Harbour Healthcare Ltd

Treetops Court Care Home

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

The inspection took place on 27 and 28 July 2017 and was unannounced. Treetops Court Care Home is a residential and nursing home for up to 70 people who have a variety of support needs, such as a physical disability, dementia and mental health needs. There were 54 people living there at the time of the inspection, although one of those people was in hospital on the days of our visit.

There was a 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. However, after our inspection the manager left so there was no longer a registered manager at the service.

At this inspection we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People were not always protected from harm because we found incidents of alleged abuse had not always been reported to the local safeguarding authority.

Training was not always effective as safeguarding incidents had not been recognised, and we observed some examples of poor moving and handling. Records confirmed training was not up to date for all staff, and staff were not always recruited safely

Systems were in place to monitor the quality of the service; however these were not always effective. Although there were regular checks carried out by the registered manager, it was not always clear what documentation had been viewed. Incidents had not been identified, such as safeguarding incidents between people who lived at the service.

Staff were not always deployed effectively, people and relatives told us they sometimes had to wait for support and we saw that communal areas were sometimes left unattended.

Plans were not always in place to support people during periods of agitation. Staff did not always have guidance to follow in relation to people's choking risks.

We observed some poor examples of moving and handling and clear guidance was not always available for staff. The administration of medicines was inconsistent, with some being given correctly and some not in line with guidance.

Not all of the principles of the Mental Capacity Act 2005 were being followed. Best Interest Decisions were not person specific. However, mental capacity assessments were being carried out and Deprivations of

Liberty Safeguarding applications were made.

There was sometimes a delay in seeking support from other health professionals for some people to maintain their health and wellbeing. However some people were receiving timely support.

Care plans sometimes lacked detail and there was not always life history information available.

There was mixed feedback about the activities available for people to partake in, with some people thinking there was not enough to do whereas other's enjoyed what was on offer.

The service could not always be caring as staff were not always deployed effectively. However, staff were kind and people's privacy and dignity was respected and we saw staff offering people choices.

People told us they felt able to complain and we saw that complaints were responded to appropriately.

People were offered a choice of meals and told us they liked the food.

People told us they felt the registered manager was proactive and supportive, however the registered manager is no longer working at the home. The provider has told us a new manager would be starting. Staff told us they had supervisions and felt supported in their role. Notifications had been submitted about incidents which the registered manager had been aware of, which is a requirement.

Building checks were undertaken to ensure the environment was safe.

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.

Incidents of potential abuse were not always reported to the local safeguarding authority.

Safe recruitment practices were not always followed to ensure appropriate staff were working with vulnerable people.

Staff were not always deployed effectively to meet peoples' needs.

Peoples' medicines were not always safely managed and people did not always have their medicine as prescribed.

Risks were not effectively managed as plans were not always in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been trained sufficiently to support people effectively.

Not all of the principles of the Mental Capacity Act 2005 were being followed.

People had their food and drink preferences catered for.

People had access to other health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The poor deployment of staff and delays in receiving support meant the home could not always be caring.

Staff supported people in a kind manner.

People were offered choices and encouraged to retain their independence.

Privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their needs assessed and reviewed however changes were not always identified and there was not always guidance for staff to follow.

There was mixed feedback about the activities available for people to partake in.

The service had a complaints policy, and people felt able to complain.

Is the service well-led?

Requires Improvement

The service was consistently not well-led.

Quality monitoring systems were in place to ensure the home was being managed appropriately. However they did not always identify incidents or issues.

A registered manager was in post who knew the people well. However they left following the inspection.

People and relatives knew who the manager was and staff felt supported by the manager.

Treetops Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

This inspection took place on 27 and 28 July 2017 and was unannounced. The inspection was carried out by three inspectors 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.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with five people who use the service and nine relatives. We also spoke with four members of staff that supported people, the activities coordinator, one of the kitchen staff as well as the registered manager and provider. We also spoke with one visiting professional. We made observations in communal areas. We reviewed the care plans for eight people and the Medication Administration Records (MARs). We looked at management records such as; quality audits, complaints, recruitment files and training records for six members of staff.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we identified a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as safeguarding incidents were not always reported. At this inspection we found there was a continued breach as safeguarding incidents were still not always reported.

