Greensleeves Homes Trust

Tickford Abbey

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

This inspection took place on the 24, 25 January, and 6 February 2018. The first day of the inspection was unannounced, we carried out an announced visit on the second day and the provider sent us the information required to complete the inspection on the 6 February 2018.

Tickford Abbey is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Tickford Abbey is registered to provide accommodation and personal care to up to 32 people in one adapted building. At the time of the inspection there were 27 people living in the home.

At the last inspection, on the 15 December 2015, the service was rated 'Good.' At this inspection we found that the service had deteriorated and we have rated it overall as 'Requires Improvement.'

There was no registered manager in post at the time of our inspection. 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. The service had been without a registered manager for seven months, a new manager had recently been recruited and commenced work at the service on 1 February.

Systems and processes in place to assess, monitor and improve the quality and safety of the service were not effective at identifying shortfalls. Where shortfalls were identified these were not addressed in a sufficiently timely manner.

Staff working in different roles within the service did not work effectively together to ensure people were provided with consistent care and support. People could not be assured that the management of the service would take appropriate action in response to allegations of abuse.

People's needs were not adequately assessed so that risks were identified and measures implemented to mitigate the impact of risks to people's safety. People did not have suitable falls risk assessments in place to identify the risks associated with people falling.

People did not always receive their care from sufficient numbers of staff and people felt that there was not enough social stimulation and activity available. Some people were left waiting for support to have their food and drink and people's nutritional records were not always accurate. However, staff were aware of people's nutritional needs and had accessed extra support as needed.

The procedures in place to protect people from risks to their health and well-being by the prevention and control of infection were not consistently implemented. The numbers of domestic staff on duty were not

sufficient to ensure that the home was cleaned to the standard identified by the provider.

The system in place to allow people and their representatives to contribute to their care plans and risk assessments was not consistently implemented. We received mixed feedback regarding people's involvement in their care planning.

Arrangements in place for managing complaints required strengthening. The service had a complaints policy and procedure in place, but this had not been adhered to. However, people living in the home knew how to complain and said they would be happy to do so if needed.

Supervision meetings were used to assess staff performance and identify on-going support and training needs. However, staff did not find these effective in addressing their concerns or supporting them to carry out their roles and responsibilities.

People were supported to maintain good health. Staff had the knowledge and skills to support them and there was prompt access to healthcare services when needed. People were supported to take their medicines as prescribed. Medicines were obtained, stored, administered and disposed of safely.

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. People felt safe in the home and received care and support from staff that understood their responsibility to keep people safe. Staff induction training and on-going training was provided to ensure that staff had the skills, knowledge and support they needed to perform their roles.

Care plans were written in a person centred approach and detailed how people wished to be supported. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005. Staff provided people with information to enable them to make informed decisions and encouraged people to make their own choices.

Staff were committed to the work they did and had good relationships with the people who lived in the home. People interacted in a relaxed way with staff, and enjoyed the time they spent with them.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risks to their health and well-being as measures in place to identify and reduce these risks were not always sufficient.

Staffing levels were not sufficient to meet people's needs in a timely manner.

The provider had not ensured that safeguarding referrals were made to the local authority as required.

There were systems in place to manage medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff working in different roles within the service did not work effectively together to ensure people were provided with consistent care and support.

People's nutritional needs were not always met in a timely way.

Staff received training to ensure they had the skills and knowledge to support people appropriately.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not always caring.

People were not routinely involved in planning and evaluating their care.

Staff treated people with kindness and compassion. There were positive interactions between people receiving care and support

and staff.

People's privacy and dignity were protected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have access to sufficient social stimulation and activity.

Arrangements in place for managing complaints required strengthening.

People were provided with individualised support by staff who knew them well.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not assured of a good quality service as there were insufficient systems and processes in place to effectively monitor the quality of people's care.

There was no registered manager in post. There was a lack of clarity amongst people, relatives and staff regarding the leadership and management of the home.

The provider asked people and staff for feedback regarding their experiences of the service.

Tickford Abbey

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.

During the inspection, we became aware of two incidents following which two people sustained serious injuries. These incidents are subject to an investigation and as a result, this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls. This inspection examined those risks.

