

Tamaris (South East) Limited

Ross Wyld Care Home

Inspection report

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Date of inspection visit:
09 November 2017
15 November 2017
10 January 2018

Date of publication:
08 February 2018

Ratings

Overall rating for this service

Requires Improvement 

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?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 9, 10 and 15 November 2017. The first day of the inspection was unannounced.

Ross Wyld is a care home with nursing for up to 54 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ross Wyld is divided into three floors providing nursing care to people with physical health needs and for those living with dementia. It is a large purpose built care home that is fully accessible to people with mobility needs. At the time of our inspection 51 people were living in the home and one person had been admitted to hospital.

The home did not have a registered manager. The new home manager was in the process of applying to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in December 2015 we did not find any breaches of the legal requirements. At this inspection we found that care plans and risk assessments lacked detail or were inaccurate and were not personalised to each individual. They lacked detail regarding care preferences including personal care, dietary needs and end of life wishes. Records of care did not show people were supported to have their needs met.

People told us there were not enough staff deployed at the service to meet people's needs and we observed that people received their meals late. Staff did not always receive the clinical support they needed to perform their roles because there was no clinical lead or deputy manager at the home.

The home had not always sought consent in an appropriate way and staff did not demonstrate a sound working knowledge of the Mental Capacity Act 2005.

The governance arrangements were not comprehensive and where those in place had identified issues with the quality and safety of the service actions had not been effective in improving the experience of people living in the home. The service was working with the local authority and clinical commissioning group to implement a plan to address concerns in the home.

Staff were knowledgeable about safeguarding adults from harm, and the provider took action to investigate and respond to allegations of abuse and other concerns raised.

The home was clean and odour-free and we observed staff using basic hygiene methods.

People living in the home had complex healthcare needs. They received support to access healthcare services and the home worked with healthcare professionals help meet people's needs. Medicines were managed safely and staff were appropriately trained.

Staff built positive and compassionate relationships with people in their care, and understood how to promote people's dignity. Staff demonstrated they understood the impact people's culture might have on their experience of care. Sexual orientation was included as part of the care assessment.

The provider had a clear complaints policy. There were systems to ensure people and relatives were able to provide feedback about their experience of the home.

Activities were delivered with enthusiasm and people felt the range of activities on offer were improving. The manager had plans in place to continue to develop the activities provision within the home.

We found breaches of five regulations relating to safe care and treatment, consent, good governance, person-centred care and staffing. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. There were not enough staff of all levels deployed to meet people's needs.

Risks to people's health and wellbeing were not safely managed because assessments did not provide enough guidance to staff about how to mitigate against them.

Medicines were managed in a safe way.

The recruitment procedure was effective in order to ensure staff were suitable to work in the caring profession.

Staff were knowledgeable about safeguarding adults from harm.

The service appeared clean and odour-free.

Inadequate ●

Is the service effective?

The service was not always effective. Staff did not always receive adequate training and support in order to perform their roles.

Staff did not always demonstrate they understood the application of the principles of the Mental Capacity Act 2005 and the service was not always seeking consent in line with the legal framework.

People were supported to have their healthcare needs met, and the service worked with healthcare professionals.

Staff supported people to eat and drink enough in line with their preferences but food and fluid documentation was not always accurately completed.

Requires Improvement ●

Is the service caring?

The service was not always caring. People told us their experience was affected when there were not enough staff deployed.

People and their relatives told us the staff were friendly.

Requires Improvement ●

The provider supported people with their independence and religious and cultural needs.

Staff promoted people's dignity and respect.

Is the service responsive?

The service was not always responsive. People's needs, were not clearly captured in care plans.

Records of care were not always updated following a change in need.

End of life care and provision was not well managed.

People and their relatives felt they could raise a complaint and they would be listened to.

The provider supported people to maintain their hobbies and interests, particularly those who were mobile.

Requires Improvement ●

Is the service well-led?

The service was not always well led because the high turnover of management roles had had a destabilising impact on the service. Managerial roles were not filled creating a lack of clinical expertise at the home.

The management structure was not always clear and staff were not always aware of who was responsible for certain duties.

The service was not organised in a way that promoted safe care through effective quality monitoring.

The provider had missed opportunities to create partnerships with external organisations to embed good practice at the service.

People and staff spoke highly of the most recent manager who was working with the local authority to make improvements.

Requires Improvement ●

Ross Wyld 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 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.

