Caretech Community Services (No.2) Limited

St Agnells House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 08 December 2015 and was unannounced.

St Agnell's provides accommodation for up to eight people with learning or physical disabilities. At the time of our inspection eight people were living at the home.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 current manager had only been in post at the home for five weeks. Four of these weeks had been as a deputy, and the final week as the manager. Many of the issues and concerns we identified were not attributable to the current manager as they pre dated their appointment. The manager told us they would apply for their registration shortly, however had not done so at the time of our inspection.

We carried out an unannounced comprehensive inspection of this service on 04 December 2014. A breach of legal requirements was found in respect of three regulations. Following the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 09, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations correlate to Regulations 10, 11, and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this comprehensive inspection to check that they had followed their plan and found that although improvements had been made the legal requirements had not yet been met. At this inspection on 08 December 2015 we found a breach of legal requirements in regulations 16, 17 and 18. 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 St Agnell's on our website at www.cqc.org.uk.

At this inspection we found sufficient numbers of staff were not always deployed to provide support to people living in St Agnell's. The manager had not always thoroughly reviewed and investigated incidents and accidents to keep people safe from the risk of harm or abuse. Risk assessments had not always been developed to positively respond to risks that were identified. People's medicines were not always stored correctly. People were supported by staff who had undergone a robust recruitment process to ensure they were of sufficiently good character to be employed at the service.

Staff felt supported by the manager to enable them to carry out their role sufficiently, however people's relatives felt the provider did not positively support the management team. Staff had received training relevant to their role, and were able to obtain further qualifications where required. People were supported to eat a healthy diet by staff who knew their individual needs well. When people required support from health professionals such as the GP or Nurse, we saw people were swiftly referred and supported.

People's personal care records were not always kept securely to ensure unauthorised people did not have access to them. Staff spoke to people in a kind, patient and friendly way and people were treated in a dignified manner. Staff consistently ensured people's social needs were met, and people felt staff listened to them and valued their views.

People received quality care, however this was not monitored and was not robustly reviewed by the provider. The home had suffered from a lack of consistent management and governance, and audits required to monitor the quality of the service had not been reviewed as required. People, relatives and staff were supported by a newly appointed manager who they felt listened to their views and encouraged feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always sufficient numbers of staff deployed to support people's needs.

Incidents did not always prompt a review of people's care needs.

People were kept safe by staff who were aware of how to identify and report suspected abuse.

People's medicines were not always stored correctly.

Is the service effective?

Good

The service was effective

People told us they thought staff were well trained and supported by the manager.

Staff told us they were supported to develop in their role.

People were supported by staff who sought their consent prior to delivering care or support.

People's nutritional needs were met.

People were supported by a range of healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were able to contribute to their care, and were kept up to date with developments.

People were listened to and their views were respected and acted upon.

Staff spoke with people in a kind and sensitive manner and ensured people were treated with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was personalised and responsive to their needs.

People were supported to pursue individual hobbies and interests.

Complaints were not managed or investigated thoroughly and did not document how they were concluded.

Is the service well-led?

Requires Improvement

The service was not well led.

The home had undergone a sustained period of instability due to management changes.

People's personal records were not kept securely at all times.

Systems or processes were not effectively established to ensure people receive a safe and high quality service.

People told us that the manager was approachable and listened to their views.

St Agnells House

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.

This inspection took place on 08 December 2015 and was unannounced. The inspection team consisted of one inspector.

Prior to the inspection we spoke with the registered manager by telephone who had subsequently left their post when we arrived. We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We spoke with a member of the contracts monitoring team for the local authority.

During the inspection we observed staff support people who used the service, we spoke with 2 people who used the service, three members of staff, the newly recruited manager and the locality manager. We spoke with two people's relatives to obtain their feedback on how people were supported to live their lives.

We reviewed care records relating to three people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

There were not sufficient numbers of staff deployed to provide sufficient levels of support to people when they required this. The new manager told us that recruitment had been one of the largest difficulties facing the service at the moment. They said they were largely reliant upon agency staff to cover the gaps, and had them self completed a night shift prior to our inspection because an agency staff member had called in sick.

