Blue Mar Limited

Colebrook Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 14 September 2017 and was unannounced. The service was previously inspected on 27 and 28 October 2015 when we rated the service as 'Good' overall. At that inspection we found no breaches of regulation, but we found some aspects of the management of the service required improvement and rated the well- led section as requires improvement.

Colebrook Manor is a care home that can accommodate up to 48 people who require nursing or residential care. There were 39 people receiving care at the time of this inspection. A few weeks before this inspection took place the registered manager resigned. A new manager had been appointed in mid-August 2017 and they had submitted an application to register, but this process had not yet been completed. 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.

This inspection was brought forward because we received some concerns and complaints about the service and we wanted to make sure people were receiving safe care. The concerns related to staffing levels, moving and handling procedures, procedures to be followed after a fall or serious injury, and behaviour and attitude of individual staff members. During this inspection we were assured that the concerns and complaints had been taken seriously by the new manager and their staff team, and actions had been put in place to address them and prevent recurrence. While we found no evidence of people being harmed by poor practice at the time of this inspection, we found a number of concerns which meant there was a risk of harm in the future. The providers had failed to implement robust systems to monitor and improve the quality of the service. They had not been pro-active in identifying issues, or dealing with issues promptly when they arose. This meant concerns and complaints may have been avoided if robust systems had been in place.

People could not be confident their personal care and health needs had been fully assessed, or that the staff had up to date information and knowledge on how to meet their health needs effectively. Before people moved into the home information was received from the local authority or hospital which outlined their needs. This information was used as the basis of a care plan for each person. However, care records were not always updated when people's needs changed and they were not reviewed on a regular basis in order to ensure that information was reflective of people's current needs.

Risks to people's health and safety had not been fully assessed, and staff did not have sufficient information to ensure the risks were minimised. People who lived with epilepsy did not have risk assessments detailing how to minimise risks from their condition. Where people were at risk of pressure ulcers, pressure mattresses had been put in place but we found three were incorrectly set. Staff had not been given information on the correct mattress settings, and there were no systems in place to monitor the mattresses. While we found no evidence that people had suffered harm at the time of this inspection due to poor risk assessment systems, there was a risk they may suffer harm in the future.

Systems to monitor the maintenance of the home were not fully effective. The overall appearance of the home was bright, clean and comfortable. A new wing had been opened on the first floor since our last inspection and this area appeared bright, modern, comfortable and spacious. However, there were some maintenance problems in some other areas of the home which may compromise people's health and safety and affected the appearance of those areas. We also found a number of other maintenance issues around the home which had not been picked up through regular monitoring of the accommodation, and there were no plans in place to show when these would be addressed.

People's capacity to make important decisions about their lives had not been fully assessed in accordance with the Mental Capacity Act 2005 (MCA). Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). 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. Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. However, there were people who lived in Colebrook Manor who would not always be able to give consent to personal care. This was not reflected in the initial mental capacity assessment or reflected in the care documentation.

People were not fully protected from the risks of abuse. Staff assured us they were confident they would recognise abuse and would not hesitate to report any concerns to the manager. However, the training records showed a significant number of staff had not received training or updates on safeguarding vulnerable adults. This meant staff may not always recognise poor practice or potential abuse, and may fail to report their concerns. Some people had asked the home to hold amounts of cash on their behalf to pay for personal items such as toiletries and hairdressing. While we found all purchases had been recorded, there were no checks or audits carried out on the records to ensure the money had been correctly recorded, and safely managed.

Staff did not receive regular individual supervision. This meant any areas of poor performance had not been picked up and addressed through formal management processes. Most staff had received training and updates on a core set of training topics, but the provider did not have an effective system to review training needs and plan future training to ensure staff were competent to meet people's needs. The lack of regular formal supervision meant staff did not have a regular opportunity to review their individual training needs with their line manager and consider any further training they may need.

Overall we found medicines were stored and administered safely. However, we found some minor issues which highlighted the need for further training, and improve systems for monitoring medicine administration systems.

