Hollyberry Trinity Limited

Trinity House Nursing Home

Inspection report

18/20 Kingsley Road
Northampton
Northamptonshire
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Tel: 01604712411

Date of inspection visit:
08 February 2018

Date of publication:
03 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8 February and was unannounced. This was the first comprehensive inspection at this home and took place following a number of concerns that had been raised by a variety of sources to the CQC about care planning, the competence of staff and the safety of people within the home.

Trinity House Nursing Home is a nursing care home. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Trinity House Nursing Home accommodates up to 23 people in one adapted building and at the time of the inspection had seven people living there.

The home is required to have a registered manager however at the time of the inspection they did not have one. 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.

Inadequate systems were in place to ensure the home provided high quality care for people. Auditing systems were irregular and were ineffective at highlighting all the areas that required improving. When audits had identified that improvements were required, there was a lack of action to make those changes in a timely way.

Feedback from people living at the home was not reviewed or acted on, and feedback from the local authority and clinical commissioning group had not effectively been actioned. The systems in place to improve people's nutritional intake were ineffective. However this had not had a negative impact on people, and people at risk of malnutrition had sustained or improved their weight gain.

Staff did not receive adequate supervision or feedback about their performance and improvements were required to the training of staff. The provider had not taken effective action to ensure that all staff providing care were competent and skilled to do so. We found that staff had not received expected training before they were able to support people, and as a result we found evidence that people were not supported safely.

People's care plans and risk assessments were insufficient and did not provide sufficient information to staff about what the risks were for each person, or how staff could reduce those risks.

There was a lack of knowledge about safeguarding procedures and how concerns should be reported and investigated. Accidents and incidents were not analysed or reviewed to identify if any learning could be made to prevent similar incidents from occurring and there had been a lack of action to ensure that the premises were safe and suitable for the people that lived within the home.

Improvements were required to ensure that people that lacked mental capacity to make decisions for themselves had decisions made about their care, in their best interests. Improvements were also required to ensure that all healthcare requirements were met, particularly those of a long term nature such as dental care.

Improvements were required to ensure people preferences were respected and they were able to wake up and get dressed when they wished. The provider also needed to ensure people had access to an independent advocate if they wished and that people's independence was promoted and encouraged.

People's care plans contained insufficient guidance for staff and further improvements were required to ensure information was current and reflected people's current care needs. People were not given sufficient opportunity to communicate their end of life wishes, and people had limited opportunities to pursue their interests and activities.

Staff were recruited in an appropriate manner, and sufficient checks were completed on staff's previous backgrounds. People were treated with kindness and staff had built positive relationships with people that helped them to feel comfortable within the home.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 was not safe.

People's risk assessments were ineffective at identifying and reducing the risks to people.

Staffing arrangements were inadequately managed to provide safe, competent and timely care to people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were insufficiently trained to provide safe and competent care.

Improvements were required to ensure staff were working with the principles of the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Improvements were required to ensure people were able to make their own choices about when they wanted to wake up and get washed and dressed.

Improvements were required to ensure people's independence was encouraged and supported by staffing arrangements.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans contained insufficient information and guidance about people's current care needs.

People's preferences about how their care should be delivered were not always considered.

Is the service well-led?

Inadequate

The service was not well led.

The home did not have a registered manager in post and the provider did not provide strong leadership which reflected a good quality service.

Governance systems within the home were chaotic and care was not adequately monitored or improved when it was clear that there were areas for improvement.

Trinity House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 8 February and was unannounced. The inspection was completed by two inspectors.

This inspection was prompted in part, by concerns we had received from the local authority 'adult quality team', the clinical commissioning group and members of the public who had contacted us. Therefore, due to the timing of this inspection, we did not ask the provider to complete 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.

We reviewed the information we held about the home, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home, to identify if they had any information which may support our inspection.

During our inspection we spoke with three people who lived at the home, four visitors/relatives, one chef, three care assistants, two nurses, the deputy manager and the acting manager. We also met with the providers.

