Central Bedfordshire Council

The Birches Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Birches Residential Home is located in Shefford in Bedfordshire. They are registered to provide accommodation for persons who require personal care for up to 31 older people who may also have physical disabilities or be living with dementia. On the day of our inspection there were 26 people living at the service.

We carried out this unannounced inspection on 27 June 2017. At our previous inspection on 24 March 2015 they were rated Good.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had a registered manager in post, however; they had not been at the service for a number of months. Another manager had taken over the service, however; the registered manager had not cancelled their registration and the new manager had not applied to register with us. 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.

People, their relatives and staff members had been through a period of consultation regarding the future of the service, led by the provider. A number of options had been discussed through meetings and other information provided. The consultation period had completed when we carried out our visit, but the outcome of this was not yet known, and was due to be published in August 2017.

Incidents and accidents were recorded by the service however; incidents of potential abuse were not always treated as safeguarding concerns which meant that external organisations were not informed of these concerns. We also saw that risk assessments were not always up to date and reflective of recent developments or changes in people's conditions. Where repeated incidents occurred, such as falls, risk assessments did not reflect that this had happened. Staff members supported people to take their medicines, however; the systems for recording this were not robust and we saw that this led to errors in the way the administration of medicines was recorded.

Staff members sought people's consent before providing them with care, however; consent was not documented in people's care plans and the service was not acting in accordance with the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff were not supported with regular supervision or appraisal, however; they did receive training to provide them with the skills they needed to perform their roles.

People and their family members were not always involved in making decisions about their care or support arrangements. Care plans were in place but they were not always person-centred. They were reviewed on a regular basis but without the input of the individual or their relatives. People were not regularly active or stimulated whilst living at the service. There were some activities at the service but these were not always reflective of people's individual preference or interests.

Quality assurance systems were in place at the service, however; they were not effective in assessing, monitoring and improving the quality of care provided. Checks and audits were carried out but were not done so regularly and were not used to help the service develop or improve.

Staffing levels at the service were sufficient to meet people's care needs and there were robust recruitment practices in place to ensure that staff were of good character to perform their roles. Staff members were kind and compassionate in their interactions with people and worked to create a positive and relaxed atmosphere at the service. People's privacy and dignity were promoted and they were provided with information about the service and what they could expect from members of staff.

People were provided with support where necessary to maintain a healthy and balanced diet. They were provide with choices about meals and drinks and were encouraged to eat as healthily as possible. We also found that people were supported to maintain good health and had access to a range of different healthcare professionals when needed.

There was a positive and open culture at the service. Staff were motivated to meet people's needs and believed in the ethos of the service. People's feedback about their care was welcomed and compliments and complaints were responded to. Feedback surveys were used to gather people's opinions and were analysed on an annual basis.

We identified a number of breaches of legal requirements during this inspection. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Incidents of potential abuse were not always treated as such. Safeguarding alerts were not raised in response to harm.

Risks assessments were in place but were not robust. They were not up-to-date and did not reflect current levels of risk to people.

People's medicines were administered by the service, however; the systems for managing and recording the administration of medicines were not sufficient to ensure this was done safely.

There were sufficient numbers of staff to ensure people's needs were met. Checks were carried out during staff recruitment to ensure staff were suitable for their roles.

Is the service effective?

Inadequate

The service was not effective.

Systems for receiving and documenting consent were not sufficient and failed to demonstrate that people had agreed to their care and support arrangements.

The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been followed.

Staff members did not receive regular supervision or appraisal. However; training was carried out.

People were supported to eat well and the service ensured their nutritional needs were being met.

Healthcare professionals were involved in people's care and the service supported appointments in the service and community.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in making decisions about their

care.

Information about the service was available to people.

Staff members treated people with kindness and compassion and worked to develop positive relationships with them. People's privacy, dignity and respect were promoted by the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always person-centred. People were not regularly involved in reviews of their care plans.