People's dietary needs were met. Staff were aware of each person's individual dietary needs and the care and kitchen staff worked closely together to ensure people were offered meals they enjoyed. The menus offered people a choice of main meals, and the chef was always willing to provide an alternative of the person's choice if they did not want any of the meals offered on the menus. Staff were attentive at meal times and ensured people received the assistance they needed to make mealtimes an enjoyable occasion.

People living in the home, relatives, staff and visitors spoke positively about the care people received and we found the atmosphere in the home was cheerful and welcoming. There was a stable staff team. Staffing numbers had recently been increased which meant staff were not rushed and had sufficient time to give people quality time, for example by sitting and chatting with them, and doing activities. We found new staff had been carefully recruited. Checks and references had been taken up before new staff began working in the home.

The home employed a full time and two part time activities organisers, and between them they ensured each person's social needs were met. They consulted with people to find out what they wanted to do, and put in place a programme of activities to suit each person, both on an individual and group basis. Outings were organised, entertainers visited the home, and staff accompanied people for walks and shopping trips. Staff organised quizzes and games. Comments from people included, "Staff come and spend time with me", "They have a band that comes in and entertainers. They get everyone going" and "All staff are very friendly and come in and have coffee with people."

People told us they were happy living in the home. We heard many example of praise for the staff team, and we observed staff offering care and support to people in a compassionate and caring way. Comments included, "It's great. Here I've got the carers and nurses on tap. I also like the company, hear voices and people moving around", "It's a happy place" and "I don't think there is anywhere else I'd like to settle".

There were systems in place to ensure people knew how to raise a complaint or make a comment. A relative told us "If we find anything we want changed, we do say." A person living in the home told us if they had any complaints they would not hesitate to speak to the new manager and said "She is very good." The new manager had taken complaints raised with them seriously, investigated them fully and ensured actions were taken to prevent recurrence. However, a book placed in the entrance hallway for people and visitors to make comments had not been checked, and actions not taken to address issues. The manager has reviewed the use of this book to ensure all comments and concerns are addressed promptly in future.

Action we have asked the provider to take for one breach of regulation can be seen at the back of the report.

For all other breaches of Regulations the details are within the key questions and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe.

People could not be confident that risks to their health and safety had been fully assessed and recorded, or that safe systems were in place to monitor the risks.

People's health, safety and well-being may be at risk due to lack of maintenance in some areas of the home.

Some aspects of medicine administration were not fully safe.

People may be at risk of abuse because some staff had not received training on safeguarding procedures and may not recognise abuse or know how to report it.

There was a stable staff team and sufficient numbers of staff employed to meet people's needs safely.

People were protected by staff who had been recruited following safe procedures.

Is the service effective?

Requires Improvement

The service was not fully effective

People's capacity to make important decisions about their lives had not been fully assessed in accordance with the Mental Capacity Act 2005 (MCA).

Staff did not have sufficient information about people's health needs to ensure their health needs were delivered effectively.

People could not be sure that all staff had been trained to be able to effectively meet their needs.

People's nutrition and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not fully caring

Staff provided sensitive and compassionate care to people at the end of their lives. However, people's end of life care was not fully planned with them.

People were looked after by staff who treated them with kindness and respect.

Staff respected people's wishes and sought their views and choices in all aspects of their daily lives.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care plans did not fully reflect people's needs or wishes.

People's social needs were met by staff who supported them to participate in a range of activities both in the home and in the local community.

People were encouraged to speak out and raise any concerns or complaints and could be confident these would be listened to and acted upon to their satisfaction.

Is the service well-led?

Inadequate

The service continues to not be well-led.

People were at risk because the provider's systems to monitor the quality of the service were not fully effective and had failed to identify or address areas where improvements were needed.

The leadership, governance and culture did not ensure staff had sufficient information to ensure people's needs were fully met. .

Staff were not well supported to enable them to consistently and safely deliver good quality care.

Colebrook Manor

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 checked 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.

Before the inspection took place we looked at the information we had received from and about the service since the last inspection. This included notifications from the provider and contact we received from other professionals and from people who use the service, staff and relatives. A notification is information about important events, which the service is required to send us by law. This inspection was brought forward because we received some concerns and complaints about the service and we wanted to make sure people were receiving safe care.