We looked at care plan documentation relating to five people, and three staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

People were not adequately protected from the risks that had been identified as relevant to each person. One person that had recently moved into the home for respite care had no risk assessments in place. However it was clear from our observations that they required support with their mobility and they were at risk of falls. Staff attempted to offer appropriate support however there was a lack of guidance in place to refer to.

Other people had risk assessments in place, for example, in relation to the risk of falls, however the grading systems within them were unclear and it could not be clearly evidenced the reasons why people were at high, medium or low risk of falls, and the difference in action that should be taken as a result. We also found that after one person had fallen, their falls risk assessment had not been reviewed or updated. Risk assessments were unclear and did not contain clear guidance. For example, one person had a risk assessment in place regarding the use of a pressure sensor mat, however the risk assessment did not evidence why this was a risk or how this risk had been reduced. This meant we could not be assured that staff had adequately considered the risks to each person, or provided sufficient guidance to ensure those risks were managed safely.

Actions to reduce the risks to people were not completed in a timely manner. For example, we found that people had risk assessments in place because the home did not have sensor alarms on the fire doors. The risk assessments identified that sensor alarms were required to be fitted however this had not been actioned promptly. The provider confirmed that they had purchased the sensor alarms but they had not yet been fitted. As a result of the inspection they were fitted immediately however there was no reasonable explanation why this had been delayed, or why they had not been fitted before the home had opened or as soon as this risk to people had been identified.

This was a breach of Regulation 12 (1) (2) (a) (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Improvements were required to the staffing arrangements within the home. One member of staff commented, "We just need to get into a routine more." There were insufficient numbers of competent staff adequately deployed around the home to keep people safe. People that required support mobilising were left unsupported, and there was little communication between staff about who was responsible for ensuring people required timely support if they wished to mobilise or walk around. People were able to choose where they spent their time, for example, in their bedroom, the dining area, or the lounge. However these areas were spread out around the home and staffing arrangements were not always sufficient to enable people to receive timely support depending on where they were. For example, on two occasions an inspector had to go and find a member of staff to help support one person who required assistance to stand up and was at risk of falls. This meant that people attempted to mobilise independently when it was not always safe to do so because staff were not available to support them in a timely way.

The provider had not utilised an effective method to determine adequate staffing levels which took into

account the layout of the building, people's care needs and had the ability to adapt to people's changing needs. In addition, the provider had not considered the skill mix and competence of staff when arranging staff deployment. This meant that the provider did not adequately manage and organise their staffing to ensure staff with the appropriate skills and competence were appropriately deployed to where people wished to spend their time.

This was a breach of Regulation 18 (1) (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Improvements were required to ensure adequate safeguarding procedures were in place. Staff had an awareness of safeguarding, but were not clear about how to carry out their responsibilities to report concerns. The management team lacked sufficient knowledge about their responsibilities to investigate concerns and when it was necessary to make notifications to the CQC. We found examples of incidents that had been referred to the local authority safeguarding team, but the CQC had not been notified. In addition, when incidents had occurred there had not always been an investigation into how this had occurred, or how this could be reduced. For example, we found that on the same day three people had received unwitnessed minor bruising however no investigation had been completed to understand the reasons for this. People and their relatives told us that they felt safe and staff treated them well however the systems in place to help protect people from harm were insufficient and we were unable to establish evidence to show that all staff had received up to date training in this area.

Improvements were required to the way in which medicines were managed. We saw that people were given their medicines in accordance to their preferences and personal abilities. For example, people that required support to take their medicines were given support in a friendly manner. However if people were able to take their medicines with minimal support, there were occasions that staff did not take the time to ensure they had been consumed. This left a risk that medicines could be dropped or hidden without the knowledge of staff. In addition, there was insufficient information about people that required support with prescribed medical creams. There were no instructions or body maps about where the creams needed to be applied and staff were reliant on their own knowledge about people's conditions to ensure this was applied in a consistent manner.