We looked at the rota which showed that permanent staff had worked excessively long shifts to cover the gaps. One staff member had completed the night shift prior to our inspection, and had then carried out the day shift the following day. The manager had also covered shifts themselves to aid with the shortfall. Staff we spoke with told us the manager was visible and hands on.

Staff we spoke with told us that during the day, when they were understaffed it was difficult getting people out to appointments or to the day centre. They explained that the providers policy was to not leave agency staff with people unsupervised. This meant that where permanent staff were limited on a particular shift, agency staff were not able to support people without an experienced staff member present.

Staff we spoke with told us this did not affect them delivering support such as personal care or things in the home, however it did mean at times people were unable to engage in community activity or attend appointments. We found when we looked in people's care plans correspondence from doctor and hospital appointments confirmed on occasion appointments had been missed. Although these were rearranged to a later date as a result people were unfairly penalised and unable to engage in community activities or appointments due to a lack of consistent staffing.

We were unable to speak with all the people living at St Agnells House due to complex learning needs, however those people we did speak with told us they felt safe. One person said, "I love it here, I am happy." One person's relative told us, "Yes [person] is safe, we come every week and have never seen anything alarming."

Staff were knowledgeable about how to raise any concerns they had. They told us they would comfortably raise concerns both within the home to the manager or externally. Staff were aware of how to 'whistle blow' if the need arose. Information and advice was available to staff that informed them how to report safeguarding concerns which included contact details for the relevant local authority. One staff member told us, "To me it's making sure people are okay, well cared for, happy and safe and report anything I am not happy with. Like, if I was to see a bruise, I body map everything, and report it straight away, and get [manager] to look. Then I keep an eye out to make sure it wasn't frequent, if it was I would be worried and would then come to you [CQC]."

The management team had used information from accident, injury and incident reports to monitor and review new or developing risks. However, they did not always ensure measures were then put in place to reduce the risks. For example, one person had previously been found lying on the floor of their bedroom early one morning. Staff were unable to account for why they had fallen as it was un-witnessed. They had a

number of bruises and abrasions to their body following the fall. The previous registered manager had reviewed the incident, and had noted they were to arrange for an occupational therapy assessment to be carried out. However when we asked the current manager if this assessment had been carried out they were unable to find out if this had been completed.

At our previous inspection in August 2014 we found that staff were not aware of the need to record incidents. We found that improvements had been made and a record of incidents had been maintained. Staff had recorded details of the incident accurately, and these were left within people's special record in their daily care notes, although not always reported on the appropriate form. The manager said these were currently extracted on a monthly basis, however agreed that this meant they may not always be aware of incidents as they happened. We spoke with the provider about the inconsistencies in incident reporting and investigating. We spoke with the manager who told us they were aware that the systems required reviewing and were in the process of addressing this.

However, at the commencement of each shift, all staff sat together for a hand over of the previous shift and any tasks that needed completing for the upcoming shift. Staff were able to talk about people's health and well-being, their demeanour, observations about how people had eaten and drank, and an overview on the person's activity for that day. Where there were concerns, for example one person was particularly agitated on the day of our inspection, and then all staff including agency staff were able to discuss the issues and keep a closer eye on them. We were satisfied that the management of risks and incidents to people was carried out through frequent discussion and handover among the staff team, but not always documented and formally reviewed.

Staff we spoke with told us they did not look at incidents that had happened in the home and reflect on how they could have managed things differently to avoid the likelihood of a repeat occurrence. The manager told us that as part of their review of the service, lessons learnt would be incorporated into team meetings, so that all staff could reflect on their practise to mitigate the risks of incidents recurring.

We looked at recruitment records for staff recently employed at St Agnells, including the new manager. We saw that staff underwent thorough pre-employment checks prior to beginning work at St Agnells. Staff completed an application and provided the details of at least two references which were taken up along with a criminal record check prior to any offer of employment being made. Qualifications that staff declared in their application were also checked and verified.

