Kay Care Services Ltd

# Hepscott Care Centre

## Inspection report

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11 October 2016

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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

This inspection took place on 5 and 11 October 2016. The visit on the 5 October was unannounced. This meant that the provider and staff did not know we would be visiting.
Hepscott Care Centre is a residential care home in Morpeth. It accommodates up to 40 older people, some of whom have dementia care needs. At the time of our visit 26 people were being cared for at the home.

The service was last inspected in July 2015 and at that time was in breach of Regulation 17 HSCA (RA) Regulations 2014 Good Governance. During this inspection we found that whilst some actions had been taken to improve the quality and monitoring systems, shortfalls in care remained. The provider had failed to implement a robust system to assess, monitor and improve the quality and safety of the services provided.

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

People had not been fully protected from the risk of abuse and improper treatment. Allegations of potential abuse had not been shared with all of the relevant authorities. Where people displayed behaviours that challenge, the risk they posed to other people had not always been assessed.

Accidents and incidents were monitored and reviewed by the registered manager. However actions had not always been taken to reduce the risk of them reoccurring. Assessments to limit the risk of people choking when eating had not been undertaken.
People, relatives and our observations confirmed there were enough staff to meet people's needs. Records showed safe recruitment processes had been followed.

Staff had been trained to administer medicines and followed good practice, however appropriate storage systems were not in place for controlled drugs.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

We found decisions had been made on people's behalf, however the provider could not demonstrate how the person's capacity had been assessed or that they had considered the principles of MCA and 'best interests' in determining the decisions. Some people's liberty was deprived because it was considered that they would not be able to keep themselves safe if they left the home alone. However the provider had not applied for the legal authorisation to do this.

Staff received training and supervision to ensure they had the skills and knowledge to meet people's needs.

People spoke highly of the food available and there was a plentiful supply of fresh ingredients. We found people's dietary requirements had not always been recorded appropriately within their care records or within the kitchen.

People and relatives told us the staff were warm and friendly. We observed staff were considerate of people's privacy and dignity.

Relatives told us the home maintained good communication with them about their family member's needs and told us they felt welcome to visit the home at any time.

Assessments of people's needs and the care plans which described how they should be cared for did not always contain accurate information and were out of date, which put people at risk of receiving unsafe or inappropriate care.

At the time of the inspection there was not a dedicated activities staff member and care staff shared this role. One relative told us that people sometimes seemed 'bored'. The manager advised that a member of staff was about to become activities coordinator, and they were going to utilise some unused space within the home as a place for activities to be held.

The provider did not have a robust system to monitor the quality of the service provided. We saw audits of care plans were carried out on a regular basis; however we found examples where they were not up to date or accurate. We found many of the issues which we had seen at our inspection in July 2015 remained at this inspection.

The provider visited the home regularly but did not carry out any formal assessments to monitor the quality of the service provided, or give written feedback to the manager.

We found five breaches of the Health and Social Care Act 2008. These related to safe care and treatment, person-centred care, need for consent, safeguarding people from abuse and improper treatment and good governance. You can see what action we told the registered provider to take at the back of the full version of the report.

The provider had not sent us notifications which are a legal requirement of their registration. This meant they were in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

## 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.

Risks had not been assessed. Action following accidents and incidents was not always clear.

Information about allegations of potential abuse had not been shared with the relevant authorities.

There were enough staff to meet people's needs and safe recruitment procedures were followed. Some medicines were not stored appropriately.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Where people did not have capacity to make decisions, they had not been made following the principles of the Mental Capacity Act 2005. Where people had been deprived of their liberty the provider had not sought authorisation to do so.

Staff had access to supervision but not had annual appraisals.

People were complimentary about the meals provided.

### Is the service caring?

**Good**

The service was caring.

People spoke highly of the staff. We observed positive interactions between people and staff.

Staff were knowledgeable about people's choices and preferences and respected their privacy.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans and assessments were not always accurate or up to date. Professional advice and guidance had not been

incorporated into care plans.

Some care plans did not contain specific information about how staff should meet people's needs. There were limited activities available at the home.

There was a complaints procedure in place.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

An effective system was not in place to monitor the quality and safety of the service. Records relating to the delivery of care were not always up to date or complete.

Relatives and professionals said the new manager was making improvements to the overall running of the home.

# Hepscott Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 5 and 11 October 2016 and was unannounced. The inspection was carried out by one inspector.

