Althea HealthCare Limited

Thorp House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Thorp House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Thorp House provides accommodation with both personal and nursing care for a maximum of 41 older people, some of whom may be living with dementia or need support with their mental health. At the time of our inspection, there were 40 people using the service.

This comprehensive inspection took place on 14 and 17 November 2017. The first inspection visit was unannounced.

There was a registered manager in place. 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 the last inspection of this service on 14 and 18 April 2016, we found that the service was good in all areas. The registered persons did not therefore need to take any action to comply with regulations. At this inspection, we found that the quality and safety of the service had declined and it required improvement in all areas. There were four breaches of regulations.

The service people received was not as safe as it should be. We found that staff and the registered manager did not act as expected to refer a concern that someone had been assaulted. A concern about rough handling was also raised with us that could place a person at risk of harm. The level of knowledge of staff and their awareness of local procedures for safeguarding people needed to improve. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were additional concerns relating to the management of risks, which systems for assessing safety had not identified. This included concerns for trip hazards within the home and in relation to moving and handling, which made some people feel unsafe. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated activities) Regulations 2014.

There was good practice in other aspects of the safety of the service. This included managing people's medicines safely, with minor anomalies being identified and addressed. Arrangements for cleaning the home contributed to reducing the risk that an outbreak of infection would not be contained.

People were not always treated with respect for their privacy and dignity. This was either through omission when staff did not offer prompt intervention to promote people's dignity, or by action taken that directly compromised privacy and dignity. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated activities) Regulations 2014.

Standards in the service had declined since our previous inspection. Governance and leadership of the service failed to sustain the good outcomes for people we found at our last inspection. Systems were not effective in proactively identifying and addressing the concerns we found. The need to ensure the service returned to good and the slippage in arrangements to properly and effectively evaluate the service represented a breach of Regulation 17 of the Health and Social Care Act (Regulated activities) Regulations 2014.

You can see the action we have told the provider to take in response to these four breaches of regulations at the back of the full version of the report.

Staff did not always receive the support and supervision they needed to support people competently. This included shortfalls in the clinical skills of nurses and gaps in training or assessments of competence for staff. Between the two of our inspection visits, the management team developed an action plan for addressing the shortfalls we pointed out.

People received support and advice about promoting their health including with their diet. We received reassurances during inspection that the quality of their mealtime experiences would be reviewed to see how these could be improved, in line what people told us. We were also assured that apparent shortfalls in people's food and fluid intake were the result of lack of accurate use of the provider's new electronic recording system and further training would be provided.

People felt that most staff were kind and caring in their attitudes. During our interviews with staff we found that they were aware of people's likes and dislikes. In some cases, working to build a picture of these that could be incorporated into plans of care to guide other staff. There were plans, following the introduction of the new electronic care planning system, to look at how people could be more formally involved in reviewing their care and making decisions about it.

People's experiences of care were sometimes task focused rather than responsive to them as individuals. However, improvements were being made in relation to enabling people to engage in hobbies and activities that were of interest to them following the recent appointment of a staff member allocated to these. There was a system for managing complaints about people's care and ensuring they were kept informed about findings. The registered manager had plans to review the arrangements for consulting better with people about their wishes at the end of their lives to ensure these were met.

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.

Actions in response to concerns about abuse were not always sufficiently robust in ensuring appropriate professional advice about safeguarding people.

Systems for assessing and managing risk were not sufficiently proactive, including those associated with the premises and safely moving and handling people. Lessons that could be learned following incidents were not always robustly implemented.

Following recent recruitment, there were enough staff robustly recruited to ensure people's safety.

Staff supported people with their medicines in a safe way.

Practices for maintaining cleanliness contributed to protecting people from the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed but staff were not always trained and assessed as competent to deliver the care people needed. The management team developed a plan to address this during the course of our inspection.

People's dietary needs were assessed and met, although their mealtime experience could be improved as could recording systems.

There were systems for sharing essential information about people's needs and risks if they moved between services or were admitted to hospital.

People had access to advice and support to maintain and improve their health.

The environment and grounds were accessible to people. However, there could be better consideration of good practice guidance in design for people living with dementia as well as reviewing heating arrangements for people's comfort.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately so that people's rights were protected. Further training to support staff to understand their responsibilities under the Mental Capacity Act 2005 was scheduled.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported with care and compassion and in a way that promoted their privacy and dignity.

Staff understood people's preferences and there were plans to improve how people were formally involved in developing their plans of care.

People were encouraged to be as independent as they could be.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's experiences of care were not always centred on their individual needs. However, improvements were in progress to ensure people could engage in activities which reflected their hobbies and interests and helped stop them becoming isolated.

There was a system in place for managing people's complaints.

People were consulted in part about their wishes for care at the end of their lives and the registered manager intended to improve this.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The culture of the service was not always empowering and communication between the registered manager and people living or working in the service could improve.

Systems for checking quality performance and meeting regulatory requirements were not working effectively and

robustly.

Arrangements for driving and sustaining improvements in the quality and safety of care people received, were not working as well as they should.

Thorp House

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We brought this inspection forward from the intended date, prompted by an incident which adversely affected a person using the service and which indicated potential concerns about the management of risk.

The inspection took place on 14 and 17 November 2017. The first day of the inspection was unannounced. It was completed by two inspectors, a specialist advisor for nursing care 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used information from the PIR, which they sent us in July 2017 to help us assess the service. We also reviewed all the information we held about the service before our inspection visits. This included information about events taking place in the service and which providers must tell us about by law. It also included information supplied to us by other bodies such as the clinical commissioning group and the local authority's quality assurance and safeguarding teams.

During our inspection, we spoke with 12 people who used the service and five of their visitors. We also observed how people were supported and how staff interacted with them and walked around the home to see how the premises was maintained.

We spoke with the registered manager, the provider's operations manager, two service quality managers, the operations director and the home's administrator. We also interviewed two staff providing nursing support, one of whom was the deputy manager. We spoke with four other members of the care team, the activities coordinator and the cook. We gathered views from a health professional who visited the service while we were there.

We reviewed records associated with the care of seven people and a summary of incidents staff had flagged up for hand over to their colleagues. We checked systems for managing and monitoring medicines administration, training records for the staff team and recruitment records for two staff. We also reviewed a sample of records and audits associated with the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2016, we found that the service was safe. At this inspection, we found that improvements were needed to ensure the safety of the service people experienced was consistent. We identified concerns that systems and processes for protecting people from the risk of abuse and in ensuring all staff fully understood their responsibilities in this area needed to improve. Some improvements were also needed in working practices to ensure people received safe care and that lessons learned were robustly implemented when things went wrong.