This second comprehensive inspection took place on the 24, 25 January, and 6 February 2018. The first day of the inspection was unannounced, we carried out an announced visit on the second day and the provider sent us the information required to complete the inspection on the 6 February 2018.

The inspection was undertaken by one inspector and one 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 expert by experience for this inspection had experience of co-ordinating care services for their relative.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider completed and returned the PIR in November 2017 and we considered this when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us; a statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by other agencies, including the local authority, who commission services from the provider. We also contacted Healthwatch; an independent consumer champion for people who use health and social care services.

During our inspection, we spoke with eight people who used the service and four people's relatives. We also spoke with eleven members of staff including care staff, senior care staff, domestic and catering staff and members of the management team. We spoke with an Admiral Nurse who was visiting the home during the inspection. (Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families and people living with dementia.) The Admiral Nurse had been recruited by the provider to support staff with the care they were providing to people with dementia.

We looked at six records relating to people's care needs and four staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, quality surveys that had been carried out by the provider, training information for staff and arrangements in place for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that their needs were thoroughly assessed so that risks were identified and acted upon as their needs changed. People's risk assessments did not consistently identify the risks associated with people's care and ensure people's continued safety. During the inspection, we viewed the records of six people, who had experienced a high number of falls; five people did not have a falls risk assessment in place and insufficient action had been taken to minimise the risk of future falls. One person had sustained a significant injury following a fall; the person did not have a specific falls risk assessment in place at the time of the fall. Although action was taken to mitigate the risk of future falls, no falls risk assessment was completed until we made the provider aware of our findings during this inspection. The provider had a protocol for the prevention and management of falls but had failed to ensure that it was followed by staff.

The assessments that were in place provided contradictory information regarding people's needs and abilities. For example, one person's mobility assessment recorded that they had capacity and were aware of the risks involved in mobilising independently. In other sections of their care documentation, it was recorded that they lacked understanding regarding risks to their health and well being. We were informed by staff that this person had limited insight regarding the risks to their safety when they tried to mobilise independently. Staff did not have access to the information they required to mitigate people's risk of falls. Appropriate support had not been provided and insufficient action had been taken to maintain people's safety.

These concerns constitute a breach of regulation 12: Safe care and treatment (1) (2) (a) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

People could not always be assured that staff were deployed effectively to meet their needs. The provider had calculated how many staff were required to meet people's needs. However, due to staff vacancies and sickness, staffing numbers did not always meet the levels required. Five people told us that this affected the amount of time they sometimes had to wait for support. One person said, "I have trouble getting someone to answer my call bell." Another person said, "I do think there seems to be a shortage of staff, with the bells ringing all the time, and no one really to sit and have a chat with us, they are very busy." A third person said, "I think they are short staffed because there is quite a long wait in the dining room to eat." This was confirmed by our observations during the inspection; people who had been served first had finished their lunch before the last people to be served had received their meal.

We observed that care staff worked hard to provide people's care, however, care staff told us they had to rush to ensure people's care needs were met. One member of staff told us "Some days there's not enough staff, we need five carers in the morning really to take the pressure off and we often don't have that many." Another member of staff said, "It's a struggle some mornings, breakfast can still be going on at 11am." During the inspection, we observed that people did have to wait for staff to tend to their requests. For example, there was a delay of forty minutes between people telling care staff they would like a cup of tea and this being served.

The lack of care staff meant that people did not have sufficient support to meet their social needs. People and staff consistently told us that, although staff prioritised meeting their physical care needs there was insufficient support available to meet people's social needs. One person said, "They don't have much time to sit and chat they are far too busy with other people that need their help more than I do." Another person said, "They don't have time to chat, but they do their best, we still get our food and our clothes washed."

The service was also short of ancillary staff to work in the kitchen and cover domestic duties. Ancillary staff told us that this affected their ability to carry out their allocated duties. One member of staff said, "There aren't enough staff, the kitchen is short of staff, so the cleaning staff have to help, then the cleaning doesn't get done." This was reflected by what people told us, one person said, "Recently I have waited for my bed to be made and my room has not been cleaned every day, I think they're short staffed." Another member of staff told us that the kitchen often ran short of staff if the kitchen assistant role could not be covered. During the inspection, we observed that staff in the kitchen were under pressure and had to rush to complete their duties.