During our inspection we spoke with four people who lived at the home. We also spoke with two relatives who were visiting at the time of our inspection, and afterwards we telephoned four other relatives. We spoke with the registered manager, the senior care lead, three care workers and a cook. We carried out observations in communal areas of the home, and with their permission, viewed four people's bedrooms.

We looked at the care records of five people who used the service, including their medicine administration records. We also looked at records relating to the management of the service, such as audits, staff files and recruitment records.

In order to gather the views of other organisations about the quality of the service we contacted the local authority safeguarding and commissioning teams. We also spoke with a care manager who visited the home regularly. We used information they shared with us in the planning of our inspection.

Prior to our inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

# Is the service safe?

## Our findings

Before our inspection we spoke to the local authority safeguarding team. They told us the registered manager had made them aware of a number of allegations of potential abuse following incidents between people who used the service. Whilst the local authority safeguarding team were investigating these allegations they had found records of other incidents, which met their criteria for referral, which they had not been made aware of.

The provider is required to notify the Care Quality Commission (CQC) about incidents which occur within the home, including any allegations of potential abuse. During our inspection we saw records of three incidents which had been referred to the local authority safeguarding team, but had not been notified to the Commission. This meant the people were not fully protected from the risk of abuse and improper treatment because incidents had not been referred to the correct authorities to monitor that appropriate action had been taken to safeguard the individuals. We are dealing with these incidents outside of the inspection process.

Some people who used the service displayed behaviours that challenge because of their dementia care needs. We saw from incident reports that there had been a number of untoward incidents between people who lived at the services. Risk assessments had not been carried out for two of the three people involved in these incidents, to determine if they posed a risk to other people and to detail actions staff should take to reduce these risks. We saw a risk assessment was in place for one person who displayed behaviours which could challenge staff, however specialist advice from the Challenging Behaviour team, about how to support this person to reduce the risk they posed to other people, had not been detailed in their risk assessment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safeguarding people from abuse and improper treatment.

We saw environmental risks noted at our last inspection had been addressed, including putting up additional signs to alert people of changes in the gradient of the floor, and carrying out a risk assessment relating to some open stairs. Some risks related to people's care needs had been considered, such as the risk they may develop malnutrition or a pressure ulcer. However we noted other risks, had not been assessed. Following an incident of choking, where the person had required medical attention, the risk they may choke again had not been assessed and steps staff could take to reduce this risk had not been identified. This meant staff had not been provided with information about how to protect people and mitigate risk.

Another person's mobility had declined and therefore regularly needed to use a Stand Aid hoist to transfer and a wheelchair to mobilise. We saw their moving and handling risk assessment had not been updated since their mobility had declined. We saw no references within their care records to the potential risks to the person's health and safety related to using this equipment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations

2014. Safe care and treatment.

People we spoke to told us they felt safe. One person said, "Yes, I'm safer here than I was at home. There is always someone around if I need them." Relatives told us they felt their family members were safe at the home. One relative said, "Oh yes she is safe, I feel that."

A schedule of checks and tests were carried out to ensure the premises and equipment were properly maintained. Fire alarms and fire doors were tested weekly. An electrical installations test had found electrics were satisfactory, and records showed the lift and hoists were serviced in line with recommendations.

Evacuation procedures were displayed around the home and staff were aware of the procedure in the event of a fire. Information about people's care needs and their regular medications was detailed on a 'Hospital admissions record' which was available to give to paramedics if people needed to be taken to hospital. This meant plans were in place in case of an emergency.

Accidents and incidents records had been monitored by the manager. We saw she prepared a monthly analysis as to the number of accidents which occurred within the home, the time of day they happened, and which people had been involved. Records showed that steps had been taken to reduce the risk of some accidents occurring again. For example, where one person had fallen over a number of times, the GP had been contacted to determine if the person should be referred to the specialist falls team. However, not all information collated through the analysis of accidents and incidents had been taken into account when planning people's care. For example, incidents of choking or of behaviours which posed a risk to other people.

During our inspection we spent time in the communal areas of the home. We saw there was always a member of staff available for people if they needed them. People's requests for assistance, for example for a drink or to be helped to move around the home, were responded to quickly. None of the people, relatives, or the care manager we spoke with raised any concern over the staffing numbers. Staff we spoke with told us they were always busy, but said they thought they had adequate staffing to run the home. We were satisfied from our observations and from speaking with people and staff, that there were enough staff to meet people's needs.

