Mr Amin Lakhani

Glen Heathers

Inspection report

48 Milvil Road
Lee On The Solent
Hampshire
PO13 9LX

Tel: 02392366666
Website: www.saffronlandhomes.com

Date of inspection visit:
18 June 2018
19 June 2018

Date of publication:
30 August 2018

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 inspection took place on 18 and 19 June 2018 and was unannounced.

Since our last inspection a new manager had become registered with CQC. 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.

Glen Heathers has a history of breaching legal requirements. Following an inspection in March 2015 multiple breaches of regulations were identified and CQC took appropriate enforcement action and placed the service in special measures for having an overall Inadequate rating. Some improvements were seen during a focused inspection in June 2015 and further improvements were found at the comprehensive inspection in November 2015 when the service was rated overall Requires Improvement and came out of special measures. However, they remained in breach of Regulation 17, Good governance. During the next comprehensive inspection in November 2016, we identified multiple breaches of the regulations related to providing safe care and treatment, safeguarding, staffing, person centred care and good governance systems. The overall rating following the November 2016 inspection decreased to Inadequate and the service was placed into special measures again. At our last inspection in May 2017 we found improvements had been made again and only one breach of regulation was found, relating to the governance of the service. The overall rating was Requires Improvement, however the key question of well led remained Inadequate and as such the service remained in special measures. CQC took enforcement action and imposed a condition on the registered provider. This condition meant the registered provider was required to undertake certain audits and to provide CQC with monthly reports about these audits.

At this inspection we found that the improvements previously made had not been sustained and we identified multiple concerns about the safety of people who lived in the service.

We found that people were at times placed at risk of harm because appropriate assessments of risk had not been carried out; staff knowledge of some risks and the management of these was not sufficient to ensure they could provide safe care; people were placed at risk because the checking of equipment used to prevent injuries was not accurate; where factors for people indicated concerns to their health, they had not been followed up and appropriate checks were not always undertaken following unwitnessed falls.

Where people had been losing weight, appropriate action had not been taken to ensure they were receiving the nutritional support they needed.

In addition, people were placed at risk because good infection control and maintenance measures were not in place. Several items of equipment were worn or ripped meaning they could not be sufficiently cleaned. There was a lack of schedules in place to ensure cleaning of some equipment. Some areas of the home smelt strongly of urine and we could not be confident that when housekeeping staff had signed to confirm

they had cleaned an area, that this had been done.

Following the inspection, we asked for an action plan to address the immediate concerns we had for people's safety. We also referred our concerns to the local authority.

Staffing levels were sufficient to meet the personal care needs of people but they did not support staff to provide any social or emotional engagement and support. Care planning was not always personalised and was not fully responsive to people's changing needs. End of life care planning was in place for some people but needed further development.

People did not always receive effective care and support because staff had not received some training to help them meet people's needs. Where training was provided in a specific areas staff competency had not been assessed to ensure they understood the area of need. People and their relatives provided positive feedback about staff. However, our observations showed that not all staff provided support in a respectful and dignified way.

There was a process in place to deal with any complaints or concerns if they were raised. However, when feedback via alternative formats such as surveys suggested concerns these were not investigated and acted upon. This meant we could not be confident the systems in place to seek feedback and address concerns were used effectively to ensure a safe and quality service was provided and drive improvements.

Despite knowing that there had been a problem with care plans and risk assessments, there had been a failure on the provider's behalf to follow this up in the home and ensure people's safety and a quality service was provided. The senior management team, provider and registered manager did not have an effective system to ensure they had good oversight of the safety and quality of the service.

Medicines were managed safely. Staff felt supported and were receiving supervisions to support them in their roles.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs. Where applicable mental capacity assessments had been undertaken and we consistently saw and were told people's permission was sought before staff provided care.

Some efforts had been made to adapt the environment to meet people's needs but more work could be done to develop this further.

People were protected against abuse because staff had received training and understood their responsibility to safeguard people. Concerns were reported and investigated. The provider's recruitment process included appropriate checks to ensure staff suitability to work in the home.

Communication with the kitchen staff needed to improve. The registered manager had defined staff roles and was open to suggestions and feedback. Staff felt supported by the registered manager and able to raise concerns at any time. They were confident these would be addressed. People and their relatives were confident to raise concerns if they needed to and spoke positively about the registered managers approach.

The overall rating for this service is 'Inadequate' and the service remains 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."

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC are considering what regulatory action to take in response to the serious concerns found during the inspection. Full information about CQC's regulatory response 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.

People were at times placed at risk of harm because appropriate assessments of risk had not been undertaken; staff knowledge of some risks and the management of these was not sufficient.

People were placed at risk because good infection control and maintenance measures were not in place.

Staffing levels met the personal care needs of people but they did not support staff to provide any social or emotional engagement and support.

Medicines were managed safely. People were protected against abuse because staff had received training and understood their responsibility to safeguard people. The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive effective care and support because staff had not received training or been assessed as competent in areas to meet people's needs.

Where people had been losing weight, appropriate action had not been taken to ensure they were receiving the nutritional support they needed.

Staff did not always act on health professional's advice or seek this at times it may have been needed.

Some efforts had been made to adapt the environment to meet people's needs but more work could be done to develop this further.

Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs. Where applicable mental capacity assessments had been undertaken and we

consistently saw and were told people's permission was sought before staff provided care.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives provided positive feedback about staff. However, our observations showed that not all staff provided support in a respectful and dignified way.

People's privacy was maintained and records were held securely and confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not always personalised and was not fully responsive to people's changing needs.

There was a process in place to deal with any complaints or concerns if they were raised.

End of life care planning was in place for some people but needed further development.

Is the service well-led?

Inadequate

The service was not well led.

There had been a failure on the provider's behalf to make and sustain improvements since the last inspection.

The senior management team, provider and registered manager did not have an effective system to ensure they had good oversight of the safety and quality of the service.

The registered manager had defined staff roles and was open to suggestions and feedback. Staff felt supported by the registered manager and able to raise concerns at any time. They were confident these would be addressed.

Glen Heathers

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.

The inspection took place on 18 and 19 June 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist nurse advisor 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. They had personal experience of caring for older people with dementia who used regulated services.

