Astracare (UK) Limited

# Harvey Centre - Mental Health Nursing Home

## Inspection report

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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? | Requires Improvement |

# Summary of findings

## Overall summary

The Harvey Centre is an 18 bedded nursing home for people living with mental health illnesses. There were 12 people in the service when we inspected on 25 May and 7 June 2016. This was an unannounced inspection.

The service is attached to Connolly House hospital, also provided by Astracare (UK) Limited. Both services are governed by the same management team. The majority of people living at the Harvey Centre had first received treatment at the hospital.

There was a new manager in post who had started their employment with the service the day before our inspection. They were in the process of applying to become a registered manager. 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.

Care records included risk assessments to provide staff with guidance on how risks to people should be minimised. However these had not been regularly reviewed and updated and did not record how identified risks should be managed.

There were mixed views whether there were sufficient numbers of staff to care and support people according to their needs. Lack of staff at meal times meant that not everyone had a positive meal time experience.

Professional advice and support was obtained for people when nutritional needs were identified. However, these needs were not regularly assessed. The meal time experience was not always positive and people lacked support to make an informed choice about their meals.

People were provided with their medicines when they needed them however there was a lack of guidance for the administration of certain types of medicines.

People presented as relaxed and at ease in their surroundings and with the staff. Systems were in place to reduce people being at risk of potential abuse. Staff had received up to date safeguarding training and knew how to recognise and report any concerns.

Staff were trained to meet the needs of the people who used the service. The service was up to date with the Deprivation of Liberty Safeguards (DoLS). People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

People were positive and complimentary about the care they received. People were treated with kindness

by the staff. Staff respected people's privacy and dignity and interacted with people in a caring and compassionate manner.

Care plans had not been consistently updated to reflect people's current care needs. They were task focussed and lacked a holistic approach to ensure people's general well-being. Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their physical needs.

There was a lack of resources, time, staff knowledge and motivation to provide people with a range of appropriate activities to ensure all aspects of their physical, mental and emotional well-being were being met.

A complaints procedure was in place. Although some concerns and complaints had been investigated and responded to, there was a lack of confidence that people's opinions were acknowledged and acted on.

The provider had quality assurance systems in place but audits and monitoring had not been carried out consistently by the management team. Records showed that some areas had not been monitored at all in the last 12 months. These systems had failed to identify shortfalls such as the failure to review and update care records and risk assessments and the lack of appropriate pressure care management.

There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met. However, there was confidence in the newly appointed manager. Other members of the management team acknowledged where there had been failings and by the second day of our inspection and started taking action to make improvements to the service.

## 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.

Risk assessments relating to people's care and support needs had not been reviewed or updated. They did not record how identified risks should be managed.

At times there were not enough staff to meet people's needs.

People were provided with their medicines when they needed them however there was a lack of guidance for the administration of certain types of medicines.

Procedures were in place to safeguard people from the potential risk of abuse.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Professional advice and support was obtained for people when nutritional needs were identified. However, these needs were not regularly assessed.

The meal time experience was not always positive and people lacked support to make an informed choice about their meals.

Staff understood the importance of gaining people's consent and were knowledgeable in The Deprivation of Liberty Safeguards.

Staff were trained and supported to meet people's needs effectively.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not always involved in making decisions about their care.

Staff were compassionate, attentive and caring in their interactions with people. People's independence, privacy and dignity was promoted and respected.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care plans had not been consistently updated to reflect people's current care needs. They were task focussed and lacked a holistic approach to ensure people's general well-being.

Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their physical needs.

There was a lack of resources, time, staff knowledge and motivation to provide people with a range of appropriate activities.

Although some concerns and complaints had been investigated and responded to, there was a lack of confidence that people's opinions were acknowledged and acted on.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Quality assurance systems were in place but audits and monitoring had not been carried out consistently. These systems had failed to identify shortfalls such as the failure to review and update care records and risk assessments

There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met.

People were positive about the management team and there was confidence in the newly appointed manager.

# Harvey Centre - Mental Health Nursing 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 unannounced inspection took place on 25 May and 7 June 2016. The inspection team was made up of one inspector, a specialist 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. The specialist advisor had knowledge and experience in mental health nursing.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the newly appointed manager, the assistant director and five other members of care staff.

We spoke with six people who used the service, one relative and a health care professional who visits the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed six people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

Care records included risk assessments to provide staff with guidance on how risks to people should be minimised. However these had not been regularly reviewed and updated and did not record how identified risks should be managed for significant areas of people's health and wellbeing including pressure ulcer care, falls risk assessment and medication.