Safe recruitment processes had been followed. We looked at four records from newly recruited staff. We saw prospective staff had completed an application form, attended an interview and were subject to two written references and a satisfactory Disclosure and Barring Service (DBS) check. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people.

We found that that premises was well maintained. Parts of the home had recently been re-decorated, and relatives commented on the improvements which had been made. The home was clean, an infection control audit was regularly carried out, and we saw staff used appropriate personal protective equipment, such as gloves and aprons, when delivering certain aspects of personal care. This meant processes were in place to reduce the risk of infection.

We observed staff administering medicines. They followed good practice in wearing a red tabard, so staff and relatives knew they were administrating medicines, and therefore should not be disturbed, which helped staff maintain concentration. Staff explained to people what their medicines were and did not rush people. We looked at medicines administration records (MAR) and saw they had been well completed, without any gaps. Codes had been used to detail why people had not taken their medicines as prescribed.

This meant there was clear documentation to show what medicines people had taken.

Staff had received training in safe handling of medicines. Their competency in administering medicines was checked annually through assessments and observations. At our last inspection we saw the temperature of the medicines room was not regularly recorded. At this inspection we saw a system had been introduced and records were available which showed the temperature of the medicines room was taken twice daily. This meant checks were undertaken to ensure medicines were stored at an appropriate temperature.

We checked the management of controlled drugs. These are medicines which are liable to misuse, and stricter storage and recording controls are needed. The controlled drugs cabinet, was very small, and could not hold all of the controlled drugs which the home administered. Some of these medicines were stored outside of the controlled drugs cabinet, in storage which did not meet with legal requirements. The manager advised us she was aware that storage of controlled drugs was not appropriate, and told us she was in the process of sourcing a larger controlled drugs cupboard.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 saw each person's care file contained an assessment to determine whether authorisation was required from the local authority to deprive the person of their liberty, however the assessment criteria was outdated. It stated people should only be considered deprived of their liberty if they made "persistent or purposeful attempts to leave", which did not reflect the deprivation of liberty 'acid test' as detailed in the supreme court judgement from March 2014.

The manager provided us with information about people's individual needs. She advised us there were 22 people who, due to their dementia care needs, may reach the criteria for requiring constant supervision to keep them safe. At the time of our inspection, DoLS applications to the local authority had been submitted for 11 of the 22 people. This meant there was a risk that 11 individuals were being deprived of their liberty without lawful authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safeguarding service users from abuse and improper treatment.

Following our inspection the manager informed us that she had requested DoLS authorisation from the local authority for the remaining 11 people.

We reviewed records in relation to the MCA. We found care plans in place for three people in relation to providing care in their 'best interests'. However these plans did not meet the legal requirements of the MCA in that they were not decision specific. Plans stated, "Staff are to always act in [Person's Name] best interest to ensure their safety is maintained" and did not specify the specific decision in which they related, include an assessment of capacity or identify that the least restrictive option had been implemented

Where decisions had been made on people's behalf, assessments of their capacity were not available. We saw a decision had been made to put a pressure sensor mat next to someone's bed. This person had experienced a number of falls overnight, and the pressure sensor mat was put in place to alert staff if this person got up during the night, so they could check on them and provide assistance. This person's care records showed they felt the pressure sensor mat was an invasion of their privacy. Following a review of their care the mat had been moved to outside of their bedroom door. The decisions to put the pressure sensor

mat in place against the person's wishes not been made in line with the MCA. An assessment had not been carried out to determine the person's capacity to understand the implications of refusing a pressure sensor mat. The manager could not evidence how they had come to the decision that the person did not have capacity to refuse the pressure sensor mat, or that the decision had been following the principles of 'best interests'.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

All of the people we spoke with told us staff were able to meet their needs. One person said, "The staff are spot on." A relative said, "I think they cope marvellously looking after everyone."

Staff had undertaken a range of care and safety related training in areas such as moving and handling, infection control and health and safety. Training was monitored and planned in advance to ensure that it remained was up to date. All staff had received training in dementia awareness, and one third of the staff team had undertaken a 12 week distance learning course on dementia care needs.

Staff we spoke with told us they received appropriate training for their roles. One member of staff said, "I've worked in other places, so I've done a lot of it before anyway. But we got everything we needed; safeguarding, moving and handling, health and safety, the lot."

