Eleanor Palmer Trust

Eleanor Palmer Trust Home

Inspection report

27 Cantelowes House
Spring Close
Barnet
Hertfordshire
EN5 2UR

Tel: 02083648003
Website: www.eleanorpalmertrust.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 November and 13 December 2016. Breaches of legal requirements were found. We rated the service as Inadequate, placed it in 'Special Measures,' and served three enforcement warning notices on the provider because of the potential impact on people using the service. These were in respect of safe care and treatment, meeting nutritional and hydration needs, and good governance. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection of 7 March 2017 to check that the provider had followed their plan and to confirm that they now met the legal requirements relating to the warning notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eleanor Palmer Trust Home on our website at www.cqc.org.uk .

Eleanor Palmer Trust Home, also known as 'Cantelowes House,' is a care home that is registered to provide accommodation and personal care for up to 33 people and specialises in dementia care. The home is run by The Eleanor Palmer Trust, a voluntary organisation. There were 22 people using the service at the time of this inspection. This was because, following our last inspection, the provider had made a decision to temporarily stop admissions into the service until care delivery concerns were addressed.

There had been no registered manager in post since May 2016. 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 manager at our last inspection, who had been in post from April 2016, left the service at the start of February 2017. A new manager had been appointed shortly afterwards and was in post for a month at the time of this inspection.

At this inspection, we found that the provider had followed their plan to address our previous concerns relating to meeting nutritional and hydration needs. However, they remained in breach of legal requirements relating to safe care and treatment, and to good governance, despite some evidence of addressing matters relating to our Warning Notices. We also found an additional breach of legal requirements relating to staffing levels.

Individual risk assessments were not kept consistently up-to-date so as to help keep people safe. This included for one person who was being hoisted, where their moving and handling risk assessment stated they were independent. Despite two recent falls, their falls risk assessment had not been reviewed and updated.

Another person had recently left the premises unsupervised, contrary to their care plan. However, this incident had not been reviewed, to minimise the risk of reoccurrence.

One person was sometimes aggressive to staff. However, there was no care plan in place about this, to help keep them and staff safe. Incidents were not consistently recorded and were not kept under review.

One person experienced pain whilst being hoisted. There was no care plan to manage this, or guidance for their as-needed pain management medicine. There were no guidelines in place for anyone's as-needed medicines.

One person had a care plan in place to help manage their risk of falling, as they experienced frequent falls. However, their care records and our observations did not show that the plan was being followed.

There were not enough staff deployed to work at the service, as staffing levels had been cut without checking that people's needs could still be safely met. Consequently, at lunch we saw some people waiting in the dining room for over half an hour to receive their first course, and dependent people did not consistently get the staff support they needed.

The lounge was very warm during the inspection. It was one degree Celsius higher than the advised maximum temperature in the Public Health Document "Heatwave plan for England – advice for care home manager and staff." We noted many people slept there, and there was insufficient support and stimulation for people with greater dependency needs.

Records of the care provided to people were still not consistently accurate and complete. Food and fluid charts for four people were not accurately filled in, and on the day of our visit, three had been filled in in advance of the food and drink being provided. Inaccurate and incomplete records undermined appropriate care practices and meant information could not always be easily accessed when needed.

However, some improvements had been made. People were now receiving their day-to-day medicines as prescribed. The needs of some people at high risk of malnutrition and dehydration were being better met. We generally found that healthcare professional advice was now being acted on, to support the health and welfare of the involved people the advice related to. There was better morale and team work evident at this inspection.

Most people using the service that we spoke with, and all relatives, said they would recommend the service. One relative explained this was "because the staff are so lovely and kind."

Nonetheless, the breaches identified in this report indicate ongoing ineffective governance of the service. There were insufficient improvements to the health, safety and welfare of people using the service despite us serving three Warning Notices on the provider soon after our last inspection. The provider remained in breach of two regulations relating to those Warning Notices, in respect of regulation 12 (safe care and treatment) and regulation 17 (good governance). There was also a further breach of regulation 18 in relation to staffing levels. The service remains in 'Special Measures.'