People largely told us that they felt safe using the service. For example, one person said, "I'm content and safe, much safer here than in my house." Another told us, "I'm quite happy here, I've got my room, my telly, I feel safe." However, this contrasted with one person who was able to describe very clearly, why they did not always feel safe. They explained, "Most staff are good but some are rough and clumsy. I am dependent on staff … Night staff push me around like a piece of meat." Their existing condition presented a risk that wounds could be exacerbated by the rough handling practices they described.

Information we held about the service, showed that formal notifications to the Care Quality Commission (CQC) about alleged abuse were much lower than expected for this type of service. There were only two such notifications in 2016 and none at all for 2017. Sometimes this can indicate that no incidents have happened. It can also mean that key staff have not recognised incidents as abusive, not properly escalated them to the safeguarding team and not formally notified CQC. During our inspection, we identified a recent concern indicating that the latter was the case.

On the first of our inspection visits, the registered manager confirmed staff had recent training in recognising and responding to abuse, with only four or five who still needed to complete it. On the second inspection visit, we found fourteen staff listed in training records were shown as awaiting confirmation of dates for training in this area. One of the nursing staff told us they had not completed this training since their appointment, more than nine months before our inspection. Training records confirmed this was the case.

The registered manager said in their Provider Information Return (PIR), that staff were given a "safeguarding procedure declaration form" to read, sign and keep. The PIR said that all staff received this in the first week of their induction at the service. For one staff member, appointed in June 2017, and new to working in care, they had no such declaration available until after the first of our inspection visits.

Care staff were able to describe what would lead them to suspect a risk of harm or abuse. They told us that they would report it to the nurse, a senior or the registered manager. However, they were not all clear who they could contact outside the service if they felt more senior staff did not properly refer their concerns. Some staff lacked confidence that, if they escalated concerns within the home, more senior colleagues always knew what to do and would take the right action. Our findings supported this. The registered manager needed to be more aware of incidents taking place and which constituted abuse.

We reviewed the electronic incident record covering October 2017, as this was the last full month before our

inspection visits. This record contained information about significant events taking place across the service that all staff needed to be aware of. We found a clear example within this single month of an incident of abuse. One person was recorded as having displayed behaviour that challenged the service and presented a risk to others requiring staff intervention. The record showed they had hurt others and had punched another person in the face. Despite witnessing the assault, staff on duty had not referred it to the safeguarding team for support or advice. This presented concerns about the information in the PIR, which stated that all staff knew what to do in response to safeguarding concerns.

The registered manager told us that they were unaware of the incident, which took place more than five weeks before our first inspection visit. They had not therefore, followed it up promptly to ensure the safeguarding referral had been made and a notification sent to CQC. The registered manager took action to make both the referral and notification after we made them aware. However, we considered that they should have been aware of the incident from the overview of incidents taking place. Staff had not reported the issue directly to the local authority safeguarding team in accordance with their responsibilities to seek advice about protecting people.

These concerns represented a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Risks to which people were exposed were assessed within their plans of care. This included risks of falls, to their skin integrity, of choking and of poor nutrition. Staff were able to tell us how they minimised these risks. People had pressure-relieving equipment in place to minimise the risk their skin would break down. However, there was room to improve the way care was delivered to minimise this specific risk and ensure people always had appropriate support to reposition.

Pressure ulcers can develop very quickly without appropriate intervention. We found that one person had a photograph of a pressure wound taken on 11 November 2017. The grade of the wound was not assessed. After discussion with nurses, it was agreed this was a grade two wound and their record was updated to reflect that so nursing staff could monitor progress. We found that the person's care plan said staff should assist them to change position at least every four hours. However, on 10 November, the day before their wound was identified, their records showed they were left for six hours without this support. After we pointed out our concerns, the deputy manager updated the person's record. This showed the frequency for assisting them to move and relieve pressure was increased to two hourly to help promote healing and reduce further risk.

For another person identified as risk of developing pressure ulcers, their records showed inconsistent practice. There was a lack of clarity about what staff should do to mitigate the risk and how often they should support the person to move if they had not changed position. The person's notes showed that staff did support them to change their position "to relieve pressure" on occasions during the day. We found that, on one night, they were not assisted for a period of over 14 hours. However, we did note that their skin was described as intact within their records.

There was no indication of consideration about these people's capacity to understand the risks to their skin if they refused support and were not able to move for themselves. If they were not able to make such a decision, there was no clear indication about what was considered to be in their best interests to promote their skin integrity.

We noted that there were regular checks on the safety of the premises. This included checks on installations such as the wiring and fire detection and containment systems. However, there were foreseeable hazards to

people in the environment that were not proactively addressed. For example, there was an incident with one toilet sometimes used by people living in the home, which did not have a bolt that could be opened from outside in an emergency. When a person had become stuck in the toilet, staff had to break the door to gain entry. This risked injury to both the person and to staff. The management team confirmed that this was repaired and a suitable bolt had been fitted. However, it had not been identified and addressed as part of routine checks for potential hazards.

We also noted rooms where there were wires trailing across the floor from call bells, pressure mattresses, pressure mats and extension leads. These presented trip hazards for both their occupants and staff. During our first inspection visit, action was taken to rectify this in one room where arrangements were particularly hazardous. At our second inspection visit, the operations manager told us about the action they were taking across the service to ensure wires and extension leads did not present a risk of trips and falls. However, we were concerned that these hazards were not identified through routine checks or the visual walk around the registered manager told us they completed.

Improvements were needed to the way that staff used equipment to assist people to move and transfer and ensure this aspect of care delivery was as safe as it should be. We found that action in response to an audit by the Commissioning Support Unit's assistant clinical quality and patient safety manager was inconsistent. Their report said that, although some care plans included details of the slings each person required, this was not present in all of them. The audit also recommended including the loops of slings to be used for each person in care plans. This information was not always in place to guide staff about each person's requirements to ensure their safety and people had concerns about their safety using the hoist.

People needing to use the hoist regularly expressed clear concerns to us about how staff did this and how safe they felt when it happened. One person was very clear with us that sometimes, flat hoist batteries resulted in interruptions when staff tried to assist them. They told us, "The worst thing about the hoist is they will get you ready and then the battery will die so they spend 5 minutes getting another. That happens a lot, it makes me feel anxious." They had particular concerns about the knowledge of staff for the way that moving and handling aids were used. They said, "Staff never seem sure about what to do, especially with the hoist. They ask 'does it [the loop] go on this one'?" Where staff are not clear about which sling to use and how to use the loops to fasten it, there is a risk that people may sustain serious injury or even death by falling from the equipment. A second person also expressed anxieties about risks when staff assisted them to move. They told us, "When you are hoisted you are left dangling. I feel like a [expletive] conker sometimes." If this happens there is a risk of accidental contact with the structure of the hoist and therefore sustaining an injury.