Activities at the service were not reflective of people's individual hobbies and interests.

There were systems in place to receive and act on feedback from people and their relatives, including complaints.

Is the service well-led?

Inadequate

The service was not Well led.

The registered manager had not been at the service for at least three months. The provider had not submitted sufficient statutory notifications regarding this.

There were quality assurance systems in place, however; they were not effective in assessing, monitoring and improving the quality of care being provided at the service.

The service had an open and positive ethos.

The Birches 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 on 27 June 2017 and was unannounced. It was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience for this inspection had personal experience of family members who used this type of 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, that the service does well and improvements they plan to make. We reviewed the PIR along with other information we held about the service, including statutory notifications. Statutory notifications contain information about key events and incidents which took place at the service, which the provider is required by law to send to the Care Quality Commission.

During the inspection we spoke with nine people living at the service and three visiting family members to seek their views and opinions of the care they received. We also spoke with three members of care staff, two team leaders, one kitchen assistant and one laundry assistant. The registered manager was not available during the inspection, but we did speak with a registered manager from another service that came to support the service during the inspection. In addition we spoke with the service's administrator and a trainer for the provider, who was visiting the service.

We also reviewed documentation in place at the service. We looked at care records for six people to see if they were up-to-date and an accurate reflection of the care being provided. We also looked at staff recruitment and training information for five staff members as well as other documentation relating to the

management of the service. This included medication records and quality assurance systems which were in place.

Inadequate

Is the service safe?

Our findings

People at the service were not always safe. Incidents of potential harm to people, which may have been as a result of abuse, had not been reported to the local authority safeguarding team or the Care Quality Commission (CQC). For example, we found an incident report which stated that one person had sustained a bruise whilst staff performed a manual handling operation using a hoist and sling. Another incident report stated that a staff member had accidentally spilled hot drink onto a person's chest. This meant that external organisations would not be aware of potential concerns at the service and future safeguarding risks to people may not be mitigated.

We also reviewed incidents which recorded that people had sustained unwitnessed falls within the service. These incidents recorded that staff took action to support the person and monitor them following the fall, however; there were some cases where there was nothing to show that the cause of the fall had been established. This meant that there was potential for these falls to have been as the result of abuse, however; the service had not contacted the safeguarding team or treated the incident as such. This meant that abuse may have occurred and would not have been identified or addressed, which increased the risk of abuse to people.

The systems and processes in place were not always operated effectively to prevent and report incidents of suspected abuse. This was a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments at the service were not always robust in ensuring that people were safe and that risks were mitigated. We saw that although risk assessments were in place and were reviewed, they did not contain up-to-date information about potential risks to people. For example, we saw one person's falls risk assessment and falls diary stated they had fallen once since January 2017. When we reviewed incident reports we saw that they had actually had five falls. Another person had 10 falls in the same time period, but their risk assessment and falls diary had only two recorded. This meant that there was potentially an increased level of risk which had not been identified and therefore had not been shared with members of staff. This placed people at further risk of harm.

We also saw that care plans were not always updated when risk assessments had been updated. For example, we saw that one person had a Waterlow risk assessment tool in place, to monitor the risk of them developing a pressure wound. We saw that changes to the score were recorded on the Waterlow tool, however; these changes were not recorded in the care plan, despite it being updated on the same day. This meant that staff members were providing care based on out of date information which was not response to changes in people's levels of risk.

General risks to people and the service had been considered, however; we found that information was not always available to staff when they needed it. For example, during the inspection we were unable to find a fire risk assessment, to guide staff in the actions to take to maintain fire safety at the service. This meant that there was a risk that proper actions would not be taken in the event of a fire. We discussed these concerns

with staff during the inspection and a specific fire risk assessment was later sourced for the service.