You can see what action we told the provider to take at the back of the full version of the report. However, full information about our regulatory response to the concerns found during this inspection will be added to this report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service remained unsafe. Overall, individual risk assessments were not kept consistently up-to-date so as to help keep people safe. Some people did not have care plans relating to specific support needs so as to help keep them safe.

There were not enough staff deployed to work at the service, as staffing levels had been cut without checking that people's needs could still be safely met. There was therefore not enough staff to support people to have their lunch in a timely manner during our visit.

The lounge was very warm during the inspection, and exceeded the maximum temperature of official guidance. We noted many people slept there, and there was insufficient support and stimulation for people with greater dependency needs.

There was no documented guidance on when to offer people their as-needed medicines, and so these were not always given when needed. However, people were now receiving their day-to-day medicines as prescribed.

Is the service effective?

Inadequate

The service was still not effective. Records of the care provided to people were still not consistently accurate and complete, particularly people's care delivery records and where needed, food and fluid charts. This undermined appropriate care practices and meant information could not always be easily accessed when needed. We also noted some ways in which the lunchtime meal experience could have been improved on.

However, some action had been taken to improve the effectiveness of the service. The needs of some people at high risk of malnutrition and dehydration were being better met. We generally found that healthcare professional advice was now being acted on, to support the health and welfare of those the advice related to.

Is the service well-led?

Inadequate

The service was still not well-led. There remained ineffective

governance systems in place as there were insufficient improvements to the health, safety and welfare of people using the service despite us serving three Warning Notices on the provider soon after our last inspection.

We identified safety risks that the management team and the provider had not recognised or addressed, particularly in relation to incidents relating to individuals using the service.

There had been no registered manager at the service since May 2016. However, a new manager had been in post for a month at the time of this inspection, and had started the process of applying to register.

There was better morale and team work evident at this inspection.

Eleanor Palmer Trust Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Eleanor Palmer Trust Home on 7 March 2017. This inspection was done to check that improvements had been made to meet the legal requirements of three Warning Notices that we served on the provider following our last inspection of 29 November and 13 December 2016.

Before the inspection, we checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider.

The inspection was carried out by one inspector, a pharmacist specialist, and an Expert by Experience who is a person who has personal experience of using or caring for someone who uses this type of care service. The team inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led? This is because the service was not meeting some legal requirements in those areas.

There were 22 people using the service at the time of our inspection. During the inspection, we spoke with seven people, two people's relatives, three care staff, two other staff members working in the service, and the manager. We also received feedback from three health and social care professionals during the course of the inspection.

During our visit, we looked at selected areas of the premises including some people's rooms and we observed care delivery in communal areas. We looked at care records of six people using the service, 16 people's medicines records, and some management records such quality auditing tools and staff meeting minutes.

Inadequate

Is the service safe?

Our findings

At our last inspection, our findings included that people were not always receiving their medicines as prescribed at both of our visits, despite us raising concerns about this at our first visit of that two-day inspection. Where people were experiencing falls, there were not often documented reviews of their falls risk assessments and adjustments to their care plans, so as to minimise the risk of reoccurrence. We found instances where further falls then occurred. Overall, individual risk assessments were not kept consistently up-to-date, or put in place promptly for new people, so as to help keep them safe. This meant the provider was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served warning notices on the provider for these regulatory breaches because of the potential impact on people using the service.

At this inspection, we found that the provider had addressed some of the above concerns relating to safety, but others remained and we identified some new safety concerns.

The service still did not have consistent systems for keeping people's individual risk assessments and care plans up-to-date in support of providing them with safe care. One person had an updated care plan relating to their risk of absconding, following further cases of absconding since our last inspection. However, there was no risk assessment in their file about them absconding, by which to demonstrate that all risks relating to the person's health and safety were being mitigated. The person's care delivery records subsequently identified a further case of them absconding, nine days before our visit. Whilst they came to no harm, their care plan had not been updated. The manager told us he had not been made aware of the incident, and so had not been able to review it to ensure further risks arising from the incident were being addressed. This all demonstrates ongoing failure to provide the person with safe care.