The registered manager told us that both she and another member of staff had completed training to instruct and supervise staff in safe moving and handling practices. We discussed with the management team that their training certificate only confirmed attendance at the course. Best practice would be to ensure that the training provider confirmed they were competent to deliver training to staff rather than that they simply attended the training. We noted that the supervision matrix provided to us for January to December 2017, provided for observation of all staff practice to ensure they were competent to support people safely to move and transfer. Despite having the registered manager and another staff member who attended the instructor's training, only seven of more than 40 staff listed were shown as having had their practice observed. For all of those seven, the dates of these observations were 16 November 2017, after our first inspection visit and after we raised concerns about practice.

We noted that one person had fallen and sustained an injury. Our review of records indicated that the fall and injury was unlikely to have been preventable. The person was assessed by nursing staff straight after

their fall, before they were assisted to move and had not complained of pain or shown signs of injury. Staff did not therefore consider contacting emergency services straight away was appropriate. However, later, their records showed a swelling to the person's wrist and that they were complaining of pain in their hip. Staff sought advice from the GP who stated it was a soft tissue injury and staff initially accepted this. However, when the person continued to complain of pain and their wrist remained swollen, staff contacted the GP again rather than for emergency advice. On that occasion, they received advice from a different GP to refer to emergency services for an X-ray. It was subsequently discovered the person had sustained both a fractured wrist and hip.

We spoke with the management team about this. The service quality manager showed us how they had emailed managers of services about the action they needed to take with staff to learn from incidents. This included asking managers to draw the attention of staff to a flow chart about falls and accidents and the action staff needed to take. It was clear about the provider's intentions for improving practice and how lessons could be learned across the provider's services. The registered manager told us that they had given a copy to nursing staff who completed checks on people's welfare after falls and had displayed the chart in the office space used by nurses. However, nursing staff spoken with told us they were not aware of the flow chart. The meeting where the registered manager said she had explained this chart to nursing staff had only rough notes and not clear minutes. The notes did not include reference to any discussions about the information and learning from the incident to reduce future risk.

These issues presented concerns that risks to people's safety were not always identified and addressed proactively within the service. The registered manager could not demonstrate she shared lessons learned with the staff team in a robust and clear manner to ensure a consistent approach to promoting people's safety.

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

People told us that there were enough staff to ensure their safety, and usually to attend to their needs promptly. For example, one person said, "If I want them [staff] I can press a button, I don't ring it very often, it's so long ago I can't remember the last time. They are always there if you need them. I can't grumble at all, they are very good." However, people particularly singled out night shifts as being a problem. For example, one person told us, "The staff on days are nice but on nights you are never sure who you are going to get. Care is rushed and there is not enough of them." Another person commented about staffing levels saying, "It's alright, I have funny turns … and I buzz my alarm. They come straight away, put me right, settle me down, it's very good. They could do with more staff at night though." A relative told us, "Over the course of four years we have had no serious concerns with the care, but occasionally the staff get a bit pushed, especially at night."

We observed that staffing levels matched what the registered manager told us they needed. During our inspection visits, staff responded to call bells promptly. Staff told us the staffing ratios had recently changed to increase staffing levels by one on the ground floor. They said this was a positive change. They did not consider staffing levels to be unsafe. However, they commented that they ran short sometimes if there was sickness. We were concerned about what people told us in relation to night staff arrangements and the skills mix of staff on shift. Staff supported the concerns people raised with us. One staff member told us, "Agency staff vary in quality, they don't know people's needs well and people don't respond well to new agency staff." This supported what people had told us about having to explain the support they needed. For example, one person told us, "We get a lot of agency staff, usually at night times, someone you haven't seen before and you have to tell them what to do."

We found that duty rosters showed the deputy manager regularly worked three 12-hour days, as they needed to fill the required nursing shifts. They were allocated 'office hours' for their deputy manager role on one day a week. They had additional responsibilities for overseeing people's nursing needs as a clinical lead and for supervising nurses, as the registered manager was not a qualified nurse. We were concerned that that these demands presented difficulties for regular reviews of nursing needs, robust assessments of new people and clinical support for other nursing staff.

However, we noted that the registered manager had made recent appointments, particularly for registered nurses, to reduce dependency on agency staff and help ensure people received support that is more consistent.

Recruitment measures contributed to protecting people from the employment of unsuitable staff. This included completing checks on the identity, references and employment histories of applicants. There were also enhanced checks on the background of applicants with the Disclosure and Barring Service (DBS). DBS checks help establish whether there are any criminal records, cautions or histories that would make applicants unsuitable for working in care services. Nursing staff were also checked to ensure they were properly registered with the Nursing and Midwifery Council and whether there were any restrictions on their practice that might affect their suitability for the role.

Medicines were largely stored and administered safely. We noted that nursing staff retained medicines keys for safekeeping. People felt they largely got their medicines on time. For example, one person told us, "I get medication four times a day by the shovel load, it's normally on time." Another person said, "My medication arrives on time." One person did say that sometimes their medicine was a bit late and another expressed some concerns about the timing of administration of insulin to help control their diabetes. They explained that sometimes there were problems in relation to this and the timing of their breakfast. This was shared by their relative.

The nursing home had recently introduced an electronic medication recording and checking system. The nurses on duty reported that this had been successful in reducing medicine errors. They confirmed they had completed training to use the system properly. The software system provided updates to the registered manager and line managers for the service if there were any anomalies.

However, we did find that one bottle of a controlled drug, opened on 1 August 2017 and supposed to be disposed of after three months, remained in use. Regular audits of these medicines had not identified the need to replace it. We raised this with the deputy manager and they took action to ensure it was disposed of safely and a new supply was issued. We also found one discrepancy in medicines. There were conflicting records about which medicine was involved, and whether it was one to control diabetes or a night-time sedative. The person's notes said that, on 20 September 2017, staff had not given their sedative, as it was not in stock. Other records indicated that it was the diabetes medicine that had not been available. We asked the registered manager to investigate this to ensure any errors were identified accurately and properly addressed.