Before the inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We also reviewed the previous inspection report and the provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. This had been completed just after our last inspection. Before the inspection we sought feedback from a member of social care staff at the local authority.

During the inspection we spoke to 12 people and 10 relatives. We spoke to 14 staff, including registered nurses, care staff, kitchen staff, activity staff, maintenance staff, the clinical lead and a senior manager. In addition, we also spoke to the registered manager. Due to the nature of people's illnesses we were not always able to communicate with them so we spent time observing the interactions between people and staff, in public areas of the home, to help us understand people's experiences.

We looked at the care records for 18 people who used the service and the personnel files for five staff members. We also looked at a range of records relating to how the service was managed. These included training records, complaints, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Glen Heathers but felt the quality of support they received varied and that more staff were needed. One person said "Yes. They look after me well and look after my needs". Another said "'Oh yes, there's always someone here, you're never alone". However, a third person told us "Generally, in the night time it's too much trouble, I feel I don't want to ask for things'' and a fourth person told us how they had to time their requests and said they avoided calling at busy times such as mealtimes because there were not enough staff. A fifth person, when asked if staff had time to meet their needs said, "Not for some people. I'm quite independent, but I feel sorry for some people. It's not the staff's fault. They don't have the time or enough staff.'

At the last inspection we found that improvements had been made and this question was rated as requires improvement. However, these improvements had not been sustained and the service had deteriorated.

At the last inspection improvements had been made and risks for people were being consistently assessed and plans developed to reduce these risks. At this inspection we found these improvements had not been sustained. We identified concerns about a lack of clear risk assessments where the care provided posed risks to people's safety. For example, several people were using bed rails. These are pieces of equipment that can help to prevent people from falling out of bed. However, the use of these can also pose risks for people such as injury and entrapment. As such, the Health and Safety Executive (HSE) stipulates that when bed rails are used during a work activity, the provider must ensure that they are safe and that risk assessments are carried out by a competent person. We found no risk assessments were in place for the people using these. For one person, we found that following a fall, bed rails had been introduced to reduce the risk of further falls from getting out of bed unsupported. However, a daily statement in their care records said this person "Has been putting [their] legs over the bed rails and removing the bumpers which could cause risk of bruising or injuring [them] self. A risk assessment is to be linked to this care plan." The plan this entry was linked to described how bed rails were to be used and did not identify the risk. The risk plan was blank and no risk assessment had been completed. This information was not included on the handover record and whilst permanent staff said they were not using the bed rails when this person was in bed, this information was not recorded anywhere. The service was relying regularly on the use of agency staff meaning that if they did not have access to the correct information about risks, the agency staff could use this equipment and place this person at risk.

During the inspection the registered manager told us that they thought these documents may have been filed away. Following the inspection visit, the provider sent us a sample of bed rails risk assessments that had been completed.

Before the inspection, via a statutory notification we had been made aware of an incident whereby a person had broken a door lock and staff found them outside the building alone. This could place them and others living in the home at risk of harm from being able to leave the building without staff knowledge and from unauthorised persons entering the building. We asked to see the risk assessment and mitigation plan regarding this and were told that one was not in place. The incident took place on 26 May 2018 and no risk

assessment had been completed or a plan developed to reduce the risks of this reoccurring or to guide staff as to the management of such an incident should this happen again. The risk assessment was not implemented until we identified this was not in place during the inspection.

At this inspection we found that people were placed at risk because incidents that had occurred did not lead to an appropriate and prompt review of their needs. For example, one person had fallen and staff and care records confirmed that following the fall they suffered with a vasovagal episode (fainted). Staff took appropriate action to address the immediate concerns and the person was taken to hospital. However, despite recording on their accident sheet the vasovagal episode and the deputy manager confirming this person "passed out" following the fall, we found their falls risk assessments had not been reviewed for a further six days and no assessment of the risk of fainting had been completed. We were told the falls risk assessment and care plan had not been reviewed until six days after the fall had happened because the electronic system used for care planning was not operational. Risk assessments can be done without an electronic system and should be done promptly following a change in need to ensure that the level of risk has not increased and the measures in place to reduce these risks are satisfactory. A failure to do this promptly and a failure to assess the risk of fainting for this person placed them at risk of harm from falls or fainting because the measures to reduce such risks had not been considered or reviewed.

For a second person we found an accident record which showed they had an unwitnessed fall at 22:00 hours as they were going to bed. As this was unwitnessed there was a risk the person may have banged their head without knowing they had done so. NICE guidance states that a post falls protocol should be in place and include the frequency and duration of neurological observations for all people where head injury has occurred or cannot be excluded (for example, unwitnessed falls). Neurological observations will enable staff to promptly identify any potential head injury and take appropriate action. Whilst we saw one set of clinical observations were undertaken, including the person's blood pressure and pulse, there was no evidence that neurological observations had been done and no one could find a record of these. In addition, despite this person's blood pressure and pulse being raised, these were not rechecked. The registered manager sent us a copy of their policies in relation to falls and we saw no falls protocol was in place and there was no guidance contained in these about how to manage a fall after it had happened. We sent the registered manager a copy of the protocol used by the local authority. A lack of neurological observations at a time when a head injury cannot be ruled out, because it was not witnessed, placed this person at risk of any deterioration of their physical condition going unnoticed.

Staff in the home were monitoring the clinical observations of people who lived there monthly. This included checking their blood pressure, pulse, temperature and blood oxygen levels. These are observations that help to identify early, a deterioration in a person's health. We found concerns that whilst these clinical observations were being taken, where these were outside the 'usual' limits for a person, no action had been taken, to either recheck these were accurate readings or to contact a health professional such as a GP. For example, we found one person's blood pressure was lower than usual when checked in May 2018 but no action had been taken. For a second person, their blood pressure was extremely high when checked on 13 June 2018, however when we discussed this with the clinical lead on 19 June 2018, they were not aware of this and could find no evidence this had been considered further. The clinical lead rechecked this person's blood pressure on 19 June 2018, following our discussion, and it had returned to a usual range. Whilst no harm had occurred to people, people were placed at risk of harm due to failures to follow up on vital observations that could suggest a deterioration in their physical health. At the last inspection we did find some concerns that specialist equipment was not always set correctly or functioning. This had not improved and we continued to find these concerns during this inspection. Of 13 people living in the service who were cared for by using an air mattress to aid the relief of pressure and aim to reduce the risk of injury as a result of pressure sores, we found four were set incorrectly, according to the information provided to staff. It is

important these mattresses are set correctly to ensure they are fully effective. Although these had been checked the day before and documented as set correctly, the records telling staff what setting they should be on were incorrect and we could not be sure how long these had been set incorrectly.

