Harbour Healthcare Ltd

Treetops Court Care Home

Inspection report

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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**

Summary of findings

Overall summary

The inspection took place on 23 August 2016 and was unannounced. Treetops Court Care Home is a residential and nursing home for up to 70 people who have a variety of support needs, such as a physical disability, dementia and mental health needs. There were 61 people living there at the time of the inspection.

There was a Registered Manager in post at the time of our inspection. 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.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People were not always protected from harm because we found incidents of alleged abuse had not always been reported to the local safeguarding authority.

We found there were some gaps in the Medication Administration Records (MAR), so it was not clear whether people had received their medicine as prescribed.

Staff did not always have the effective training they required to assist someone who had challenging behaviour and this had left both people and staff at risk.

Risk assessments were in place to support people and staff however they had not always been followed or updated following a person's needs changing.

Systems were in place to monitor the quality of the service; however these were not always effective. Although there were regular checks carried out by the registered manager, it was not always clear what documentation had been viewed. Incidents had not been identified, such as safeguarding incidents between people who lived at the service, the number of episodes of challenging behaviour some people were experiencing and staff needing to intervene and omissions in the medicines documentation.

There were limited activities available for people to partake in, with some people thinking there was not enough to do.

Accidents were documented and action taken and they were analysed for trends in order to prevent and reduce future occurrences and action had been taken after each accident.

Staffing levels were sufficient to meet people's needs and staff had the appropriate checks in place to

ensure they were safe to work with vulnerable people. Staff had the appropriate training to care for the people who lived in the home.

The principles of the Mental Capacity Act (MCA) 2005 were upheld and people's consent was gained and appropriate people were consulted if someone lacked capacity. There were Mental Capacity Assessments in place and appropriate Deprivation of Liberty Safeguards (DoLS) application had been made.

People were offered a choice of meals and people told us they liked the food.

People had access to healthcare services and referrals were made when necessary to other professionals for their input.

Staff were caring and people's privacy and dignity was respected. The registered manager and the staff knew people who lived in the home very well. People had things explained to them to offer reassurance and so they could make a decision, such as when they were being hoisted the staff clearly explained each step of their support.

People, relatives or representatives had been involved in the planning and review of their care and treatment.

There was regular opportunity for people, relatives and staff to feedback about the care, through a variety of different formats such as surveys, comment cards and in conversations with the registered manager. People also knew how to complain and were confident it would be dealt with if something was raised.

People told us they felt the registered manager was approachable and supportive. It was also evident that action had been taken if an issue was identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Peoples' medicines were not always safely managed and people did not always have their medicine as prescribed.

Incidents of abuse were not always reported to the local safeguarding authority.

The risks involved with supporting people had been documented but had not always been followed or updated to reflect changes.

There were sufficient staff to support peoples' current needs.

Safe recruitment practices were followed to ensure appropriate staff were working with vulnerable people.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not been trained sufficiently to support people effectively.

Peoples' consent was gained and people were encouraged to make decisions where possible. The principles of the Mental Capacity Act 2005 were being followed.

People had adequate amounts of food and their preferences were catered for.

People had access to health care services and were supported by staff where required.

Is the service caring?

Good

The service was caring.

Staff knew people well and supported people in a caring manner.

Peoples' views were sought and taken into account in their care.

Privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People had their needs assessed and regularly reviewed however changes were not always identified.

Some people felt there was not enough to do.

The service had a complaints policy, and people knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality monitoring systems were in place to ensure the home was being managed appropriately. However they did not always identify incidents or issues.

A registered manager was in post who knew the people well.

Staff felt supported by the manager and had confidence in them.

Treetops Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 23 August 2016 and was unannounced. The inspection was carried out by two inspectors and a medicines inspector.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services. We spoke with seven people who use the service, four relatives and five members of staff that supported people as well as the registered manager. We made observations in communal areas. We also made observations of five people being given their medication. We reviewed the care plans for seven people and the Medication Administration Records (MARs) for seven people who use the service. We looked at management records such as; quality audits, recruitment files and training records for five members of staff.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from incidents of abuse as they had not always been reported to the registered manager by staff. As alleged incidents had not been reported or identified we could not be sure that appropriate action was taken to keep people safe from future incidents. We looked at records that showed incidents of alleged abuse between two residents had been documented, but these had not been reported to the local safeguarding authority. There were also two incidents of alleged abuse which involved staff that had been documented and thoroughly investigated internally, but these had not been reported to the local safeguarding authority. All safeguarding incidents must be reported to the local safeguarding authority to investigate. Staff we spoke with were able to identify abuse and they knew how to report it. However, due to some incidents not being reported it suggested their training had not been sufficient or that some staff were not aware of the process of reporting concerns. This meant people were not protected from the risk of abuse reoccurring because it had not been reported to the local safeguarding authority. Incidents may have continued to occur due to the registered manager not always being made aware of incidents and staff not always recognising abuse. Therefore the appropriate action may not be taken and people could be at risk of experiencing abuse in the future. We have been informed that the safeguarding referrals have been made since the date of the inspection.