A relative explained to us that they had seen staff leave the medicines trolley open and unattended and expressed some concerns for people's safety because of it. However, this did not happen during our inspection visits.

Supervision records did not support assessment of wider aspects of nurses' competence and skills to administer medicines in the way people preferred. This should include how nurses interacted with people, explained about their medicines and implemented appropriate hygiene and security measures. The

management team made some progress to implement these assessments between our two inspection visits. We noted that the deputy manager administered medicines competently during our inspection. They ensured they checked the relevant details and explained briefly to people what their medicines were for. They confirmed people had taken them before completing the electronic record.

Senior care staff said that, although they did not administer medicines, they did have access to medicines training. They felt this helped them to understand what medicines were for, and to be aware of any side effects that people might experience.

We saw that standards of cleanliness within the home were good. People were satisfied that their rooms were clean. For example, one person told us, "They come in everyday to clean my room." Staff wore personal protective equipment such as gloves and aprons when they supported people with their care. There were checks to ensure a schedule of regular cleaning, which helped to protect people from the risk that any infection would spread. We saw two toilet brushes in their holders sitting in discoloured water rather than being of a kind that could be suspended and dry. This could potentially harbour infection. We asked the registered manager to consider with infection control advice, whether the toilet brushes in use were suitable.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2016, we found that the service was effective. At this inspection, we found that improvements were needed to ensure people experienced a good, effective service. Training for staff to meet people's needs competently had declined. Staff were not supported to complete induction in a timely way and there were gaps in the skills of staff including nursing staff. This compromised how care was delivered in a way that achieved effective outcomes for people.

People's records showed that their needs were assessed and there was guidance for staff about how to meet them. However, people expressed some concerns to us that not all staff were as skilled as they should be. They lacked confidence that staff could always deliver the care they needed in the right way. For example, one person told us, "They [staff] don't seem to have their mind on what they are doing. They should know what they are doing." They went on to say, "We get a lot of agency staff, usually at night times, someone you haven't seen before and you have to tell them what to do … I feel bad as I have to rely on them and I worry they will not do it right."

The registered manager told us in their Provider Information Return (PIR) that there was a moving and handling 'champion' in the home. We confirmed this during our inspection visits. However, people's comments and anxieties suggested staff needed more monitoring, assessment and support in this area to assist people competently.

Another person told us about their percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is inserted through a person's abdomen directly into their stomach, so that they can receive their nutrition, fluids and medicines. The person said, "They [staff] seem to know what they are doing to an extent, but they are a bit confused about my PEG feed."

There is clinical evidence that serious complications can arise from the insertion of such tubes, needing close monitoring and nurses need to be able to identify and manage complications. We found that one person's care plan identified the need to replace a specific "balloon gastrostomy tube" every 12 weeks. The person's records showed that it was replaced on 22 May 2017, so was due to be replaced again on 15 August 2017. Their records showed the tube was eventually replaced on 25 September 2017 and not as required within the care plan. The deputy manager told us that a replacement tube had not been available at that time but they had increased the supply and now had three replacements. They went on to say they were unsure whether nursing colleagues had all received training so they could change it when it was due. Whether through lack of equipment or lack of training, the person had not received the support their care plan said was required to meet their assessed needs.

A nurse told us they had not completed training in the care of a person with a tracheostomy or gastrostomy tube. The training information supplied to us did not show that they, and other nursing staff, were up to date with their competence and skills in tracheostomy management. However, the deputy manager and a nurse had completed their competency assessment for tracheostomy care between the first and second of our inspection visits. Dates for a further eight staff were shown on the new training plan as to be confirmed.

Two nursing staff told us that, since their employment at Thorp House, they had not completed training in catheter care, diabetes and associated blood monitoring, and in the management of syringe drivers. We were concerned about this because there were people whose healthcare needs required staff to be competent in those areas. This training was also recommended in the audit by the Commissioning Support Unit's assistant clinical quality and patient safety manager. Their visit was completed in February 2017 and we found similar concerns for nurse training nine months later.

Our review of the training programme showed that the majority of the staff team needed training to understand and support people effectively who were living with dementia. The service also set out to support older people with mental health needs but staff said they had only basic training in this area. We also found that the service was providing support to a person living with dementia who also had a learning disability. Staff did not have training in this area either. One staff member told us, "I work with [person]. I do find I'm lost with communication."

All but one care staff member spoken with expressed some concern about training and support. We found it difficult to establish what training staff had completed, and when it was next due, from records. We spoke with the registered manager, administrator and a quality service manager about how the electronic training was both recorded and monitored. They considered that, when staff enrolled on updates, this 'overwrote' when they had previously completed it. This meant it was not possible to confirm that the provider's expected renewal dates were met.

We identified concerns for the completion of induction training and in support for new staff. We spoke with one staff member for whom their role at Thorp House was their first experience of working in care. Despite being in post since June 2017, they had not yet completed all the expected training. We noted that three of the five staff completing the provider's survey in October 2017 said they did not think they had received a suitable induction programme. This confirmed our concerns. We found that a new staff member's six-month probation period was coming up to expiry. The staff member told us that they had some initial feedback about their performance. They did not think they had a probationary review or regular formal supervision to discuss their performance and development needs. Their records showed one formal supervision session in September 2017, just over two months after their appointment. There were no further opportunities for supervision shown in records, until after the first of our inspection visits.

Care staff confirmed that they had supervision but the frequency of this varied. All but one expressed some anxiety that they did not feel supported by the home's management. The registered manager supplied us with their supervision matrix. They told us that the provider expected supervision to take place six times a year, one of which would be an annual appraisal. The schedule for the period covering January to December 2017 did not support that this happened. There were significant gaps, with some staff shown as having received supervision only once during that period. The same record showed that none of the staff had their competency assessed in relation to personal care, moving and handling, hand hygiene and nutrition until after the first of our inspection visits.

However, between the first and second days of our inspection, the registered manager, operations manager and a service quality manager developed an action plan to address shortfalls in training and supervision. This showed a programme of required training, including in clinical skills, with some dates already confirmed. The training matrix was being updated and the effectiveness and sustainability of arrangements will be checked again at future inspections.

Staff offered choices and assistance to people so that they could receive enough to eat and drink to meet their needs and keep them well. People using the dining room had access to condiments and napkins and

were offered a choice of cold drinks. Staff offered people assistance or prompting to eat and drink where they needed it but music was loud and not conducive to conversation. The quality of people's mealtime experience could be improved.