The inspection took place on 12 and 14 September 2017 the inspection was unannounced. The inspection was carried out by two inspectors on the first day, and one inspector on the second day.

During the inspection we spoke with 15 people who were living or staying in the home, six relatives, the new manager (not yet registered) and 12 members of staff. We also spoke with two health and social care professionals who were visiting the home. We also observed people at lunchtimes in the dining rooms, and during activity sessions in the lounge areas. This helped us to gain an understanding of the way people and staff interacted, and how staff communicated and supported people.

During the inspection we looked at records which related to people's individual care and to the running of the home. These included eight care plans, medication records, four staff recruitment files, training records, complaints and incident records, maintenance records, and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not fully safe although people told us they felt safe living in the home and were positive about the care they received. A new manager had been appointed in mid-August 2017, a short while before this inspection. They had already identified and acted upon a number of safety issues, for example low staffing levels, since they began working in the home. Although in general people were safe, the service had an inconsistent approach that sometimes put people's safety, health or well-being at risk. During our inspection we found a number of issues relating to prevention of risks that had not been identified and addressed by the provider. People living in the home and their relatives told us they felt safe, and we found no evidence of people being harmed by poor practice at the time of this inspection. However, the lack of robust systems to assess risks and ensure measures were put in place to reduce those risks where possible meant, there was an increased risk people may suffer harm or abuse in the future.

At the time of our inspection we found no evidence that people had experienced harm due to unsafe care. There was a stable staff team who knew people well and knew how to meet their needs safely. However, some risks associated with people's particular health needs had not always been fully identified within the care plans. This meant there was a risk that new or agency staff may not have access to the information they needed to ensure risks to people's health and safety were minimised. For example, two people who were being supported with their continence needs had catheters. Their care plans gave some information about the care the staff should provide with their catheters, but missed some important details, such as the size of catheter they needed, how often this had to be changed and possible complications; and how staff should manage these. The records did not contain information about dates of catheter insertion or sizes used. This meant that staff did not have the necessary information to manage risk and care for people's continence needs safely.

Risk assessments had been completed for most areas of risk. However, some risk assessments did not provide sufficient specific guidance and instruction for staff to follow to manage or mitigate risk. For example, four people who lived with diabetes had their condition controlled by insulin. We also looked at care plans for other people who lived with diabetes whose condition was controlled by diet or tablets. Their care plans documented their diabetes as part of their medical history and where blood glucose levels needed to be monitored we saw records showing this had been carried out. However, the care plans and risk assessments did not always guide staff how to identify and respond to symptoms of a low or high blood sugar level in order to keep people safe. This meant that staff could miss significant early warning symptoms which may help avoid risks associated with diabetes.

We heard examples of good practice in relation to prevention of pressure wounds. Staff with nursing qualifications had provided training to the care staff on prevention of pressure wounds. We heard examples of people being admitted with pressure wounds, for example after admission from hospital, and returning home a few weeks later with completely clear skin. However, risk assessments did not provide sufficient information to ensure staff fully understood all aspects of risk and how to prevent pressure wounds. For example, one person had a pressure ulcer on their heel. When they had been admitted to the home a care plan was written on 31 August 2017 which stated that their skin condition was intact but was at risk of

pressure damage. The risk assessment showed the person needed a pressure mattress and repositioned every two hours. A body map was completed on the 5 September 2017 which showed vulnerable areas to the left elbow and sacrum, a graze to the hip and a pressure sore to the left heel which had not been graded. However, following this discovery the care plan and risk assessment had not been reviewed or updated to guide staff on how to manage the pressure damage and mitigate further risk of skin deterioration. The care plan was not updated with this new information. This meant staff did not have the most up to date recorded information to enable them to know how to support the person safely and prevent further damage. However, the information had been passed to staff verbally in staff handover sessions. The records showed that they had intended to submit a referral to the tissue viability specialist team, but we could not see evidence this had been carried out. We asked a nurse and the registered manager why the referral had not been sent but they did not have an explanation for this. The nurse sent the referral during the inspection. We spoke with staff on duty who confirmed that they knew the current status of the person's skin integrity and they were carrying out the correct actions despite the lack of recording. However, the failure to submit a referral to the tissue viability speciality promptly when the issue was identified had meant there was a risk the person did not receive the best possible treatment to ensure the wound healed quickly. After the inspection we were shown an updated risk assessment and evidence to show the tissue viability service had been involved in the person's care. We also saw the person's wounds were healing well.