New staff undertook induction training. This consisted of reading policies, shadowing experienced staff and a range of training. The induction had been designed to incorporate the Care Certificate. The Care Certificate is a set of minimum standards for care workers. We saw new staff completed a workbook to demonstrate their understanding of the training they had undertaken, and had completed competency assessment to ensure they had the skills to deliver care safely. This meant processes were in place to provide staff with training to equip them for their roles.

Staff received regular opportunities to discuss their practice in supervisions sessions. Staff we spoke with, and records, confirmed supervision sessions were held once every two months. One staff member said, "We have supervisions all of the time. When you just finish one it feels like it's time for the next one straight away. I think they are every two months. If I need to speak with [Name of Manager] I'd just do it though. You don't need to wait for supervision."

Whilst supervision sessions had been held consistently, the manager acknowledged appraisals were not up to date. She said, "It will have been a while since there were any appraisals. I said to [Name of Provider] I'll be able to start them from October, when I've been here a year and have known the staff for a year. I can't appraise them when I haven't known them." When asked if staff had received an appraisal before she had started working in the home she said, "I don't know, I couldn't tell you. Records were very poor before I started here." This meant staff had not had a formal opportunity to discuss their performance, and personal development needs. The manager told us she was in the process of planning appraisal meetings with all staff who had worked at the home for over a year.

We checked how people's dietary needs were met. People and their relatives spoke very highly of the food on offer. One person said, "It's very nice; always decent." A relative said, "The food seems excellent. They have a fantastic cook, and they can always get something to eat, no matter what time it is. It really seems superb."

We spoke with a member of the kitchen staff, who showed us around the kitchen. We saw there were lots of

fresh fruit and vegetables, as well as a good supply of meat and store cupboard ingredients. The kitchen staff member told us they were able to purchase everything they needed to provide people with a varied diet.

We checked whether people had access to health care services. People and relatives told us that staff contacted relevant healthcare professionals when required to meet people's health care needs. Records showed that people saw their GPs, district nurses and attended hospital appointments as and when required. However, we noted communication with health professionals was not always well managed. Records showed a social worker had requested the service contact a person's GP to assess whether a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should be put into place. The GP had been contacted in June 2016, but there was no further information detailed about the outcome and a DNARCPR had not been put in place. We discussed this with the manager, who subsequently contacted the GP, and found they had completed a DNACPR for the person in July 2016, however it had not been sent to the provider and no staff had followed this up.

We checked how the adaptation, design and decoration of the premises met people's needs. Most of the people who lived at the home had a dementia related condition. We saw visual signs had been used around the home, and bathroom and toilet doors had been painted contrasting colours to the wall to aid people's orientation.

Good

# Is the service caring?

## Our findings

People and relatives told us that staff were caring. One relative said, "They are all extremely patient, just helping her. I have no complaints at all." Another relative said, "[One staff member] is excellent with her. They all seem to interact with her, but [Name of staff member] is very, very good with them."

We spent time in the communal areas of the home and watched people's and staff's interactions. All of the interactions we saw were positive. Staff talked to people whilst they were carrying out their tasks. We saw one staff member chatted with people about their favourite drinks whilst they were giving them a cup of tea. Another staff member played a game of dominos with a person and gently engaged the person in some friendly competition saying, "It must be my turn to win this time. I can feel it." During our inspection we saw one person liked to spend time in the office with the manager. The manager displayed warmth towards them, saying, "[Name of the person] likes to be in the office where it's all going on, don't you [Name of Person]?"

We spoke with staff who were knowledgeable about people's likes and dislikes. Staff were able to tell us about people's previous jobs, their families and the activities they enjoyed in the home. Care records included a good level of detail about people's preferences and were personal to the individual. For example, one care plan stated, "[Name of Person] will attend entertainment, such as singers, they can often be heard saying "what a racket" but appears to be enjoying themselves and is often caught singing along."

Records promoted people's privacy and dignity. We saw references throughout care plans which prompted staff to offer choice, knock on people's doors and consider people's dignity when providing personal care. For example, one care plan stated, "[Person's Name] is able to choose his own clothing. Staff to offer choice and be aware [Person's Name] will usually state "not bothered owt will do" however choice should be encouraged."

Staff we spoke with described the ways that they respected people's privacy and dignity. One staff member said, "When we wash people we'll keep them covered up as much as possible." During our inspection we noted that staff knocked on people's doors and announced who they were before they went into people's rooms. We saw that staff were considerate of people's dignity when supporting them, for example, we saw staff knelt down beside people and quietly talked to them when they were giving people their medicines.