Ross Wyld Care Home accommodates up to 54 people across three floors. Two of the floors specialised in supporting people with complex nursing care needs, including people receiving end of life care. Another floor specialised in providing residential care to people living with physical health needs. Many of the people living in the units were also living with dementia.

Before the inspection we reviewed the information we already held about the service. This included notifications the provider had submitted to us. A notification is information about important events which the service is required to send us by law. We sought feedback from the local authority contract monitoring team.

The inspection took place on 9, 10 and 15 November 2017. The first day of the inspection was unannounced. The inspection was completed by one inspector, two specialist advisors who were experts in nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with five people who lived in the home and five relatives. We observed care delivered in communal areas of the home, including activities. We spoke with 13 members of staff including the home manager, regional manager, the team leader, the chef, a member of domestic staff, an activities coordinator, two nurses, a nurse support practitioner and five care workers. We reviewed the care files of five people including assessments, care plans and records of care delivered. We reviewed six staff files including recruitment and supervision records. We also looked at the training records, complaints, incidents and various other policies, documents and audits relevant to the management of the service.

Is the service safe?

Our findings

People and relatives gave us mixed feedback about whether they felt safe in the home. One person said, "I don't feel entirely safe" whereas another told us, "I am really happy here, I do really feel safe."

We found people were not protected from risks to their health and wellbeing. The provider had not assessed all risks people faced and assessments available did not include comprehensive guidance for staff about how to mitigate identified risks. For example, the diabetic assessment for one person provided conflicting information and stated that they had been diagnosed with Type 1 diabetes in one part of the documentation and Type 2 in other parts. Documentation was not easy to navigate as information was split between four different files.

People were at risk of developing pressure ulcers. Records showed 20% of people living in the home had pressure ulcers. This is a high proportion of people living in the home. Care plans did not provide enough detail for staff to follow to minimise the risk of pressure ulcers developing. For example, one care plan was not clear about early detection signs staff need to look out for. The treatment plans put in place by external health care professionals were not developed into care plans and we observed that they were not followed in practice. The provider did not have a robust pressure ulcer policy or procedure available to guide staff as the previous policy had been withdrawn pending review. Staff we spoke with could not give clear explanations about how to care for people at risk of pressure ulcers and we observed that three people's pressure relieving mattresses were not fit for purpose. The provider told us these would be immediately replaced and they would arrange for extra training for staff.

People living in the home were described as presenting with verbally and physically aggressive behaviour, particularly while receiving support with intimate care tasks. This was identified as being a risk to both the person and the staff supporting them. The information about how the risks were mitigated was insufficient and meant people were at risk of unsafe care. For example, one person had a care plan and risk assessment in place that said '[person] tends to be verbally and sometimes even physically aggressive towards staff when approached to be given care or assisted with food.' There was no plan about what staff should do or say to support the person in the event of aggressive behaviour.

Environmental risks not always well managed. The service had been assessed by external experts in fire safety and had been judged as needing to make improvements. We asked the provider to send us the fire safety action plan to implement improvements but one was not available.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure there were enough staff deployed to meet people's needs. People and their relatives told us staff were not readily available to support people. One person told us, "I don't feel entirely safe, I am new here. There is staff shortage here, especially when I want someone to take me to the toilet. Most of the time I have to wait while I am bursting. The other day they had to take me to my room to change

because I wet myself. Sometimes the nurse is on the rush and doesn't have time to talk to you. There is too much work". A second person told us they were sometimes left in pain when a nurse was not around to alert to their situation. A relative told us, "There is not enough staff in here but those I meet here, they do their job well. Because of the staff shortage, they put people to bed early at 4.30pm but when I am here, [my relative] stays here with me. [My relative] seems happier being [in the lounge] rather than in their room, because there is no one to talk to up there where [my relative] has to stare at the walls."

Staff told us they thought there were not enough staff working at the service. They told us this impacted on patient care because they were often delayed in repositioning people at risk of pressure ulcers by up to two hours and did not have time to complete paperwork. A care worker told us that if there are not enough staff available then people who need support to leave their bed cannot do so that day. We noted that staff had raised their concerns during meetings but did not feel these had been dealt with.

During the inspection we observed that people who required support to eat lunch had to wait for 20 minutes for an available staff member before they could eat. There was only one nurse on duty who had to provide support for all three floors.