The systems in place to manage people's medicines were not sufficient to ensure that medicines were given in accordance with the prescribers' instructions. We saw that Medication Administration Record (MAR) charts were completed in full and staff signed to say that medicines had been given. However; we checked stock levels for 15 different medicines at the service and found that in five different cases the numbers of medicine in stock were greater than were recorded on MAR charts. This showed that there were occasions when staff members signed to state that medicines had been administered, when they had not been. This placed people at risk as their medicines were not always given correctly.

Care and treatment was not always provided in a safe way for people. The provider had not carried out sufficient steps to assess the risks to the health and safety of people living at the service or done all that was reasonably practicable to mitigate risks. There were also not effect systems in place to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe at the service. One person said, "I feel very safe here, there has never been a problem." Another person told us, "Yes its safe here. I would speak up if was worried about anything." Relative also felt that their loved ones were safe. One relative said, "She's in safe hands here, no worries in that respect." Records and incident reports showed us that staff took action in response to incidents and accidents at the service, to make sure people were safe immediately after.

Despite the lack of detailed records, staff worked hard to respond to risks to people. One person told us, "I have a walking frame and staff keep an eye on me." Another person said, "I have a falls mat in my room, they come as soon as the alarm goes off." Staff members confirmed that they took action after incidents and were aware of those who had recently sustained a fall.

People felt that staffing levels at the service were sufficient to ensure their needs were met. One person told us, "Staff are busy but there seems to be enough of them." Another said, "There's usually enough staff, if someone goes sick they are busy but they stay cheerful." Relatives also felt that staffing levels ensured their loved ones needs were being met. One relative said, "I think there's usually enough staff." Another told us, "There is very low staff turnover, that's so good for continuity."

During our inspection we saw that staff members were attentive to people and did not appear rushed in responding to their needs. We reviewed staffing rotas and saw that staffing levels were consistent and staff told us that they were based upon people's needs. If there was a change in the level of need, staffing levels would increase.

Staff told us that, as part of their recruitment, the provider carried out background checks of staff, to ensure they were suitable for their roles. We reviewed staff files and saw that checks such as disclosure and barring service (DBS) criminal record checks and previous employment references were carried out. This ensured that staff were of good character.

Inadequate

Is the service effective?

Our findings

People's consent to the arrangements in place for their care, treatment and support had not been documented or evidenced. We reviewed the care plans for six people and found that only two of these had signed consent forms in place. There was nothing to show that other people had agreed to the content of their care plans, or that their care had been discussed with them, to ensure they were happy. During the inspection we did observe staff members seeking people's consent for day-to-day decisions and offering people choices.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. People's care records showed that the principles of the MCA were not being met by the service. For example, we found that there were no MCA assessments in place, to ensure best interests decisions were made for those people who were unable to provide their consent to their care and support arrangements.

There were also ineffective systems in place for the management of DoLS authorisations. We spoke with staff about the MCA and DoLS and were informed that two people had DoLS authorisations in place. We reviewed the files for these two people and found that no initial MCA assessment had been carried out by the service, to determine if those people lacked the mental capacity to consent to their care arrangements. This meant that the service applied to deprive these people of their liberty without assessing their mental capacity before they did so. We also found a third person's care plan which had a DoLS application in place, which was awaiting authorisation by the local authority. There were no MCA assessments associated with this application.

The two DoLS authorisations which were in place were no longer valid. They had both expired in June 2016 and there was nothing to show that the service had re-applied for these DoLS authorisations. There was also nothing to suggest that the people in question had new MCA assessments carried out to show that they were now able to consent. This meant that the service was depriving these people of their liberty, without following the established procedure in the MCA and DoLS.

People's care and treatment was not always provided in a way which demonstrated that their consent had been sought and recorded. There were not sufficient procedures in place to ensure the service was acting in

accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members were not provided with regular support and supervision by senior and management staff at the service. One staff member told us, "I have had supervision but not for a long while. We need feedback regularly." Staff members told us that they were aware of the provider's policy to have formal supervisions at least every three months, however; none of the staff we spoke with had received this. We checked staff files and saw that there were very few recorded supervisions. Some staff had received one or two supervisions in the past year whilst other had not received any. We also saw that no staff members had received an annual appraisal or review of their performance since 2015; despite the provider's policy stating this would take place.