We were concerned that at least two member's of staff were administering insulin to diabetic patients and had not been assessed as competent in understanding diabetes and the administration of insulin. Diabetes UK 2010) recommended that no member of staff, registered or otherwise, perform blood glucose monitoring unless they have a sound knowledge base of diabetes, received training on blood glucose monitoring using the meter specific to their place of employment, aware of how to interpret the reading(s) obtained and subsequent action to be taken. We asked a member of staff who administered insulin to describe a hypoglycaemic (hypo) episode (low blood sugar) and how to manage this. They were unable to tell us this and described a hyperglycaemic episode (high blood sugar). Whilst these are both dangerous for people, the management of them is different and it is therefore essential staff can recognise these and know the appropriate action to take. This staff member was unable to tell us what blood sugar level would suggest a hypo and they were not able to tell us. Although they said they would check care plans for this information we found the information in one person's care plan stated a hypo would be 3mmols/L or below. A registered nurse and the clinical lead were unable to tell us what evidence this plan was based on. Diabetes UK 2017 states hypoglycaemia occurs when blood glucose levels fall below 4 mmol/L. In addition, a further member of staff was not able to tell us how they would identify if a person was in a hypo or what the risks of not taking prompt action would be. Failing to take prompt action for a person in a hypo could lead to coma. If staff are not able to recognise a hypo there is a risk they may not take prompt action to address this which could place people at risk of significant harm.

The failure to ensure that risks associated with people's needs were effectively assessed; that plans were put in place and followed to reduce those risks; and to ensure staff were competent to provide safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we asked for an action plan to address the immediate concerns we had for people's safety. We also referred our concerns to the local authority. We received an action plan and were told that care staff who were administering insulin were no longer doing this and further training and competency was being sourced; Staff's competency regarding clinical observations was being assessed and the clinical audit was being reviewed; all care plans and risk assessments were being audited; previous risk assessments that were in place before the provider changed the care plan system had been reviewed and made available to staff; everyone's weight had been rechecked and their mattresses set accordingly; an audit of bed rails and bumpers had taken place, risk assessments implemented and new bumpers ordered.

There were occasions when we found clear and comprehensive information about risks for people. For example, one person was at risk due to eating a variety of items. This was clearly recorded, assessed and plans developed to reduce the risk. We observed the plans being followed. For another person there was comprehensive information about a health condition that posed risks of bleeding and bruising.

People told us they felt that Glen Heathers was clean and tidy. For example, one person told us, "Yes, when we have a cleaner. They seem to come for a few days and then disappear. It's better when we have a regular one". A second person told is "Absolutely spotless". However we found the environment and some equipment was not always and infection control measures were not always taken to promote people's safety. Where bed bumpers were used we found most of these were worn and ripped. When we pointed out to the clinical lead how worn and torn one person's bed rails were they responded by saying "They are, aren't they". They took no action to change these and we observed these to be in place the second day of

our visit as well. The bed bumpers on one person's bed were dirty. The registered manager told us they had no schedule in place for the cleaning of these and we could not be assured these were cleaned regularly. Worn and ripped areas would make it impossible to maintain infection prevention measures. Following our inspection the provider told us that an audit of bed rails and bed bumpers had been undertaken and bed bumpers were replaced as deemed necessary.

We found the same for chairs in the dining room. There were no records of these being cleaned, the seats were stained and worn. In one area of the home were two specialised chairs which staff told us people used. One of these was heavily worn and ripped, the other was dirty. Despite pointing out how dirty this chair was to a member of staff, it still was not cleaned. Following the inspection we were told the worn and ripped one that was used was a person personal chair which we were told was cleaned by staff.

Three bedroom carpets were heavily stained, one of these had a strong smell of urine and we found a further two bedrooms smelt strongly of urine. The registered manager told us that for one person this was due to the carpet needing replacement. They were unable to tell us when this would take place as due to the person's needs they did not leave their room.

In one sluice area we found swing lid bins were in use rather than a pedal bin, which would reduce the risk of infection spread, bags of rubbish were stored on the floor; the sink was very stained with limescale making it difficult to clean fully and the plug was full of tissue. In the second sluice the sink drain was brown with rust, making this impossible to clean effectively.

On the second day of our visit we found in one person's room, under their bed was pair of reading glasses and tissues. We asked a member of the housekeeping staff if the room had been cleaned and they said they would be doing this shortly. Later that day, once the housekeeping staff had left, we checked cleaning records and these had been signed to say the room had been cleaned, including moving the bed. If this was accurate we would expect that the person's glasses had been picked up and the tissues removed, however when we checked these remained on the floor under the bed. We could therefore not be confident that the cleaning records were accurate.

Weekly cleaning audits were undertaken and the last was completed on 16 June 2018. This identified that three bedrooms had been checked and no issues were found. It also stated that the sluice areas were checked and no concerns were found. An Infection control audit had been completed with a recorded date of 'April/May' 18. This found that carpets were not clean and in good condition, that there were no elbow taps with mixers in the clinical room and that there was a lack of foot pedal bins for the clinical room. Despite identifying this no action plan had been developed to address these issues. The maintenance plan we were provided with did identify the room whose carpets needed to be replaced due to strong smells of urine, however it did not identify work was needed on the carpets of the two rooms which were stained. The other room where we found a strong smell of urine did not identify any action needed. We found no plan to address the issues we found in the sluice areas or regarding the furniture.

Following our inspection the provider confirmed a further environmental audit had been undertaken and an action plan developed, with this being shared with the appropriate staff members. This included a plan to replace or clean carpets, purchase pedal bins and deep clean sluice areas.