These concerns constitute a breach of regulation 18: Staffing (1) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the management team and they made arrangements to ensure that the required staffing levels would be consistently met going forward.

The procedures in place to protect people from risks to their health and well-being by the prevention and control of infection were not consistently implemented. Although the home was visibly clean, staff shortages had affected the ability of staff to follow the environmental cleaning schedule. Cleaning schedules were not being adhered to as staff were unable to complete all the work required. This meant that some areas of the home were not cleaned as often as the provider had identified as necessary. Staff told us that they had been trained in infection control and food hygiene and understood how to work in a hygienic way. One member of staff said, "We wear aprons and gloves and wash our hands."

People could not be assured that the management of the service would take appropriate action in response to allegations of abuse. During the inspection, we were informed of incidents that had occurred between people living in the home that should have been reported to the local safeguarding authority. Staff had recognised the seriousness of these incidents and had ensured that they were reported to the management of the service however, the appropriate alerts had not been made. This was discussed with the management team and the appropriate referrals have now been made to the safeguarding authority.

People were supported by staff that knew how to recognise when people were at risk of harm and knew what action they should take to keep people safe. One person said, "Very safe, I have been here a while now, the staff are very good, very kind that makes a person feel safe." Staff were able to tell us about signs they looked out for which may suggest somebody was at risk of harm and the action they would take. One member of staff said, "I would report concerns to a senior or manager, if I had concerns about the people here, I would ring CQC or the safeguarding team."

People received their medicines, as prescribed, in line with the home's policy and procedure. We observed that staff spent time with people explaining their medicines and ensuring they had taken their medicines. One person told us "I am on medication, morning and night, it's always on time, they stay to watch me take it, and they don't go until I have." Staff followed guidelines for medicines that were only given at times when they were needed for example, Paracetamol for when people were in pain. The medicines policy covered receipt, storage, administration and disposal of medicines and people's medicines were stored securely.

Regular checks and audits of the medicines were undertaken by the deputy manager; any issues identified were rectified in a timely fashion to ensure medicine errors did not happen.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that staff working in different roles within the service worked together to ensure they were provided with consistent care and support. There had been no registered manager at the service for several months and a number of staff told us that this had had a negative impact on the consistency of the service. Care staff told us that they did not feel part of a wider team, were unsure of the standards they should be working to and unsure who they should speak to regarding concerns. For example, care staff told us they had concerns regarding two people's manual handling needs that they had not felt able to report to senior staff. We discussed these concerns with the provider who took immediate action to arrange for people's manual handling needs to be reassessed.

Domestic and catering staff told us that they did not feel part of the wider staff team and that they did not always receive the information they required to carry out their roles effectively. Catering staff described improvement initiatives that had been implemented but not continued. They had carried out work and provided information for these initiatives to the management team, but had received no feedback. For example, a working group to improve the menus had produced new menus, but these had not been implemented. We discussed these concerns with the provider who took immediate action to arrange for feedback to be provided and improvements implemented. However, sufficient, timely action had not been taken to ensure that all staff were working together to provide people with a consistent service.

Staff had access to support and supervision; however, this process had not been effective in enabling staff to raise the concerns that they raised during the inspection. Staff told us that they were concerned about the deployment of staff and amount of activity available to people, but did not have confidence that these concerns would be addressed.

Supervision meetings were used to assess staff performance and identify on-going support and training needs. However, staff did not find these effective in addressing their concerns or supporting them to carry out their roles and responsibilities.

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). However, this information was not always transferred to people's care plans to inform staff of the support they required. Records relating to people's nutritional intake also required improvement. Staff did not consistently record the food and fluid intake of people identified as at risk of malnutrition. People could not be assured that there was an accurate record available for health care professionals to reflect upon when reviewing people's nutritional needs. This had been identified by the provider prior to the inspection and addressed with staff; however, sufficient action had not been taken to ensure that the required improvements were made.

Improvements were required to ensure that people's nutritional needs were adequately supported. Due to staffing deployment, people were not always provided with their food in a timely way. We observed that some people had to wait for their lunch as staff were busy supporting others and staff were rushed during the lunch service. However, people were positive about the food provided and told us that they were

provided with plenty to eat and drink. One person said, "The food is very good, they don't stop feeding you." Another person said, "The food is good, if I don't like what is on the menu they will accommodate me with something else." We saw that people were offered a choice and that drinks and snacks were freely available for people to help themselves.