A safeguarding concern had been raised with the local authority in connection with a pressure ulcer which had not been referred for treatment in a timely manner. The person had developed a grade three pressure ulcer. A member of the management team acknowledged that lack of communication amongst the staff team had led to the delay in the person receiving the appropriate care. The person's records included a tool used to assess the risk of a pressure ulcer developing. They had been assessed as being at very high risk in the three assessments which had been completed since August 2015. However there were no details of support plans or preventative measures in place to prevent a pressure ulcer from developing. A body map in the records did not show the location of the pressure ulcer. This had been added by the second day of our inspection after we pointed this out to the manager.

Risk assessments were in need of review. As well as pressure care management, risk assessments relating to falls and risk of malnutrition had also not been updated. For example, two people's falls risk assessment in September and November 2015 indicated that they were at high risk of falling. There had been no further review and there were no detail regarding what measures were in place to reduce risk.. One person's records showed that their moving and handling assessment had last been completed in August 2014. Without frequent assessment and review staff could not be certain that they were supporting people in line with their current care needs. Where risks had been identified staff had no guidance to inform them how they could minimise these to reduce the likelihood of people coming to harm.

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered. This meant that staff may not be aware when a person needed medicine such as pain relief because there was no guidance to show how people communicated that they were in pain when they were able to verbalise how they were feeling.

Care plans contained details regarding the administration of medicines covertly. Mental capacity assessments had been carried out in relation to this and appropriate guidance had been sought from the healthcare professionals prescribing the medicines. However, there was no guidance relating to covert medicines included with people's medicines administration records so that they were available at the time of administration. This meant that there was a potential risk people may not receive their medicine in a manner which would not compromise its safety or effectiveness.

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

There were mixed views whether there were sufficient numbers of staff to care for and support people

according to their needs. A person told us, "I'd like to have more, look, they're on the go all the time, exhausted." Another person said, "Sometimes I think we need more staff." They explained, "Because the current staff don't always have time to take an interest in you." Two other people told us that they thought there were enough staff to meet their needs. A member of staff said that there was, "Always a qualified nurse on duty." However, they also commented that they would like, "More staff to provide care." We observed that the staff did not always have the time to spend engaging with people. For example, we observed a member of staff start a game with a person, throwing a ball to them. The person's face was animated showing they wanted to play. However, the member of staff was only able to throw the ball twice before needing to attend to another person. A short while later another member of staff took over but only threw the ball once before they were needed elsewhere. The person appeared confused and upset by the lack of meaningful interaction.

Lack of staff at meal times meant that not everyone had a positive meal time experience. For example, we observed that people requiring assistance with lunch had to wait for up to half an hour whilst the others were eating because there were not enough staff to meet everyone's needs. Two people who needed assistance with their meals were being supported by one member of staff rather than receiving individual attention and support.

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

Medicines administration records (MAR) identified staff had signed to show that people had been given their medicines at the right time. A person told us, "I have a handful of tablets in the morning, [staff] bring them to me at breakfast and I take them with a cup of tea, it's the same every day." A member of staff told us that they had a good working relationship with the pharmacy that supplied people's medicines. They commented, "The process is excellent…there's no room for error."

People presented as relaxed and at ease in their surroundings and with the staff. A person told us they felt safe and added, "That's important, isn't it?" Four other people also told us or gestured that they felt safe and a relative commented, "I imagine [person] feels safe."

Systems were in place to reduce people being at risk of potential abuse. Staff had received up to date safeguarding training and knew how to recognise and report any concerns. A member of staff told us, "I would speak to the nurse in charge first, the manager, [director] or [assistant director] or CQC (Care Quality Commission)." Another staff member explained that there was a poster displayed in the staff room which included the relevant contact details for the appropriate professionals who were responsible for investigating concerns of abuse.

Risks to people injuring themselves or others due to premises or equipment were limited because there were maintenance and service contracts in place to ensure the premises was well maintained and safe. Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Recruitment records showed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Requires Improvement

# Is the service effective?

## Our findings

Staff were provided with the training they needed to meet people's needs and preferences effectively. A relative told us that the staff were, "Very good…seem well-trained," and that they were able to, "Meet [person's] needs." A member of staff commented that, "We get plenty of training, some e-learning some practical such as fire, moving and handling and talks on dementia." New members of staff were completing the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their work. This demonstrated that there was a support system in place for staff that developed their knowledge and equipped them with the skills they needed to provide appropriate support for the people in their care.

