Epping Care Home Limited

# Treetops Care Home

## Inspection report

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23 June 2017

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## Ratings

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|---|---|
| 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? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection was undertaken on 21, 22 and 23 June 2017.

Treetops Care Home provides accommodation and personal care to up to 52 people. People living in the service may have care needs associated with dementia. There were 35 people living at the service on the day of our inspection.

At the time of this inspection a registered manager was not in post. A manager had been appointed in July 2016 and was in the process of making an application for registration with the commission. The process was completed soon after the inspection and the manager is now registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection of the service in October 2016, we judged that improvements were needed to management and quality systems. At this inspection, we found that the service was not well led and there were continued weaknesses in the provider's approach to monitoring, improving and sustaining the quality of the service. Risk management plans were not always in place or kept up-to-date or adhered to so as to support people and keep them safe. Accurate records were not consistently available to identify and to guide staff on how to meet people's assessed care needs. Where guidance was available, staff did not always know about it or put it into everyday practice. Attention was needed to ensure that people consistently had sufficient drinks of their choice and nutritional input that meet their needs. People did not always have the opportunity to participate in social activities and engage in positive interactions to ensure person centred care. Staff induction, training, support and competence assessment procedures were limited. There was a lack of active staff supervision and direction.

Improvements were needed to ensure that up to date guidance and procedures about protecting people's rights and safeguarding them was implemented. The service also needed to ensure that all of the people living there were routinely cared for in a way that respected their dignity.

People's medicines were safely managed. Arrangements were in place to support people to gain access to health professionals and services.

People felt able to raise any complaints and felt that the provider would listen to them. Information to help them to make a complaint was readily available. People living and working in the service had the opportunity to say how they felt about the home and the service it provided and be listened to.

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

## 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 consistently safe.

The provider did not have suitable arrangements in place to protect people against risks in the service and for the safe use of equipment.

Improvements were needed to ensure safeguarding and recruitment procedures were consistently implemented.

Sufficient staff were deployed and people's medicines were safely managed.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff were not provided with a level of induction, training, ongoing supervision and assessment that enabled them to meet people's needs well.

People's nutrition and hydration needs were not consistently met. Improvements were needed to ensure that guidance was followed in regards to people's ability to make decisions.

People had access to healthcare professionals when they required them.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Improvements were needed to ensure people were treated with dignity and respect. The service had not shown a routinely caring approach in the way it supported people's care. Most interactions between staff and people were positive, however the care provided was often task focused and routine based.

People were supported to maintain relationships and people's

visitors were welcomed.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care was not always planned so that staff had guidance to follow to provide people with consistent person centred care.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement that met their needs.

The service had arrangements in place to deal with comments and
complaints.

## Is the service well-led?

**Inadequate**

The service was not well led.

Management of the service was not effective and there was a lack of managerial oversight and leadership in the service.

The provider's systems to check the quality and safety of the service were not robust and had not identified shortfalls or sustained previous improvements in the quality of the service overall.

Opportunities were available for people to give feedback, express their views and be listened to.

# Treetops Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 was undertaken by two inspectors on 21 and 22 June 2017 and one inspector on 23 June 2017 and was unannounced.

We brought forward the planned inspection of the service in response to ongoing concerns by the local authority, mainly relating to medicines and nutrition. Before the inspection, we looked at information that we had received about the service. This included information we received from the local authority and any notifications from the provider. Statutory notifications include information about important events which the provider is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection process, we spoke with 9 people who used the service, 7 of people's relatives, a healthcare professional, eight members of staff, the manager and the provider's representative.

We looked at ten people's care and fifteen people's medicines records. We looked at recruitment records relating to three permanent and four agency staff. We also looked at the provider's arrangements for supporting staff, managing complaints and monitoring and assessing the quality of the services provided at the home.

Requires Improvement

# Is the service safe?

## Our findings

While people told us they felt that they or their relative was safe in the service, this did not concur with our overall findings. Improvements were needed to protect people against risks to their individual safety and wellbeing.

Safe moving and handling practice was not always used, putting people at risk of harm. We saw staff use their hands under people's arms to assist people with mobility, which is an unsafe practice and may result in injury to the person. We also observed staff attempt to raise a person from their wheelchair to a standing position on three occasions by holding the person under their arms, without success, as the person was clearly unable to stand or to weight bear. This placed the person at risk of physical injury from the unsafe technique staff were using. When we made them aware of it, the manager addressed this with staff immediately.