Staff members did not receive appropriate supervision and appraisal as was necessary to enable them to carry out their duties. This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt that staff member's received training, which equipped them with the skills they needed to meet their needs. One person said, "They know what they are doing." Another told us, "They all know what they are doing. The senior carers show the newer ones what to do."

Staff members told us they received training on a regular basis and felt that this helped them to provide people with the care they needed. One staff member told us, "Yes I have a lot of training." Another said, "I am doing the care certificate."

We saw that new staff members at the service completed induction training to help them learn about the service and the people they would be supporting. Records showed that all staff also received regular training and refresher sessions, to help them build and maintain their skills. The Care Certificate was used for new and established staff, to help ensure they achieved the essential standards needed to perform their roles.

People were positive about the food and nutritional support they received from the service. One person told us, "The food is very good, plenty of it and good choice. They'll always find something you like." Another person said, "The food is really good, nice and hot and I can get an alternative if I don't like it." Relatives also felt the food at the service was good. One relative told us, "From what I've seen it always looks great."

Staff members told us that people were able to choose what they wanted to eat and that the kitchen was aware of specific dietary or cultural needs people may have. We observed staff providing choice to people and ensuring they received drinks and snacks throughout the day. People's preferences and nutritional needs were recorded in their care plans and staff completed food diaries for people where necessary.

People were supported to see healthcare professionals, such as their GP or district nurses, on a regular basis. One person told us, "The doctor comes in each Monday; you just ask to be added to the list." Another person said, "They call the doctor in if I'm poorly, they come quickly." Relatives were also positive about how people's health was managed. One said, "Yes [relative] sees the psychiatrist, the CPN (Community Psychiatric Nurse) and the optician. I go to the appointments if I can or a carer will go. It's well organised."

Staff members confirmed that they were able to support people with appointments if relatives were unable to, and that healthcare professionals visited the service on a regular basis. People's care plans showed records of input from healthcare professionals, which staff members used to ensure people received care in

accordance with their guidance.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback about people's involvement in planning their own care and support. Some people felt they were involved and were able to contribute to their care, whilst others had not been as involved. One person told us, "I need to chat more about my care." Another person said, "We have talked about my preferences, but I haven't seen it written down." A third person said, "We discuss my care, they take notice of what I want."

The care plans we reviewed did not evidence that people had been involved or consulted in their care and support. We saw that care plans were in place for each person but they did not show how the person had been involved, or if they were happy with the content of those care plans. This meant we could not be assured that people were involved in making decisions about their care.

People's relatives told us that they were able to contribute to their family member's care. They also told us that members of staff kept them up to date with any changes or developments in people's care and support needs. One relative said, "They communicate well with me, by phone or when I visit." We saw there were records in place which documented when relatives were contacted. However; we found that these records were not always followed up or used to update the person's care plan. For example, we saw one care plan where the family contacted section recorded that a relative informed staff that they had power of attorney for that person. This was not referred to anywhere else in the person's care plan and the service had not taken action to obtain a copy of this or the decisions that the power of attorney related to.

We saw that there was important information available to people and their relatives. There were notice boards displaying information including details about how to raise a complaint and useful contact numbers such as the local authority safeguarding team and the Care Quality Commission (CQC). We also saw that a notice board had been set up to provide information about the consultation which was taking place regarding the future of the service.

People told us that staff members treated them with kindness and compassion. One person said, "I couldn't get anywhere better. There's lovely staff to care for me." Another person told us, "They are very friendly and will do anything to help me." Relatives also told us that they found the staff to be caring, both in their interactions with them and their family members. One relative said, "The staff are very kind to [Family Member], they speak to her in a nice way."