We observed that people were shown two options of plated food for their main meals. This helps people who live with dementia to choose their food. One person told us, "It's a new thing, showing people what there is to eat." However, not everyone needed choices presented in this way, as some people were able to read and understand a menu. We saw that the written menu displayed did not match what was on offer for people. It did not therefore present a meaningful choice and was likely to increase confusion or misunderstanding. One person living in the home advised a member of our inspection team, "Ignore it, it's always wrong."

The timing of their meals was an issue for one person. They told us, "I get in my chair at 7am and I get breakfast around 8.45am. The time when I get my insulin varies a lot. I have a biscuit and I have a glucose tablet when I wake up, as I don't know what time breakfast's coming. It's a while between getting up and eating." The information they gave us showed that on occasion, the timing of their breakfast was not always as they felt they needed for promoting their health. They told us, "Say I ring my alarm in the morning because my breakfast hasn't come, the fact that I'm a diabetic doesn't seem to mean anything to some of them."

People spoken with expressed some conflicting views about the quality of the food with most commenting that it could be improved. One person said that it was not appetising and gave an example of "runny mince with a blob of potatoes on the side." However, they went on to say that staff had made them something else when they had complained. Another person told us, "I couldn't eat either of the meals today. The meat was not nice. I just had banana and yoghurt." They said that they supposed they could have asked for something else but had not done so. A third person said, "The food is like all these places, they cook veg without salt. It's tasteless. They do some good pies and stews. The soup is like tarmac but apparently it's got to be like that for the others [people using the service]." Other people told us the food was good and they enjoyed their meals. For example, one person said, "Very good, the food, it's very good. I have soft food. They [staff] assist me to eat and it's good." A relative told us, "The food is good, all cooked fresh. The pureed food is all in separate portions." This practice helped the person to experience different flavours and colours of the components of their meal.

We discussed people's views as expressed to us with the management team. They incorporated the need to improve the mealtime experience for people into the action plan they devised following the first of our inspection visits.

People who were likely not to eat enough had their weight checked regularly and their intake of food and drink monitored. For some people there were 'red alerts' highlighted on their electronic records indicating they had not had enough to drink. For example, one person's alert for 15 November 2017, said staff had only offered 400ml of drink and the person had accepted just 375ml. On 16 November, their records showed staff offered 200ml of drink and the person accepted only 75ml.

A service quality manager told us that managers of the provider's services were expected to check these and follow up issues of concern. We followed up the alerts for the person further with the service quality manager. We found that staff had not consistently used the correct way to record drinks on the electronic system. People had been offered more to drink than their specific records of fluid intake showed. The drinks they accepted did not appear in the right place in the records and so the red alerts were generated. We found that sometimes the actual amount of food people had eaten was also unclear so did not show people

were properly monitored in this area. However, for one person at high risk of weight loss, we found that staff were successful in their interventions and the person was now gaining weight.

We concluded that people received the support and encouragement they needed and that the shortfalls flagged up were a result of inaccurate records. The service quality manager undertook to provide further training for staff to complete records accurately and so ensure better, more robust recording of people's food and drink intake.

The cook told us snacks were available during the day and evening and they had recently added fresh fruit to the menu, which staff took round every day on the tea trolley. Cakes, biscuits and snacks like crisps and homemade milk shakes were available particularly for those identified at risk of unplanned weight loss. One person told us how they were regularly offered biscuits and crisps. The cook was able to tell us about people's dietary needs including who required a special diet or a soft diet due to the risk of choking.

Where people needed to access other services, for example an admission to hospital, we saw that the recording system generated a care plan that staff could print for other agencies. This included information about the support people needed and risks to their wellbeing. This contributed to ensuring to promoting consistency and continuity of care if people needed to transfer between services.

People were supported to access advice about their health and wellbeing. One person told us, "I believe the doctor comes on a Thursday, but I haven't had to call on one yet." Nursing staff were aware of the importance of encouraging people with aspects of their health. The deputy manager told us how they were able to access district nursing advice where people were not already in receipt of nursing care. They could also access advice from occupational therapists and physiotherapy. One visitor did comment to us that they felt a person could do with more advice from a physiotherapist so that they could benefit from getting out of bed. One person was able to gain support and specialist advice about managing diabetes and for treatment of a potential complication of their condition.

Staff told us there was regular support from two local GP practices so that people could seek their doctor's advice when they became unwell. They said that there were regular visits and they faxed a list of people wanting or needing to see the GP. They described this as working well. People were also able to gain support from an optician and chiropodist to contribute to their wellbeing. We noted that a mental health practitioner visited one person during our inspection. However, staff failed to record this promptly on the person's electronic record to confirm the input and support they had received. We were concerned about one person's loose dentures, which could potentially be a choking risk but also make it difficult and uncomfortable for the person to eat. This needed following up for the person to see a community dentist or dental technician to get support in this area.

The registered manager reported that, as Thorp House was a nursing home, it was sometimes difficult to get access to specialist support and advice about tissue viability. They were reviewing options to see how best they could ensure nursing staff remained up to date and able to support this aspect of people's health.

There were ramps throughout the home where there would previously have been changes of level. This enabled people with mobility difficulties or using wheelchairs, to move around. There was a lift between floors with an access staircase for staff. However, people's individual needs still needed consideration in respect of the rooms they were offered when they moved in. For example, one person told us they had trouble with adaptations in their own room. They told us, "My room is not sorted yet; the floor of the bathroom slopes and the toilet is too low, so I have a commode until it's sorted."

We noted, and people raised with us, that the heating was not consistent throughout the building. Our inspection team agreed that some parts of the home felt cold. Although busy staff may not notice this, people who were immobile were not as comfortable as they would like. For example, one person said, "The heating is very unreliable; sometimes it doesn't come on at all. I do have a heater that can be plugged in. There is also a terrible draught from my window, I don't know if things are old and need replacing." Another person sitting in the lounge told us, "It can get a bit chilly in here."

One person told us that they were cold but we were not able to turn on the radiator, as the control was not easily accessible from the radiator cover. The maintenance person addressed this but on the second day, which was warmer and the sun was shining, the area was too warm. Care staff could not access the radiator control easily and so could not turn it down or off again. We noted that the corridor to the rear of the home and outside the kitchen felt cold and again, radiators were not turned on. We considered this should be reviewed in the registered manager's daily walk around checks she told us were completed.

People were able to have some of their belongings around them so their rooms felt more homely and some people had done this. People were able to receive visitors in their rooms. There were communal areas on both floors that they could use as an alternative if they wished. There was also a garden area. There were steps down onto garden paths from patio doors some people had in their 'bungalow' accommodation. However, there were other doorways in the home providing level access the grounds via ramps if they needed this. The garden had seating and tables so people could enjoy the fresh air when the weather allowed.