People received their medicines regularly however improvements were required to the systems that were in place to ensure they were ordered on time and without delay. The current systems relied on staff noticing that people were running low on their medicines, before they had ran out. This meant staff had spent unnecessary and excessive amounts of time chasing up prescriptions and ensuring they were in the home before the person had ran out of their medicines.

Improvements were required to the systems to ensure that adequate infection control measures were in place. The home appeared clean and tidy however there were insufficient cleaning records to show a robust cleaning schedule was in place. The cleaning records were inconsistent and there were no schedules to show the cleaning requirements or expectations. Staff were provided with protective equipment including gloves and aprons to help prevent the spread of infection.

Improvements were required to ensure lessons are learned and improvements are made when things go wrong. Following incidents and accidents, an initial review took place. This review concentrated on the health and welfare of the person involved but failed to review the circumstances of the incident, or what led to the incident to review if any improvements could be made. There was a lack of strategic direction and each incident was reviewed as an isolated incident.

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

Ineffective and insufficient systems were in place to ensure staff had the appropriate skills and experience to provide competent and safe care to people. New staff were required to complete a basic induction and the provider told us they relied on people's previous experience to demonstrate they had the necessary skills to provide safe care. There were no assessments of staff's competence and staff were not required to complete mandatory training in key areas of care, for example manual handling training to help people stand or sit down safely. We saw that staff incorrectly and unsafely supported people to stand and mobilise which could cause harm to people. We also saw that staff relied on the provider to observe people in communal areas. This meant that when people attempted to stand up the provider intervened and discouraged them from doing so as they had not been trained in how to support people to stand up or mobilise safely. This meant people were not always encouraged to do as they wished, or that they were able to receive safe and timely care from competent staff.

Improvements were required to ensure that staff were adequately supervised and given feedback about their performance. Staff supervisions had been booked, however no meetings had taken place with staff, including with new staff. There had been no competency assessments of staff and there had been a lack of recognition that staff required further training to ensure they were skilled to complete the job adequately.

This was a breach of Regulation 18 (1) (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Pre admission assessments for people moving into the home were completed adequately however improvements to the assessment process and the information gathered for a respite stay required improvements. We reviewed care plans for people that moved into the home on a long term basis and saw that the staff had an adequate insight into people's care needs before they moved into the home. However for people staying at the home on a respite basis, care plans lacked sufficient information about people's preferences and the care they required to keep them safe.

People were supported to eat and drink enough to maintain a balanced diet however improvements were needed to ensure that one member of staff supported one person at a time with their meal. We saw that one member of staff supported more than one person at a time with their meals and this approach did not reflect good practice or a person centred approach. This approach shows a lack of respect for each person, does not build a positive experience for people and can result in people having to wait for staff to help them with their meal. The home employed a chef that produced meals to meet people's needs and wishes. People were given a choice of meals and were supported to eat well. One person said "The food is all right, you have a choice as to what you have to eat." A relative told us, "My [relative] loves the food." One person required additional meals and snacks outside of meal times and staff supported these needs well.

Improvements were required to ensure that people's healthcare needs were met. People's immediate and short term healthcare needs were adequately addressed; however there was an inconsistent approach to managing people's long term health care needs. For example we identified that people's dental needs were

addressed in an inconsistent manner and staff were not knowledgeable about how these needs would be met.

Staff made referrals to other services when necessary, for example, the falls referral team when people were at high risk of falls, or had experienced falls, or specialised medical teams when necessary. One person and their relative told us that their medical condition had improved since they had moved into the home. They said, "Since coming here [Name's] [name of medical condition] has really improved, it's probably the best it's ever been!" Staff were aware of the advice and guidance that had been received from other professionals, and followed this guidance to help ensure consistent care for people.