People were not always protected from incidents of abuse as they had not always been reported to the registered manager by staff. As alleged incidents had not been reported or identified we could not be sure that appropriate action was taken to keep people safe from future incidents. We looked at records that showed incidents of alleged abuse between two residents had been documented which resulted in injuries, but these had not been reported to the local safeguarding authority. Someone had unexplained bruising which had also not been reported. All safeguarding incidents must be reported to the local safeguarding authority to investigate. Staff we spoke with were able to identify abuse and they knew how to report it. However, due to some incidents not being reported it suggested their training had not been sufficient or that some staff were not aware of the process of reporting concerns. This meant people were not protected from the risk of abuse reoccurring because it had not been reported to the local safeguarding authority and staff had not always recognised abuse. Accidents and incidents were analysed on a monthly basis. However, one professional we spoke with said, "I think the home need to improve the incident and falls analysis." Some incidents were not being identified and therefore were not included in the analysis, this meant trends were not always being identified to determine if any preventative action could be taken to keep people safe. This meant people were not always protected as action to reduce the risk and likelihood of an incident occurring again had not always been taken.

This issue demonstrated a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always followed safe recruitment practices. Records showed that checks had been made with the Disclosure and Barring Service (DBS) – a criminal records check - to make sure people were suitable to work with vulnerable adults. However, if a member of staff had a conviction on their DBS, appropriate risk assessments and plans had not been put in place to ensure people were protected. When we asked the provider about this, they told us they were unaware of any staff members with conviction(s) as there is a process to follow in which each application is considered by a management team to decide whether each member of staff would be suitable to work in the home. On this occasion this information had not been supplied to the provider. We saw in another member of staff's file that there were no references from their previous employers. Therefore the registered manager had not checked that the person was suitable for working with the people who lived in the home. The service was also using agency members of staff and the registered manager was not verifying the agency staff members' suitability to work at the home. There was a risk that people may have contact with staff who may not have the correct level of training, whether DBS checks were clear and if they were entitled to work in the UK as this evidence had not been verified by the registered manager. This meant we could not be sure that people were supported by staff who were suitable to work with people who used the service

This issue demonstrated a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always deployed effectively. People and relatives told us they had to wait for support and we saw occasions when communal areas were left unattended. One person told us, "I know they are busy so I don't ask them [the staff]." Another person commented that staffing was, "sparse at times." One person asked us for help as there were no staff in the lounge. They said, "I've been waiting ages and ages." They told us they had been there since lunch time and it was now 2.30pm. A relative was also present and we asked them if any staff had been in the lounge, they told us, "They come and they go." We had to go and get a member of staff to support the person into a more comfortable position. Another relative we spoke with said, "I wish there were more staff, you can never find them. The weekends are a nightmare." Another relative told us, "The staff are nice but they are short-staffed." In another lounge area, an incident occurred between two people when they both became agitated. One person was shouting 'help me'. No staff were present in the communal area. We stayed with the people and a visiting relative had to go and look for a member of staff. A member of staff we spoke with said, "It depends, sometimes its ok and sometimes we struggle. Yesterday a member of staff had to go and cover a different unit." They went on to say, "It can be difficult if people are not having a good day." Another member of staff said, "The staff struggle, people want things doing." This meant people were not always supported effectively as staff were not always deployed where required.

Some people needed to be repositioned periodically to help prevent them from developing any skin damage. Two people's records showed they were not being supported to be repositioned at the times they were supposed to be. The guidance in one person's plan stated they should be repositioned every two hours, however the person developed an area of pressure soreness and the guidance was changed to three hourly repositioning. Due to the person developing a pressure sore, the amount of time between repositions would not usually increase. This meant there was inconsistent information available for staff and people were at risk of developing pressure sores and becoming unwell.