The above issues are a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew who to contact if they had any concerns about their safety. People and their relatives told us they would inform lead staff on the floors or the manager of the service. Staff had received training in safeguarding adults from abuse and had a good understanding of what may constitute abuse. Care staff were aware of their duty to report any concerns to the nurse or the manager and to record the incident. Staff were aware they could escalate their concerns if it had not been dealt with appropriately. One staff member told us, "I have to report it to the nurse. I need to see if they take it up. If not I would tell the regional manager, social services, the Care Quality Commission or police. Otherwise I'm not helping residents." This meant people were protected from potential abuse.

Records showed people received their medicines as prescribed. Medicines were administered by trained nursing staff and we saw medicines were administered safely. Medicines were stored safely and securely at appropriate temperatures, including medicines that required refrigeration. We reviewed medicine administration records which did not contain any errors. There were clear protocols in place for people who required specific medicine on an as required basis and we observed that these were followed correctly.

However, the provider was storing surplus medicines that were to be returned in plastic bags on the floor. This was not in line with NICE guidelines which states that medicines for disposal should be stored securely in tamper-proof containers within a cupboard until collection.

A thorough recruitment process meant people were supported by staff who were suitable for work in the caring profession. Recruitment files contained criminal record checks, application forms, proof of their right to work in the UK, and two references for each staff member. This meant the provider had carried out appropriate checks to ensure staff were suitable to work in a care setting.

No one was identified to us as being the lead staff member to prevent and control the spread of infection. There was no clear system for ensuring daily routine and regular deep cleaning of the home. This meant there was a risk that prevention and control of infection practices were not being followed. Despite this, the areas of the home observed appeared clean and there were no malodours. We saw staff had suitable personal protective equipment available to them, such as gloves, aprons, hand washing facilities and these

were appropriately used.

Incident records showed the service investigated and responded to concerns in a timely manner and where appropriate referrals had been made to healthcare services. The paper records in the service had a section to be completed regarding any follow up actions or lessons learnt. This was not completed on the paper documents and the service had not seemed to embed improvements in areas such as pressure wound care. We spoke to the manager about this who told us training was being arranged for staff regarding skin care for the following week. This meant the provider was beginning to put measures in place to make improvements in areas with high incident levels.

Is the service effective?

Our findings

The provider drafted assessments of need before people moved into the home. People's religious and cultural needs and sexual orientation was captured but there had not been consistent consideration of how people's background would impact on their care plans relating to different areas of care including continence, medicines, mobility, nutrition and hydration, and personal care.

Care plans in relation to skin care and wound management were not detailed and the home was not using and applying best practice guidance in these areas. The care plans were not clear nor goal focussed and did not demonstrate the provider had kept up to date with best practice in supporting people living with conditions such as dementia. There was no detailed or personalised information about the impact people's diagnoses had on their daily experiences or guidance for staff on how to ensure people were not disadvantaged by their diagnosis.

These issues were exacerbated because staff were not always provided with adequate training and support to meet people's care and support needs such as to support people who had pressure ulcers and diabetes. The service did not have a clinical lead to provide support about treatment of people living at the home. The provider-arranged clinical group supervisions were overdue as the last session recorded was dated December 2016. Nurses did not receive supervision from an internal or external clinician. This meant staff did not have an opportunity to discuss and reflect on clinical work.

The above issues with training and supervision of staff are a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received other mandatory training sessions set by the provider about non-clinical care tasks such as moving and handling training. Supervisions were held on a regular basis for care staff providing a forum to discuss their work over a given period. New staff underwent an induction when they started working at the service.

People were given food in line with their preferences and dietary requirements. However, the provider could not always be assured people were eating or drinking enough because staff did not accurately record the amounts of food and fluid people had or how much they weighed. Staff were aware that they were to record amounts in food and fluid charts however, those we reviewed had missing entries and totals were not calculated so staff could not know whether people had received the right amounts or further action needed to be taken. Weight records we reviewed were not up to date. For example one person who was to be weighed weekly had last been measured 12 days prior to the inspection. This meant risks to people's nutritional intake were not being appropriately mitigated.

People and their relatives had mixed views about the quality of the food. One person told us, "The food is too spicy." Whereas another person told us, "The food is great. If you don't like it they give you alternatives." We saw people were given choices about what they ate and menus had a choice of three main meals. Staff we spoke with understood who required more support such as requiring a soft diet. The chef told us they

knew what people did and did not like to eat and provided food in line with people's religious requirements.