There were suitable arrangements for the safe receipt and disposal of medicines. We saw medicines were booked in by two staff and returned to the pharmacy when no longer required. When people required medicines to be ordered this was carried out expediently. We checked the stock records for two people's medicines and found the physical stocks in the cabinet matched the tally in the record.

People were supported to take their medicines by staff who were trained and had their competencies checked and assessed in the workplace. Guidance was available to staff to read in relation to the specific medicines they administered. This ensured staff were aware of any potential side effects that the medicine may cause. Where people were prescribed, 'As required' medicines, such as laxatives, or painkillers, guidance was available to staff about when to use, and how people communicated they required this, where they were unable to verbally communicate.

When we looked at the medicine records for people, they had mostly been completed as they were administered. However we found examples where people had refused or not had their medicines, but the reason had not been recorded as required. This meant it was difficult for staff to track back to confirm if a

person had received their medicine as needed. We also noted that the temperature of the medicines cabinets in people's rooms had not been maintained. When we checked the daily record that staff were to complete we noticed gaps in the recording. This meant that effective monitoring had not been carried out to ensure medicines were stored within safe temperature levels.

Good

Is the service effective?

Our findings

People's relatives we spoke with told us that staff were well supported and had the necessary skills to carry out their role. One relative said, "They work hard and know how to do their jobs, the staff are lovely, our concerns are the turnover of managers who haven't had the support from above. There have been changes to the locality managers, and the managers of this place. From our point of view the managers do well, but they don't get the support from on top."

Staff we spoke with were complimentary about the previous registered manager and the current manager. They said that they felt supported to develop in their role, and that they could take any concerns to the manager who would support them. Staff explained to us they had been trained in a variety of areas key to their role, including safeguarding, moving and handling, epilepsy awareness, and first aid. One staff member said, "I've done so much training in the last six months with my induction. I had to read the care plans, shadow staff, observe feeding and hoisting, and then do the training in things like mental capacity, DoLS, epilepsy. I love working here." A second staff member said, "I have support, it's been hard with the management changes but I could go to the team when I needed to."

Staff we spoke with told us that they had received an induction that was thorough and enabled them to provide care safely. One staff member told us, "Induction was reading through the care plans to get to know people, then shadowing an experienced carer and observing care being provided, as well as the usual training around safeguarding and moving and handling." However, the manager told us that they did not formally assess temporary agency staff. They told us that the agency provided them with a pro forma sheet that detailed the staff members skills and qualifications. We asked if they then assessed and reviewed the care they provided and they told us they did not formally.

Some people who lived at the home were unable to communicate with us verbally so we observed how staff interacted with and supported them in communal areas such as the lounge and dining area both during mealtimes and when people were relaxing. We saw that staff were patient and used a variety of both verbal and non-verbal techniques to communicate with people, establish their wishes and obtain consent before any care or support was provided.

The manager was aware of consent arrangements and described to us a difficult situation they had faced at the home. They told us that they had recently refused to discuss matters relating to a person's financial position with a member of their family. They told us they had refused to discuss the information and requested further verification because they were not comfortable the person had the correct permissions to either act on their behalf, or to be provided with confidential information. The manager was quite clear that because people had relatives who visited regularly, this did not mean they also were able to make autonomous decisions for people without the appropriate consents being obtained. They told us they were going to ensure that the appropriate legal consents had been sought and evidenced. Where necessary they would approach social services for the use of an advocate.

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 provider worked within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection we found that nobody who lived at the home had been deprived of their liberty and so DoLS applications and authorities were not required.

Staff received training about DoLS and how to obtain consent in line with the MCA. They were knowledgeable about how these principals applied in practice together with the circumstances in which DoLS authorisations would be necessary. We saw that where people may have lacked capacity to make their own decisions in certain areas, assessments and best interest decisions were properly structured, formalised and reviewed in line with requirements of the MCA.

People and relatives were positive about the food people were provided with. One person told us, "The food is nice and there is a lot." One person's relative told us, "[Person] is now eating much better and is putting on weight." Menus were agreed with people who lived in the home, and were based upon people's favourites. Where possible the cook tried to make the food as homely and comforting as possible, but people were also reminded about the need to eat healthily. For example, minutes of a meeting showed that meals and food had been discussed and it was agreed that more fresh fruit would be made available.