Equipment was not always used properly to keep people safe where this was identified as required by risk assessment. One person's risk assessment noted that bedrails were required to be in place when the person was in bed as the person felt safer. The person was found on the floor of their bedroom at about 10pm, having fallen from their bed during the late evening of the first day of the inspection, as the bedrail had not been put in place. Records showed that staff had checked the person at 8pm and 9pm; however they had not observed that the bedrail was not in place. The manager told us that they had taken appropriate actions to address this with the staff.

Risks were not always fully assessed to limit risks to people's safety. One the first day of our inspection, staff used a piece of equipment, a hoist, to transfer a person from their wheelchair to an armchair. Staff did not complete the hoisting task safely. The person's legs were raised to an overly high level which meant that the person's feet were at risk of skin damage or entrapment injury as they were being lowered into the armchair. Some aspects of the person's risk assessment did not have clear detail in place, such as which hoist and sling to use to support the person. We later identified that the sling used had not been assessed as being of a suitable size for the person's height and weight and was not a suitable type for the actual manoeuvre being carried out. This also happened as mentioned in the next paragraph where the sling was the wrong size. We made the manager aware of the concern and they confirmed they would ensure a suitable sling was assessed for and made available for the person without delay. The provider's representative subsequently confirmed that this was promptly addressed and made available for the person's use.

Where risks were assessed, staff did not complete the actions identified to mitigate the risk. On the second day of our inspection, we noted that two people had been sitting in their wheelchair for a long period. One person in particular had slipped sideways and was physically unable to move and reposition themselves. Prolonged pressure on parts of the body without relief for long periods can lead to discomfort and result in pressure ulcers, especially for those unable to reposition or to mobilise. We checked these people's records and found that one person was identified as at very high risk of developing pressure ulcers. The other person's records noted, 'If I remain in the same position for long periods my skin could breakdown…I am at

high risk of my pressure areas breaking down'. The two people had remained in their wheelchairs from 10.55am and 11.25am respectively until 3pm when we intervened and asked the manager to arrange for staff to support the people's comfort and safety. Following our intervention, the manager instructed senior staff to hoist one of the two people above from their wheelchair to an armchair.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to some aspects of staff recruitment. We looked at the recruitment records of three staff employed since our last inspection. While most of the required information was available, gaps in two people's employment history had not been identified and explored. Although two references had been taken up for another staff member, one of these had not been sought from their most recent employment in a care setting as required. The manager told us they were unaware of this detail of the regulation and would ensure it was completed in future. We requested the profile records for four of the agency staff working in the service at the time of the inspection. These were readily available and contained suitable detail.

Improvement was needed to safeguard people living in the service. The manager and most of the staff had attended training in safeguarding people, and agency staff had signed records to confirm their professional accountability in reporting any concerns. While staff we spoke with knew how to recognise abuse and report concerns, they did not demonstrate a consistent understanding of safeguarding people as they had not, for example, recognised unsafe moving and handling practices or the need to report this as a concern. The local authority had been monitoring the service due to identified incidences of concern, such as relating to nutrition and medicines. Clear and organised records of these concerns had been maintained. The manager confirmed they had alerted the local authority as required of the fall of the person from their bed.

People told us that, while at times it was busy, they felt there were enough staff to meet people's needs. One relative said, "I do feel [person] is safe. I have peace of mind now as there are staff here 24/7 to help. There are enough staff." The manager told us that a full review of staffing levels, including impact of the environment, had been completed in the service about two months previously and that staffing levels had then been increased. We sampled four weeks staffing rotas. These demonstrated that the care staffing levels advised to us by the manager as required had been met. However, the manager told us there was no ongoing assessment to ensure that staffing levels remained suitable, taking into account any changes in people's needs over time.

While the activity co-ordinator was on leave, no extra staff had been rostered to provide additional support to this aspect of people's care. The manager told us that not all the care records were allocated to a senior staff to update. There were only two permanent senior staff in post on day shifts who, along with an identified long term agency staff member, had responsibility to review and update the care plans and risk assessments for all of the 35 people living in the service. The senior staff told us that they did not have sufficient time available in a week to complete this task along with their other duties. The service was endeavouring to recruit more permanent senior and care staff. In the meantime they used regular staff from two agencies to support as much consistency and continuity as possible for people using the service.