Most people on the nursing floors ate their meals in bed. On the first day of the inspection we observed lunch being served 50 minutes later than the set meal time. Staff explained that this delay was due to staff not being available to support people to eat their meals safely on an individual basis so people had to wait until staff were free. This meant people were not being supported to have a positive experience of meals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Where people lacked capacity to consent to their care and treatment the provider had made appropriate applications to the local authority to deprive them of their liberty. Copies of these authorisations were contained within care files ensuring staff were aware of people who were deprived of their liberty.

The provider recorded who had capacity to consent to various aspects of their care. Records for people who were recorded as not having capacity showed relatives had signed consent forms for some medical interventions but it was not clear they had legal authority to do so. Relatives can only consent on people's behalf if they have the appropriate legal authority to do so. Where someone has nominated a decision maker for situations when they lack capacity, and this has been recognised by the Court of Protection, this is called a Lasting Power of Attorney (LPA). The provider did not always have records about relatives who had legal authority to make decisions about care and treatment on behalf of people living in the home. Despite this, we saw relatives had signed to indicate consent on care plans reviewed.

Staff understanding of the principles of the MCA and how to apply them to their roles was varied. More senior staff demonstrated they supported people to make choices about their care. However, others did not demonstrate they understood the MCA. One care worker said, "I don't know." Staff were not aware that people who had capacity could make decisions for themselves even if they would be deemed unwise nor did they demonstrate knowledge of LPA or who was subject to a DoLS authorisation. This does not demonstrate an understanding of the principles underpinning the MCA.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files were unclear about people's healthcare needs and diagnoses, such as those related to diabetes, but records showed people were supported to access healthcare services when they needed to. People and their relatives told us they felt well supported and could see a doctor once a week if they needed to. Records demonstrated that a GP made a weekly visit to the service. Staff made records of GP visits input. Care workers understood how to monitor people for signs of deterioration such as a change in mood and told us they would report any concerns about people's presentation to nursing staff who were professionally qualified to identify these conditions.

The construction of the building did not lend itself to its use as a care home. There were many small rooms

and lounges split over three floors. This meant that staff had to access different floors to support people. The manager reflected that this also hindered people from socialising or partaking in activities as much as possible. The building had been adapted for people's needs and each floor had fully accessible bathrooms. People's bedrooms had a limited amount of personalisation and people had their own belongings and pictures. One relative told us, "My brother has a beautiful room up there but he feels a little bit isolated and I am also concerned about his liberty".

Is the service caring?

Our findings

Staff developed compassionate relationships with people using the service. People and their relatives told us they had good relationships with staff. One person told us, "The staff are very helpful and kind. When we have activities and I need help, they are always there. They know what I like and what I dislike." A relative told us, "They are polite and interactive." A second relative said, "I have never seen any trouble. The staff are friendly, they always say hello". Staff had fostered a good relationship with the people living at the service and spoke warmly about them. One staff member told us, "I know them well. Every morning greet them talk to them we share jokes together." Another member of staff said, "It is a 'privilege' to be with them in their home.

People and staff told us the delivery of compassionate care was sometimes affected by staffing levels. One person said, "The staff do not have the time to talk to you, they are too busy." Care staff explained that they did not always have time to talk to people properly or provide care tasks in a timely manner. This meant people were not always receiving compassionate care as there was variety in people's experiences dependent on the amount of staff present.

Staff supported people to express their views and involved them in day to day decisions about their daily lives and support. A person told us, "The staff always ask me what I want. I continue to do things the same way I used to do at home." We observed people being supported in a way they chose to promote their independence and staff told people what they were going to do to them before they did it. A staff member told us how they support people who cannot verbalise their needs, "I can see by their expression what they want. And their body language." However, care plans did not always contain clear guidance about how to best support someone to share their views. For example, one person's care plan stated, 'Check for any evidence of frustration through non-verbal means. Repeat if needed' but there was no explanation about how staff were to do this beyond 'keeping calm.'

People's diversity was respected and the provider supported people to retain relationships if they wished. People's sexual orientation was captured in their care records and staff explained how they treated everyone the same regardless of their orientation, religion or background. A family member told us, "My daughter and her husband come to visit [my relative] and his two friends visit him regularly as well." A person told us, "I feel respected and I have never felt embarrassed". People's familial relationships were recorded and well understood by staff so that support could be offered where appropriate.