Our discussions with staff revealed there were no people in receipt of care from the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The manager informed us that no one at the home was currently using an advocate. An advocate represents and works with a person who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Relatives we spoke with told us they always felt welcome at the home. One relative said, "I've been there at different times of the day, I've visited over breakfast and then popped back in later at about 7pm. I can go in whenever I want." Another relative said, "We did visit a few homes before we settled on Hepscott. There was something about it as soon as we walked through the door. There was a nice feeling about the place." Relatives also told us that the home kept them up to date with information about their family member. One relative said, "They are always very friendly. When I go in they'll let me know how [Relative] has been keeping, or if they need to they'll call me up." This meant the service was open and welcoming to relatives.

Requires Improvement

# Is the service responsive?

## Our findings

Care had not always been planned in a way which would meet people's needs. We saw two letters from healthcare professionals detailed instructions about how to care for people; one was from a challenging behaviour team and another from a dietitian. We saw instructions from the letters had not been incorporated into people's care plans.

We saw assessments and care plans contained a varying amount of specific details and were not always up to date. For example, one person's care plan for medicines stated they were compliant with taking their medicines. However, within a letter from a psychiatrist about this person it stated they thought staff were trying to poison them when they gave them their medicines. There was no information about these anxieties within the person's care file and how staff should support the person when they had these thoughts.

Care plans were reviewed on a monthly basis. However, we found examples where reviews did not take into account the changes in people's needs. One person's care plan described them as, "having a good appetite", and stated they should be weighed monthly. Records showed this person had lost more than 10% of their weight in three months, required a fortified diet and should be weighed weekly. These omissions meant that there was a risk people may receive incorrect treatment since their care records were not always up to date.

The care people received was not always linked to an assessment of their needs. Records showed that some staff had made changes to the way people should be cared for, such as encouraging one person to eat a softer diet, without assessing their needs. Without an assessment of need we could not be sure that this change to their care was appropriate.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Person-centred care.

Whilst we found evidence of shortfalls in care planning, assessment and delivery, the people we spoke with told us staff were responsive to their needs. One person said, "They do everything I need." A relative said, "I've noticed a big difference from when [My relative] went in. There seems to be a lot more stimulation for him and he's really improved."

During our inspection we saw that staff took part in some activities with people, for example, playing games or sitting down and talking with people. One relative said, "When I go in they'll often be dancing or singing, keeping [my relative] busy. Staff do engage with him. It's not just [my relative], you can see them going around everyone. I don't think it is staged for my benefit." However, we saw limited planned activities on offer. Relatives confirmed this, with one family member telling us, "The only criticism I have is that sometimes when I visit in the afternoon they seem to be sitting around not doing anything, a bit bored, just watching TV." The manager acknowledged this and explained at that time they did not have a dedicated activities staff member. However, they told us they had identified one staff member who was very engaging with people, and they were about to take on the role of activities coordinator on a part time basis. The

manager also told us they were going to utilise an area of the home, which was currently being used for storage, to become an activities lounge where people would be able to have the space to take part in a range of activities.

People we spoke with told us they knew how to make a complaint, but advised us they were happy with the service they received. The manager told us no formal complaints had been made in the previous 12 months, but that a complaints procedure had been provided to all of the people who used their service which explained how any complaints would be investigated and responded to.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection in July 2015 we had found records had been completed to a poor standard, with evidence of records which was unnamed, undated and incomplete. Care plans had not always been updated when people's needs had changed, and the systems in place to monitor the quality of the service provided had not been robust enough to identify these shortfalls. After that inspection the provider wrote to us to advise us of the steps they were taking to address these issues.

However, during this inspection we found many of these shortfalls were still on-going.

At the time of our inspection there was a registered manager in place. Our records showed she had been formally registered with the Care Quality Commission since January 2016. The manager was present during our inspection and assisted us with our enquiries.

We found that the provider had failed to ensure there was adequate governance and oversight to prevent the systematic failings and shortfalls in a wide variety of aspects of the service that we identified at our inspection. Systems and processes were not fully in place or operated effectively, to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we found risks had not been assessed, care plans were out of date and did not incorporate advice from healthcare professionals. The manager carried out a number of audits and checks on aspects of the service. However, these had not highlighted the concerns which we found. One person's care records contained conflicting and confusing information. Their records had been audited in May 2016 by the registered manager, and actions identified for staff to update this person's care plans and risk assessments. Staff had signed to say these changes had been made, however we saw no evidence that care plans or risk assessments had been updated, and information within them was out of date. This meant auditing systems in place had not driven improvements.