Improvements were required to the premises to ensure that people were safe. A stair gate was at the bottom of one set of stairs however this was inadequate and did not lock. There were no stair gates on another set of stairs and no assessment or consideration had been given to the safety or adequacy of these arrangements, in consideration of the people that were living at the home. In addition, one of the staircases had spiky newel caps throughout the staircase, on the banister and no consideration had been given to the safety of this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

We found that there was a lack of understanding of the requirements of the MCA. One member of staff said, "Yes, I've heard of the Mental Capacity Act." They were unable to tell us about how this impacted on their work, or the principles they needed to adhere to keep people safe. The provider had submitted appropriate applications when it was necessary to minimise or restrict a person's liberty. However improvements were required to the providers procedures once the management team had recognised that people did not have the mental capacity to make some of their own decisions. For example, we found that the provider had recorded that one person did not have mental capacity to make their own decisions in relation to aspects of their care; there were no best interest decisions about their care, or details about if they had a representative or power of attorney to help with their health care decisions. At the time of the inspection no DoLS applications had been reviewed or approved by the local authority.

Requires Improvement

Is the service caring?

Our findings

Improvements were required to ensure that people were given care that met their own preferences. Throughout the morning we saw that some people had been supported with their personal care needs and had been supported to have a wash and get dressed, but had then returned to bed and had gone back to sleep. One person told us they were still asleep when staff supported them with their personal care, and could not recall who had helped them or what had happened. They said, "I was asleep when they changed me; I can't remember who did it." People's care plans did not record that this was how anybody liked their care or was how they wished to be supported with their personal care needs. We also saw that three people recorded in a survey that their bathing preferences were not always accommodated and no action had been taken to rectify this.

Improvements were required to ensure people had access to an advocacy service and people were fully involved with their care. An advocate is a trained professional who supports, enables, and empowers people to speak up and can be particularly helpful for people who have to make important decisions about their care. The home did not have any links with independent advocacy services however people living at the home had the support and involvement of relatives. We saw that there was some evidence of people and their relatives having involvement with their care plans however this involvement was not continuous and people's care plans were not always up to date with their current preferences.

People's independence was not always encouraged. We saw that one person attempted to stand up on several occasions. Staff did not offer to support the person to go for a walk despite their care plan stating that they enjoyed walking around the home. The acting manager told us they had already supported them earlier to have a walk around the home and there was a lack of recognition from staff that people may require further assistance to have their preferences met.

People were treated with kindness. One person said, "The staff are approachable, I could speak to any of them. The staff are nice, I feel safe and secure." We saw that staff had developed positive relationships with people and spent time talking to them about their past, the local area, or their interests. Staff encouraged and supported a friendly environment where people laughed and sang if they wished and people were relaxed around staff. Further improvements to maintain a positive relationship between staff and people living at the home would include that staff ask people if they would like a drink when staff got drinks for themselves.

People's privacy was maintained and staff spoke to people with respect. One person told us, "They [the staff] treat me well. They are respectful." Staff asked people discretely when they required assistance with their personal care needs and did so in a manner that enabled people to maintain their dignity. One member of staff explained, "I tell people what I am doing to put them at ease. I ensure the door is shut, keep constantly talking to them, cover up lower body and encourage people to do as much for themselves as possible."

People were given choices about how they spent their time. People were asked where they would like to eat,

and where they wished to go within the home. One person said, "I can spend my time in my room and I sometimes go downstairs if I want to." Staff were knowledgeable about people's preferences. Staff provided people with opportunities and encouragement to spend time in different areas of their home to help prevent isolation and loneliness.

Requires Improvement

Is the service responsive?

Our findings

Improvements were required to ensure that a consistent approach was given to care planning and to ensure that relevant information was recorded and utilised. People had care plans in place, however they were confusing and did not always contain adequate information about people's preferences, or relevant and current information about how people required their support. For example, a dehydration screening tool had been completed for one person however there was no evidence this was necessary for this person, and there was no guidance for staff about what the outcome of this assessment meant for the person, or if any improvements to their care were required. There was other information and guidance within people's care plans that was not relevant to them or their health conditions and there was no accompanying information or explanation about why they had been contained in people's care plans.