People's religion and cultural needs were captured in their care plan and staff knew how best to support them with these requirements, such as providing food appropriate to their religion or not discussing their religion if they chose not to do so. Records demonstrated that religious leaders frequently visited the service and were given the opportunity to partake in weekly worship. The provider had arranged for regular musical performances from places of religious worship.

People's privacy and dignity was not always promoted and feedback was mixed. A relative told us that, "Yes, my mum's dignity is respected. For example, they close the curtain when I am helping them to wash and to

dress her up. And sometimes I think they do this too much as it is only us in her room. But they still insist on closing the curtain". A second said, "Yes, they are respected. [My relative] is always well dressed; [person] is seated in their chair comfortably. And yes, they feel supported". Staff members told us that they viewed people's privacy with the utmost importance and kept private information confidential. We observed staff knocking on people's doors before entering and closing doors while providing personal care tasks.

However, people's experiences were affected by low staffing levels. We observed people left in aprons after meal times had finished and people told us they had accidents waiting for staff to assist them to the toilet. This meant that people were not always treated with dignity.

Is the service responsive?

Our findings

People and their relatives felt staff understood their likes, dislikes and backgrounds. One person stated, "Yes, the staff know what I like and if they don't, I tell them. They also know I am from [continent]." A relative told us, "Every person is an individual. I have seen the staff assist my mum. I have confidence in them". Despite these positive comments, care plans lacked detail regarding people's preferences and were not personalised. Documentation was found in four different places including one document in their bedrooms called 'About me'. One of the documents viewed had been completed by the person's relatives and contained information about their working life, hobbies and personal history. However, others had been poorly completed or were blank. The provider explained that the inconsistent level of detail was dependant on the level of input from people's relatives.

Information in care plans did not always contain enough detail about how people wished to receive their care. For example, one care plan we reviewed contained no information about how people like to be washed or dressed. Information about how to support people to communicate what care they wanted was limited. For example, one person's care plan stated, 'Talk in a calm way' with no further information about how to do these things.

Care workers were encouraged to read the care plans regularly before providing care. However this was not a realistic expectation because documentation was found in four different files in four different locations and were difficult to navigate to gather the information required. For example, the 'observations and bedrail check' stated that it was not for recording repositioning information but contained boxes that were filled in for position and no space to record information relating to bedrails. This means there was a risk vital information may be missed if all files are not read or updated.

We noted that care records were not always updated following a change in a person's care needs. For example, one assessment was due for review in April 2017 and not been completed by the time of the inspection in November 2017. Staff we spoke with explained that they did not always have time to review documentation due to a lack of staff. Treatment plans from visiting health care professionals were not included in people's care plans meaning they were at risk of not having their healthcare needs met.

The provider did not do enough to support people to plan their end of life care. One person was approaching the last stage of their life and their care documentation was inadequate to ensure that care was provided at this stage in line with their preferences. The person's preferred place of care and what happened to their body was recorded and signed by the person's relatives but did not contain information about what they wanted to happen at the final moments. There was no consideration of the person's likes and dislikes. The person had a valid 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) in place however the section where this would be discussed with the person's family was blank, contrary to best practice. The provider had referred the person to the palliative team, however there was no evidence of discussion or planning available. The provider had not identified a staff member to be the lead specialist in End of Life care and no robust links with local hospices or professionals had been made to provide expert guidance to staff.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who could mobilise to the lounge areas were supported to maintain their hobbies and interests. The home had recently recruited an activities coordinator and was in the process of recruiting to a further part time position. A broad range of activities were available in the lounge including gentle exercise classes, cultural celebrations and arts and crafts. A successful parent and toddler group was held weekly which people thoroughly enjoyed. The activities coordinator was enthusiastic and we observed that they were well liked and interacted well with people living at the home. They had made good links with local places of worship and schools to provide extra festivities at the home. The coordinator evaluated each session and reported on whether people were engaged or not and made modifications where necessary. One person said, "I like entertainment; I sit and listen to songs, I also like to do the kick feet. We have enough activities and they know that I like throwing in the rings." Another said, "I am a musician and I play guitar. I did something for a TV programme. The staff know I like music and I am going to play with the manager for residents on Christmas". The service organised weekly trips to a local park, pub or bowling alley for people that wanted to attend.