People had pressure relieving equipment in place to minimise the risk of pressure damage such as pressure relieving seat cushions and mattresses. However, when we checked one person's mattress setting we found the pressure mattress was not set correctly for the person's weight. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set at. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage. We looked at the mattresses and records for another two people identified as at risk of pressure damage. One person's mattress was set for a person of 125kgs, their last recorded weight taken on 12 September 2017 was 64.9kgs. Another person's mattress was set for a person of 200kg, their last recorded weight in August 2017 was 45.7kgs. Despite the pressure mattresses being incorrectly set, there was no evidence people had been adversely affected by the incorrect settings, or had developed pressure ulcers due to lack of care. We brought these concerns to the attention of the manager who immediately responded by checking all mattresses in the home. By the second day of our inspection the manager and staff team had taken prompt action to ensure all pressure mattresses were correctly set and there were systems in place to regularly monitor the settings to ensure they were correct.

Some people were at risk of irreversible external and internal bleeding due to taking specific blood thinning medicines for their health conditions. There were no risk assessments in place guiding staff on what action to take if these people injured themselves. Staff we spoke with were unaware of the possible complications of these medicines and the importance of seeking medical assistance if the person taking the medicine suffered an injury.

The risk management plan in relation to one person who was a high risk of falls lacked detail. The plan informed staff to "use appropriate equipment" and "ensure wearing suitable footwear" but did not detail what equipment or what suitable footwear was. The failure to have identified and detailed potential risks for people and inform staff of what actions to take put people at risk.

We looked at the arrangements for people living in the home, visitors and staff to raise any concerns about potential abuse of people living in the home. Before this inspection we received a concern relating to possible poor staff attitude and behaviour. This had been investigated by the local authority safeguarding team and where issues were substantiated we were assured the new manager had taken immediate action to address them. During this inspection the manager told us that as a result of the concerns they had taken a

number of actions including a review of the night staffing arrangements. They had increased the number of staff on duty at night, and had moved some day staff to night shifts to improve the monitoring of staff practice and to enable them to pick up and address any potential poor practice quickly. Day staff we spoke with assured us they would not hesitate to speak with the manager or a senior member of staff if they had any concerns about potential abuse. There was information available around the home on safeguarding procedures and contact details of external agencies to contact in the case of abuse. However, when we looked at the training records for staff we noted that approximately half of the staff team had not received training on safeguarding adults. This meant there was a risk some staff may fail to recognise abuse, or know how to report it. After the inspection the manager told us safeguarding training had been arranged for the near future.

The provider had failed to ensure safe systems were in place to reduce the risk of financial abuse. The home held amounts of cash on behalf of many people living there. The cash was not held in separate accounts and instead the cash was held in one joint suspense account, which is not good practice. Individual records were maintained showing purchases made on behalf of people and the balances held. However, the records were not double checked by a second member of staff to verify the purchases or ensure the balances were correct. The records were not monitored regularly by the provider to ensure people were protected from financial abuse.