Although action was taken subsequent to our inspection, the issues of cleanliness and worn equipment found during the visit placed people at risk because good infections controls measures were not operated at that time. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff responded to their requests for support and this was mostly done in a timely way. However, one person told us they timed their requests to fit around mealtimes. They said "Even at mealtimes when they're doing the meals, they don't have enough staff. They should have extra staff at mealtimes". Another person told us that although they felt staff came as quickly as they could, if it was a busy period they would have to wait and a third said their waiting time depended on how busy it was and how many staff were on duty. While we observed that staff did not have time to provide social and emotional support for people, we did observe that they responded promptly to people's requests for personal care support.

Since our last inspection changes had been made to staffing levels and skill mix. The number of nursing staff had reduced to one per shift with the support of a care practitioner; the number of staff in the afternoon had decreased to four care staff. The registered manager had introduced a 06:00am to 12 noon shift, which we were told by staff had helped them during busier periods.

The provider operated a dependency assessment to determine the staffing levels needed in the home, however, the most recent assessment only reflected 30 people living in the home and had therefore not been updated to reflect the current needs of all the people living in the home which was 32 people.

We were not assured that the system used to assess and deploy staffing was effective in ensuring staffing met people's needs effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines as they needed them. One person said "Oh yes. They bring it" and a second said "Every morning. The nurse is really good about that".

Medicines were stored safely in locked trolleys, rooms and fridges. Staff checked the temperature of medicines storage daily to ensure this would not impact on the medicine's effectiveness. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised. Staff checked the records before administering the medicines and then signed for these once the person had taken them. We looked at the Medicines Administration Records (MAR) and found no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes. As required (PRN) medicines had protocols in place to guide staff to the use of these medicines. The system of daily, weekly and monthly audit checks of medication administration continued to be operated and was working well to monitor the safe management of people's medicines.

Safe recruitment processes were in place. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

People were protected from the risk of abuse because staff understood how to identify and report it. They told us they had received training in keeping people safe from abuse and this was confirmed in the staff training records. In addition, competency based discussion took place with staff about their knowledge of safeguarding. Staff told us they would have no hesitation in reporting abuse and were confident that management would act on their concerns. We saw where staff had identified potential safeguarding concerns, all bar one, had been reported to the local authority safeguarding and investigated. The manager

was not aware of the one potential safeguarding issue when we discussed this and took immediate action to begin investigating this during our inspection, including addressing the failure to alert the manager with staff involved. For all other potential safeguarding issues there was evidence that any required actions were considered and carried out.

Since the last inspection the registered manager had made improvements to the monitoring of unexplained bruising and skin related issues. The registered manager reviewed the records of these on a regular basis and audited them monthly. They had identified patterns which suggested improvements to staff practice may have been needed and acted to address these. Staff told us the registered manager was always reinforcing the importance of skin management and being extra vigilant during moving and handling and personal care tasks.

Inadequate

Is the service effective?

Our findings

People told us they felt staff were trained and knowledgeable. One person said, "They are, for my liking' and another said "Oh yes. They know everyone and what's what". A relative told us "I suppose they are. They all use the same system for putting creams on, so that proves they're trained".

At the last inspection we found that improvements had been made and this question was rated as requires improvement. However, this had not been sustained or improved on.

At the last inspection in May 2017 we found that improvements had been made to the training of staff. However, during this inspection we found concerns regarding training and the assessing of staff competence. Whilst we observed that training was made available and being undertaken by staff, some of the concerns we found (reported in the Safe domain) meant we were concerned that the frequency of training was not sufficient.

For example, the training matrix recorded that the cleaning staff had received infection control training as had the member of staff who completed the cleaning and infection control audits. However, this training had not been done since October and November 2015. We found multiple areas within the home were not only unclean but also posed infection control risks due to being poorly maintained. If the training had been effective in ensuring staff's understanding and competence, it would be expected that the home was clean and those items which posed infections control risks would have been identified within the audits and action taken to address these but they had not been. In addition, if the training was effective in ensuring staff's understanding and competence we would expect that when we pointed out to staff how worn and ripped certain items were that they would have taken action at some point over the two days we visited to address these, but they did not."
In addition to nurses administering insulin to people who were prescribed this, two other senior staff were also doing this. Whilst the training matrix recorded that they had undertaken training in diabetes, competency assessments to ensure these staff had a sound knowledge of diabetes and the management of this had not been undertaken. The clinical lead told us they were confident in these staff's ability. However, for one of these staff members, their description to us demonstrated they did not have a sound knowledge or competence.

One person living in the home could display behaviour which challenged others and at times records reflected they had become physically aggressive towards staff during personal care. Whilst some of this person's care plan gave tips for staff about how to manage this, such as walking away, giving the person time and returning a bit later, daily records of this behaviour suggested this may not be happening. For example, one entry recorded that the person was left to calm down after personal care was given which suggested that staff continued to give personal care rather than following the care plan. The registered manager told us that staff had received mental health awareness and challenging behaviour training. The training matrix showed that only seven of 24 staff providing direct personal care had received mental health awareness training and the provider told us two registered nurses were mental health nurses. Only eight of 24 staff who delivered care had received training which would support their understanding of managing

behaviours which challenged. In addition, we noted that at least 15 people were living with dementia and most others were living with some form of mental health condition. It is essential that staff have an understanding of these conditions and how they could impact on a person in order that staff can provide effective and appropriate support.

Staff employed to plan and carry out activities had received no specific training to help them be effective in their role as activity coordinators. We found no plan of activities was in place to aid people in deciding if they wanted to join in and people's feedback about activities varied.

A failure to ensure staff completed training that would support them to carry out their role effectively and to ensure they had been assessed as competent was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new supervision policy had been introduced since our last inspection. Supervisions with staff had improved and these were being completed more frequently. Staff said these were open discussions which they found useful. They told us these sessions gave them the opportunity to address any concerns and to receive feedback that would help them in their role. They told us although they had these supervisions they could approach the registered manager at any time.

