covert medication for people who had fluctuating capacity or how to manage over the counter medicines such as mild painkillers. We saw at this inspection that proper arrangements for the management of covert medication was not in place and there were no arrangements in place for people to receive a mild pain killer if they needed one overnight. As such peoples individual needs and rights were not met.

Relevant checks on gas, electricity, lifts, hoist, fire equipment and electrical equipment were in place and updated in accordance with legislation.

The provider did not seek formal feedback from the staff or people who used the service through questionnaires. Questionnaires for people living in the service were available but there were no arrangements to distribute these to people. Relatives received a questionnaire each year. We saw that in general the questionnaires from relatives were positive contained some areas of concern that needed addressing, which included laundry and activities.. The registered manager confirmed that they had changed the laundry and increased staff in order to deliver more activities prior to the latest questionnaires however these issues had persisted into the latest questionnaires. No further action had been taken to address the views of relatives.

Although the manager undertook medication audits these had failed to identify issues and areas for development that we identified at this inspection.

We also looked at how the service audited accidents or incidents. Some incidents such as unexplained bruising were not been followed up to determine cause or take action to prevent further injury to people. Accidents were audited but the audit looked at how well the record had been completed.

The audit did not determine potential patterns or trends in order to protect people living in the service. There was no auditing of the accuracy and quality of care records such as care plans. The registered manager explained this was because both she and the deputy wrote all the care plans and would be in effect checking on their own work. The

Requires improvement

Is the service well-led?

care plans had not been audited by the provider as part of their quality monitoring of the service as neither the manager or deputy could be fully objective in auditing their own work.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support.

The atmosphere in the service for people living there was open and inclusive they made it clear in conversation that they felt well supported, cared for and able to discuss any concerns they had. All the staff we spoke with told us that they enjoyed working in the service. They told us that they found the management approachable and supportive. The service has been run by the same management team for over 10 years and staff told us the majority of them have worked there for over 10 years as well. They told us that the service was a “good” place to work.

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 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider did not make sure that proper arrangements were in place to assess, monitor and plan effectively to meet the individual needs of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not have effective systems in place to make sure that they regularly assess and monitor the quality of the service in order to identify, assess and manage risks relating to the care and safety of people using the service were not in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not have effective systems in place to make sure that medication was not always managed safely or given in a manner that meets people's individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements to obtain and act in accordance with people's consent.**

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 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider did not make sure that proper arrangements were in place to recognise and investigate complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities in order to deliver care and treatment to service users safely in a manner that meet their individual needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.