Another person needed a lot of support from staff. We saw two staff hoisting them from a chair to a wheelchair, and a staff member told us this was standard support for them. However, their moving and handling risk assessment within their care file was undated and stated that the person was independent and so the risk assessment did not need to be completed further. Risks relating to supporting this person to move and to be hoisted had not therefore been assessed, mitigated and documented. This was particularly important as one staff member told us the person could be physically aggressive when being hoisted. There was a similarly blank risk assessment relating to supporting this person to use a wheelchair, despite them being brought to the dining room in one for lunch. The mobility care of this person was not therefore being provided safely.

The same person had two accident records within the previous month of being found on the floor in their room. One case noted a skin graze, the other that paramedics were called due to the person vomiting. However, their undated falls risk assessment could not have been updated, as it stated that the person had had no falls in the last year. Their mobility care plan was last reviewed on 30 December 2016, and so had not been updated to take the accident records into account. It included a record that the person was to be referred to the community falls service, but with no update. When we spoke with the falls service following the inspection visit, they could not confirm that a referral had been made for this person. The provider was

not mitigating risks to the person's health and safety from falls.

This person was having their food and drink intake monitored, as there was recognised risk relating to low intake and some historic weight loss. We saw that the person could eat independently at lunch, but that staff needed to prompt and monitor them. One staff member told us the person threw their food away a few weeks ago. Their care records occasionally referred to them eating little. However, there was no care plan in place for this person about what support they needed to eat and drink, which did not support them with safe care.

This person was seen at lunch to respond aggressively to staff at one point. Staff feedback and care delivery records identified that the person could react aggressively to staff. However, there was no care plan in the person's file about aggression, to explain how to support them in a manner that aimed to keep the person and staff safe. This did not help to ensure the person received safe care.

Another person was seen to be hoisted during our visited. Before using the hoist, staff put a sling around the person. The person told staff that the sling was "too blasted tight," but staff responded that they had a big jumper on. Staff attempted to hoist the person but the person said, "Take it off it's hurting my leg" and "You are pressing on my bad leg." The person had a heavily bandaged right leg and the standing hoist pressed against the lower part of her leg. Staff did offer for the person to have their lunch in the lounge instead and so avoid being hoisted. However, the person declined, and staff did not then do anything further to try to prevent the pain during the hoisting manoeuvre.

We checked the person's care plan and found no pain management guidelines, despite the person having prescribed medicines for dealing with pain when needed. We found a record of the person being prescribed the medicine within their records of healthcare professional visits, however, guidance from this on pain management had not been transferred to their care plan. Their medicines care plan simply stated that the medicine was as-needed, without clarifying when and why it would be offered. The person's medicines administration records provided no further guidance. The person also had no falls risk assessment in place despite having had a fall at the service in August 2016. These matters did not ensure that the person was being provided with safe care.

We found that the service did not have individualised protocols in place which covered the reasons for giving 'when required' medicines, what to expect and what to do in the event the medicine did not have its intended benefit. We found this for 9 out of the 16 people that we reviewed.

For one person who self-administered two inhalers, there was no individual risk assessment in place to ensure that it was undertaken safely. This person was currently under referral of a specialist team. We found that the provider did not have a self-medication policy to provide a level of medicines governance around this area. We brought this to the attention of the manager who informed us this was due to be implemented along with the change in medicines policy in general.

One person's care records, following recent falls, showed that they had been referred to the community falls team for advice, and that a more appropriate bed to help prevent night time falls had been acquired. Their updated care plan encouraged staff to support the person to walk and undertake exercises. This was for the purpose of regaining muscle tone and minimising the risk of further falls, as the plan identified that they were at high risk of falling. However, there was no reference to this support occurring within the person's care records of the previous five days. We did not see this support occur during the morning or afternoon of our visit. Instead, during the afternoon, when the person got up, staff encouraged them to sit down again. This did not demonstrate that all reasonably practicable actions, to mitigate risk of the person falling, were

taking place in support of providing the person with safe care.