We observed people being supported to eat both their breakfast and lunch. People were able to choose were they ate with some opting to sit at the dining table and others wishing to watch TV or talk with staff. The atmosphere was sociable, people were talking about their day, staff and people were seen to be enjoying each other's company. When people were supported to eat they did so in a patient and calm manner, not rushing people, and not leaving them to assist others. Where people were able to eat they were encouraged to maintain their independence by the use of spouted beakers for drinking and finger foods where possible.

We saw that staff monitored people's weight and where people required a food or fluid chart to document their intake, these were maintained. Where there were concerns about people's nutritional needs, or where people had swallowing difficulties, such as dysphagia, they were referred to dieticians and speech and language therapists for review. The recommendations from these reviews were clearly displayed for all staff to review prior to assisting people with their meal. For example, we saw guidance for one person was to have a soft meal with thickened liquids. Staff were clear when they explained this to us, and demonstrated they were fully aware of how to support this person.

Peoples health needs were supported by a range of healthcare professionals. We saw that arrangements were in place with a local GP surgery, and people were further referred for support to services such as district nurses, psychiatrists, podiatrists and social workers. One person's relative was very positive about the care St Agnells staff supported their relative to receive. They told us that they felt their relative was incorrectly diagnosed with a condition that affected their eating, subsequently; they were placed on a pureed diet to prevent choking. However, they said that the person did not enjoy eating this way, and so the staff arranged a meeting with the dietician, who listened to their concerns and reviewed the guidance. They said this subsequently had a positive impact upon the person. The said, "[Person] used to refuse because they didn't enjoy the food, I mean would you like it all blended up together. We had a battle to get [person] back on to the foods they like, and can eat, but now they eat well."

This demonstrated to us, that staff, people, and relatives had worked positively with other professionals to find solutions that support people positively, without placing them further risk.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them in a dignified manner and respected their privacy. One person told us, "They are kind and lovely to me." One person relative said, "Never have I seen anything that makes me think people are not treated in anything other than a dignified way." We observed throughout the inspection that when people required assistance, staff approached them in a sensitive manner, and quietly escorted them to assist them. We saw that no fuss was made, and once staff had assisted them they were quietly brought back to re-join the group.

People's relatives said people were treated with kindness and compassion by staff. One person told us, "[Person] is always clean, the care is second to none, they all are so kind with [person] we really don't have any complaints at all about how they care for [person]."

Staff had developed positive relationships with people, we saw constantly through our inspection that staff and people shared smiles, jokes, conversation and discussed shared interests that engaged people positively. People looked to be comfortable and at ease with the staff which promoted a relaxed and comfortable atmosphere within the home.

We saw that staff responded positively to people who were distressed. One person was clearly agitated on the day of our inspection referring to people and staff in a derogatory manner. Staff were observed to spend time with this person, and demonstrated a patient and caring attitude towards them. They spent time with them, spoke to them warmly and attempted to distract them with activities and discussion. Gradually throughout the day, the person's mood levelled and their agitation abated. We saw that later they were engaged at the dining room table completing a puzzle, contently on their own.

People and their relatives were kept informed about their care and support needs. One person's relative told us staff regularly kept them informed of how their relative was getting on. They said, "We have such a good relationship with the staff, they just come and sit down and listen to our viewpoint, they always let us know how [person] has been." We observed one person's relative sitting with a staff member discussing a possible winter inoculation for their relative. The staff member was seen to sit patiently and listen to their concerns, and then agreed to follow up their request with the GP.

We saw that people's care plans had been developed in an easy read format that enabled people to develop and review their care plans. Each person reviewed their care plan with their key worker and where possible a family member. One person's relative told us, "We have a meeting here, they give me the paperwork and care plan and we all sit down and look at the options and agree on what [person] needs."