Medicines were safely managed. People's medicines were administered safely in line with the prescriber's instructions. Medication administration record (MAR) charts were completed consistently and a check on the quantity of medicines in stock was accurate. Medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines were received into the service and given to people. Observation of the medication rounds showed this was completed with due regard to people's dignity. We heard staff quietly ask people if it was a suitable time to bring their

medication to them. Regular audits had been completed and additional daily checks by other staff members had been introduced to improve safe practice and recording. The manager and staff involved in the administration of medication had received recent training and competency assessment. Where senior members of the service's permanent staff were not available on shift, qualified agency nurses were rostered on duty to administer medicines, as an additional failsafe.

Requires Improvement

# Is the service effective?

## Our findings

Our observations showed that staff were not suitably skilled and competent in their role of leading and supporting people's care appropriately. Staff did not receive appropriate induction training, ongoing supervision and appraisal to support them in their role and ensure that they remained competent. Where staff had received training, they did not always use the learning from their training effectively. We observed poor practice both by care staff and by senior staff who were leading and supervising the care staff and acting as role models.

Staff were provided with basic training when they started working at the service and it is noted positively that this was 'classroom' rather than electronic based training. Staff told us this training was useful to them in their role. The manager told us that all care staff were enrolled on, or already working towards a recognised qualification in care. However, staff told us, and the manager confirmed that there was no formal recorded induction process in place when staff started working to ensure that new staff understood their role and were competent to carry it out. Staff, including those who had no previous experience in care, were provided with two shifts shadowing another member of staff in line with the provider's policy. There were no clear criteria as to what learning this was intended to provide and whether it had been successfully achieved. This meant there was no clear, demonstrable method to determine if new staff were able to work to suitable standards and provide care in line with the provider's aims, objectives and with legal requirements. One inexperienced staff member told us, "It was hard really in the first few months." Another inexperienced staff member who had also shadowed said, "There was no formal induction. It was just jump in really. It could have been much better."

The provider's policy on formal supervision stated that staff would have a minimum of five supervision sessions each year, which would be held in private. Staff and the manager confirmed that while group meetings took place, there had been no regular individual supervision provided to review staff practice, development and welfare. A one to one meeting had been completed with new staff after a set time period. This had also taken place with staff in response to incidents or concerns raised, such as medication errors, rather than as a regular supportive process to help staff reflect on and maintain good practice. The manager and staff confirmed that no appraisal of staff performance in their role had been undertaken to set goals or enable identification of any required learning so that suitable support could be planned for and provided.

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

Improvements were needed to ensure people received suitable hydration and nutritional support of their choice. The first day of our inspection took place on reportedly the hottest June day for 30 years. The only 'fluid' offered to people sitting in the communal areas between breakfast and lunch, which was not served until 1.45pm, was a very small glass of smoothie. This was more to boost both nutritional and calorific intake than to provide fluid. Some people refused this stating they did not like it. One person, who was able to request this, was given an alternative cold drink. A second person said, "Any chance of a cup of tea?" This

was provided but not offered to any of the other people sitting in the room. This was despite people's records showing that they needed support with fluid intake such as, '[Person] needs reminding to keep hydrated as is at high risk of dehydration'. We made the manager and the provider's representative aware that, despite the hot weather, people had not been offered additional drinks and they confirmed they would ensure these were provided to people. On the second day of our inspection, although people were being offered a lot of fluids, these were only in form of cold drinks, apart from mealtimes. We asked the manager about this and they were unsure why this was and addressed this immediately as it appeared that staff had misinterpreted our concerns raised on the previous day of inspection.

Formal nutritional risk assessments had been completed to identify those people who were considered to be at risk of malnutrition. Five people's weight and malnutrition screening records showed that they had sustained a weight loss of between 5 kilos and 10 kilos in a six month period. Food and fluid monitoring charts for one of these people showed gaps of days when no intake was recorded. People's care plans had not been updated to record their weight loss and any actions taken to address it. The care plan of the person with the highest recorded weight loss contradicted this however, stating that the person had steadily been putting on weight and that the person was able to eat and drink well. Observation and staff confirmation showed this was clearly inaccurate at the time of the inspection. While weight records had been completed, the person's malnutrition screening record had not been completed over a five month period. This meant that records could not be relied upon or used as an accurate tool to ensure effective monitoring and management of people's nutrition and hydration needs.