Care plans lacked sufficient information about people's care. We saw that for one person who displayed behaviour which may harm themselves or others, there was a lack of information about potential triggers of this behaviour, or adequate details of what had happened in the past. There was insufficient information about how staff should support the person if they displayed this behaviour and there was a lack of analysis following incidents.

People staying at the home on a short term, or respite basis, did not have adequate care plans in place to ensure they received safe and consistent care. The care plans for respite care were basic and did not provide sufficient guidance for staff.

People's preferences were not always respected. One person's care plan recorded that they had a preference to only receive their personal care from a specific gender however there were no plans in place to ensure this was respected. When we spoke with the person about this, they told us they did not have a preference and was unsure which gender of staff supported them. This showed a lack of involvement and review of people's care planning.

Improvements were required to ensure people's end of life wishes were identified and considered. We saw that one person had an end of life care plan in place however the information was basic and was inconsistent with the information that the staff had already obtained during the assessment procedure. Records did not show that the person had been involved or consulted about why their preferences had not been recorded, or reflect if the person had changed their mind about their preferences. The provider had recognised that improvements were required to care planning for people's end of life wishes and was in the process of arranging for staff to have training in this area of care.

People were not assured that they could always have access to information in accordance with their communication preferences. The service had not looked at how they could fully 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. There were no arrangements in place to consider how people could be supported in this area. Further improvements were required to strengthen this area of care and ensure

people's communication needs were supported, for example with access to easy read information.

There were limited opportunities for people to participate in activities within the home. People were assisted to follow their interests, for example, people were asked if they wanted to participate in a quiz and were given encouragement to do so and to have some fun. Dominoes, board games and a keyboard were available for people to use if they wished and staff promoted these items to people. However, relatives told us that activities were lacking and could be improved, to help stimulate people and their interests.

The provider recognised cultural and special events and enabled people to celebrate them with their friends and family if they wished. For example, on St Valentine's Day people were able to invite their loved one into the home for a romantic meal together and people who wished to visit church with their family were supported to do so.

A complaints procedure was in place however the contact details of external organisations to enable people to escalate their complaint outside of the home required updating. People and their relatives told us that if they had concerns they would approach the providers or management team. There had not been any complaints since the home had opened, however we saw that the management team had acted on people's feedback about improvements required to laundry arrangements.

Inadequate

Is the service well-led?

Our findings

Procedures to review the quality of the service were inadequate and required a significant improvement. The delivery of high quality care was not assured by the leadership, governance, systems, or culture within the home.

There was a lack of vision and understanding about the requirements of a well led home that provided high quality care to people. The provider had failed to identify that the systems in place were ineffective at highlighting and actioning change. The provider believed that improvements would be made once the home had more people living in it, but there was a failure to ensure that robust systems were in place to ensure that the people already living in the home received the care they required. The approach within the home to ensuring people received consistent care in accordance with their preferences was unsystematic and varied without explanation. Information was recorded about people that was not relevant and there was a lack of action when systems highlighted that improvements were required.

The governance within the home was chaotic and irregular. The provider had failed to recognise that the governance systems had failed to review and improve the quality of the home. There were audits in place within the home, however they were inconsistent, and no explanation could be provided to the timeliness of the audits. For example reviews and auditing of wound management, falls, pressure sores, skin tears were conducted haphazardly meaning there were no consistent reviews to ensure people were receiving appropriate care and treatment.

Inadequate action was taken when audits highlighted that improvements were required to the quality of the service. For example, we saw that one person's bathroom temperature was recorded as being at an unsafe temperature and there had been no recognition of this, and no action had been taken. Following the inspection, the provider took action to rectify this however the approach to auditing was ineffective and the staff completing the audits had a lack of knowledge about safe requirements.