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at had been developed clearly with the involvement of both the person and their relative, but also with the involvement of health care professionals where needed. The individual care plans identified in detail how to support a person with a particular area of care. For example, care plans relating to personal care clearly depicted the approach staff should take, how the person liked to receive their personal care, and what the person liked to do for themselves. Where people had communication difficulties, the care plan identified how to communicate with the person, and described how the person communicated their wishes to a staff member. One staff member told us, "With [person] when we help them get dressed in the morning we get out two or three different outfits. [Person] very clearly tells us by a nice smile if they want to wear a particular thing, or if not, we are very clear they don't want it."

People received personalised care that was responsive to their needs by staff who clearly knew the person well. One person's relative told us, "They know [persons] needs, their likes, dislikes, I mean they know [person] likes to have a cup of tea, a cuddly toy and a particular programme on the TV. If [person] doesn't have that then they staff will get a shout and will know what [person] wants." We asked staff what personalised care meant to them, one staff member told us, "Everyone is different, it's getting to know them personally, on their level, and understand how to give them what they need, when they need it, and how they want it in the way that they like it."

People clearly received the care they required when they needed it, and had choice and control about their daily lives. One person relative told us, "[Person] has been here for four years and St Agnells is their home." One person told us, "The staff are really nice and are helping me cook today." A second person told us, "They help me when I ask them, they are very nice people."

Wherever possible, staff actively encouraged people to assist in the running of the home. Staff encouraged people to assist with preparing the table for lunch and clearing away the dirty crockery. One person had asked to redecorate their bedroom, and the manager had sought the involvement of both the family and the person. They had spent time going to the furniture and decorating shops choosing furniture, paints and soft furnishings that reflected their personality. During the inspection we observed numerous similar examples that demonstrated how staff supported people to remain as independent and in control of their lives as possible.

People who lived at St Agnells were now encouraged to be an active part of the wider community. We have reported how on occasions due to a lack of available staff people were not always able to attend appointments, however we found there was a range of personal interests and activities people pursued whilst in the home. People enjoyed a variety of different activities which were now being provided in the community. These ranged from attendance at the day centre to shopping trips, visits to the pub for lunch, animal therapy hair salon days, pyjama days and day trips and parties. When people were in the home, staff supported them to engage in a range of one to one activities. We saw that people happily sat and drew pictures, cooked, played games, read, watched television, sung and socialised freely. The home was adorned with works of art created by people, who proudly displayed their creations.

People, their relatives and staff told us that everyone was busy preparing for the Christmas party, which was due the following week. The manager told us they had invited a range of people's friends, families, staff and also professionals who were involved in supporting people living at St Agnells.

People were not isolated, and staff went to great lengths to ensure people were both not alone, and also had frequent contact with their families. One person told us, "I like it when [staff] is here because they are good and spend time helping me." One person relative told us, "

People told us they were aware of how to make a complaint if they were not happy. One person said, "If I am not happy [staff member] will fix it for me, or the manager." One person's relative said, "If we have any worries we would raise it and it would be dealt with. I have been told how to raise a complaint, I just haven't needed to." Information was provided to people and visitors about how to complain, and if they are unhappy with the outcome then the details of external organisations were provided. We looked at how complaints were managed by the manager.

Where complaints or concerns were raised, these had not always been reviewed and responded to and a clear record had not always been maintained of how they were resolved. For example a complaint had been made by a person in relation to their care. They had raised with the manager that they felt staff had shouted at them which made them worry. When we asked for a copy of an investigation report, the manager did not have one to produce as one had not been completed. The actions noted on the complaint form were to ask staff how they support the person and then to monitor them. No evidence was available that these areas had been completed. When we asked the manager how they had concluded the complaint they told us, "I have ruled out that staff shouted at [person] because I have worked with them on different shifts and know they wouldn't do it."

This was a breach of Regulation 16 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. Prior to our inspection we spoke with the previous manager who at that time was working their notice period. They provided us with an overview of the actions they had taken since being in post such as identifying training for staff, accessing further development opportunities, and improving how people were treated in a dignified manner. The manager told us that they had worked at St Agnells for seven months, however had only received a supervision meeting with their line manager the month prior to them leaving. They told they felt they had been unsupported in their role.