Although staff monitored people's nutritional status by checking their weight on a regular basis, we were concerned that they did not always take any action if people were losing weight. For example, we found one person had lost a significant amount of weight over a period of seven months. Whilst we saw daily records recorded contact with an external health professional were made in November 2017, we could not see any action taken by staff. This person then became unwell so it would therefore have been even more important to try and ensure good nutritional intake. We found records in the home which suggested the continuing weight loss for this person had been discussed with an external health professional on 16 February 2018. An external health professional told us that in February 2018 staff at the home were advised to start recording the person's intake on a food chart, give them an enriched diet and to contact the dietician for further advice. We could not find any information to suggest these actions had been taken. Their last malnutrition assessment showed they were at high risk. This person's care plan had been reviewed in June 2016 and recorded that they were having a normal diet but smaller portions as their appetite had decreased. It contained no information about their weight loss and there was nothing to suggest they needed their food intake monitored or a fortified diet. Kitchen staff told us this person was receiving a normal diet, that this was not fortified and the information on display in the kitchen did not contain any instructions under the title "weight management". Kitchen staff also told us they did not receive information about people's weight from staff. The registered manager told us this would be recorded in the kitchen staff communication book, however we found no entry to reflect this. Food monitoring charts were in place for this person but they contained no information to support any decision making as they did not record what food was provided. In addition, there was no evidence of review of these records which would demonstrate the person's intake was being monitored and evaluated. Whilst this person had begun to start putting weight back on and was stabilising, it was concerning that this did not appear to be due to planned, appropriate actions being undertaken.

For a second person, we saw that their weight records showed weight loss and significant drop in June (possible scales error on May record). Staff had taken the decision to check this person's weight on a weekly basis. The records suggested this was due to be checked on 10 June 2018 but the person was in hospital. However, they were discharged on the 11 June 2018 and as of the 18 June 2016, staff had not rechecked this person's weight to be assured that weight loss was not an ongoing concern. The staff member who we were told was responsible for ensuring the weight records were completed was unable to tell us why this had not

been done but told us they would do this that day.

The failure to take appropriate action when weight loss suggested concerns and assessments demonstrated a risk was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we were sent information which showed the second person's weight had been rechecked and was improving. We also received an action plan which told us the food monitoring charts had been reviewed and that these would be evaluated weekly; a meeting had been booked with kitchen staff to discuss communication and everyone's weight had been reviewed and where appropriate requests to GPs for review had been made.

Staff told us that people were always offered high calorie snacks such as biscuits, cakes, chocolate bars and homemade milkshake at tea rounds. To support people who were on a soft or pureed diet to have sufficient calorie intake, alternative options were available, including yogurts and pureed cakes. People spoke positively of the food and said this was enjoyable. They were given choices of meals and told us if they didn't want something from the menu, or changed their minds, something else was always available. The kitchen staff were aware of people's needs, likes and dislikes. They knew who needed their meals to be delivered in a soft or pureed format to enable them to eat without risk of choking or swallowing difficulties. People who required support and supervision at meals times were provided with this, although we noted at time some of this support was not always dignified.

People told us they had access to other health professionals and we saw records showing that external teams such as GPs, dentists, speech and language therapists and older person's mental health teams were involved. One health care professional told us they felt staff were "Getting better at recognising concerns more quickly". However, we were not confident that external advice was always sought in a timely manner or that the advice was followed through. For example, we were unable to conclude the advice for one person with weight loss had been carried out and where clinical observations such as people's blood pressure indicated potential concerns, we found no discussion with other medical professionals had taken place to ensure the changes were not placing people at risk.

Some people in the home were living with catheters which required replacing by the nursing staff on a scheduled basis to prevent infection and other complications. The replacement of these had been done but there was no plan or schedule in place to ensure the next change was done within an appropriate timescale and to ensure this would not be missed. For one person, the clinical lead told us their catheter had not been changed when this was due. We were told this was because they had been unwell which demonstrated that they had responded to the person's current situation. However, this had not been documented, there was no evidence of multidisciplinary discussion regarding this decision and no plan to review this decision. At the time of our inspection this person's catheter had not been changed. This had been due five weeks prior to our inspection. This placed the person at increased risk of developing infections.

A failure to ensure clinical observations which suggested people may be at risk were followed up, and the failure to ensure care was planned so people were not placed at risk, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The clinical lead told us this would be reviewed for this person during the week of our inspection and we were provided records which reflected this had been done following our inspection.

Staff providing personal care received handovers at every shift and a written record was available to support

this. However, on the first day of our inspection the record available to staff was out of date. It contained no information for two people who had moved into the service, the room number for one person was not accurate and it contained information for another person who had passed away. The registered manager corrected this and staff had access to this new document on the second day of our visit. Staff felt that they communicated well as a team but we were concerned that some kitchen staff told us they were not provided with information that would help them to ensure people received adequate nutrition.

People told us staff always asked for their permission before providing personal care. One person told us "I think so, they're very helpful here" and another said "Oh yes. They say, do you mind?".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspection we heard staff asking permission from people before they provided care. They checked people were ok to receive support before providing it. For example, at lunch time we observed that people were invited into the dining room and asked if they wanted assistance. Staff understood the importance of always assuming a person can make their own decisions and their descriptions of the Mental Capacity Act 2005 demonstrated that they understood how to apply this in practice. Mental capacity assessments had mostly been completed where needed, although we did find one person moved bedroom on return from hospital and we found nothing to evidence staff had sought this person's consent or had undertaken a mental capacity assessment. Other records showed that mental capacity assessments associated with decisions such as managing medicines and sharing information had been done and best interests decisions had been recorded.

Where DoLS had been applied for, mental capacity assessments had been completed. The manager had a system in place to track the expiry dates of these and any conditions that were required to be met. There were no conditions imposed with the DoLS that had been authorised.

Some efforts had been made to ensure the environment met people's needs but more work could be done to develop this further. Most flooring helped to reduce the risk of falls and most communal areas were well lit. In one area of the home, contrasting colours had been used to distinguish doors from walls. Some signage was in place but this was often small and not very clear. There were small signs indicating the way to the dining room, living room and to bedrooms (by number) which could be unclear for people living with dementia or poor sight. Bedrooms were numbered and some included a picture of the person and their name. However, names were small and positioned at the top of the doors.