There was not always guidance to follow in relation to people's needs. For example, one person was witnessed throughout the day to sometimes cough whilst eating and drinking. When we looked at their care plans, it was recorded that there had been a choking incident recently whereby staff had to intervene and administer back slaps. The person's plan had not been updated following this to guide staff how to reduce the likelihood of this occurring again or what to do should it happen again. Another person was also at risk of choking and their plan did not detail how to reduce the chance of the person choking. We asked the permanent staff about this and they knew the person was at risk of choking; however there was a risk that new or agency staff, which were being used in the home, would not be aware of the risk. This meant some risks were not be adequately assessed and planned for so people's health and wellbeing were not always been protected.

We saw some poor examples of staff supporting people to move within the home. For example we saw a person being supported to move in a hoist; however the sling being used was supposed to be used for taking people to the toilet. The person was not being supported to go to the toilet and their care plan did not specify that they required a toileting sling due to their needs. We also saw that some people's moving and handling plans were not being followed or they did not contain sufficient detail. For example, one person was noted as needing a large sling, however we saw them being hoisted in a medium sling. Another person was wearing a special belt to help staff support the person; however their moving and handling assessments made no mention of this equipment. This meant there was not clear guidance for staff to follow and people could receive inconsistent care as there were agency staff working and new staff may also start who may not know people's needs.

Occasionally people became upset, anxious or emotional. There were not always detailed risk assessments in place for people who needed support when they became anxious. This meant people could cause injuries to themselves and injuries to staff if they are not supported to manage their behaviour effectively. This meant people were not cared for in a way that matched their needs and was personal to them.

Another person was noted as becoming anxious when they were being hoisted or supported with their personal care. Their care plans did not reflect that the person could become agitated at these times, and there was no guidance for staff to follow to enable them to support the person effectively. The person had also been prescribed a medicine which can help them feel calmer. This medicine should be given as and when required, also known as 'PRN' medicine. There was a PRN protocol in place for this medicine for this person however; it did not give guidance on how staff could decide when it was required, other than the prescription. We saw that a review of the person's anxiety plan had mentioned that the person was 'occasionally' given the PRN medicine. However, the medicine records showed it was being given most days prior to this review and this had continued following the review – but no further analysis had taken place. One some occasions it had not been possible to determine why the medicine had been given as the records stated the person was not in an agitated state but the PRN medicine was administered. This meant the person was not always being supported appropriately and there was insufficient guidance for staff to follow.

We saw records for one person which stated they required cream to be applied twice a day as required. However, the records showed this was only being applied once a day and it was not clear if it was being offered to the person a second time during the day. This topical medicine was applied to help alleviate pain, therefore the person may have continued to experience pain if they did not have it applied as prescribed. We saw one medicine that should be refrigerated after it was opened and it was not being kept cool. Other medicines we checked had the correct amount in stock and staff were signing to confirm it had been administered. This meant the administration of medicines was inconsistent, with some being given correctly and some not in line with guidance.

When we asked people and relatives if they felt safe living in the home, the responses we got were, "Very much" and "Yes". A relative we spoke with said, "The staff check my relative at night and there are secure doors."

People were kept safe as the premises were checked and plans were in place to ensure people could be evacuated in the event of an emergency. Building checks were also undertaken to ensure the environment was safe.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we identified a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not have effective training. At this inspection we found there was a continued breach as safeguarding incidents were still not being identified and some staff did not have current training.