Records showed that one person had a swallowing assessment by a healthcare professional due to concerns regarding choking and aspiration. This is where people may inhale food or fluid into their lungs with potential impact on their safety and health. A trial using a fluid thickening agent was recommended and clear instructions were provided to staff. Three weeks following this professional assessment, the person was still receiving fluids without the thickening agent. Timely action had not been taken to limit the risk. Records showed that action to follow up the prescription request had only been made on the day prior to our inspection. We made the manager aware of this situation and they confirmed they would take immediate action to ensure the thickener was obtained for the person.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about the choice and quality of the food and drinks available were positive overall. People spoke positively about the food and drinks served. One person told us, "I think for a place as big as this, the food is really good." Another person said, "I like the food. I get lots of choices and lots of cups of tea while I am watching television."

Improvements were needed to ensure the service was working fully in line the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Assessments of people's capacity had been completed and where appropriate, best interest decisions had been made in most cases. One person's records however showed that, while a sensor beam was used in the

person's bedroom, no best interest assessment was in place relating this. The beam alerted staff each time the person moved enough to break it, meaning the person's movements were supervised without the proper safeguards being in place. Where people were assessed as lacking capacity, evidence was not available that relatives making decisions on people's behalf had the legal authority to do so. The manager told us that they were attempting to obtain this detail from relatives so that it could be noted within the person's records. Capacity assessments were not routinely reviewed to ensure they remained accurate and current as required.

Staff had attended training on MCA and DoLS. Staff ability to share their knowledge and understanding of this and of consent varied widely, with senior staff having relevant knowledge. However, people told us that staff sought their consent. One person said, "Staff always ask me about everything, they are never bossy." The manager confirmed that DoLS applications had been made to the local authority where required and that no specific conditions were in place relating to these. Where DoLS authorisations had been granted, the commission had not been notified of this as required. The manager told us they were unaware of this requirement and that would submit the notifications as soon as possible. These were subsequently received.

A healthcare professional told us that staff were not always available to join them when they attended people in the service. This was because at times senior staff were very busy, such as in in medication administration, and could not be disturbed. The healthcare professional advised that information was shared with senior staff, who followed advice and added, "Staff do the best they can." We saw that staff sought medical attention for people, for example, where a person sustained a fall. People told us that staff did call a GP for them if they needed it, or made sure they got to their healthcare appointments and that services such as chiropody were routinely available.

Requires Improvement

# Is the service caring?

## Our findings

While some people told us they found the staff to be respectful and caring, this did not always align with our observations and our overall findings of the way people were cared for during our inspection.

Improvements were needed to ensure that staff approached people in a respectful way and that people's dignity was promoted. A senior member of staff showed a chess set to a group of people sitting at the 'activity' table. The staff member then said, "Chess. You have to be clever for that." The staff member then took away the chess set. One person walked around the communal rooms for a period of at least 35 minutes. Staff did not recognise that the person's top was noticeably stained or offer to help the person to change. A senior staff member had assisted a person to the toilet and had clearly not ensured that the person's trousers were securely fastened. On returning to the communal area and before we could intervene, the person's trousers fell down. Although the staff member did respond immediately and supported the person with their clothing, this did not show consideration for the person's dignity.

Staff approach to people was otherwise polite and staff knew and addressed people by name. Much of the interaction was task led and staff mostly communicated with people only while providing them with support, such as providing medicines, or in relation to mealtimes. This meant there was limited active engagement of people by staff.

People told us of positive caring experiences in the service. One person said, "Staff are so kind in the way that they chat with you. Staff are quite friendly." Another person told us, "Staff are very kind and I am happy here". Relatives also told us of respectful relationships and of always feeling welcomed in the service. One relative said, "Staff are very nice, very happy and jolly and also helpful. I admire them as it is not always easy. Staff are polite and I have never heard or seen anything disrespectful here." Another relative said, "Staff are respectful, even when [person] is challenging and they have a hard job. Dignity is respected, you can see in the way that [person's] clothes are always nice."

There had been no new admissions to the service over the past two months. We noted that pre-admission assessments were in place for people who came to live in the service prior to this. Relatives confirmed that both they, and the person where able, had been involved in the person's care decisions. Care records were not always signed to demonstrate this, however a relative told us, "I am aware of the care plan and speak with [senior staff member's name] about it regularly." Another relative said, "I have seen the care plan and they do let me know things and changes, like issues with medicines." Some people's records had very detailed information in a 'pen picture' about the person which showed that relatives had been involved in the gathering of information towards the person's care planning.