During the morning we noticed that the covered radiator just inside the entrance of the lounge area was so hot as to cause discomfort when touched. This was adjusted on request. The lounge was very warm during our visit. The thermometer on the wall just next to the radiator measured 27 degrees Celsius at 12:10. This was one degree higher than the advised maximum temperature in the Public Health Document "Heatwave plan for England – advice for care home manager and staff." A number of people slept during the morning in the lounge, including the person closest to the radiator who was asleep when we checked them at 10:40, 11:01 and 12:10. During lunch in the dining room next to the lounge, some people asked for a window to be opened, and we noticed people sleeping at the dining table. The management of heat in the lounge and dining area was not being used in a safe way to care for people. We informed the manager of this during and after visit, and he undertook to ensure that temperatures were checked regularly.

The above evidence, of failing to keep people's individual risk assessments and care plans up-to-date in support of providing them with safe care, and of the excessive heat in the lounge and dining areas, is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that some risk assessments and care plans had been updated since our last visit, including for one person where they had been bruised as a result of glasses they were wearing. Another person was professionally advised to wear glasses but refused to. This was now documented as an identified risk and what staff should do to help. There was a bed-rails risk assessment in place for someone using bed-rails. People's pressure care risk assessments were being kept under regular review and plans being updated where needed. Records showed that action was taken where needed.

Staff rosters showed that staffing levels at the service had been reduced from five to four care staff in the mornings. This occurred over two weeks before our visit. The manager explained that this was in line with there being less people needing support. However, staff told us that this presented them with difficulties in providing people with care that met their needs and preferences. One staff member said that a number of people needed the support of two staff, but less morning staff resulted in people sometimes being upset at having to wait. Another staff member told us there was not enough staff to help at lunch. One person told us of having to wait for their morning medicines.

The manager told us lunch ordinarily took place at 12:30. At lunch we saw some people waiting in the dining room for over half an hour to receive their first course. The first person brought to lunch was at 12:10, but lunch was not served until 12:57. We saw this person arguing with another person using the service at around 12:30, which may have been related to the wait they were experiencing. Several people complained that they did not have cutlery in place. Some got up and put cutlery on the tables themselves. At 13:12, two staff finished providing toileting support and started to help serve lunch. At 13:15, one person got up and left the dining room, saying, "I'm fed up waiting." One person spilt soup on their clothing before staff supported them to put an apron on. Whilst staff did their best to support everyone, they were not able to stay sitting with everyone that needed support to eat. They only finished distributing meals at 13:30. We saw four people in the dining area needing support to eat but only three staff being able to help them. This did not demonstrate that there were enough staff deployed for lunch.

During the morning and the afternoon, staff provided support to people such as with drinks and mobility. There was an activity session in the dining room before lunch that nine people attended. However, we saw that a number of people slept in the lounge during the morning. This included one person between at least 10:40 and 12:10. A staff member told us the person needed attention and people to talk with. One person in the afternoon twice used their call-bell to ask staff to support them to their bed but staff declined as it was

"not time yet." The person was visually impaired and we saw that they needed staff support to move about safely. This all indicated that there were not enough staff deployed to provide continuous support and stimulation to people with greater dependency needs.

Our checks of staff rosters showed that there were less staff than the planned four care staff working on six day shifts during February. This was on the afternoon/evening shifts of 10, 11, and 12 February, and the morning shifts of 12, 25 and 27 February.

We also noted that the role of deputy manager had been vacant since before our last inspection, which further undermined there being enough staff deployed to meet people's needs. Following the inspection, the manager told us that the post had been recruited to pending recruitment checks.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the manager informed us that staffing levels for the morning were being increased and that someone had been recruited to the role of deputy manager on a part-time basis.