The provider had not consistently assessed, monitored and mitigated risks relating to the health, safety and welfare of people in the home; and not all records relating to people's care was accurate or complete. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Some aspects of medicine storage and administration were not safe. We found some minor issues that indicated staff knowledge and monitoring systems could be improved. Records relating to the application of one person's weekly strong pain relieving patch were confusing and unclear as to when the medicine had been given and when the next dose was due. This was because there were two medication administration records (MAR) records for the one medicine. One record showed the patch had been administered on the 5 September 2017 and was due to be replaced on 12 September 2017. The other MAR chart recorded that the patch had been re-applied on 4 September 2017 as it had fallen off, applied again on 7 September 2017 and the chart indicated that staff should replace it on 11 September 2017, only four days later. This meant the person may have received too much medicine. We immediately brought this to the attention of the registered manager who checked the stock and signing out records of this medicine and found that the medicine had only been signed out once, on the 5 September 2017. They told us they thought the second MAR chart was a duplicate chart that should not be with the MAR. They said they would speak to staff about the incident as they could not identify the staff member from the signature on the MAR, which is also not good practice.

Some people were prescribed 'as required' (PRN) medicines. However, there were no protocols in place to guide staff as to when the medicine may be required. Recording of when PRN medicines were offered was not consistent. We could not be sure people were receiving their medicines when required or that non-medication approaches were considered first.

Records were made on the MAR charts to indicate the application of creams and ointments were completed by the care staff. The records were held in people's bedrooms along with the creams. However, these contained a large number of unexplained gaps which indicated the creams may not have been applied as directed by the prescriber or that staff were not applying the creams. Where people were at risk of skin damage such as pressure ulcers, failure to apply creams as prescribed could increase the risk of skin

damage.

We also saw tubs of people's prescribed fluid thickening agents for those people identified as being at risk of choking stored on top of tables in their rooms. Staff were unaware of national guidance which states all thickening agents must be stored safely to reduce risk to people. There was a risk that staff had failed to recognise the risks relating to the storage of some prescribed medicines.

The provider had not always ensured the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

During the inspection we looked at how people were supported with their medicines and medicines storage. We observed a nurse administering medicines to people. They explained to the person what their medicines were and why they had to take them. Medication Administration Records (MAR) were completed once staff observed the person taking their medicine. We checked a random sample of boxed medicines and found that the stock agreed with the records maintained. We saw that there were no gaps in administration records which indicated that people were receiving their medicines safely, consistently and as prescribed. There was a system and process in place for the ordering, storage, handling and disposal of medicines and the temperature of the medicines storage room and fridge were taken on a daily basis.

During our inspection we met a clinical pharmacist who visited the home on a weekly basis to provide support and guidance with individual prescription needs and medicine issues. They worked closely with a local GP who visited the home on a monthly basis. The aim of the service was to provide pro-active support to ensure people's individual medicine needs were addressed promptly. Their role did not include monitoring of administration procedures, although they were available to give advice and guidance to staff on any specific issues staff requested. They told us, "They are really good here. This is one of our best homes." They went on to say, "They are always very well organised. Staff know what they are talking about. They are very pro-active. Very 'hands on'. On the whole they are brilliant."

Some areas of the home had not been maintained safely. The overall appearance of the home was bright, clean and modern. However, we noted some areas where maintenance was needed but there were no plans in place to address the issues. The provider showed us a plan of the maintenance issues that had been noted for repair, but the issues we found were not on that list. For example, we found four areas in the ceilings that had been patched but not plastered and painted, and there was a hole in the plasterwork in the visitors' toilet. This affected the overall appearance of the lower ground and ground floor corridors and visitor's toilet and may also compromise the fire precautions. Some double glazed windows in people's bedrooms had broken seals and the windows were completely misted up which meant people were unable to gain any pleasure from looking out of their windows. A wet room on the ground floor had a wet floor due to the gradient of the floor being insufficient to enable the water to drain properly. During our inspection we saw people who used the toilet in this room were walking on a wet floor, which meant there was a high risk of slipping.

On the lower ground floor building equipment including a cement mixer had been stored in the corridor outside the hairdressing room. This not only looked unsightly but also created a hazard which may prevent safe exit in the case of a fire. A room that was used to store continence pads was also used to store paints and maintenance items which meant the area could not be kept clean or tidy. The laundry room had exposed patches in the flooring and damage to the sink unit which meant the area could not be kept clean and presented a risk of cross infection. The conservatory roof was dirty and the room was used to store equipment, which meant the room did not appear comfortable or inviting. Some areas outside the home

were in need of tidying and maintaining, for example garden waste and equipment was left piled up outside the home. Therefore, some areas of the home put people at risk of harm.