Staff were provided with training in equality and diversity, although only 11 of 24 staff had completed this. They were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. One member of staff told us how the home had supported previous people in relationships. The registered manager and staff were clear that discrimination would not be tolerated and were confident any human rights or equality needs people had would be met.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that improvements had been made and this question was rated as good. However, this had not been sustained or improved on.

Feedback from people and relatives about individual staff approaches to support was positive. One person told us "Very good. See the ladies who look after us. They are good ladies, nice ladies but sometimes they don't have the time, so you don't ask them" and a second said" "The staff are lovely". One person told us "Absolutely top rate", when asked if staff were kind, caring and compassionate. Most people felt staff tried to get to know them and that they got on well with staff. One said "Yes, I think so. They have a laugh with us, now and again" and another said "As a rule. I have a bit of banter with them, light hearted banter. I appreciate that". However, some people provided feedback that was concerning.

For example, one person said "The day staff are wonderful, the night staff, less so. The night staff have an ignorant attitude. They're sarcastic, that's the general demeanour". We informed the registered manager of this who said they would investigate this with the person. Another told us "Some are very young, some are from agencies and some are difficult to understand". They then described how their clothes have been given to other people living in the home, even though the person's name is on them.

People told us they were supported to maintain their independence. One person said "Oh yes, I like to be independent. "They shower me and take off my support socks, but I try to do as much as I can for myself. They would wait on you if you let them". This person told us how they often went out independently. Another said, "Oh yes, they leave you to do it, if you want to do it". People mobilised freely around the home.

When we did observe staff interactions with people, we found these were mostly positive. Most staff spoke kindly and compassionately with people. They communicated with people at eye level and offered reassurance when they saw this was needed. Although we also observed some interactions that did not demonstrate staff cared or were aware of the need to show respect and maintain people's dignity. For example, on one occasion we observed a person was provided their lunch time meal in their room and although the member of staff stayed with them, they did not communicate with the person at all. They cleaned cream from the person's t-shirt without asking permission or telling them what they were going to do. The following day we observed that a different member of staff offered this person their meal and whilst the person did not engage with the member of staff, the member of staff made several attempts and offered encouragement before telling the person they would bring it back later. They bought the person's meal back later. Whilst this demonstrated that the member of staff understood this indicated the person needed some time and they supported them in an appropriate way, it was concerning that in this person's room the clock showed the wrong time and the picture of the TV was so badly pixelated that it was unwatchable. We advised the maintenance staff of this.

We observed one person dropped a biscuit on the floor and was unable to reach it to pick it up. A member of staff picked this up and returned it to person's plate, then left the conservatory. The member of staff then came back and asked the person whether they wanted the biscuit. The person said they did but then the

carer told them they could not have it because it had been on the floor. Although the member of staff did bring the person another biscuit, the approach and communication by this member of staff could have caused confusion and distress. It would have been a more appropriate response for the member of staff to have removed the initial biscuit when they found this on the floor and provided another at that time, while clearly explaining to the person what they were doing.

On another occasion, a person was bought their meal in their room. The member of staff was not able to tell the person what the meal was when they asked. Whilst the member of staff adjusted the person's table across their bed to enable them to eat their meal more easily, they did not appear to notice that next to the person's bed was an open commode with urine it in. Another member of staff noticed this and removed it.

Another member of staff was seen assisting a person in their room. As the meal was pureed and not obvious what it consisted of, the staff member told the person what the meal was and showed them the food. The member of staff ensured the person knew what they were being served with each mouthful and interacted with them in a patient and friendly manner, without rushing them.

We received mixed feedback from people and their relatives about being involved in the development of their care. One relative told us they had been involved and their relative's care plan had been reviewed several times. Whilst another relative said they were aware of a care plan but that it needed updating following a fall and a change in their relative's mobility. They said, "We've been told we'll be involved in the care plan". Following the inspection, the provider sent us a document which showed the care plan had been reviewed. However, this did not evidence the involvement of the person or their relatives. Some people's records contained "This is me" documents which provided information regarding people's life history and we were told were used to get to know people. Staff had a good understanding of people's likes, dislikes, preferences and history. People and their relatives did tell us that regular meetings with the registered manager were held and we saw that at the last meeting the registered manager had requested the input of families to support the development and review of care plans.

People said their privacy was maintained and we saw staff closed doors when providing personal care. Some people had chosen to be supported by only one gender of staff and this choice was clearly documented and respected. Records were held securely and confidentially.

Requires Improvement

Is the service responsive?

Our findings

People spoke positively about living at Glen Heathers and felt staff responded well to their needs. However, our findings suggested that support was not always planned in a person centred way or was fully responsive to people's changing needs.

Prior to moving into the service, a pre- admission assessment was completed. The document used to complete this did not prompt the assessor to consider the persons spiritual, cultural or sexual needs. Staff told us these would be met and were clear that discrimination would not be tolerated by any staff member or management.

Tools were available to staff for completion following admission. On admission to the home, nationally recognised assessment tools based on best practice guidance such as Waterlow (used to assess risk of skin breakdown), MUST (used to assess risk of malnutrition) and FRASE (used to assess the risk of falls) were in place. These tools aim to enable staff to identify the level of need and ensure appropriate plans of care are developed. However, we found these were not always completed. For example, for one person who moved into the service recently, no MUST, Waterlow or FRASE had been completed. In addition, no plan of care had been developed to ensure they were given appropriate support with their eating and drinking or their personal care.

The registered manager was aware of the Accessible Information Standard (AIS). This was introduced in August 2016 and applies to people using the service who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, and/or who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate. The registered manager advised that if people needed alternative communication formats/aids this would be provided.

We found an entry in one person's daily records dated April 2018 that suggested pictures were used to communicate the procedure that was to take place beforehand with the person. This person found it difficult to communicate and became physically challenging during personal care. The deputy manager said they had never seen these communication aids. A member of staff showed us a folder of pictures held in the dining room that were not specific to personal care and said they sometimes used pictures with this person. The registered manager told us a communication system was in place for this person but no one could show us this.