Staff told us and we saw in their records that one to one supervision's were not taking place regularly. Supervisions give staff the opportunity to talk through any issues, seek advice and receive feedback about their work practice. A member of staff told us that they, "Valued clinical supervision," but didn't feel that this happened often enough. The assistant director acknowledged that supervisions had not been taking place as often as they should and showed us plans to put a more structured system in place involving other senior members of staff.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. Mental capacity assessments had been undertaken in relation to DoLS and were also in place where people lacked capacity to make other decisions, such as about their daily routines, meals and medicines.

We observed that staff sought people's consent before providing support or care and acted in accordance with their wishes. A member of staff talked to us about how they did this when people were unable to verbalise their wishes, "I still talk to them…do you want [brand of cereal] or cornflakes? Do you want these socks, this jumper?"

There was a four weekly rotating menu which was planned in advance. People had been asked what they would like to see on the menu and families had also been consulted when people were not able to easily

express their preferences. One person said, "I don't see the menu much, it should be everyday but it's not." They added, "You just have what you're given." A relative also confirmed, "I had to choose [person's] food in advance," and this was "Several weeks in advance." This meant that people lacked choice at the time the food was served and had little opportunity to change their minds.

People were mostly complimentary about the food provided and we saw that it looked colourful and appetising. One person said, "You get very good food, the cook is excellent." However one person commented that they would like a better selection and told us that the food was, "Eatable," but, "Could be better."

The mealtime experience was positive for some people. Staff were attentive, patient and sensitive to these people's needs. For example, we saw a member of staff assisting a person with their meal. They checked with them whether they were ready before offering each spoonful and waited patiently while they ate. However, other people had a less positive experience during their lunch time meal because they had to wait for up to half an hour before staff were able to support them. Once staff were available we observed two people being assisted by staff with little interaction or individual attention. This demonstrated that although some staff were sensitive to people's needs and gave them the time they needed to enjoy their meal others were focussed on their task and did not deliver person centred support.

People were provided with enough to eat and drink and supported to maintain a balanced diet through a varied menu. Where issues had been identified such as difficulty swallowing, guidance and support had been sought from health care professionals, including dieticians and speech and language therapists. Although people's food and fluid intake was recorded there was no assessment of this and tools provided in people's care plans to assess their risk of malnutrition had not been completed with any regularity. This meant that staff were not provided will all the information they needed to ensure that they were meeting people's nutritional needs appropriately.

People had access to health care services and received ongoing health care support where required. A GP visited the service twice a week and we saw records of visits to health care professionals in people's files. A person told us how they were supported to visit the dentist and added, "We go in a taxi." This showed that staff were aware of people's routine health needs and involved health and social care agencies when additional support was required to help people stay well.

Requires Improvement

# Is the service caring?

## Our findings

Care plans documented people's likes and dislikes and preferences about how they wanted to be supported and cared for. For example, It was recorded in one person's care plan that, "I like a bath but don't like water running down my back…I like comfortable clothes. I suffer with cold feet so like socks on." Most people had a 'My Chart' which gave an overview of the person and what was important to them. People and their families had initially been involved with these but they had not been regularly reviewed and updated. For example, we saw in one person's care plan that there was an assessment of their involvement, choices, preferences, rights, like and dislikes. This had been completed in April 2013 but had not been reviewed. This meant that the service could not demonstrate that it had taken steps to ensure that the records were still relevant.

People were not always aware of their care plan and what it contained. One person discussing their care plan said, "They make one but I don't know where it is or what they do with it." Another person commented that, "They ask me how I am, like when I get up in the morning," but didn't know if they had a care plan. When asked how staff involved them in discussions about their care a person told us, "I suppose they just do it." A relative commented, "I thought they were supposed to keep it [care plan] in their rooms but I haven't seen a copy of it." When speaking about reviews of the care plan they added, "I was invited in the early stages, the last being a couple of years back, but I haven't been since."

People told us that in the past there had been meetings were they could get together with staff and other people who used the service. One person said, "There has been a meeting or two." They added, "I suppose it gets us together, that's all. The staff do it all." Another person confirmed, "They [staff] choose what we talk about." Minutes of a meeting held in February 2016 showed that people had been given the opportunity to make comments about the new conservatory, activities they would like to take part in and possible options for a holiday. However, it was unclear what actions had been taken as a result of the meeting. For example one person had commented that the conservatory may need some window protection as it was hard to see and too bright. We saw that no blinds had been fitted in the large conservatory and although it was clear that people enjoyed sitting in this area near the garden, they commented that it did get very hot. We observed staff needing to ensure people were wearing hats inside, to protect them from the bright sun shining through the windows. Although people's opinions had been sought it was not clear whether these had been acknowledged and acted on.