People and their relatives told us the service was safe. One person said, "I lock my door at night in case anyone is rambling around" but clarified that staff checked on them at night which they were fine with. A relative told us, of their family member, "Staff walk her with her stick." Another said, "There is always staff about."

We found that all prescribed medicines were available at the service and were stored securely. Controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people.

Records indicated that people received their medicines as prescribed, including controlled drugs and short courses of antibiotics. There were no gaps in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed. People's behaviour was not controlled by excessive or inappropriate use of 'when required' (PRN) medicines.

We spoke with two people who reported that they took and received their medicines in a timely and correct manner. Medicines were administered by senior carers that had been trained in medicines administration. We observed a member of staff giving medicines to a resident and found that staff had a caring attitude towards the administration of medicines for people.

Inadequate

Is the service effective?

Our findings

At our last inspection, our findings included cases where healthcare professional advice from a dietitian, an optician and a GP had not been acted on, which may have compromised the health and welfare of the involved people the advice related to. There was ongoing failure to effectively meet the needs of some people at high risk of malnutrition and dehydration. Records about the care of people using the service were sometimes inaccurate or incomplete, which undermined appropriate care practices. This meant the provider was in breach of regulations 12, 14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served warning notices on the provider for these regulatory breaches because of the potential impact on people using the service.

At this inspection, records of the care provided to people were still not consistently accurate and complete. When we checked the food and fluid charts at 10:30 for the four people who were being specifically monitored due to greater welfare risks relating to nutrition and hydration, we found that three had already been filled in for food and drink at lunch that day. The fourth person's had not been recorded for that day. At 15:55 we saw that none of the records had been changed or added to, despite one person having a different lunch to what was pre-written. These were not accurate, complete and contemporaneous records relating to these four people.

One person's recent food chart stated the lunch they had and did not indicate that any of it was not eaten. However, the staff handover sheet for that afternoon recorded stated that they left most of their meal. The accuracy of the food chart was important as the person was had had recent dietitian advice and was at higher risk of malnutrition.

We brought these records to the manager's attention during the morning. They undermined our confidence in the accuracy of other such food and fluid charts, which were all fully filled in but which indicated that everyone drank between 2000 and 3000ml a day. Given that we saw that dependent people, even with support, were not able or willing to drink much, these totals were unrealistic in practice, which the manager agreed with. He told us he would ensure that staff recorded how much each person had drunk, not how much was offered to them, and that spot-checks of the records would occur.

People's individual care delivery records remained inaccurate and incomplete. Records from the previous two weeks occasionally contained no information on the person's care and welfare between having breakfast and going to bed. There was no afternoon and evening record for one person for five of the ten previous days. Their care delivery record omitted a day and night entry completely on one of those days. There was no daytime record for another person on one day, and no daytime record beyond breakfast for them the following day except for an incident involving them. The staff handover sheet for that day recorded that the person was behaving in a way that made the incident likely; however that was not recorded in the person's care delivery records. The staff handover sheet on the day of our visit omitted that three people had been visited by the district nurse and hence what changes to their care were needed, if any.

Records about people's care did not demonstrate that aspects of their care plans were being followed, and

so were not accurate and complete. One person's dietary support plan, on dietitian advice, advised for them to be offered two glasses of full fat milk daily. Staff told us this was occurring, and guidance in the dining area reminded them of this. However, the person's food and fluid charts made no reference to the milk being offered or consumed on five of the previous six days.

Another person's care plan stated for them to have an hour's bed rest daily, to help avoid the development of pressure ulcers. However, a staff member told us the usually person refused this. Their care delivery records across the previous two weeks made no mention of whether the person was supported to have daytime bed rest or if they refused it. The records were not accurate and complete, and so did not help the service to evaluate how effective the care plan was.

There were occasions when people's care records were contradictory. One person had a behaviour chart record about their aggression towards staff for one morning, but their care delivery record made no mention of the behaviour. A monitoring chart recorded that one person was unusually sleepy during one morning, but there was no mention of that on their care delivery record. This person was also recorded as having a runny nose on two recent handover sheets, without that being referred to within their care delivery records on those days.