The premises was not always properly maintained and there was a risk of poor hygiene standards in the laundry room This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment

The provider had plans in place to address some larger areas of maintenance. On the first floor there had been a major area of refurbishment and improvement since the last inspection and this area appeared bright, clean, modern and inviting. The manager told us there were plans to improve other areas of the home to bring them up to the same standard, for example they planned to replace flooring on the ground floor in the near future. However, there were no records in place to show some of the maintenance issues we found above had been identified, or a plan in place to show when they would be completed by. When we gave feedback on our findings to the manager on the first day of the inspection, actions were taken promptly to address some of the issues we found. For example, on the first day of our inspection a ground floor shower room was out of action due to a faulty outlet pipe and this was repaired on the second day of the inspection. A skip was obtained promptly to remove the garden waste and equipment that had been left piled up outside the home. Action was taken immediately to patch and re-plaster the holes in ceilings. The manager told us they planned to carry out regular checks on all areas of the home in future to identify any safety issues, or maintenance needs. People told us they were satisfied with the way the home was kept clean, and their laundry was cared for. Comments included "I think that it is very clean with no unpleasant odours"

Records showed that equipment such as electrical equipment, hoists, lifts and fire safety equipment had been regularly checked, serviced and maintained.

Before this inspection took place we received information about five separate concerns about the service. These issues included low staffing levels, moving and handling procedures, procedures to be followed after a fall or serious injury, and behaviour and attitude of individual staff members. The concerns were investigated by the local authority safeguarding team. Where issues had been substantiated, we had been assured from the local authority that the manager of the home and staff team had responded quickly to the concerns, taken prompt action by reviewing their practice, identifying where mistakes had been made, and taking action to minimise the risk of similar incidents occurring again. Staffing levels had been increased, and disciplinary actions had been taken where necessary. We did not carry out an investigation of the issues as this had been dealt with by the local authority. However, we checked to ensure no breaches of regulation were linked to the issues which could have impacted on people's care.

We looked at the arrangements for moving and handling people safely, including the training of staff and individual moving and handling plans for people. We found that moving and handling was now well managed to ensure people were safe. A member of staff had been nominated a moving and handling 'champion'. They had attended a 'train the trainer' course in the last year on moving and handling to provide them with the skills and competence to provide moving and handling training and yearly updates to other staff members. They monitored staff practice, reminded staff of current best practice, and sought advice and guidance from specialist health professionals on any individual moving and handling issues. They ensured staff had the knowledge and information to assist each person safely. They checked moving and handling equipment and ensured suitable equipment such as hoists, slings and slide sheets were available for each person according to their individual needs.

We looked at the procedures followed by the home following a fall. We were assured that staff always took

care to assess the person to determine any injuries, and they sought medical attention and/or advice promptly if they had any concerns. They also carried out frequent observations after any fall to ensure that any undetected injuries are identified quickly. The manager was unable to locate their policy on falls during our inspection. They told us they were aware the policy may need to be updated to specify when staff should contact relatives or representatives after a fall. After the inspection the manager told us they were in the process of implementing a new policy in line with current guidance.

There were sufficient staff employed to safely meet the needs of people living there. Before the inspection we received concerns relating to staffing levels. This had been passed to the manager of the home who had investigated the concerns, found staffing levels were low, and they had taken prompt action. The new manager told us they had reached an agreement with the providers to increase the staffing levels in recent weeks. This had been achieved initially by using agency staff, but they hoped to recruit more permanent staff in the near future. They were in the process of advertising and recruiting new staff at the time of this inspection.

Staff rotas showed staffing levels had been planned in line with people's dependency to ensure there were sufficient staff on duty at all times to meet people's needs. The manager considered the dependency levels of people living in the home to help them determine safe staffing levels. Staff rotas showed that during the days there were two qualified nurses on duty plus 11 care staff to care for 39 people. In addition there was one full time and two part time activity organisers, catering, domestic, administrative and maintenance staff. At night there was one qualified nurse and four care staff on duty.