Staff members told us they were committed to providing people with the care they needed and developing positive relationships with them. One staff member said, "I just want to look after the residents in a nice way. I love getting to know them." Another told us, "I enjoy making them happy."

During our inspection we observed positive interactions between people and members of staff. It was clear that staff knew people well and had worked to generate a friendly and calm atmosphere. Staff were patient and made sure that people were given the time that they needed to express themselves and engage in communication with them.

Staff members were mindful of people's need for privacy and worked to ensure they treated people with dignity and respect. One person told us, "They always shut the door when I'm having a wash. I have been asked if I mind a male or female carer." Another said, "They know that I only like a make carer for my bath and are very good at making sure I get that."

We spoke with staff who told us that they received training in dignity and respect and felt it was very important that people were treated well at the service. Throughout the inspection we saw staff knocking before going into people's rooms and talking to people sensitively and providing them with the privacy they needed. Records confirmed that staff received training in this area and that important information, such as people's preferred gender of support staff, was recorded.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person-centred care. People told us that they had care plans in place, however; they and their relatives were not always part of the review and evaluation process for these plans. One person told us, "I have seen my care plan and it was reviewed recently but my daughter didn't know about it and I didn't realise it was happening. I wanted her there as I get really anxious." Another person said, "We went through them on admission, but not since. That was a while back."

Relatives also told us that they had not always been part of the review process for people's care plans. One relative told us, "Although I have seen the care plans about a month after she came here, I would like them to be reviewed as I think she needs more help now."

We looked at people's care plans and saw pre-admission assessments were used to learn about people's individual care needs before they moved to the service. There was evidence that these were used alongside conversations with people to develop their care plans. However; there was not evidence to show that people had been involved in reviewing their care regularly.

We saw that individual sections of the care plans, such as mobility, personal care and nutrition plans were in place. They were reviewed on a monthly basis however; these reviews were conducted by members of staff and there was nothing to show that people were involved in the process. This meant that care was being reviewed but not in an inclusive and person-centred way.

There were some activities on offer at the service, however; people were not always able to follow their interests or engage in stimulating activities. People gave mixed feedback about the activities at the service. One person told us, "We had an Elvis singer and went to the shops; that's what I like to do." Another person said, "I sometimes go in the garden, not much else to do." A third told us, "I just have a paper delivered and don't do the activities."

Staff members told us that there had been developments made in this area to try to increase the activities on offer for people. One staff member said, "We have tried to do a few more activities but we have found that people were too tired."

We saw that domestic staff at the service were also trying to support staff by providing people with activities. Some people were happy to engage in these however; there was nothing to show how the activities on offer had been planned. They did not take account of people's individual interests or preferences, which meant that not everybody had access to activities that they wanted to engage in.

We found that there was an activities folder in place where each person's engagement in activities was recorded. This had not been completed on a regular basis, therefore we were not able to tell how regularly different activities had been attempted with people, or how successful they had been.

The care and treatment people received did not always meet their needs or reflect their preferences. This

was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were able to provide feedback about their care and support and could make complaints if they needed to. One person told us, "I have complained in the past to the manager, we have met and I was listened to." Another person told us, "My family have raised a few concerns and felt that it got sorted."

Family members felt confident that any issues they raised were taken seriously by the service, and that actions would be taken to rectify their concern. We saw that there were systems in place to document feedback including compliments and complaints. These were acted on appropriately and a log was completed to evidence this.

We also saw that a feedback survey had been completed. Staff members told us that this was conducted amongst people and their family members to gain some insight into their views around their care. We saw that the results from the 2016 survey had been collated and analysed and were available to people and visitors to the service.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager, however; they had not been at the service for at least three months. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke with staff members who told us that the registered manager had moved to manage another service within the provider group towards the end of 2016. We found that the provider had notified us on 10 March 2017 that the registered manager would be replaced by the deputy manager. However; we did not receive an application to de-register the previous registered manager or to register the new one. This meant that the previous manager remained on our register, despite not being at the service. In addition, the provider was obliged by law to send the CQC a notification to inform us when the registered manager was absent from the service for over 28 days, however; no such notification was sent.