We had mixed feedback regarding the training. When we asked one person if they thought staff knew what they were doing they told us, "Some do, some don't." We were told that most training was online. One member of staff said, "I hate online training, you get much more from face to face training." Another member of staff said, "The training is online, not face to face. Even the moving and handling is online." We saw records that some staff had received training, but there were some gaps where staff were not recorded as having received training. We observed some poor examples of moving and handling which showed that training had not been effective for all staff. Some staff had not received training regarding end of life care. However a number of people who used the service were nearing the end of their life and were being supported by staff without this training. This meant there was a risk that some people may not receive appropriate care and support at the end of their life as some staff were not trained. Some staff had also not received dementia training however many people within the home were living with dementia. Staff we spoke with were able to tell us about the different types of abuse. They all told us they would report concerns to their manager if they suspected someone was being abused. However, there had been safeguarding incidents which had been documented by the staff but they had not been reported to either the registered manager or the local safeguarding authority. This meant that staff training had not always been effective in supporting them to identify safeguarding incidents. The training matrix showed that some staff had not received training in relation to safeguarding. This meant people were cared for by staff who did not always feel they were effective and incidents were not always being reported.

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

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. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

If someone lacked capacity to make a specific decision, any decision should be made in their best interest. We saw that some of the best interest decisions recorded in people's files were photocopied and not individual to each particular person and there was not always evidence that other relatives or professionals had been involved in the decisions. Each best interest decision should be personal. Another person had a best interest decision recorded however; the person had been assessed as having capacity. If people have capacity, the staff or others should not be making decisions for them. When we asked the registered

manager about this told us the best interest decision paperwork should not have been in the person's file any longer and it was an error. This meant staff did not always have clear guidance about whether someone had decisions made for them and decisions were not always personal to each individual.

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. The registered manager had identified a number of people who they believed were being deprived of their liberty and had made appropriate DoLS applications to the supervisory body. This meant people were protected under the principles of the MCA and were not being illegally deprived of their liberty.

People had access to health and social care professionals; however we saw that this was not always in a timely manner. One person told us, "Sometimes I have a bad stomach and they look after me." Another person told us they were visiting the dentist again soon. A relative we spoke with told us, "I ask the staff about my relative's health all the time. They take action if anything changes. The nurse visited recently and the doctor has been." They went on to say, "My relative was very poorly, the GP came and everything was done as it should." However, we saw that one person had been coughing whilst they were eating and drinking and their records showed they had not been seen by a Speech and Language Therapist (SaLT) for nearly two years. Another person's records showed they had not had input from a Community Psychiatric Nurse (CPN) for several months despite continuing to experience periods of anxiety and the frequent use of medicine to help keep them calm. Other people's records showed that some people had accessed GPs, opticians and a chiropodist. A relative told us and we saw recorded that a specialist nurse visited a person with a particular condition. This meant some people were able to access health services where necessary, however this was not always in a timely manner for others.

Staff told us they had supervisions. One member of staff told us, "We have one to ones to discuss how we can improve." Another member of staff said, "We have supervisions quarterly to check we're ok, if there are any problems and if we're doing anything wrong to let us know." We saw that the registered manager had a record of when supervisions were next due. This meant staff could discuss subjects they needed to in order to continue to support people effectively.

People told us they liked the food and we saw they were offered choices about what they had to eat and drink. One person said, "The food is good." A relative we spoke with said, "My relative gets a choice of food; they're on a special diet." Another relative we spoke with said, "The food is great. They go out of their way with food. My relative can't have certain food and they cater for it." Another relative told us, "My relative got a choice of food. There were occasions my relative wouldn't want something and they'd get them something else." A member of staff we spoke with told us, "I give people choices I show people the food." We saw a member of staff encouraging a person to try their food and offering them an alternative if they did not like it. We also saw one person ask for an item of food that was not on the menu and staff catered for the request. We asked a member of kitchen staff what a person's dietary needs were and they were able to confirm the advice given by professionals. This meant people we supported to have food of their choice and guidance about dietary requirements was being followed.

Requires Improvement

Is the service caring?

Our findings

The support people received could not always be caring as staff were not consistently available to assist people in a timely manner. The registered manager also did not always verify the suitability of staff to work with people who used the service. People were sometimes left uncomfortable and had to wait for assistance from staff, people were not always helped to move safely and staff were not always present to prevent incidents from occurring. Action to keep people safe and input from other health professionals to maintain people's health and wellbeing was also not always sought in a timely manner.