Signage to assist people with orientating themselves, including identifying their own rooms, could improve, for example by people choosing or making a picture to display nearby that would help. We also discussed with the registered manager that the choice of wallpaper in one lounge was not conducive to good design for people living with dementia. This was because it consisted of realistic representations of books and bookshelves and so could be frustrating for people who would not be able to pick up these 'books'.

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.

The registered manager understood when applications should be made and the requirements relating to MCA and DoLS. Applications had been made as appropriate to ensure that any restrictions on people were lawful. The outcomes of most of these were awaited.

We saw that staff asked for people's consent before they assisted them with their care. The deputy manager administered medicines and checked whether people were happy to take them. We also saw staff asking people if they needed assistance at mealtime, for example to cut their food. Staff were not up to date in their training for the MCA but they were able to describe the importance of seeking people's consent and offering people choices. They understood the importance of delivering personal care that was essential in people's

best interests. They were able to explain to us how they were flexible in their approach so they were more likely to gain people's agreement and cooperation.

Between our two inspection visits, the management team developed a plan for addressing gaps in staff knowledge in this area. This showed that the whole staff team was to attend one of the training sessions taking place on 28 November 2017 to refresh their knowledge and awareness.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in April 2016, we found that people experienced a good, caring service. At this inspection, we found that improvements were needed. Some staff interactions were caring and compassionate. However, we also observed, and people told us, some interactions were not caring and respectful of people's privacy and dignity.

We spoke with the registered manager and senior managers about our concerns and some poor staff practice both observed and explained to us. The provider's operations director told us that the service used to have staff who acted as 'champions' for aspects of care and that this had included a Dignity Champion. However, the registered manager agreed that this level of oversight and monitoring by a responsible staff member was no longer in place.

One person told us, "There are two older staff that are very good, but some of the younger ones tell you off. Sometimes you get two and they are chatting away to each other and not concentrating on you. You don't feel secure with them." They went on to say of some staff, "They don't want to do anything, they don't care and push you and pull you." Another person gave us an example of how they felt about their dignity and privacy when a staff member was administering medicines. They told us, "The other day I was on the commode with the screen up and [staff giving medicines] came in. I told them 'go away' but they walked in and popped them [tablets] in my mouth. I've never been so embarrassed."

We observed that people's bedroom doors were routinely left open rather than this being clearly shown as a preference. This included for one person who could not use the toilet in their en-suite pending adaptations, and so had to position a 'hospital type' wheeled screen to prevent people seeing them using the commode. However, this did not protect their privacy from people being able to hear what was happening as they walked by.

We saw the occupant of another room was sitting naked with their door wide open. We saw three staff look into the person's room as they walked past but they did not intervene. This left the person in an undignified situation. The person did not receive support to promote their privacy and dignity until the next staff member came along to help them. We also observed that a staff member providing supervision in a lounge did so in a manner that was intrusive and more consistent with policing than supporting. They stood leaning against the wall with their arms folded, not engaging with anyone and not sitting with people using the area.

These issues arose while members of the inspection team were present when staff are usually more alert to their conduct and behaviour. We were concerned that what we were told and observed for ourselves indicated a lack of attention to consistent caring practices and interactions.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

However, we also noted that there were good interactions. For example, we heard one staff member chatting in a friendly and respectful way with a person who needed assistance to eat their lunch. They sat next to the person and supported them at their own pace. In their interview with us, they spoke about people and their needs in a respectful and compassionate manner.

One person told us that they were happy about the support they received. They said, "They [staff] are really sweet, really nice, I can't complain about them at all. They're friendly and nice to you." Another person told us, "It's very pleasant living here. The staff are nice, and they will do the extra bit for you. We are looked after very well, if you ask for something they always say, they will see what they can do." A third person explained, "The carers are very good, cooperative, caring. Several times their time has finished and they have stayed to finish the job." A visitor to the service said that staff showed "endless patience" with people.

Staff confirmed that they did not always know about people's family histories and backgrounds. This could make it more difficult for staff to communicate meaningfully with people about the things that were important to them. However, some staff had established this through working with people and could describe people's backgrounds to us. This included the activities coordinator who was able to explain how, for one person who was living with dementia, they had discovered part of their history during the course of offering a particular activity.

Staff were largely knowledgeable about people's likes and dislikes. One staff member described in detail how a person who could not express themselves verbally could communicate how they were feeling. The staff member was able to explain how the person used facial expressions and sounds. They agreed this was not reflected in the person's care plan but undertook to arrange this so other staff would be more aware. Another staff member told us about a person's preferred music and choice of television programmes.

Staff members told us how they offered people choices, for example about what they ate, their drinks and what they wore. The majority of people felt they were able to make choices about their care, although one did comment, "I get a bath when they [staff] tell me I can. I sometimes get to wallow in it for 5 minutes." One person told us that they let staff choose their clothes as it saved them worrying about it. Another person told us, "I can please myself what I do."

The electronic records did not always show how people had been consulted and involved in developing their care plans. However, a staff member told us how they did spend time, when they had the opportunity, talking to people about their preferences and what they wanted. The registered manager explained in their Provider Information Return that they intended to make improvements in involving people and their family representatives if they wished, in developing plans of care.

People's accounts about their care showed that staff encouraged their independence. For example, one person told us, "With me I do it if I can do it, they let me wash myself a bit, they hold the face cloth near my face and I rub my face over it. I clean my own teeth." Another person explained, "I've come on leaps and bounds as I'm making myself do things as the girls are so busy. I don't want to trouble them." A third person described how staff supported them with their baths and said, "They put my trousers on. I normally wash my bits and do. I was using wipes but now they have got me a bowl."

People told us that they could have visitors when they wanted to. We observed that visitors came and went during the course of our inspection and could spend time with their family members.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2016, we found that it was responsive to people's needs. At this inspection, we found that there were areas for improvement.

People's needs were assessed before they moved into the service. However, people described the practical delivery of their care in ways that suggested it was focused on tasks rather than them as individuals. For example, one person told us, "I have a wash at the basin, a shower 2-3 times a week, a bath once a week. They [staff] usually tell you when it's your turn." The comments we received about personal care all reflected that people felt staff told them when they would be supported with a bath or a shower, rather than their preferred times being considered. One person told us that, "Some staff know my needs. Others don't and they don't even ask." This indicated that staff may not always be aware how they should respond to each person's individual needs and preferences.