A large proportion of people who lived at the service were nursed in bed. It was recorded that there was a 'resident of the day' scheme in place whereby that person got more attention from staff to carry out activities that they liked in their room and got to pick a special meal. We observed that one person's room had been redressed to look like an office so the person could reflect on their previous job as an administrator. Music, audiobooks and television played in people's rooms but we did not observe any other activities taking place for people who could not leave their rooms. The provider told us that the additional activities coordinator would support the work begun and further develop the range of activities that people can do in their rooms.

The home had a clear policy regarding complaints, which included the expected timescale for investigation and response and how to escalate concerns if people were not satisfied with the response. People told us, "I would tell the manager but I have never had to make a complaint; and when I say something, the staff listen". A second told us, "If I were not happy with something or someone, I would tell the person face to face or tell the manager. They normally listen and if something can be done, they will do it". A relative told us, "My mum is safe, if there is a concern, I raise it and it is looked into instantly." Records showed the home had investigated concerns in a timely fashion. There was a computer system in the entrance hall for people to leave anonymous feedback if they wished. We saw that this was monitored by the manager.

Is the service well-led?

Our findings

The management structure of the home did not always provide clear lines of responsibility and accountability. The home had been run by three different managers over the period of 18 months. The current manager had overall responsibility for the service. However, the manager was not a clinician and was not supported by a deputy manager or a clinical lead. A team leader was appointed but they were not a clinician either and this caused confusion amongst staff about who was accountable for certain tasks. One managerial position was insufficient to run the service and complete the improvement works required. This also meant that clinical staff were not able to access expert support which staff reported as a hindrance to carrying out their roles.

The service was not organised in a way that promoted safe care through effective quality monitoring. Following internal audits and external reviews by the local authority the home had an action plan in place to address issues with the quality and safety of the service. The audits had identified a range of issues such as those with pressure ulcer care in Spring 2017. We found these shortfalls persisted and were still found during the inspection. This meant the actions in place to address these concerns had not been fully effective. The provider also completed an ongoing rotation of audits however these did not highlight all the issues identified by the inspection. Further documentation was contained in unordered folders and was not in a chronological order with a logical set of outcomes. Where issues were found there was not always a plan of action to rectify the situation. For example, the care plan audits did not identify all the issues we found and there were no action plans to improve the plans reviewed.

The provider had not fostered partnerships with other organisations. Strong links had not been made with local hospices or palliative care teams to embed best practice around End of Life care. The provider had not reached out to other services or local resources to make up the shortfall in clinical expertise in the home. This meant they had not sought adequate support or supervision for nursing staff. The service did not have any plans to develop the service such as methods to embed good practice or new technical systems.

Feedback from people, relatives and staff about the culture and atmosphere at the home was mixed but all agreed that the new manager had begun to make improvements. People spoke highly of the new manager and told us he was approachable. A person told us, "The manager is [manager's name]. I speak to him and he listens". A second told us "I do speak to him. He does listen". A third said, "He listens. He plays piano and I play guitar". However, staff morale was muted and staff reported they did not always feel well supported or part of a wider team. One staff member said, "You don't get the support from management that everyone needs." Daily meetings of leaders within the home took place which staff found useful to discuss pressing matters but more structured meetings were not always detailed enough or followed up appropriately such as the clinical governance committee meetings. This meant that staff did not always have access to forums to discuss their roles.

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

People and their relatives felt they were involved in the day to day running of the service. One person said, "I am a residents' representative and make sure that people feel safe and I help them to settle in." A relative said, "I get invited to the relatives' meeting and I am happy the way the home is run". Records demonstrated that resident meetings were held regularly where people were asked for their input about such things as the food and activities provided. We noted that people requested fresh cakes in these meetings and that the provider had arranged for fresh cakes to be available daily. The manager made rounds of the service and followed up on suggestions that people or staff made.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate, did not meet their needs and did not reflect their preferences. Regulation 9(1)(a)(b)(c).
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The care and treatment of service users was not provided with the consent of the relevant person. Where the service users were unable to give such consent because they lacked capacity to do so, the registered person did not act in accordance with the Mental Capacity Act 2005. Regulation 11(1)(3).
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 The care and treatment was not provided in a safe way for service users. The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and do all that was reasonably practicable to mitigate any such risks. Regulation 12(1)(2)(a)(b).
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Treatment of disease, disorder or injury

governance

The provider had not established effective systems to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2)(a)(b)(e)(f).

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified and skilled staff were not deployed in order to meet people's needs. The provider did not ensure staff received appropriate support, training, supervision and appraisal to enable them to carry out their roles. Regulation 18(1)(2)(a).