Staff referred people to their GP and a dietitian when they had been assessed as being at risk of malnutrition. Catering staff had a good knowledge of people's dietary needs and were able to describe how they met different people's dietary requirements. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. For example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed.

People's care needs were assessed to identify the support they required. Each person received an assessment of their needs before the service agreed to provide their support. The initial assessment included the person's health and medical background as well as their emotional and social support needs. The information gathered was used to produce a plan of care that was reviewed and updated as staff got to know the person.

The provider was aware of the protected characteristics under the Equality Act; their policies and guidelines reflected this. The culture of the organisation was open to providing care that met people's needs without the fear of discrimination about their age, sex, culture or religion and this was reflected in the pre assessment process.

Staff had a good knowledge and understanding of the needs of the people they were supporting. One person said, "The staff seem skilled to me, from what I have seen they seem to know what they are doing. There are quite a few people who need that extra care; they seem to handle them well." Staff received the training they required, to enable them to confidently and competently support the people living in the home. One member of staff said, "The training is good, it's mostly face to face courses. We also did the Virtual Dementia Tour; it was really helpful and had a big impact." (The Virtual Dementia Tour enables staff to experience for themselves the physical and mental challenges people with dementia face.)

People were encouraged to make decisions about their care and their day-to-day routines and preferences. One person said, "Oh yes, they will always ask your permission to do things." People who lack mental capacity to consent to arrangements for necessary care and treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA 2005). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of people's rights regarding choice, and appropriate assessments were carried out with people.

People were supported to access a wide variety of health and social care services. Staff had a good knowledge of other services available to people, including multi-disciplinary health services and mental health support. We saw information recorded in people's care plans regarding advice that had been provided by other professionals to ensure people were receiving support in the best way to meet their needs.

People had regular access to healthcare professionals and staff were vigilant to changes in people's health. One person said, "I have been in hospital a couple of times while I have been here, they are pretty quick to call a doctor out for me." We saw that input from other services and professionals was documented clearly in people's files, as well as any health and medical information.

People's diverse needs were met by the adaptation, design and decoration of premises. There was a range of communal areas available for people to spend time in and we saw that people moved freely around the home. People's rooms were comfortable and personalised and any equipment they required to meet their needs was readily available; for example equipment to support them to move.

Requires Improvement

Is the service caring?

Our findings

The system in place to allow people and their representatives to contribute to their care plans and risk assessments was not consistently implemented. We received mixed feedback regarding people's involvement in their care planning. Some people and relatives that we spoke with said that they were not aware of the information contained in their care plan and they did not know how their care needs were evaluated and reviewed. One person said, "I don't know what a care plan is, I've never seen one." Another person said, "I don't know what a care plan is, I have not been asked anything about my health or anything like that." The management team told us that people's care plans should be discussed with them and that they should be consulted about their care plan on a monthly basis. Some people confirmed that they had been consulted. One person said, "I was part of co-ordinating my care plan, all my wishes and preferences were taken into consideration." However, this had not consistently happened in practice. People did not always have the opportunity to make their wishes and views known regarding how they wanted to be supported; there was a risk that people would not receive support in the way they preferred.

Although people told us that staff shortages had affected the time they sometimes had to wait for support they described staff as very caring towards them. One person said, "Other than me telling you about them being a bit slow answering my bell, I think they are very nice people, very pleasant and respectful." Another person said, "They never sit down, they are on the go all the time, but they do know us all individually, I have always been spoken to respectfully." We observed that although staff were busy, they engaged with people in a warm and caring manner whilst they were providing their support. Staff were familiar with each person's choices and needs and people were relaxed and comfortable when interacting with staff.

Staff treated people with kindness, respect and compassion. People told us that they had positive relationships with staff, one person said, "They [staff] are very caring, they will ask me if I'm ok, knock on my door and say "You ok, [person's name], do you need anything?" It's nice to know that they are there." Another person's relative said. "The staff are always friendly, welcoming and polite."

People's choices in relation to their daily routines and activities were listened to and respected by staff. One person said, "I am not so mobile, I can walk with a frame but I need help with washing and having a bath and I can have a bath whenever I want one." Another person said, "There's no rushing you to go to bed, you could sit in the lounge watching TV all night if you wanted to." We observed interactions between staff and people and saw that people were given the time they needed to express themselves and guide staff in supporting them in the way they chose.