Sometimes people felt that their aspirations were not always met and progress could be slow in following up issues to improve their quality of life. One person said that they would like to be more mobile around the home. They were not confident that staff followed things up to assist them with things they found difficult to arrange for themselves so they could achieve their wish. They told us, "I haven't been able to get myself a wheelchair and they don't seem to have a spare one." Another person said, "I'm washed in bed by one staff. I'd love a shower. I'd love to get out of bed." Staff needed to explain to the person whether there were reasons it was not possible to help them as they wished. A third person told us, "It took them 6 months to arrange to get a TV magazine for me."

The deputy manager told us that the electronic records were in the process of being improved. They told us they thought this would help to ensure that staff had the information they required to meet people's individual needs. The electronic system for monitoring and planning care created alerts when plans of care were due for review so that staff could check for any changes. Staff were able to flag up important issues in the electronic records for hand over between them. This contributed to ensuring they were aware of any changes or significant events affecting people's wellbeing or care.

We found people's individual records were not always clear and personalised in the way they recorded the care that staff delivered and how people responded. For example, we found comments in daily records that people had been in pain but the chosen electronic 'mood' state was that they were either content or happy. A service quality manager told us how they intended to arrange for additional training so that staff would be clearer about this and how to make records more person-centred.

People's experiences reflected that their basic personal care needs were met and that staff responded to changes in their health when they needed to. For example, one person told us, "I have a pad which they [staff] check out regularly. I've got all sorts of creams. When I came in here I had a very painful rash, but they've sorted that out now." A visitor also expressed their satisfaction with care and that it met their family member's needs. They told us, "[Person] is always clean, 100%, they change her nightdress twice a day. I check her over to make sure she has no sores and she's fine." They also commented, "They [staff] always

communicate with me about any changes. [Person] has talcs and creams for her body and they are being used."

People did not always feel that their social needs were met and that they were supported to follow their hobbies and interests. For example, one person told us, "All day I watch telly. A few times staff come in and chat." Another person said, "I watch TV. If I didn't, what else would I do?" A third person explained, "The trouble is, there isn't much to do. That's a problem, there's nothing regular or proper. We did a bit of tai chi this morning, a bit of painting. We have just started someone coming in to give a service once a month. Before that, we never had anything like it. When I was at home I used to go to chapel once a week." This indicated that the way the service was meeting their spiritual needs was improving but that they had not previously had those addressed properly.

Some people did not leave their rooms and were at some risk of social isolation affecting their mental wellbeing. For example, one person told us, "They [staff] took me down for the fireworks. I don't go down as there is no one to talk to. I've had a few depressed days, but I get myself up."

However, we noted that the activities coordinator was newly in post and already had plans to improve this area. They said they spent time with people to get to know what people enjoyed doing and described some of the activities as "portable." They said they could do these with people who spent much of their time alone in their rooms, such as hand or foot massage, reading with people or spending time with them chatting. They told us about plans they had for the future, were keen to develop their role and said they were given the autonomy to do so. We noted that they did provide some cover for laundry and other tasks when staff attended training during one of our inspection visits. Alternative arrangements for cover may be needed to ensure improvements in meeting people's social needs can be sustained.

People told us that they could complain about things if they needed to. Complaints made by people or their representatives were recorded and dealt with in line with the provider's expected timescales. Records showed the investigations made to address complaints and how the findings were shared with complainants. There was only one recent complaint and we noted that the operations manager was involved in supporting the investigation. They also liaised with the complainant about the outcome and findings. One visitor told us how they had raised a concern about a minor issue and had this resolved quickly. Another visitor said, "I haven't had to complain about [person's] care at all in four years. I'm very satisfied." We noted that compliments made about the service considerably outnumbered complaints received.

We discussed with the management team that the complaints guidance displayed needed updating so that it was clear for people how they could escalate concerns they did not feel were properly addressed. It did not include the role of the ombudsman in reviewing issues further. It also told people they could escalate their complaints to the Care Quality Commission (CQC). CQC has no statutory powers to investigate complaints although we do take patterns and the nature of complaints into account when we inspect services.

We noted that some people had information about the arrangements they wanted in place at the end of their lives. This included discussion with them (or with their family members) about their wishes for resuscitation should they have a heart attack and the sorts of treatments they would be willing to accept if they went to hospital. One person spoken with said, "They [staff] did ask me about resuscitation." This helped staff to establish what the person's wishes were. We saw that another person had a red folder in their room with information about their preferences. This included whether and when the person might go to hospital and what treatment they would consider acceptable.

We noted that the registered manager said in the Provider Information Return (PIR) that they intended to improve this area of practice. The registered manager submitted the PIR to us in July 2017 and said that, within a year, they expected to introduce formal, face-to-face training for staff to support people well at the end of their lives. Progress towards meeting this will be evaluated at the next inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in April 2016, we considered that the leadership of the service was good. At this inspection, we found this key question required improvement.

The current systems for assessing and monitoring the quality and safety of the service were not working as well as they had done previously. They did not identify concerns for managing risk and compliance with regulations that we found. They did not take into account people's individual experiences as recounted to or seen by us. Overall, the outcomes for people in all other areas had slipped and without this being identified as a concern.

The culture of the service was not as inclusive and empowering for either staff or people using the service, as it had been at our last inspection. We received conflicting views from the staff team about morale and how well they felt supported. These varied from describing the registered manager as approachable to suggesting that she did not understand how the home was operating and the pressures on staff. Some did not feel that the registered manager would assist them to deliver care if they were short staffed or in an emergency. The registered manager told us that she did help staff if it was necessary but we had some concerns about this. The registered manager did not follow the same dress code for personal safety that other staff did and so could place herself or others at risk if she did deliver care.

Comments from people using the service and their visitors supported staff views that the registered manager was not always 'visible' around the home. People using the service were unclear about management arrangements. One person told us, "I don't know who the manager is." Another person said, "I haven't seen the manager for months." A third person commented, "The management seem to be a bit fluffy, they take a while to get things done."

One out of five visitors spoken with was confident about the registered manager and her abilities. They told us, "The manager has been here over a year, she won 'manager of the year'. She's quite good, so is the deputy manager." However, this view of the registered manager was not consistent with the views of others. For example, one visitor identified two staff to us who they thought were in charge but one was the deputy manager and the other was the administrator. A second visitor told us, "The manager never comes to see [family member] to ask how she is. I mean it's not all about sitting in the office." Another relative commented that they never knew, when they visited, whether the registered manager was in the home or not as they did not see her around the building.