People's individual risk assessments highlighted that there were no fire alarm sensors on external doors. This had not been adequately recognised or actioned in any premises audit. During the inspection we raised concerns about the lack of fire alarm sensors and this was rectified immediately however the provider was unable to explain why this had not been actioned promptly. In addition, no auditing systems had recognised that the open staircase could be risk to people that lived at the home, and no action had been taken to reduce those risks.

Ineffective systems were in place to monitor people following an incident. For example, following an incident or injury, staff completed a body map to document where the injuries were and took photographs of the injury. However there were no records to show that this had been monitored after an initial 48 hour period. In addition, if there were subsequent injuries identified these were recorded on the same body map. This was an ineffective method of monitoring injuries and this had not been identified or rectified by the provider.

There were insufficient quality assurance systems to observe and review staff deployment and performance. There were no systems in place to ensure that adequate numbers of staff with sufficient competencies and skills were available to provide safe and compassionate care to people. Ineffective systems were in place to ensure staff received effective and adequate training to provide safe care to people and this failure had led to people being supported unsafely.

Quality assurance systems were not thorough enough to identify that people at risk of weight loss, or requiring additional nutrition or hydration, were reviewed, and managed effectively. Staff had not identified goals or targets for people at risk of malnutrition, or reviewed if further action was required in a timely way if people had eaten or drank little amounts. However, we found that when people required referrals to healthcare professionals such at dietitians or nutritionists, this had been carried out and people's weight had been maintained or improved. The systems in place to monitor people's nutrition required improvement.

Quality assurance systems had not identified that people's care plans and risk assessments did not provide current and specific guidance to staff to ensure people received their care in accordance with their preferences and in a safe manner. They were not adequately reviewed when changes were required and effective auditing systems were not in place after a serious incident to ensure that lessons could be learned and changes implemented if necessary to prevent similar occurrences.

The management team failed to review and action feedback about the service. Systems were in place for people to provide feedback however they were not analysed or utilised to review or improve people's care. For example, three people recorded in a survey that their bathing preferences were not always accommodated. No analysis or reviews of their personal care records had been made, and no changes had been made to how they were supported with their bathing.

In addition people's personal care records were incomplete and there were significant gaps between entries which suggested that people had not received any support with their personal care needs for up to 10 days in a row. We spoke with people and their relatives who told us they had been supported with their personal care needs on a daily basis and they were always supported to be clean. One relative said, "I come every day and [name] is always clean and fresh." This meant that improvements were required to ensure that people's records reflected the care they had actually received.

Furthermore, the local authority and clinical commissioning group had recently visited the home and provided feedback about improvements that were required. The providers had failed to take effective action to remedy and improve the service and this inspection found many similar concerns to those issues that had already been highlighted to the providers two months earlier.

This was a breach of Regulation 17 (1) (2) (a) (b) (e) (f) Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

The home did not have a registered manager in place, and had been without one in place for almost two months. The provider had asked the registered manager of their other home to oversee the management of Trinity Nursing Home, with the assistance of a deputy manager. The provider was in the process of recruiting a suitable registered manager however at the time of the inspection no applications for a registered manager had been received.

There was a lack of knowledge from the provider and management team about the statutory notifications that were required to be submitted to the Care Quality Commission (CQC). We found examples of

safeguarding alerts that had been submitted to the local authority that had not been submitted to the CQC and this had not been identified by the provider. This demonstrated that the provider has a lack of understanding of the regulations.

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 12 HSCA RA Regulations 2014 Safe care and treatment People had insufficient risk assessments in place that did not clearly identify what people's risks were or how they could be reduced. When clear risks had been identified prompt action to reduce those risks had not been taken.

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 Staff were insufficiently trained and supervised to provide safe and competent care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems were inadequate and did not recognise where improvements were required, or take sufficient action to make the required improvements.

The enforcement action we took:

We issued a Warning Notice against the Provider.