A satisfaction survey had been sent to people who used the service and their relatives. The results had been analysed and people had mainly responded positively. However, there had been no action plan created to note what, if any changes, had been implemented following people's feedback.

We asked the manager what quality monitoring and assurance was undertaken by the provider. She advised us the provider visited the home regularly, up to once a week. However, she advised that any assessment of quality or feedback provided to her was done informally. She advised us the provider did not carry out any quality monitoring audits or provide her with written feedback following their visits. This meant the provider had failed to implement a system to assess, monitor and improve the quality and safety of the services provided.

We found evidence of poor communication and record keeping. We noted a request to a GP, made four months before our inspection, had not been followed up on. Records showed a letter from a dietitian had been received three weeks before our inspection. Staff were unable to find this letter during our inspection,

although we were provided within a copy after the inspection.

We noted changes had been made to two people's care without assessments being carried out. When we highlighted this to the manager they told us these entries had been made by a specific member of staff, who they had previously noted had not completed care plans or assessments to the required standards. We asked if these previous concerns had been fed back to this member of staff and we were told they had been discussed, but the manager was unable to show us copies of supervisions or disciplinary records which evidenced this. This meant the provider had failed to assess, monitor and mitigate risks to people.

There was no evidence of the last appraisals which staff had received. The registered manager advised us she was in the process of arranging these meetings, but acknowledged it had been over a year since staff had last attended an appraisal.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

There had been incidents involving people who used the service which met the criteria for legal requirement that the provider submits notifications to the CQC as part of their registration. These incidents had not been notified to us.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

We fed these shortfalls back to the manager, and she told us she had been working through making improvements to the service. She advised us that when she had started working for the service, after a period when the service had been without a registered manager, records were in a poor state and policies and processes were not being followed. She told us she was working through policies, procedures and making improvements to care records.

We spoke with people, relatives, and a care manager about the leadership at the service. All of the feedback we received was positive. One person said, "[Name of Manager]? She's great. Lovely woman." A relative said, "[Name of manager] is turning the place around. It's being refurbished; they've put in a new carpet and a lovely bathroom, downstairs was a bit tired, but she's had it painted. She's done quite a lot in the short time."

A care manager who regularly visited the home said, "The new manager is professional. She's done a good job and the home has really come a long way since she's started. They seem to be methodically working through care plans to make them better." They continued. "The manager and the deputy are getting in touch more often. I try and encourage open and honest channels and they are responding. They are informing me about any falls or hospital admissions. It's a good relationship with them."

Staff told us they found the manager to be very supportive. They told us the manager was always available if they needed any assistance or support. One staff member said, "[Name of manager] is good, very approachable." Staff meetings were held regularly. Staff views on the service, and how it was run, had been sought in March 2016 through a staff survey. The responses had been positive, with staff responding to indicate satisfaction to questions about whether they received enough training, were happy within their jobs, and if they thought changes implemented had improved the home.

People who used the service were regularly asked for their views on the service during monthly meetings. Minutes from these meetings showed people had been asked for their input on a range of areas, such as

planning menus, organising activities, and arranging trips out of the home.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment of people was not always appropriate or met their needs. Assessments of the needs and preferences for care and treatment of people were not always up to date. Regulation 9 (1)(a)(b)(3)(a)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided safely. Risks to the health and safety of people had not always been assessed and action had not always been taken to mitigate any such risks. Regulation 12 (1)(2)(a)(b)(g). |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>There was a lack of evidence to demonstrate that care and treatment was always provided with the consent of the relevant person. Regulation 11 (1). |

**The enforcement action we took:**

We imposed conditions on the provider's registration.

| 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<br><br>The correct action had not always been taken following allegations of abuse to ensure that the person was protected from abuse and improper treatment.<br><br>Deprivation of Liberty Safeguards [DoLS] applications had not all been submitted for authorisation where it was indicated that people's plans of care amounted to a deprivation of liberty. Regulation 13 (1)(2)(3)(5). |

**The enforcement action we took:**

We imposed conditions on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people and others. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(f). |

**The enforcement action we took:**

We imposed conditions on the provider's registration.