Improvements were needed to end of life planning in the service. The manager told us of a person who was assessed as requiring palliative care. This was confirmed in a record of communication with the person's relative which stated, '[Person] is now being cared for under palliative care'. While basic historical information was recorded, no plan of care had been put in place to support this aspect of the person's care

as they approached the end of their life. There was no indication on whether the person may have months, weeks or days to live in order to aid care planning arrangements and discussions with those acting on the person's behalf. There was no information detailing the person's pain management arrangements, healthcare arrangements and the care to be provided so as to provide comfort to the person at the end of their life. This demonstrated that people's end of life care was not suitably planned for and that those acting on their behalf were not involved in making decisions ensuring the person's wishes and preferences were promoted. This meant that people's 'end of life' wishes were not recorded in line with guidelines issued by the National Institute for Health and Care Excellence [NICE].

Requires Improvement

# Is the service responsive?

## Our findings

Personalised care plans were not always in place in a timely way or were not sufficiently accurate to support responsive and consistent care for people living in the service. We were not assured that all of the people were receiving the care and support they needed as records showed that suitable care was either not given consistently, or was inconsistently recorded or not at all. This included people's needs in relation to mobility, nutrition and hydration as well as end of life care.

One person's care plan said they were able to stand, to mobilise and transfer from chair to chair with the assistance of one staff member. The person's mobility needs had clearly increased recently and they were no longer able to complete these actions. All staff were not aware of the change to the person's needs, repeatedly attempting to get the person to stand. When this was not successful, staff showed a disinterested approach and did not check with the manager what actions they should take to ensure the person received appropriate care. This meant that the person was left in their wheelchair for an extended period of time. The person's care plan had not been updated in response to the changes to provide staff with both clear information and direction on the person's current support needs and how to meet these.

Where care plans were in place, staff did not always know the detail of the person's care needs or complete the stated actions. One person's records stated that the person had a severe hearing impairment; however two staff members told us that the person did not have any hearing loss. The person's care plan stated that while they had limited communication skills, the person could understand if staff wrote things down on a whiteboard. We did not see any staff use a board or any other method to write things down as a way to communicate with this person throughout the inspection. A staff member said, "You can write things for [person], they used to have a board but I don't know where it is."

One person's care plan stated that they used a walking aid when mobilising. We saw the person walk regularly during the inspection; however they did not use a walking aid. Some staff held the person under their arm while walking; other staff led the person by holding their hands, while other staff allowed the person to walk independently. The manager confirmed that the care plan was inaccurate and the person did not require a walking aid. The person was identified as being at risk of choking when eating due to their particular posture and being drowsy. There was no reference to this in the person's care plan to instruct staff and ensure the person received the appropriate care.

Another person's records and discussion with a relative confirmed that the person, who was living with dementia, often became extremely anxious and distressed, particularly when personal care was provided. There was no care plan detailing the nature of the person's behaviour's. Information regarding the person's response was also not evidenced within their care plan relating to personal care so that staff had guidance on supporting the person consistently and appropriately.

People had varied experiences of social support and contact. Improvements were needed to ensure that all people, including those living with dementia, had consistent opportunities for social engagement. People

and relatives told us that they were usually provided with a good range of social activities that they enjoyed. This included regular outings such as to the pub, shopping or to a jazz club, led by the activities coordinator. We observed that, in the activities coordinator's absence, there were limited opportunities provided for people by the care staff, with an over-reliance on music being played. This included the same disc being played three times consecutively while it also conflicted with the television that other people were looking at but confirmed they could not hear. We saw that seven people were involved in a formal exercise activity by an external therapist, which was a routine activity on the planned programme. One staff member was instructed to play a board game with a person. At times, the staff member did not speak with the person for several minutes. They equally did not interact with the other five people in the room who sat in their chairs along the walls without any opportunity for engagement or mental stimulation. Over a period of two days, the only other activities we observed were three people having their nails painted and two people doing some colouring.

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

While our observations found that not all people were consistently provided with suitable care, some people expressed positive views about the care they experienced. One person said, "I like it here, I like the company. I also love to read and I go to my own room, I can go to the quiet room to knit and I love it. I have a shower every day or a wash if I prefer, I can choose. I love the entertainment and I have plenty to keep me busy." Another person said, "I am very happy here, they are very good staff. I'm not a very sociable person but I have been asked and I did go out. It was a lovely trip. This is a good home. I am able to do most things for myself but staff do keep an eye on me, staff are really good, I have never known people so helpful." A relative said, "I cannot fault the care, I am very happy with it. They are coping very well. [Person] has deteriorated, but is well cared for and staff know [person's] ways. Another relative said, "[Person's] care is pretty good overall. [Person] came for a respite stay but loved it so much they wanted to stay."