Despite this, people and relatives told us they were happy with the carers they were supported by. . One relative we spoke with said, "The staff are nice. They talk to our relative well." People's dignity was respected by staff and people were encouraged to be independent. One person told us, "I wash myself and then wait for the carers to dress me." A relative said, "The staff gave my relative confidence to have a shower." When we asked one person if they felt treated with respect they replied, "Oh yes!" One relative we spoke with said, "My relative was treated how I would want someone to be treated." We observed staff making positive comments to people. For example we heard one member of staff say, "You look lovely today, such a lovely smile" and another staff member said to a person, "Your perfume smells lovely." The kitchen staff also walked around and chatted with people. We also observed staff dancing with a person in a communal area and it clearly made the person very happy. This meant people were supported by caring staff.

All residents felt that they were asked and explained to before something happened and felt that their privacy was maintained. One person we spoke with said, "They talk to me and I talk to them." We saw staff offering choices to people, such as whether they wanted to wear an apron during meals, what they would like to eat and drink and where they would like to sit. For example we heard one member of staff say, "Would you like to wear this [apron] to protect your nice jumper?" We also observed them offer an apron to another person who did not want to wear one and their choice was respected. A member of kitchen staff entered the dining room and checked with a person first prior to opening a window in the warm room. A nurse was giving medicines to a person who was asking lots of questions. The nurse explained about the medicines and showed the medicines to the person first. When people were being supported to move, such as in a hoist, we saw staff checking people were willing for staff to support them and also explaining each stage of the moving. For example, we heard one member of staff say to a person, "I'm just going to take the sling off you now, is that ok?" This support was not rushed and it meant that people had explanations when they needed them and were supported to make decisions about their care and treatment.

The home was spacious and allowed people to spend time on their own if they wished. There were communal areas, individual bedrooms as well as spaces in the corridors for people to sit should they wish to. People also told us they felt the home was clean. One relative said it is, "Always nice and clean." Another relative said, "The cleanliness of the place is good." This meant people could choose where they spent their time in a clean environment.

Requires Improvement

Is the service responsive?

Our findings

Care plans lacked detail and there was not always clear guidance for staff to follow. One visiting professional we spoke with said, "The home need to improve their care plans." There was not always evidence of people being involved in the developing of their care plans and risk assessments. No one we spoke with told us they were involved but people knew they had a care plan. One relative said, "The management are not proactive in coming to talk to relatives." One relative we spoke with told us their loved one had had a change to their diet recently but they did not understand why and it had not been explained to them. The reviews of plans were also not always effective, for example one person had their medicine usage reviewed and it was noted as 'occasionally' needing their medicine, but the person had received it regularly and the plan had not been updated to reflect this. Other relatives said, "The staff understood my relative's needs" and went on to say, "They knew my relative's quirks." This meant some people were supported to have care that met their needs, but this was not consistent for everyone as there was a risk that they may not have the care they require as information was not always readily available.

There was an activity coordinator that we spoke with, however we did not observe any organised activities on the day of our inspection. There was mixed feedback about the opportunities people had to partake in meaningful activity. One person commented, "They don't take us out. They take us into the conservatory" and they went on to say they felt, "parked in the lounge." We overheard another person say, "All we do is watch adverts and wait for dinner." In the lounge area downstairs we saw people sitting in communal area sitting in front of the television and staff were not engaging with people. Another person told us, "Sometimes they [the staff] forget I am a different age to some other people." Another person said, "I didn't get asked to go out on the trip." We were told by the registered manager that there was a mini bus available that was shared between the home and other homes owned by the same provider which was used the previous day and would be used the day after our inspection. This minibus was available periodically throughout the year. We saw there was a plan in place from the activities coordinator. One person told us, "We played darts on the lawn" and told us they enjoyed it. A relative told us, "The activity person is very good, they put on bingo and darts. It was lovely, people were laughing and reminiscing" however they went on to say, "They have worked very hard against all the odds – sometimes they are asked to do care instead of activities." This meant activities were available for people to partake in however; some felt there could be more available.