The above evidence demonstrates records about people using the service that were not accurate, complete and contemporaneous, which is a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence of people gaining weight where this was appropriate. A relative told us that their family member was "very frail" when they started using the service but had since gained weight and was "much more alert and responsive." We saw records made by a visiting dietitian in which they stated that the service had followed their plan and so the person could return to monthly weight checks. Records in people's care files indicated regular reviews of the person's weight and dietary intake, in support of promoting their health. People's nutritional assessments were being kept under review.

There was positive feedback about the food and drink provided. One person said, "The food here is very good." They explained about there being three meals and three other occasions each day when there were warm drinks and biscuits. Another person told us that the food was "always quite good." A relative said of the food, "It looks very nice. There's a lot of effort made to cater to everyone's needs."

Staff paid a lot of attention to trying to support people to eat and drink. They could tell us signs of dehydration. They told us that recent training through Barnet Social Services had helped with this. They knew who needed support with eating and in what situations. A relative said that in respect of their family member, "They spent lots of time helping her eat." The cook told us of who had specific diets including extra cream, and there was information readily available to remind staff of some people's specific dietary needs such as diabetes or preferences such as vegetarianism.

At our previous inspection, we found that the service was not liaising well with community healthcare professionals in support of meeting people's needs. At this visit, we found improvements. People told us of acquiring professional advice such as from GP visits. One person said, "I've got new glasses." Relatives told us, "'If it's deemed necessary they arrange for a doctor to come in" and "The chiropodist comes around every so often." A healthcare professional told us the service made referrals appropriately and followed their advice.

People's care records showed that there were regular visits from the district nurse team. District nurse

support was requested where the service identified that someone had needs that their team could assist with. People had also been visited by other healthcare professionals such as GPs and psychiatrists. Where significant risks of falls had been identified for two people, referrals had been made to the community falls service for their support, although not in a third person's case which we have considered further within the Safe section.

We did not improve the rating for Effective from inadequate because there were other breaches of regulations relating to Effective that we did not check at this inspection as we did not take enforcement action in relation to them following the last inspection. We will check them during our next planned comprehensive inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection, our findings included that there were ineffective governance systems in place, as we identified shortfalls that the management team and the provider had not recognised or addressed. Most staff we spoke with during the inspection process reported poor morale. We did not find a positive, open and inclusive culture at the service. There had also been no registered manager at the service since May 2016. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider for this regulatory breach because of the potential impact on people using the service.

At this inspection, despite some improvements in the quality of auditing service standards, there remained a breach of legal requirements relating to good governance of the service.

The service had not had a registered manager since May 2016. The manager at our last inspection, who started in that role in April 2016, left the service at the start of February 2017. A new manager had been appointed shortly afterwards and was in post for a month at the time of this inspection. We met them during this inspection. They told us they had experience of supporting services to make necessary improvements. Our records showed that they had started the process of applying to be the registered manager of the service.

The provider had implemented a monthly audit process for the care service in light of the findings of our previous inspection. The CEO had undertaken two such audits in 2017. They were more robust than previous audits as they better considered whether appropriate care was taking place at the service, not just asking for feedback from anyone present and checking the environment. For example, they checked on whether significant accidents had been properly reviewed so as to help ensure that risks were minimised. There were reports about any complaints made. Records were also reviewed, such as for health and safety, and staff training. Actions were set where any concerns were identified. We noted that the most recent report provided good feedback from different sources about the new manager's impact. However, the audits did not include specific focus on the Warning Notices we served on the provider, so as to identify ongoing risks relating to the Warning Notices and help to address them. As we found ongoing breaches relating to two of the Warning Notices, these audits were not effective at ensuring compliance with the Fundamental Standards.