The provider or registered manager had not notified the Care Quality Commission of their intention to be absent from the service for a period of 28 days or more. This was a breach of Regulation 14 (1) of the Care Quality Commission (Registration) Regulations 2009.

There were quality assurance processes in place at the service, however; they were not effective in monitoring and improving the quality of care being provided at the service.

For example, we saw that monthly medication audits were completed on a monthly basis, however; they failed to prevent mistakes occurring as we found a number of errors in terms of medicines management at the service. We looked at the medicines audits which had been completed and saw that they had not been completed in full. The audit tool provided a scoring system, to demonstrate how well the service had performed against the criteria of the audit. These had not been completed for any of the medication audits we saw which meant the provider could not determine if the service had improved or not on a month by month basis.

We also saw that there were a number of monitoring systems in place at the service, which were not completed in full on a regular basis. For example, we saw that daily hoist checks had been implemented, but these were not completed fully. We saw that there were 20 days with missing signatures between 01 March and 26 June 2017. There was nothing to show that these checks had been reviewed by management or action taken to ensure staff completed them fully. We saw that there were also multiple gaps on cleaning records which had not been review by management. This meant that areas of the service which required improvement had not been highlighted and corrective action had not been implemented.

We saw that monthly nutritional reviews, infection control audits and catering audits were scheduled, but again, these were not completed fully and failed to demonstrate how the service was performing.

During May 2017 we found that the only audit which had been completed was the housekeeping audit. The other monthly checks had not been completed. In addition, up to the 27 June 2017 we found that no audits had been completed and that the manager was on leave for the remainder of the month. This suggested that no audits would be carried out that month, which meant concerns would not be highlighted and actions would not be taken to rectify them.

There were not effective systems and processes in place at the service to assess, monitor and improve the quality of care being provided at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a positive and open culture at the service. People and their family members told us that they were aware of the consultation which may result in the closure of the service. They explained that they had some apprehension about this, but felt they had been well supported by staff members and the provider and had been kept well informed. One relative told us, "I am so pleased about the way the [potential] closure has been handled; we have had individual meetings as well as big meetings. I feel well informed."

People also told us they were aware of who the current manager at the service was, and felt well supported by them. One person said, "I feel able to say what I think to her, she's very understanding." Another told us, "My daughter talks to the manager if there's any issues."

Staff members also felt well supported by the manager. One staff member told us, "She's a good manager, very approachable." Another said, "We can also get support from the manager, even if it's on the phone."

There were regular meetings for staff members to discuss developments at the service. These included updates regarding the ongoing consultation and potential closure and we saw that the provider had organised human resources meetings to help provide staff with assurance and guidance about their futures.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The provider or registered manager had not notified the Care Quality Commission of their intention to be absent from the service for a period of 28 days or more.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received did not always meet their needs or reflect their preferences.

The enforcement action we took:

Urgent Notice of Decision to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's care and treatment was not always provided in a way which demonstrated that their consent had been sought and recorded. There were not sufficient procedures in place to ensure the service was acting in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The enforcement action we took:

Urgent Notice of Decision to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a

safe way for people. The provider had not carried out sufficient steps to assess the risks to the health and safety of people living at the service, or done all that was reasonably practicable to mitigate risks. There were also not effect systems in place to ensure the proper and safe management of medicines.

The enforcement action we took:

Urgent Notice of Decision to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes in place were not always operated effectively to prevent and report incidents of suspected abuse.

The enforcement action we took:

Urgent Notice of Decision to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems and processes in place at the service to assess, monitor and improve the quality of care being provided at the service.

The enforcement action we took:

Urgent Notice of Decision to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff members did not receive appropriate supervision and appraisal as was necessary to enable them to carry out their duties.

The enforcement action we took:

Urgent Notice of Decision to impose a condition