Most people told us there were sufficient care staff and nursing staff on duty to meet people's needs although six people said they had to wait at busy times. One person said, "At this time of day (early morning) it can take staff a while to answer the bell." They went on to tell us they didn't mind waiting. Another person told us, "They look after us to the best of their ability but when they get short staffed, when people go sick, we have to wait." However, one person said they had to "wait a very long time to see staff." They added, "I had to wait 35 minutes for the toilet." During our inspection we observed call bells were answered promptly and staff responded to people in a timely manner. A health care professional who was visiting the home at the time of our inspection told us they felt there were sufficient staff whenever they visited. A person living in the home told us the home used, "Mostly their own staff rather than agency. That's good for continuity"

Careful recruitment processes were followed to ensure new staff were entirely suitable for the job. Applications for vacant posts were processed initially by the home's administrator who ensured checks were completed with the Disclosure and Barring Service (DBS) to ensure the applicants had not been barred from working with vulnerable adults, and they did not have any previous convictions that may indicate they posed a risk to people's safety. They also gained references from previous employers and character references to help them assess the applicant's suitability for the post. Applicants were not offered a job until all checks were completed and an interview had been carried out.

Requires Improvement

Is the service effective?

Our findings

People did not receive a service that was fully effective.

The provider had failed to ensure staff received adequate supervision. This meant the management team were unable to provide evidence to show how they monitored staff performance and competency, or how they provided individual support to staff on a regular basis. There was a risk that poor practice may not have been identified or addressed promptly. It also meant that staff did not have an opportunity to regularly discuss any concerns, training issues, or areas in their work they needed guidance and support in. Before this inspection took place we received concerns about possible poor practice by staff. These were investigated by the local authority safeguarding team. The manager, when informed by the safeguarding team of the concerns, told us they had investigated the concerns which had been substantiated and these were being addressed through individual staff disciplinary procedures. However, the lack of regular, planned one-to-one supervision for staff showed meant that some poor practice may have been long standing, and had not been picked up promptly by the management team, challenged, and addressed through monitoring, training, guidance and support. The lack of supervision records also meant there were no records to show how poor practice had been identified or addressed. We were assured the concerns raised before the inspection were in the process of being addressed through disciplinary procedures. The manager told us they would implement a plan to provide regular supervisions in the future.

All staff had received induction training at the start of their employment which ensured they had the basic skills and knowledge to meet people's needs. However, provider's systems to identify, plan and implement ongoing staff training needs were not effective. The records of training staff had received had not been kept up-to-date. The provider did not have a training policy in place. This meant the provider could not demonstrate how they had monitored staff training needs and how they had satisfied themselves that all staff had the skills and knowledge to ensure people's needs were fully met.

The records showed that all staff had received training and regular updates on fire safety, food hygiene, infection control, and moving and handling. Topics relevant to the needs of people living in the home, such as safeguarding, health and safety, Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had only been completed by a few of the staff. There were no systems in place (for example through regular supervision, staff meetings, or memos) to identify individual staff training needs, or plan the future training needs for the whole staff group. Training records were not checked regularly to identify missed or overdue updates for training topics the provider had identified as essential to ensure staff were competent to meet people's needs.

Most staff told us they felt the training they had received was good. For example, all staff we spoke with told us they had received training on first aid, moving and handling and food hygiene since they began working in the home. However some said they would like further training. For example one care assistant said they would like to receive training on palliative care. The lack of effective training plan to meet the ongoing needs of the staff, and failure to ensure all staff received adequate training in topics such as safeguarding, dementia, or Mental Capacity Act meant there was a risk staff did not have sufficient knowledge to meet all

areas of people's care needs effectively

The provider had not ensured all staff caring for people received appropriate training and supervision. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

Staff who had no previous experience in working in a care setting were encouraged to gain a nationally recognised qualification known as the Care Certificate in the first few weeks of their employment. The Care Certificate covers an identified set of standards which provides health and social care workers with a basic level of essential knowledge. Further training and regular updates were provided to staff on some essential topics such as fire safety, food hygiene, infection control and moving and handling and the record showed all staff had completed this training. Staff had been supported to gain further qualifications. In addition to the qualified nurses employed, over half of the care staff had achieved nationally recognised qualifications such as National Vocational Qualification (NVQs) and diplomas. This meant that some areas of training provided to staff were satisfactory and provided care staff with training in some key areas.