People told us they had no complaints but if they did they would feel able to approach the manager or the provider's representative and felt they would be listened to. One person said, "if I was worried, I can ask to see the manager." All of the 17 people who completed the provider's recent satisfaction survey confirmed they would know who to speak with if they had a complaint and believed they would be listened to. People were given information on how to raise any complaints and the provider's complaints policy was displayed. This gave people information on timescales within which they could expect a response so people knew what to expect. A system was in place to record complaints and to show any actions taken. Records of complaints received in the service was well organised and showed that actions were taken in response to people's comments and complaints.

Inadequate

# Is the service well-led?

## Our findings

Our last inspection of the service in October 2016 noted that while significant improvement had been made, some areas of weaknesses remained. It was confirmed that with stable management in the service these further developments would be made. At this inspection we found that the required further improvements had not been achieved and the previous improvements had not been sustained.

The service was not effectively led. The service had a permanent manager in post for 11 months. While the manager was not provided with regular formal recorded supervision, the provider had ensured that the manager had had additional assistance from external consultants, who the manager told us had been very supportive. The current staffing structure did not include an identified role that provided a link between the manager and the care team. The manager told us that the provider was endeavouring to recruit a deputy manager. We found that there was a lack of leadership and oversight throughout the service, including of the actual care provided to people, that impacted on people's well-being.

Sufficient improvements had not been made to the provider's quality monitoring arrangements. Risk was not always identified and where it was, remedial action was not always taken to ensure people's safety. Records relating to the care and treatment of people were not always clear, accurate and comprehensive to support staff in providing suitable care to all the people in the service. Staff did not always have suitable guidance and support. Procedures were not in place to ensure staff competence and that this was maintained. Organisation of records relating to the management of the service, such as relating to fire and water safety management were not always clearly structured and were, at times, difficult to access when requested. The provider's systems had not identified the concerns that we found or put suitable actions in place where required.

Systems for improving the service through auditing and assessment were not effective and audits were not fit for purpose. The manager's care plan audit contained only a date for each month to show if the care plan had been reviewed. It did not show what areas of the care plan had been checked and identify gaps or inaccuracies so that actions could be taken. Similarly, the malnutrition screening tool audit recorded only 'low, high or medium' with no information as to what this meant for the person, and what actions had been taken. The monthly audit record of people's risk of developing pressure ulcers noted a score for each person each month. No analysis was demonstrated of the audit data and the manager confirmed that this had not been completed. This meant that the information had not been assessed so that necessary actions could put in place to support improvements including in people's safety and well-being. This indicated a lack of understanding and that the audits were completed as a routine task rather than an ongoing management tool to support oversight, planning and service quality improvement.

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

Following our inspection provider's representative updated us on how they had responded to immediate

risks to people in the service following our inspection. The Local Authority is also supporting the service to ensure quality care provision.

The service had looked for ways to engage people's views and to involve them in the service. Most people, relatives and staff told us they found the manager and/or the provider's representative to be approachable and supportive. Relatives told us there were opportunities to express their opinions on the service, for example, through attendance at relatives meetings. The manager told us that a consultant led information evening had been held recently, to inform people about safeguarding, MCA and DoLS and that 15 people had attended. We saw that a relatives' satisfaction survey had been carried out in May 2017. The analysis of the 17 responses showed that relatives overall were content with the service provided. Comments included, "We feel all [person's] needs are met to a high standard." People had offered comments for suggested improvements and the manager told us that action plans to these were being developed.

The manager told us that they had allocated the task of completing a survey of residents' views to the activity co-ordinator and it was expected this would be completed when the staff member returned from leave. The manager told us of a new system put in place to reward and appreciate staff in the service so as to support staff morale, retention and good practice. One staff member told us they had found it a positive experience to be nominated for and be judged as 'carer of the month'. The manager also told us of their planned involvement in a local incentive which supported quality outcome for people such as reduced hospital admissions.

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 registered provider had not protected people against the risks of inappropriate care and treatment. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not protected people against the risks of inappropriate care and treatment. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The registered provider had not protected people against the risks of receiving inadequate nutrition and hydration. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not operated effective systems to protect people against the risks of inappropriate or unsafe care as robust arrangements were not in place to assess and monitor the quality of the service provided. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had not ensured that staff were provided with necessary support, training, supervision and appraisal to enable them to carry out the duties of their role.