We received mixed feedback about activities in the home. One person said "They don't cater much for my interests. I tend to watch TV, lots of repeats" while another said "I don't go, it's a joke. Those exercises! I get enough exercise. It feels a bit childish, they put on the music and they sing 'Run Rabbit Run'. That's not me". People were able to choose if they wanted to join in the activities and one person told us how "I'd rather not. It's not me. I see the hairdresser and have my nails done". Other people said "They do have activities. I occasionally join in, mainly in the music and exercise. That interests me" and "I like the exercises. It's very good, it keeps you active. I like the quizzes, they test your knowledge".

External entertainers visited the service and we observed this on the first day of our inspection. People who were present seemed to enjoy this session of exercises. In addition, following the inspection the provider sent us newsletters which showed other special events that had been put on for people, including celebrating the Royal Wedding, a theatre show and visits from farm animals. Apart from the external activities we could not find an activity plan for people to know what was happening in the home that they could participate in. On the first day of our inspection, the member of staff employed to deliver activities suggested exercises as an activity, however, this was following the external exercises session and people did not engage. The activity coordinator decided to take one person out into the community. However, no other activity was put on for other people. On day two of our visit, we observed very little activity and stimulation for people. Although the activity coordinator arranged a session for the afternoon, only five people joined in and did not want to do the activity that the member of staff proposed. As such they sat and chatted which people appeared to enjoy.

During the inspection we observed that other than when the activity coordinator and external activity provider, staff did not have time to provide social and emotional support for people. People told us they felt staff didn't always have time to spend with them. One said "'My needs are met, but I feel they could have more time with each person. It can be quite busy here for the staff". A second person told us "I'm quite independent, but I feel sorry for some people. It's not the staff's fault. They don't have the time or enough staff" and a third said "They're always rushed off their feet". A relative told us they did not feel there was enough staff. They said "No. I really think there should be someone in here [living room]. They say there's enough, but I don't think this is quite right, sitting on their own all the time. But it's not any good if they take on a couple more staff and they just do the paperwork all the time. These are their residents and some of them don't have visitors. You just need to talk to them and they all join in. They need to interact with them more".

We observed few interactions between staff and the people who used the living room, beyond the provision of drinks and other practical assistance. Staff rarely entered the living room or the conservatory and very rarely sat and socialised with people. Some of the staff waved to people when they passed the open living room door. Two of the four staff we spoke with about staffing levels told us they did not get time to provide social support to people. One said, "Carers don't get time to provide social support but (manager) is looking at a fifth member of staff for the afternoons". A second said "Care staff don't get the chance to sit with people and give some social interaction. (Person's name) needs a lot of interaction, (they) like to wander and high risk of falls and we don't get time."

A failure to ensure a person centred approach to planning and delivery of care to meet all needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. All the people we spoke with told us they knew how to complain and were confident to speak to both staff and the registered manager. The registered manager told us that when concerns were raised they dealt with them straight away in line with the provider's policy. Records mostly reflected complaints were investigated and a response was provided.

At this inspection no one living at the home was at the end of their life. Relatives told us they had been involved in some discussions about their loved one's end of life care but this tended to relate to whether the person should be taken to hospital or be resuscitated in the event their heart stopped. The manager was aware of the need to start developing people's end of life care plans. However, staff were aware of what end of life care involved and the provider had a policy in place to guide them. This included identifying when a

person was deteriorating and possibly entering the end phase of their life; involving the medical team early and sourcing appropriate medicines to ensure they were pain free; ensuring any spiritual, cultural and religious needs were understood and supported as well as involving the person's family if this was the person's choice.

Inadequate

Is the service well-led?

Our findings

Since the last inspection the manager had become registered with CQC. 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.

Since the introduction of the changes to the way in which CQC inspects locations, Glen Heathers has not achieved an overall rating of Good or a rating of Good in the well led question. Since March 2015, Glen Heathers has had four comprehensive inspections, with this being the fifth. Of these four inspections, the service has been rated overall Inadequate twice and has been rated Inadequate in the well led question three times. At this inspection the rating for well led remains as Inadequate and improvements have not been made. Throughout these inspections we have found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, we took enforcement action and imposed a condition on the provider's registration. This condition required them to undertake a number of systems to monitor the service and to provide us with a monthly report. The aim of this condition was to support the provider to improve their governance processes. This has not been successful and we continued to find a breach of Regulation 17 at this inspection.

The provider had introduced a new system for care planning and risk assessment which we were told went live on 24/4/18 at Glen Heathers. We were told this system should have migrated with the previous system and transferred all care plans and risk assessments over. However, this had not been successful. Despite this being recognised on 24/4/18, insufficient action had been taken to address this. We found no evidence of care plan audits. The registered manager said they sampled care plans each month and would document this on the system and then tell staff what was needed. However, the registered manager told us they did not keep a record of whose care plans were audited and when so we were unable to track this. The general manager showed us a care planning audit tool they said had been drafted on the first day of our inspection to aid the process of recognising what was needed for care plans. However, this was almost two months after it was recognised that the appropriate information was not on the system.

The registered manager had completed a report on 8 May 2018 which identified those people who they considered needed risk assessments in place. However, we found this report did not identify the concerns we had. For example, one person who lived with diabetes had no care plan or risk assessment in place guiding staff about how this affected the person or how they should monitor and support the person with this condition. Bed rails were being used without being risk assessed and plans implemented.

In the monthly report sent to us at the beginning of June 2018 this recorded "All care plans are in place on Caresys (new system). We have transferred all risk assessments and nurses are beginning to adapt to the new system. Care plans are being kept under review in good time using the system. Reviews are checked weekly so nurses are aware of what it due. This system is working." As this did not reflect our findings, we could not be confident that the information being sent to CQC monthly was accurate or that the system used to ensure care plans and risk assessments were appropriate and in place was effective. Failing to make

sure this information was available to staff, could place people at risk.

Whilst we were told that some information such as some diabetes care plans and bed rails assessments had been previously completed and were on the old system, these had not been made available to staff when it was identified the information had not migrated to the new care plan system. Following the inspection, we were told these records had been taken from the old system and made available to staff.