This issue demonstrated a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always give medicines to people as prescribed by the doctor. For example, one person chewed the medication before swallowing it. The home did not have any information to show that this had been discussed with the GP and that it was safe for the person to take the medicine in this way. This meant that this person's medicine may not be as effective as it was not being taken in the way it was prescribed.

We found concerns about the arrangements in place for handwritten Medication Administration Records (MAR). Some of the MAR charts had important information missing such as the strength of the medicine or how staff needed to administer the medicine. This meant there was limited information for staff to be able to administer the medicine as prescribed.

We found gaps on people's MAR charts, where there was no staff signature to record the administration of a medicine or a reason documented to explain why the medicine may not have been given. This is important information as it shows if the person has taken their medicine as prescribed. The registered manager provided us of evidence of the action they had taken following our feedback during the inspection.

When people were prescribed a variable dose of a medicine such as 'one or two tablets to be taken' we found that the quantity given was not always recorded. This is particularly important for pain relief medicines. It was therefore not possible to determine if people had been given the maximum prescribed dose or could be given a further tablet for pain relief. This means people could be at risk of not receiving enough or of receiving too many of their pain relief tablets as it had not been recorded how many they had taken on each occasion. For medicine that should be taken 'as and when required', called PRN medicine,

the instructions available for staff did not always contain detailed personalised information regarding when the medicine should be given and how a staff member could assess whether a person needed their PRN medicine or not. This means there may have been occasions when people did not have their PRN medicines when they needed them.

We looked at the records for people who were using medicinal skin patches which showed where the patches were being applied to the body. However, the patches were not being applied and removed in line with the manufacturer's guidance, which could result in unnecessary side effects. For instance, if you apply some patches in the same area, this can cause thinning of the skin and leave the person susceptible to damage in that area.

Medicines were stored safely in locked trolleys in a locked room. Medicines that need cold storage were kept in a temperature-monitored fridge. Controlled drugs (medicines that require extra records and special storage arrangements because of their potential for misuse) were stored securely and recorded correctly. Any waste medicines that had not been used were also disposed of correctly.

There were risk assessments and care plans in place to support staff to assist people in moving around the home. We saw a risk assessment that had not been fully completed with mitigating plans in place to reduce a person's likelihood of falling, so they could be at a higher risk of falling until plans were in place for staff to follow. We also saw one risk assessment had not been updated following a person's change of needs. The plan stated this person needed a stand aid to help them stand up and move, however we witnessed the person now required hoisting. The care plan had not been updated following this change in need, even though it had been reviewed regularly. We observed that the moving and handling techniques the staff used to hoist this person were safe. This meant that although techniques used to assist people were safe, the documentation to support this was not always up to date and could mean people were at risk of receiving inconsistent and unsafe care if new staff started.

We saw there were plans in place to ensure people remained healthy by weighing them to ensure they did not lose weight. We saw evidence that the registered manager monitored weight loss and made referrals to a dietician or a GP if a person lost a certain amount of weight and nutritional supplements were put in place. However, some people had been identified as requiring weekly weight checks, but the records showed that these people were not consistently weighed on a weekly basis. This meant people could be at risk of losing weight and it not being identified in a timely manner.

Occasionally people became upset, anxious or emotional. There were risk assessments in place for people who needed support when they became anxious and we saw staff following these plans. We saw a person become anxious and the member of staff who was supporting them was changed to a different staff member, this was documented in their support plan and when we spoke with staff they told us that is how they supported the person when they became anxious. This meant people were cared for in a way that matched their needs and was personal to them.

People were kept safe as the premises were checked and plans were in place to ensure people could be evacuated in the event of an emergency. Equipment checks were also undertaken to ensure staff were using safe equipment to support people.

Accidents such as falls and action taken following an accident were documented and were analysed by the registered manager to spot trends. For example, one person fell whilst going to the toilet and they considered the option of a floor sensor so that staff would know when the person was moving and go to assist them to reduce the risk of them falling again. A form would be completed with the details of the

incident, for example the day and time of the fall, and any action taken as a result of the incident occurring. This means people were protected by reducing the risk and likelihood of an incident occurring again.