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

The atmosphere within the service was relaxed and welcoming. A person told us that one of the best things about living at the service was, "The friendliness of the staff. That's what makes it enjoyable here." Another person gestured, "Yes," to staff being kind and compassionate. A visiting healthcare professional confirmed that, "People always seem to be very kind."

People were positive and complimentary about the care they received. A person said that the staff, "Are very

good and helpful." Another person told us, "They assist me a lot, like getting up in the mornings…they help me get a wash."

We observed staff demonstrating empathy, understanding and warmth in their interactions with people. For example, when two members of staff served hot drinks to people they were attentive and spoke to all people in the room throughout the process so that everyone was involved. A relative told us, "All members of staff are very nice, they're always smiling." They added that the staff, "Seem to be patient," and "Caring." Staff talked about people in an affectionate and compassionate manner and were caring and respectful. A member of staff commented, "I love my job, I'm happy when they're happy."

Although there were some shortfalls in how the service demonstrated it overall, staff told us how they promoted people's right to choice and independence. One member of staff talked about how they knew it was important to, "Let them [people] make their own choices as much as possible." They told us how they were aware of one person's capabilities so, "Like to let [them] walk a bit." Another member of staff explained how they promoted independence, "By giving time, respect, encouragement and providing dignity." This demonstrated that staff knew people well and took time to encourage people in order to assist them to be as independent as possible.

People's privacy and dignity was promoted and respected. A person told us that staff , "Make sure my door is closed," when they helped them to wash and dress. They added, "They [staff] have never been rude to me." We observed that staff were discrete in their interactions with people where appropriate.

Requires Improvement

# Is the service responsive?

## Our findings

Daily notes for each person contained details regarding daily tasks and activities, what people had to eat and drink and details about their mental health and general well-being. However, individual care plans were seen to be mainly task focused and lacked details about people's emotional needs and how best to support them with any mental health issues they may have. For example, we saw an incident form in one person's care plan which recorded details of a situation where the person had become physically aggressive whilst personal care was being provided. It had been recorded on the form that it had been explained to the person that this was, "Unacceptable behaviour." There was no record of how the person felt after the event, analysis of potential triggers which had led to the person's distress or details of how they should be supported following the incident. Staff demonstrated that they had an awareness of how to deal with challenging situations such as these. One member of staff told us that it was important to, "Talk calmly, be friendly. We've all had training for that." However, the lack of information about potential triggers meant that it was not clear to staff how they should respond to changes in people's emotional state to prevent a situation escalating, causing the person and others around them distress.

There was a designated area for therapeutic activities which was referred to as the "Day Centre." An activities co-ordinator was employed Monday to Friday and mainly worked with small groups of people in this area. A member of staff explained, "At 10.30 there are activities in the day centre. Three or four go at a time." There had been a number of planned group activities over the last year including a curry evening, cheese and wine evening and St Patricks Day party. However, records showed and people told us that there was a lack of general activity for much of the day. Our observations confirmed this. The forms used for recording people's activity stated, "This form is to be maintained on a daily basis." However we saw that these had not been completed to show what people had been doing each day. One person's form for the previous month showed 10 activities recorded, six of these were listed as "music" and another as "nails cleaned and cut." A high proportion of entries seen on other forms listed music, TV, radio and DVDs as activities, with occasional group activities also recorded. One person spoke about activities and said, "We don't have any really [activities]. Some of the staff might read something of interest to patients." They commented, "I enjoy sitting reading," but pointed out that there wasn't a shelf with books available for people to choose to read. They added. "Sometimes staff bring in their old books when they've read them, but 'I'd like more."

There was an activities board which displayed activities which were to be taking place each day. We did not observe any of the advertised activities take place during our inspection. A relative spoke to us about the board and said, "I've never seen any of those activities carried out." One person told us that they felt there was too much television on, "I like company. But wherever you are, there's that [pointed to television]." They went on to say they believed that, "The TV stops people communicating with each other, we're not encouraged to talk to each other."

A person told us, "Sometimes I go to the Day Centre, we have quizzes and that…Discuss matters of interest and bowls. I haven't been lately, but usually go twice a week." There was little evidence of resources available to assist staff in providing meaningful activities outside of the day centre. We observed staff looking at magazines with people, using them to engage with them and start discussions. We also observed

a member of staff using a crossword/quiz book with a group of three people. Whilst the manner of the staff member was caring and inclusive, the actual activity did not engage people in a way that was meaningful or helpful as no one was able to answer the questions. Staff appeared to lack understanding, motivation or resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions. This meant that there was not a holistic approach to people's care and support to ensure their general wellbeing.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Staff used 'The Care Programme Approach (CPA)' which is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health needs or a range of related complex needs. People who were part of this programme were supported by care co-ordinators who had carried out an assessment of their needs. This was reviewed annually and we saw that people had been involved in these reviews together with their families. In one care plan it had been recorded, "Had a CPA this morning, Son attended."