The monthly report sent to us at the beginning of June 2018 stated, "Weights are kept under review by both [manager] and [care practitioner]". Whilst we saw weight management reviews being completed, we were concerned that these did not identify when professional advice was not being followed; when kitchen staff were not aware of the need to fortify foods and when care plans were not sufficient to guide staff. This meant that we could not be assured that the weight management reviews were effective in ensuring risk was appropriately assessed so people's needs could be met in a planned way.

Whilst weekly cleaning audits were in place and infection control audits were being undertaken, we were not confident these were effective. The most recent cleaning audit found no issues, despite us finding two days later, heavily stained carpets, strong urine smells, heavily lime scaled buckets and sinks. The last infection control audit did not identify the issues we found in relation to worn and ripped bed bumpers, furniture and other concerns we found (reported in the Safe domain). An effective audit would have identified these issues. Whilst this infection control audit did find some areas that required improvement, such as the need for curtain cleaning schedules and pedal bins, no action plan had been developed to monitor completion.

The registered manager said that since the last inspection the senior manager audits had changed. They told us the senior management team visit three monthly to complete their audits and that these are unannounced. The registered manager said the team of senior managers each take an area to review and send a summary report to the registered manager, who then produces an action plan which is sent to CQC monthly. The March 2018 report suggested that drinks were now provided by a member of staff who did not provide care so as not to take care staff away from other duties. The action plan did not address this. One member of care staff told us that they do this in the afternoons which takes them away from other duties. We observed this during our inspection.

The March 2018 report did not clearly identify actions although we found some areas of the report indicated action may be needed. This included giving thought to ensuring the medicines trolley did not affect the mealtime experience and medicines could be given after lunch. The action plan sent to CQC did not address this.

We reviewed the May 2018 audit as the general manager told us that the May 2018 visit was to validate that the action plan following the March 2018 audit had been completed. Whilst this looked at medicines, it did not report on the comments from the previous report, the fact this had not featured as part of the action plan or whether anything had been done to address the suggestion. Throughout the inspection we observed medicines being administered during the lunch time meal.

As the reports did not correlate to the action plans we could not be confident that this system of senior manager auditing was effective. The general manager completed a monthly audit check book which was used to ensure audits were undertaken. In the May 2018 check book under the risk assessment section it recorded "SMT audit 8.3.18" suggesting the senior management team had looked at risk assessments during their March 2018 audit, although this report did not reflect this. As the senior management team were aware that the care planning system had not migrated sufficiently in April 2018 and that vital information about people's support needs and risks was not transferred, it would be expected that the senior manager audit

for May 2018 would have reviewed this. However, the May 2018 audit did not record that any care plans or risk assessments had been looked at and the audit check book referred to an audit undertaken before the system changed. Knowing that there has been a problem and failing to follow up to ensure people's safety and that a quality service is delivered places people at risk.

The May 2018 senior manager audit reported on weight management. This stated that there was clear evidence of discussion and actions taken where appropriate. We had not found this for one person. There were no clear records, the kitchen was not aware to fortify the person's meals and no referrals had been made as per professional advice, which was not recorded.

Clinical audits were being undertaken but were not effective. These did not look at clinical observations for people and as such no one had identified concerns about a lack of follow up when these were out of range. Whilst falls audits were completed, these were not fully effective as they had not identified that appropriate action had not been undertaken for one person following an unwitnessed fall.

This meant we could not be confident the senior management team, provider and registered manager had an effective system to ensure they had good oversight of the safety and quality of the service.

A system was in place to record and audit accidents that related to falls and skin integrity. These audits looked for patterns and trends as well as recording any individual action that had been taken for people. We saw significant improvements in the recording and management of skin related concerns and unexplained injuries as a result of this. However, where incidents of aggressive behaviour had occurred, these were not recorded as incidents and no analysis of these had taken place to ensure people and staff could be protected.

Whilst feedback from people and their relatives were sought and their feedback analysed, we were concerned to read some of the comments provided and to find no evidence of how these had been investigated. For example, one comment from a relative survey analysis expressed concern that they often found their family member had soiled bedding with the commode full. Although the analysis report provided an explanation about people's right to refuse care and support and it commented that that rooms were checked hourly and that the staff would implement a recording chart to show when they changed bedding and emptied commodes, it was not clear that this concern had been investigated to determine if the measures in place were sufficient. A comment from a person stated that personal care could be better but the analysis and action plan did not address this. In addition, a further comment from a relative survey analysis said "If I thought the resident could cope with moving to another care home I would move". This is a particularly concerning comment suggesting this relative had a number of concerns and was not happy with the care and support being provided to their loved one. Despite this, there was no evidence this had been investigated and acted upon. There was nothing included in the analysis or action plan to address this or provide reassurance this had been acted on. We asked the deputy manager about this who told us they were unable to find any information about this and "Was not involved" in the survey feedback.

This meant we could not be confident the systems in place to seek feedback and ensure a safe and quality service was provided, addressed concerns and made improvements.

A failure to ensure good governance systems were in place and operated effectively to assess safety and quality of the service and to drive improvements was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they thought the home was well run and spoke positively about the registered manager.

One person said "It's well managed, with the proviso it's short staffed. All the time". Another person said "Oh yes. They had a man manager. He was kind, but he never got things done, not like this one". A relative said "[Manager] has made a massive difference in making it more like a house. It's peoples' home, rather than a home" and another said "It's very good. We were fully informed why they changed management. They [the manager] seem to be settled in". Although relatives told us they saw the registered manager regularly, people said they didn't. One said, "I've seen her about twice". A second said "I've not seen her, hardly at all, she seems nice" and a third said "Not on a regular basis. She's friendly".

Staff spoke highly of the registered manager. One told us they were "A lot happier now [manager] is here. [Manager] has made a lot of changes which we were resistant to initially but have been good". They provided an example of making sure carers could access care plans. They told us the registered manager had boosted morale and defined roles. They and all other staff spoken to said they found the registered manager easy to approach and were confident they took things seriously. Staff told us the registered manager was continually seeking feedback and suggestions from them as well as giving them feedback. One member of staff said "[Manager] makes staff feel motivated and is now making them do more training".

The registered manager told us how they tried to link in with others to aid learning and positive changes. They had worked with the local authority at the end of 2017 and told us they engaged with the clinical commissioning group and care home's association.