People told us there were sufficient staff to meet their needs. One relative we spoke with said, "The staffing ratio is fair, they have time to sit and hold my relative's hand". Another relative we spoke with told us, "I am happy with the home, the staff are very good and there are enough of them" and, "When I leave to go home, I feel confident my relative will be looked after". From our observations we saw that care and support was not rushed and people were supported at their own pace. This meant people received care from sufficient levels of staff in order to meet their current needs.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of their interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK as their identity had been checked. This meant that people were supported by staff who were suitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

Staff had not been trained effectively to know how to manage people's challenging behaviours and some people with dementia needed extra support to help them manage their behaviour towards staff. We observed an incident where a person had made a biting motion towards a member of staff; however the staff member moved their hand quickly so no injuries were caused for either the person or the member of staff on this occasion. We also saw a record where a person pulled a member of staff's hair and the person's hand had to be removed from the staff member's hair. Records showed that some staff had been trained to manage this type of behaviour; however the training had not been effective as incidents had continued to occur. This meant people could cause injuries to themselves and injuries to staff if they are not supported to manage their behaviour effectively. Staff could also be at risk of injuring people and themselves if they used the wrong technique to manage a person's behaviour. By having effective training in place to manage challenging behaviour it would help staff reduce the incidents between people who use the service.

There had also been safeguarding incidents which had been documented by the staff however it had not been reported to either the registered manager or the local safeguarding authority which meant that staff training had not always been effective in supporting them to identify safeguarding incidents. Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training, which was both online and face-to-face and we saw records to confirm this. However, the training was not always effective as people were not always supported to manage their challenging behaviour and incidents were not always reported. There were no formal supervisions in place and competency had not been consistently checked, so areas for improvement had not always been identified. The lack of structured checks of staff understanding of their training may have contributed to why incidents had not always been reported. This meant people were cared for by staff who did not always have sufficient training to support them effectively.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the registered manager. There were documented conversations with staff if an issue needed discussing and there were also staff meetings and a staff survey held. We saw when something had been raised through feedback from staff that it had been acted upon. For example, staff had felt they had not seen a formal job description and this was provided to them by the registered manager.

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. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

People or their legal representatives were involved in care planning and their consent was sought to confirm

they agreed with the care and support provided. One relative told us "I am always involved". We saw staff checked with people and they gave consent prior to supporting them. For example, we saw a nurse explaining to people that their medicine was ready and offered them water. The process was explained to people so they could make a decision and it was not rushed. We also saw staff seeking consent prior to placing an item of clothing on someone. This meant that people were supported to make decisions about their care and treatment.

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. For example, we saw assessments in place regarding whether a person should have bed rails installed on their bed and also assessments about whether a person was capable of using a call bell. The assessments were clear and documented the methods staff needed to use to communicate the information to the person. This meant people's best interests were considered appropriately and people's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager had identified a number of people who they believed were being deprived of their liberty and had made appropriate DoLS applications to the supervisory body. This meant people were protected under the principles of the MCA and were not being illegally deprived of their liberty.

People told us they liked the food and were able to make choices about what they had to eat. One person we spoke with said, "I get to choose and can have something else if I don't like what's on the menu". A relative we spoke with told us, "My relative is happy with the food as it's homemade. They offer my relative a choice. If my relative is ill the staff will make something they'll want". We saw that people were given choices of food, for instance people could choose a cooked breakfast if they wished and we saw a variety of lunch and dessert choices. We observed during lunch that one person commented upon their food and the catering staff replaced it with no issues so people had the option to change their mind and staff accommodated this. Drinks were also offered frequently throughout the day and people were encouraged to drink. People were supported to have a meal of their choice by organised and attentive staff and people were served at the same time so people did not have to wait for support. We saw a staff member support a person whilst sitting at a table along with other people which meant the person was able to experience their lunch along with other residents and did not have to eat alone. This meant people got to eat at the same time; people were not left waiting and were supported to maintain their diet and fluid intake to remain healthy.

People had access to health and social care professionals. A relative we spoke with told us, "Staff accompany my relative to the doctors if they need to go". Another relative we spoke with said, "If my relative is unwell they ring for medical assistance, they [relative] knocked their hand the other day and the nurse put a dressing on it". Records confirmed people had access to a GP, podiatrist, Community Psychiatric Nurse and an optician and could attend appointments when required. We also observed that a Speech and Language Therapist (SALT) visited to assess a person's swallowing ability and a specialist nurse visited a person with a particular condition. This means people were able to access health services where necessary.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. One person we spoke with said, "There's no two ways about it, they are caring". Another person we spoke with told us, "The staff are very caring and friendly". A relative we spoke with said, "It's much better here, it's excellent, they are lovely staff and my relative loves them". Another relative we spoke with said, "When I come, my relative is clean and tidy and they are very caring staff". We also observed people singing together over lunch time. People's care was not rushed enabling staff to spend quality time with them. A relative we spoke with told us, "The staff are very patient". We observed staff asking how people were and staff were kind and considerate. This meant people were supported by caring staff and appeared happy in the home.