However, these reviews referred only to this element of peoples care records and did not take into account changes in relation to people's preferences and wishes or management of risk associated with physical health needs. Care plans had not been consistently updated to reflect people's current care needs. One person's records showed that although weekly clinical observations had been carried out there had been no general review of their physical needs for the last three years. Another person's records contained a moving and handling assessment which had not been updated since 2014. Risk assessments relating to pressure ulcers, falls and risk of malnutrition had also not been updated. Records were disorganised and it was not clear what was current information and what should be archived. Without up to date information about people's care needs staff could not be certain that they were supporting people appropriately and that all their health care needs were being met.

The new manager acknowledged the problems with the care plans and by the second day of our inspection had started to identify what areas needed priority in order to make progress towards reviewing and updating all records. The assistant director also took the concerns raised on the first day of our inspection on board and had produced a new audit tool to enable the management team to monitor the review of people's care plans and other records.

Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their physical needs. A person commented, "They're [staff] there when we need help," for example, "If I want help with something in my bedroom."

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. A relative told us about some concerns they had raised where they felt they had needed to push for answers. They felt the issues had never been properly resolved by the management team. However, records seen of previous complaints showed that they had been investigated, responded to and action plans put into place. A person told us that they hadn't made any complaints. They said, "It's better to talk to someone straight away so a complaint isn't necessary." Another person told us, "I haven't anything to complain about."

Requires Improvement

# Is the service well-led?

## Our findings

The provider had quality assurance systems in place but audits and monitoring had not been carried out consistently by the management team. Records showed that some areas had not been monitored at all in the last 12 months. For example, management of challenging behaviours, consent to treatment, management of physical disorders and some elements of medicines management. The audit matrix which recorded when monitoring had been carried out indicated that each element of the service provision was only audited once a year.

These systems had failed to identify shortfalls such as the failure to review and update care records and risk assessments and the lack of appropriate pressure care management. This showed that quality assurance systems needed to be more robust to ensure all potential shortfalls were identified and responded to appropriately to ensure the delivery of safe, effective and responsive care and to drive continuous improvement.

There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met. A relative told us, "Physically, it's fairly simple, they're changed and fed." However, when it comes to activities to stimulate people, "I felt early on that in fact there's not much stimulation." The feedback we received from people and our observations confirmed this to be the case.

Records showed that people and their relatives had been asked to complete satisfaction questionnaires but it was not clear what action had been taken as a result of these. The assistant director told us there were plans to hold relatives and residents meetings every four months. We saw minutes of a residents meeting held in February 2016 but there were no dates arranged for future meetings to take place. A relative said that they were not asked for feedback and commented, "We used to have cards to fill in but there was nowhere to put them. On occasions in the past, the box was hidden behind the plants, now there's nothing." A person spoke to us about whether they had opportunity to give their views and told us, "They just get on with it, we just do what they say," This demonstrated that people and their relatives were not always empowered to voice their opinions or could be confident that they would be listened to and appropriate actions would be taken to improve the service.

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

There was however confidence in the new manager. One staff member said, "I think [new manager] is brilliant. There will be good changes, [they are] very approachable." A visiting healthcare professional commented that they felt the manager to be, "Proactive." The manager had started their employment at the service the day before our inspection but had already identified areas where improvement was needed, particularly in relation to people's care records. The manager observed there was a need to look at, "Where are we failing and what can we do better?" On the second day of our inspection we saw that work had begun on updating the care records and the assistant director also showed us details of a new audit tool they

planned to implement to ensure care plans were reviewed, updated and appropriate actions taken.

Staff gave positive comments about the management of the service. One member of staff said, "The management here are brilliant, sympathetic. The new manager is lovely, friendly." A visiting healthcare professional told us, "I always find them very accommodating. It's definitely improved."

Staff told us that they felt the management team was approachable and provided support when they needed it. One member of staff commented, "I see them [management team] around quite a bit. I'm very happy to go to them. I do think they listen." Another said, "[Assistant director] is very thorough, very helpful, very approachable, it's very much a team effort." This demonstrated that staff were confident that they could raise any issues of concern and that these would be dealt with appropriately.

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>People were not always involved in making decisions about their care.<br><br>Care plans were task focussed and lacked a holistic approach to ensure people's general well-being. |

| 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 records and risk assessments had not been regularly reviewed and updated and did not record how identified risks should be managed. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Audits and monitoring had not been carried out consistently. Quality assurance systems had failed to identify shortfalls. |