The privacy and dignity of each person was respected by all staff. The people we spoke with confirmed this, one person said, "They are very respectful when they wash or bath me, they talk to me, you know like; 'shall we do your back now [person's name]?' And when they bath me they say 'are you ready to come out now?' I feel comfortable with them, they never rush me." We saw that staff knocked on people's doors before entering, and that care plans outlined how people should receive care in a dignified manner. Staff we spoke with understood the importance of confidentiality and people's confidential information was stored securely.

People were supported to be as independent as they were able to be; staff encouraged people to do as much as they could by themselves. One person said, "I am as independent as I can be, like washing myself, I only need help with having a bath, the carers are very kind there's nothing I could say wrong about them."

Requires Improvement

Is the service responsive?

Our findings

Staff did their best to engage people in activities but people told us that the lack of staff affected the number of activities available and there were not enough varied things to do. People who had lived in the home for some time spoke positively of previous activities and trips out, but commented that there was less to do now and they felt bored at times. One person said, "There have been activities since I came here, I have joined in, but not many, like today it is very boring, most of them will fall asleep in a chair." Another person said, "I go out a lot with family and friends, but when I don't it can be boring." A third person commented, "It can get very boring just sat watching television."

Staff also told us that there was not enough activity provided for people. One member of care staff said, "We talk to people while we're helping them but there's not enough for people to do." Another staff member said, "We need staff to be able to do activities, nothing really goes on for people to do, we're never able to take the residents out, they're always sitting in the lounge." A third member of staff commented, "Activities are very lacking, in the last six months I've not seen people go out, we did have one trip to the garden centre planned but it was cancelled." We observed some activities taking place during the inspection. A member of staff encouraged people to take part in armchair exercises kicking a ball back and forth and people enjoyed a visit from a Pets As Therapy dog. (Pets As Therapy provides volunteers and their pets to undertake therapeutic visits to hospitals, hospices, nursing and care homes.)

The provider was aware that activity provision was lacking in the home. They had recently arranged for the re-deployment of a member of care staff to activity provision. The re-deployment of the staff member taking on their new duties had been delayed due to shortages in the care staff team. Sufficient, timely action had not been taken to ensure that people's support met their social as well as physical needs.

Arrangements in place for managing complaints required strengthening. The service had a complaints policy and procedure in place, but this was not always adhered to. We saw that responses had been provided to several complaints made in 2015 and 2016, but no recent complaints were recorded. Recent audits and conversations with staff identified that complaints had been made and investigated; the complaints log was not an accurate reflection of complaints made. None of the people we spoke with had been provided with information regarding how to complain but told us they would be happy to make a complaint if needed. One person said, "I haven't got any information on how to complain but I would feel confident enough to do so."

Staff knew people well and had an in-depth understanding of their care and support needs. People said that they were happy with how staff supported them. One person said, "I think they support me very well to keep my independence. I am happy with whoever comes to support me, they are all very nice." The Admiral Nurse recruited by the provider to work with staff and families to support people with dementia was visiting the home during the inspection. They had been advising staff on the best way to support a person who found it difficult to accept help to meet their personal care needs. They were visiting the home regularly to provide support to people, their relatives and staff and ensure that the care and support provided at the service was responsive to people's needs.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. No one currently living at the home was receiving end of life care but staff spoke knowledgeably about the support they had previously provided to people. They described liaising with palliative care services to ensure that all necessary measures were in place to make the person as comfortable as possible. When people reached the end of their life their care plan reflected this as well as the action that needed to be taken by staff to provide appropriate support.

Care plans were person centred and gave good descriptions of how people should be supported. Staff were provided with clear information regarding how they should respond to people in particular situations. For example, where people required support with personal care, their care plans provided staff with clear guidance on how to do this. Where people required support with their emotional needs and behaviour, staff were provided with detailed information about how best to communicate and support them.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given . People's needs were considered as part of their pre assessment and the provider offered people the opportunity to receive information in alternative formats such as large print.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager for seven months. 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. A manager had been recruited by the provider, and had begun work at the service, however had not remained in post. A second manager had been recruited and commenced at the service on the 1 February 2018. They were aware of the need to apply to the Care Quality Commission to register as the manager.