The deputy manager had conflicting demands upon their time from needing to cover a high level of nursing shifts while also being expected to offer clinical expertise because the registered manager was not a nurse. Some staff attributed a decline in morale to feeling tired because of working to cover shifts. Issues were raised with us that some staff gossiped about one another rather than working together as a team. Communication across the staff team was not as good as it should be. For example, staff told us there were staff meetings but if they were unable to attend, they did not get feedback about the discussions. One staff member told us they had missed the last two because of days off and other commitments. They could not

tell us what had been discussed.

The registered manager showed us that they had rough notes of a full staff meeting and a nurses' meeting, both taking place in September 2017. Rough notes of another meeting for nurses had no date on it so the registered manager could not confirm when it had taken place. There were also rough notes of a senior staff meeting that took place in June 2017. However, when we asked, there were no formal minutes available that staff could refer to. This would contribute to staff not all having the same information about the issues discussed, the improvements needed and what developments there were within the service. It may have contributed to the perception shared with us that there was a "top down" management style with little consultation.

The lack of proper recording of such meetings also meant that the registered manager could not show how she had acted in response to guidance from a service quality manager. This was about the need to take action to increase staff awareness of the process for the safe management of falls and seeking subsequent advice in response to these.

The registered manager stated in their Provider Information Return (PIR) that they completed a "visual daily walk about." However, we were concerned that this was not sufficiently robust in identifying and addressing areas of both risk and for improvement. This included for example, not identifying and addressing trip hazards from trailing wires until we pointed it out, and people's concerns about heating.

The PIR referred to the "safeguarding procedure declaration" given to staff to read, keep and sign within the first week of their induction. The information was unreliable as we found one staff member had not completed this between June and November 2017. The absence of this signed declaration was not identified on the personnel file checklists.

The registered manager also stated in the PIR that there was a training matrix in place for all staff and that it was continuously monitored and updated. We found that this was not the case and the matrix was not up to date and monitored, as the registered manager had stated. There was a lack of oversight and monitoring of the delivery of supervision, training, including induction, and competence assessments in line with the provider's expected frequency and standards. Although the management team subsequently developed a robust action plan between our inspection visits, the slippage was neither identified nor addressed until the inspection team raised concerns.

A service quality manager told us about the provider's expected systems for managers to monitor any concerns arising from records and the electronic system for planning and recording care. Despite having access to information on a 'dashboard' to alert the registered manager to concerns, for example arising from poor recording of fluids, action was not taken to investigate and address them. We found that records relating to food and fluids were inconsistent and not always accurate.

The registered manager had not reviewed records of incidents taking place to see whether action was necessary to address these. She had overlooked an assault which we found clearly described in records. This was not addressed through adult protection procedures and not notified to the Care Quality Commission (CQC).

We noted that the Commissioning Support Unit gave a report to the service following their visit in February 2017. This contained a number of recommendations for improvement, shared with CQC, the local authority and Clinical Commissioning Group. Action was not consistently taken in response to this to show the service worked openly in partnership with other agencies.

We discussed with the registered manager, the concerns raised with us about people's experiences of care at night-time. We asked the registered manager about expectations for unannounced night-time audits and checks to assure herself about standards. This was because of the concerns expressed by people and regular staff about night staff arrangements, approach to people and competence if they were agency staff. She told us that she was overdue to complete such a check and had not done one for some time. She was not able to produce the records of any previous audits or checks to assure us that these were robust in ensuring good outcomes for people.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider had displayed the rating CQC awarded to the service at our last inspection, on their website. The registered manager displayed a copy on a wall just outside her office. This was in a rear corridor used to access a small number of rooms, not by the main entrance. The registered manager told us it was also displayed on the wall in the front hall. We asked a service quality manager to help us locate this when we could not immediately see it. We eventually found a previous inspection report in the back of a unit for leaflets under the desk in the hall where it was not otherwise visible. We did not therefore consider that the registered manager had displayed it conspicuously within the service. The service quality manager undertook for this to happen.

The registered manager told us that they had provided opportunities for people using the service and their relatives or friends to meet with them and discuss their views. They said that these meetings had not been well attended and there had not been one for some time. However, we found that people were not all aware that there were any opportunities to express their views or discuss the development of the service through such meetings. One person told us, "I have not heard of any residents' meetings." A visitor to the service also said, "They used to have a relatives' meeting but now they say if you have any comments make them. Different managers have different ideas."

We raised our concerns about people's lack of awareness about what was in place. The registered manager and operations manager took prompt action to address this. They sent invitations to people's families and friends so they would be more aware of the dates for meetings. This would enable them to arrange to attend if they had other commitments.

The management team told us about the provider's new system for monitoring the quality of the service and completing relevant audits. This electronic system would ensure registered managers completed the checks and audits the provider required. It included information about incidents and accidents so trends and risks could be monitored and analysed. The system was not yet fully operational but as explained to us, it would contribute to making the monitoring process more robust.

We found that, despite this being a difficult inspection for the registered manager, she was open to our feedback about concerns. We asked why it had taken our visit to identify shortfalls from expected standards and the registered manager told us, "I took my foot off the gas. I need to up my game." In the two days between our inspection visits, she had worked hard with her line managers to put together an action plan for improvements including in training and recording systems.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always act to promote people's dignity and ensure they were not left in undignified situations when people were not able to take such action for themselves. There were also occasions when the actions taken by staff infringed people's right to privacy and dignity and was not respectful. Regulation 10(1), (2) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with the safety of the premises were not always proactively identified and addressed. Staff did not always understand how to use equipment for moving and handling people in a safe way and so people felt vulnerable. Action taken following falls and in relation to suspicions of injury was not always appropriate and lessons the provider considered should be learnt and addressed following incidents, were not always implemented robustly so all staff were aware of them. This exposed people to the risk of unsafe care and treatment. Regulation 12(1), (2)(a), (b), (c) and (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes for investigating and reporting any allegation of, or evidence of abuse were not operating effectively. Any incident taking took place between people using the service, including assault, was not always and consistently recognised as abusive and reported as such. The registered persons did not always show they had appropriate oversight of, and reporting systems for, concerns about abuse. Regulation 13(1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes for assessing, monitoring and improving the quality and safety of the service people received were not operating effectively and did not properly take into account the experiences of people using the service. Processes for assessing, monitoring and mitigating risks were not robustly and effectively implemented. Governance systems were not effective in evaluating and improving practice and so the quality and safety of the service people experienced had declined. Regulation 17(1), (2)(a), (b), (c), (d)(ii) and (f)