People's dignity was respected by staff. We observed that doors were kept closed when people were supported to the toilet. One relative we spoke with told us, "They're very good when assisting my relative to have a bath, no one comes in". People received care and support from staff who had got to know them well. One relative we spoke with said, "They are very obliging staff, my relative is brighter and more relaxed since being here". This meant people's dignity was taken into account by staff that knew them and people were treated with respect.

We saw staff offering choices to people, such as where they would like to spend their time, what they would like to eat and drink and what they would like to do. We also saw recorded in the care plans how people preferred to be supported so people had been involved in establishing their care plan. People were also given the information and explanations they needed, at the time they needed them. For example; we observed a person being hoisted and the staff explained each stage of what was happening and the person looked relaxed and comfortable whilst they were being hoisted. This meant it would help the person be aware of what was happening and reassure them.

The home had recently been refurbished. People's bedrooms were personalised and decorated to their taste. A relative said they were consulted about the move and their relative was able to choose their own wallpaper. They told us the move had been successful and the person was less anxious and there was more space in the room for their relative to walk about. The relative we spoke with said, "Because the furniture didn't match the room they bought all new, it's excellent". This meant people were able to live in a space that was personal to them.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. For instance, people's views were sought through care reviews and annual surveys. The registered manager also did frequent walks around the home and spoke to individual people and documented their conversation and acted upon feedback. For instance, two people felt they needed extra support to tidy their room and this was arranged for them so their personal space was in the condition the people preferred it.

The home was spacious and allowed people to spend time on their own if they wished. There were communal areas, individual bedrooms as well as spaces in the corridors for people to sit should they wish

to. We observed a person sitting listening to the radio in a corridor and chatted to different people who passed by. This meant people could choose where they spent their time.

Requires Improvement

Is the service responsive?

Our findings

Care files were not always up to date and did not always reflect a change in people's needs. We saw an example of a person's moving and handling needs that had changed however their plans had not been updated to show this change. Care files had been reviewed regularly by staff but changes had not been documented. If a different member of staff or if a new member of staff was supporting that person, they may not have known their needs had changed and the person may not have been supported according to their needs. However, there were some examples of responsive care from speaking to people and looking at the records. A relative we spoke with told us, "The staff know my relative, they know the warning signs when they get anxious and there is a continuity of nurses". We saw in people's files that they were personalised and had details of what the person liked and the support they needed. We observed that one person's needs had changed in relation to behaviour and that the registered manager and staff took action to gain support. There had been a medication review and change of medicines and the person was responding to the change. This meant some people were supported to have care that met their needs but this was not consistent for everyone and there was a risk that they may not have the care they require.

There was an activity coordinator. However, some staff felt there could be more for people to get involved in as there was not enough variety of activities to interest different people. One person we spoke with told us, "There is not much to do". We saw that bingo had been arranged for people to partake in and we also heard people singing over lunch time, reading the newspaper and listening to the radio in a seating area near the entrance. People also used the outside seating areas. There was also some opportunity for people to access the local community, a relative we spoke with said, "They can get a member of staff to accompany my relative outside and on trips". This means some people were supported if there were activities they enjoyed available, however those who did not like those activities or had different abilities were not consistently supported to partake in their hobbies and interests.

People or their relatives were involved in developing their care, support and treatment plans. A relative we spoke with told us "My relative was offered the choice of whether to involve family in their care planning but they didn't want to". This meant people were supported to be involved in planning their own care and could make choices about who was involved.

People were supported to maintain their independence and access the community. People had their needs assessed before they moved to the home. Where people required support with their personal care they were able to make choices and be as independent as possible. A relative we spoke with said, "They can get a member of staff to accompany my relative outside and on trips".

Regular resident and relatives meetings were held. One relative we spoke with told us, "I went to a relative's meeting two months ago, they are very useful". This meant people were given the opportunity to feedback about their experiences of the home.

People told us they felt able to complain and speak to staff about queries and knew how to. One person we

spoke with told us, "I'm always ready to talk to staff depending on what I needed". Relatives told us they feel they could go to the manager and believed their concerns would be acted upon. One relative told us, "I could go and see the manager but my relative feels able to complain". Complaints and concerns were taken seriously and used as an opportunity to improve the service. Complaints had been documented, investigated and responded to as per the policy. This meant people could feedback about the service and it would be acted upon.