The lack of consistent management since July 2017 had affected the quality and safety of the service experienced by people living in the home. The provider had deployed interim managers; however, this had not resulted in sufficient leadership or oversight of the quality of care being provided to people. There was a lack of clarity regarding the management and leadership of the home. People, their relatives and staff told us that they were unsure who was in charge of the service and whom they should talk to about the service people were receiving. One person's relative said, "There has been a lot of chopping and changing, I have never been introduced to any of the stand ins who have worked here." Staff did not feel engaged in the running of the service and told us that the lack of manager and frequent managerial changes had affected the consistency of the service provided to people.

There was insufficient monitoring of the quality and safety of the service. A system of audits was in place; however, these audits had not been carried out as often as the provider had determined necessary. For example, infection control was scheduled to be audited monthly but had not been audited since September 2017. The lack of auditing meant that the inability of staff to follow the environmental cleaning schedule was not identified. Audits that had been carried out were not effective at identifying or addressing shortfalls. Audits of people's care documentation had been completed; but they had not resulted in the improvements required to people's nutritional records.

The governance systems in place had not resulted in an adequate level of provider oversight of the service. It had also not been identified that safeguarding referrals had not been made to the local authority as required.

There was a lack of oversight of the quality of people's risk assessments and risk management plans. Assessments were not completed and did not provide staff with the information they needed to mitigate people's known risks. For example, where people had a history of falls, staff had not followed the provider's falls protocol by carrying out a specific falls risk assessment. People were at risk of not receiving safe care, as there was no effective system in place to monitor people's falls to ensure that risk assessments were in place, accurate and met people's needs.

Quality assurance processes were not consistently effective at ensuring the actions required to implement improvements were taken in a timely way. The provider had identified that staffing deployment was not always meeting people's needs. There had not been a timely response by the provider to ensure that a

consistent staff team was deployed to provide people's support. This had affected people's experiences of care and access to social stimulation and activity.

The management team were aware that people and their relatives were not consistently involved in discussions and reviews of their care needs. Insufficient action had been taken to ensure that people were informed of the opportunity to discuss how their care would be provided.

These concerns constitute a breach of Regulation 17: Good governance (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection the provider recognised that they had not taken sufficient, timely action to mitigate the impact of the lack of consistent management at the home. They recognised that the level of provider oversight and quality assurance systems in place had not been effective and had not identified the concerns found during this inspection. An action plan was implemented to embed a strong system of quality assurance and auditing that would be regularly reviewed to ensure that it was effective at identifying and resolving where improvements were needed. The provider was committed to supporting the new manager to make the improvements required and had begun the process of rectifying the concerns identified during the inspection.

The provider had a process in place to gather feedback from people, their relatives and staff through surveys and meetings. One person told us that they had attended the meetings and that they were an effective forum for people to engage in the running of the service. For example, one person had requested a meal to be added to the planned menus and this was served the following day. We saw minutes of previous residents and relatives meetings; where discussions had taken place about staffing, catering and activities. Feedback from residents and relatives was positive about these meetings although they said the meetings had not been held for some time. The most recent meeting minutes that were available were dated May 2017.

The provider had recently carried out a survey of people and their relatives to gain their views of the service they received. The responses to this had been collated and the provider was producing an action plan to address the areas where people had indicated improvements were required.

During staff meetings, staff had the opportunity to contribute to the running of the service. We saw meeting minutes, which recorded discussions about documentation, staff duties and training. The provider had recently introduced a daily meeting attended by key staff to discuss what was happening in the home that day. We observed this meeting taking place during the inspection and staff had the opportunity to discuss the plans for the day and raise any concerns with the management team.

Policies and procedures were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies such as mental capacity and whistleblowing.

The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

At the time of the inspection, it appeared that we had not received statutory notifications of deaths or other incidents that had occurred in the home. These are notifications that are required to be submitted by the provider to CQC by law and we are currently looking into this matter.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's risk assessments did not consistently identify the risks associated with people's care and ensure people's continued safety. 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided to people. There was a lack of effective leadership and management in the home. 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of staff were deployed effectively to meet people's needs. 18 (1)