People told us they felt able to complain and speak to staff about queries and knew how to. One relative told us, "I do complain. I complain to the staff and it is generally sorted." Another relative we spoke with said, "I'm a person that doesn't mind complaining. I can speak to staff on the floor and tell the manager – they always dealt with it and I am satisfied." Another relative said, "I'd go to the manager to complaint. I'd be confident that I would get a response." We saw that complaints had been documented, investigated and responded to as per the policy. This meant people could feedback about the service and it would be acted upon.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we identified a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as safeguarding incidents were not always identified and medicine audits were unclear. At this inspection we found there was a continued breach as audits were still not effective in identifying concerns and audits were not always clear.

The service had quality assurance systems in place however these had not always been effective in identifying issues or action had not always been taken by the registered manager to address issues. The provider carried out an audit which identified that some actions needed to be taken. For example; the moving and handling plans needed to indicate the size of the sling if people required hoisting and people's life histories needed to be recorded. The provider had done another audit following this and some of the same issues had not been addressed. During our inspection we saw that some of these had still not been addressed. One action had been to ensure that the necessary people had best interest decisions recorded, which should be individual to each person. However, best interest decisions had been photocopied with the person's name added at the top and they were not individual to that person. That meant timely and appropriate action was not always being taken to resolve concerns identified.

Care plan audits carried out by the registered manager did not go into detail and issues we had identified had not been noticed by the registered manager. No actions had been noted however we found that some care plan documents were not always fit for purpose. For example, people who were at risk of choking did not have clear risk assessments and people with behaviour that challenges did not always have plans in place for staff to follow. There was no evidence of audits of daily records, therefore safeguarding incidents had not been recognised and concerns had not been reported. We also viewed the medicines audits. We identified during the previous inspection that there were concerns with medicines and the auditing of medicines. We found during this inspection that audits were still not clear. The audits were only ticked, there was no detail as to what was looked at to determine it was correct and all audits viewed were identical. We saw that when a medicine error had been identified no action was recorded as to what action was taken to protect the person at the time and how it would be prevented in future. There was no evidence that charts monitoring the amount of fluid people were drinking were being checked to ensure they were drinking enough. This meant there was a risk people may not have been consuming enough fluid but this may not be identified and acted upon.

This issue demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a service improvement plan in place which was updated by the registered manager and monitored by the provider. However, there were still outstanding concerns and it did not identify the concerns we fed back following our inspection. This meant the service was monitoring its performance however further work was required.

The registered manager knew the people who lived in the home as they were able to answer our questions

and tell us about people living in the home. People told us they knew who the registered manager was. One relative we spoke with said, "The manager is absolutely wonderful. They are proactive, listens, is sympathetic and deals with personal quirks." Another relative told us, They know what they need to do, they're proactive." A visiting professional said, "The manager has been extremely open and willing to engage with us." Staff told us they felt supported and had and we saw evidence that staff meetings were held. A member of staff told us, I love the manager, they work very hard." Another staff member said, "The manager is nice, I could go to them." Another member of staff told us, The manager is fine, I get on with them."

The registered manager had notified CQC about significant events that they were aware that they are required to notify us of by law. We used this information to monitor the service and ensured they responded appropriately to keep people safe.

At the time of our inspection there was a registered manager in post. However since our visit, the manager is now no longer in post. The provider told us steps had been taken to manage the home until another manager was recruited.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not been recognised by staff or identified through audits therefore some incidents were not reported to the local safeguarding authority.

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 were in place to monitor the quality of the service; however these were not always effective. Although there were regular checks carried out by the registered manager, it was not always clear what documentation had been viewed. Incidents had not been identified, such as safeguarding incidents between people who lived at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Risk assessments and plans had not always been put in place to ensure people were protected if staff had a criminal conviction.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Training was not always effective as safeguarding incidents had not been

recognised and we observed some examples of poor moving and handling. Records confirmed training was not up to date for all staff.