One staff member told us that they could get scratched by a couple of people when providing support to them. They knew to record about the person's behaviour on their care records, but said they did not record incident records if they were scratched. They could not confirm that the manager was aware of these instances. We checked one of these people's recent care delivery records and found instances relating to them being aggressive, including that they were "hitting the staff" and "assisted to bed with her normal aggression." However, these entries were not made in the person's behaviour chart, and were not recorded as separate incidents that could be directly brought to the manager's attention.

One person's care delivery records indicated that they had recently left the premises unsupervised, contrary

to their care plan. The manager told us he was not aware of this incident when we brought it to his attention. When the manager checked with senior staff about the incident, a team leader said that there was no system for making separate incident records in the service. The manager undertook to ensure that all safety incidents were now brought to his attention. We found that the incident was not recorded within the provider's "monthly accident and incident audit" records.
This evidence fails to demonstrate that the provider and manager were ensuring that there was an effective system for overseeing that risks, relating to incidents that compromised the safety of people using the service and staff, were being assessed and minimised.

We found that the first-aid kit in the office contained a number of out-of-date items. This included five medium sterile dressings and two eye-pad dressings with use by date of July 2015, and many small sealed swabs with expiry date of September 2015. We removed these items and brought them to the manger's attention. There was not an effective system for checking that these first aid items were in-date.

At our last inspection, the provider's policy on quality auditing was not sufficiently robust so as to ensure effective governance of the service. At this inspection, we were not provided with the policy when repeatedly requested, and so we concluded that it had not been updated. This did not show that systems to ensure effective governance had been reviewed and improved on, so as to help ensure compliance with the Fundamental Standards.

A week after the inspection, the manager sent us an updated action plan in respect of matters needing improvement at the service. We could not see that it included any of the matters of concern we brought to the manager's attention at the end of our inspection visit, despite these being recorded and passed onto the manager on our Initial Inspection Feedback Summary sheet. This did not demonstrate action to mitigate risks relating to the health, safety and welfare of people that we identified to the manager in writing.

The breaches identified in this report indicate ongoing ineffective governance of the service. There were insufficient improvements to the health, safety and welfare of people using the service despite us serving three Warning Notices on the provider soon after our last inspection. The provider remained in breach of two regulations relating to those Warning Notices, in respect of regulation 12 (safe care and treatment) and regulation 17 (good governance).

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we gave the manager a list of records to be copied to us as part of the inspection process, requesting that these be provided within 48 hours. We requested some additional documents by email the following day. Many documents had not been provided six days later, so we reminded the manager and the CEO about what was outstanding. A few further documents were provided the following day, but some remained outstanding. The failure to provide the documents despite requests, or explain why specific documents could not be provided, did not assure us of a well-run service.

Staff told us that morale at the service was better as the new manager listened to feedback and explained decisions. This made for a more comfortable working environment. A senior staff member told us of improved communication throughout the team including through handovers and team leader meetings. Staff told us of knowing how to whistle-blow. There was now a notice in the staff room reminding staff about how to whistle-blow. Staff also told us that the CEO visited on a regular basis and spoke with staff.

Relatives also provided positive feedback about the new manager. One told us that the new manager is

"very hands on; you ask him for something and he does it." Another relative said that "staff seem happier."

The manager told us there had been one staff meeting since their appointment along with informal meetings by which to coach senior staff and listen to their concerns. Minutes of the staff meeting provided staff with guidance on their roles such as listening and empathising more with people using the service, and plans for presenting at the service more professionally such as through wearing standard uniforms.

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 The registered persons failed to ensure that care and treatment is provided in a safe way to service users, including: • through assessing the risks to the health and safety of service users of receiving the care, • doing all that is reasonably practicable to mitigate any such risks, and • Ensuring that the premises are used in a safe way. Regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to establish and operate effectively systems to ensure compliance with the Fundamental Standards. This included through failure to • assess, monitor and improve the quality and safety of the services provided, • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, and • maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 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 registered person failed to ensure that sufficient numbers of staff are deployed in order to meet the requirements of the Fundamental Standards.
Regulation 18(1)