There had been significant changes to the senior management role, and a replacement senior manager had been in post for two months. The previous registered manager for St Agnells also had held the position of locality manager, which meant they had not been able to provide the support and direction that the home required as they had line management responsibilities in other homes. People's relatives told us that in 18 months there had been four different people in the management role, they said, "From our point the managers do well, but there is a high turnover of managers who don't get the support. The home is let down and doesn't get the support from above."

The current manager had recently been promoted from the position of deputy, who had been in post for five weeks. They told us it was their intention to register with the Care Quality Commission. However since being in post, in either managerial capacity, staff told us that the manager had worked positively to ensure people had received the best level of care they could provide.

We saw that audits had been carried out in the home and the actions of these were carried out. For example, a recent pharmacy audit had noted that guidance for handling medicines was not available to staff. The new manager had rectified this and made a copy available. We also noted that monthly safety checks were in place looking at environmental safety, infection control and finances for people who used the service. However, we were unable to find any auditing completed by a senior manager that looked at areas such as incidents, staffing, or complaints for example.

We asked both the manager and locality manager for a copy of the service improvement plan. They provided us with a copy of a plan that had been developed by the previous registered manager, who was also the locality manager. This had been developed in March 2015 and not updated since July 2015. However as an audit tool we found it was ineffective as the registered manager was auditing themselves with no senior manager having oversight. The newly appointed locality manager was visiting the service on the day of our inspection to review and update the plan. We asked why this hadn't been completed since July, they told us, "I've only been in post for three months." We asked them to forward a copy of their findings to us, which they agreed to do the same day, prior to them going on annual leave. They agreed to send us their findings, however we did not receive these as agreed.

When we carried out our inspection in December 2014 the manager told us that a room once used as a sensory room had been neglected and used as a storage area, and meeting room. They told us that they were in the process of returning this room to the people who used the service to use. However at this

inspection, no action had been taken to address this and the room had become more cluttered with archived records and furniture. The newly recruited manager showed us how they had met with a company who specialised in developing sensory areas for people to use. They said they were in the process of collating quotes for this work to be completed, however, this had not been carried out since our previous inspection.

Records relating to people's care and support were not always held securely. Staff completed people's daily records, charts and incident reports at the dining table. We noted on several occasions that records relating to people's care were left open and available to anybody to read. In a bookcase in the same room, people's weight and monitoring charts including continence records were available for people to remove and read should they be inclined to. This did not protect people's personal confidential information, and should visitors read this information it would not protect people's privacy and dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that notifications to the Care Quality Commission had not been made as required. For example safeguarding notifications had been sent to the local authority safeguarding team in relation to incidents that may place people at risk of harm. However the manager had not ensured these incidents were passed to CQC as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff and relatives told us that the new manager was approachable and listened to their views and opinions. One staff member said, "It was [new manager] who got us the trip to take the residents to Lapland, we had asked for a Christmas trip but it never happened until now." A second staff said, "Team meetings with the last manager were less pleasant, with this manager I feel they talk to us and listen to us like adults. They are committed to improving things here, everything we ask for [manager] has done."

We saw that surveys had been carried out by both relatives and people about the quality of care they received. Relatives we spoke with confirmed that they had completed the survey, however felt that they were slightly formal and not particularly useful, as they spoke regularly with the manager and gave feedback adhoc. They said that the relatives meetings held were also not particularly beneficial as very few people attended, and at times they could become overburdened on individual issues and not about the service as a whole. The manager was aware of the issues relating to meetings and was developing this area.

Staff we spoke with told us they had regular team meetings and were able to raise concerns and question decisions. Staff said that meetings had been beneficial and open. One staff member said, "[Manager] explained the changes they wanted to make and asked for our views." A second staff member said, " It has been difficult, what with all the managers coming and going but with [manager] what we have raised [manager] has discussed with us and brought in new changes. What [manager] is trying to achieve is a home environment, [manager] has come and wants people out and about, so we are all like one big family."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18. The manager had not informed the Commission of incidents they are required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) The provider had not ensured a robust investigation and where necessary proportionate action was taken in response to any complaint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) The provider had not ensured that arrangements were in place, including the recruitment and retention of a management team to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.