Requires Improvement

Is the service well-led?

Our findings

The service had quality assurance systems in place however these had not always been effective in identifying issues. For example; we saw that incidents were recorded in the handover sheets and also within a person's records. However, some safeguarding incidents had not been reported and had not been identified by the registered manager from the documentation. We asked the registered manager about these incidents. The registered manager told us they had not been made aware of the safeguarding concerns by staff and the incidents had not yet been picked up in audits of the paperwork. We have been informed that the safeguarding referrals have been made since the date of the inspection. Care documentation audits were place, the registered manager did spots checks on a regular basis however these were not detailed as to exactly what documentation had been audited and had not identified some issues. We found other examples of care files where changes to people's needs were not documented and staff were now supporting a person in a different way. Therefore, if a new or different member of staff supported this person after reading their care plan, they may have supported them in an inappropriate and unsafe way that did not meet their needs.

We looked at the system in place to monitor and manage medicines. The provider did not have a clear system in place for recording medicine errors. This meant that there was no evidence of learning from past mistakes and there was an increased likelihood that the same error could happen again and people were not protected against these risks. The audits had also not identified the issues that we found during our inspection. For example, there was a risk of people not receiving the correct amount of their prescribed medicines as the number of tablets administered was not recorded, so people's symptoms, or if they were experiencing pain, may not be relieved and this had not been identified as an area for improvement. Although checks on documentation were carried out by the registered manager it was not always clear what had been checked. This meant that the systems in place to monitor, manage and mitigate people's risks with medicines were not effective. Since our inspection we have been sent evidence of a medicine check being carried out and action taken if a medicines error has been identified.

This issue demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager clearly knew the people who lived in the home very well. People told us they knew who the registered manager was, "I saw the manager when I first arrived, they were very pleasant". A relative told us, "The manager is particularly caring, they'll do anything to help my relative. I can call to ask their opinion about things for my relative". Another relative we spoke with said, "The manager is hands on and has done a lot of talking to staff, it's like a well-oiled machine". People told us they felt they could go to the registered manager directly if they wanted to give any feedback. Staff also told us how they felt about the registered manager, "The manager is very approachable". Staff meetings were held to discuss things within the home, such as the needs of people and medications issues. Feedback forms were also readily available throughout the home to enable people to feedback. This meant people had the opportunity to provide feedback and action was taken where necessary.

There was a service improvement plan in place which was updated by the registered manager and monitored by the provider. For example, it had been identified a staff survey was required and this action was completed by the provider. The results were analysed and further actions added to the service improvement plan. This meant the service was monitoring its performance and planning how things could be improved. Since our inspection the service has provided us with an updated improvement plan following feedback.

The registered manager had notified CQC about significant events that they are required to notify us of by law. We used this information to monitor the service and ensured they responded appropriately to keep people safe. Since our inspection, we have also received further notifications regarding the action taken for the incidents we became aware of during our inspection.

People's experience of care was monitored through daily walk arounds by the registered manager which included speaking to people and checking the environment. These were documented and action taken if issues were raised. For example, one walk around had identified the garden was overgrown so it would not be pleasant for people to utilise the space, action was taken to tidy the garden area. A relative we spoke with said, "The environment has improved since the new provider has taken over". The registered manager would also visit the service at night in order to capture what was happening within the home at different times of the day. Any issues that were identified were documented and the appropriate action recorded. The registered manager explained they also worked shifts providing care to people in order to get to know people and see how the staff were working. This meant quality was monitored at a variety of times and action taken to ensure quality.

The registered manager was being supervised and felt supported by the provider and felt they had the flexibility to do things the way they wanted with support from the provider. The registered manager said they could call the provider for support they needed, and have done. They also gave the example of being able to increase staffing if they need to. This meant the registered manager felt supported in their role to manage the home and care for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from harm because we found incidents of alleged abuse had not always been reported to the local safeguarding authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were in place to monitor the quality of the service; however these were not always effective. Although there were regular checks carried out by the registered manager, it was not always clear what documentation had been viewed. Incidents had not been identified, such as safeguarding incidents between people who lived at the service, the number of episodes of challenging behaviour some people were experiencing and staff needing to intervene and omissions in the medicines documentation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the effective training they required to assist someone who had challenging behaviour and this had left both people and staff at risk. Safeguarding training had not always been effective as staff had not recognised and reported incidents of abuse.