All staff had received an annual appraisal in recent months, and they told us the new manager was very approachable and was always willing to give them time to discuss issues if they requested. Staff also told us they felt well supported. While staff felt supported and could discuss issues with the manager, they did not receive supervision where they had agreed time put aside to discuss their development, look into their practice

The lack of training for staff on the Mental Capacity Act 2005 (MCA) was demonstrated by our findings that staff were not always working within the principles of the Act. 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. Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. However, there were people who lived in Colebrook Manor who would not always be able to give consent to personal care. Initial mental capacity assessments had been carried out but these were not always clear and did not fully explain the reasons why an assessment was carried out, or fully explain the decisions made on behalf of the person. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. Mental capacity assessments made generalised statements, for example, 'does the impairment or disturbance make the person unable to make specific decisions'; it did not specify what these decisions or choices were. This told us mental capacity assessments whilst undertaken, were not decision specific and reviewed and were not recorded in line with legal requirements.

We identified that certain decisions, for example, the use of bed rails to keep people safe, had not been asked, considered or referred for a best interests meeting. We saw no best interests decisions had been recorded in any of the care plans we looked at relating to the use of bed rails Staff were unable to tell us about how certain decisions were made, who had been involved in the decision making process and where they had been recorded. This meant that people could be restricted or not receive care that was in their best interests and putting them at risk. This was not protecting people's human rights or working in accordance with the Mental Capacity Act 2005.

Lack of training on the MCA and failure to record decision making processes meant there was a possible risk that staff may fail to meet their legal requirements regarding the MCA in future, but overall staff recognised

the importance of seeking advice if they were uncertain. This meant that people could be restricted or not receive care that was in their best interests and putting them at risk. This was not protecting people's human rights or working in accordance with the mental capacity

The provider has failed to ensure staff understand and follow the requirements of the Mental Capacity Act 2005 or ensure people do not suffer unnecessary or disproportionate restraint. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). There were three appropriate authorisations in place for people living in the home. The manger told us they had recently had discussions with various relevant professionals about another person who they were concerned may have been deprived of their right to return to live in their own home. The manager had a good understanding of their legal responsibilities in relation to DoLS and knew who to contact if they needed advice.

People's nutritional needs were fully met. People told us they enjoyed the food at Colebrook Manor. Comments included "I don't have any complaints, it keeps me fit enough", "The food is good. They feed you well, it's decent food" and "The food is very good. I enjoy my lunch and get a choice." Relatives told us they were happy with the food their relative was given. One relative said, "My husband eats everything and gets second helpings. There is always a choice. I think the chef does very well. Some people, who required support to consume their meals, were supported with dignity. Staff encouraged and informed people of what they were eating at an appropriate pace and manner.

People were encouraged and supported to maintain a balanced diet. The chef knew what people liked to eat and they had developed menus based on people's preferences. Menus had a number of different options but the chef was able to prepare something specific for people if they did not like choices that day. For example, the chef had prepared a ratatouille especially for one person, and another person had requested pasty and chips. One person had a very poor appetite, and staff offered gentle encouragement to try to tempt the person to eat a little more. The staff member said they had only offered a small amount because they were aware the person was put off their food if they were faced with large portions.

Where necessary, staff provided people with soft or pureed meals which were presented in an attractive way to ensure people still had an enjoyable meal time. The chef had information about who was taking supplements and high calorie foods. Staff spoke positively about the meals people received saying, "The food here is lovely. People are generally very happy [with the meals]. If they don't like something we do our best to find something they do like. The kitchen staff are really helpful." We observed people were offered regular drinks throughout the day. Staff told us people had access to drinks and snacks at any time during the day or night.

People were supported to access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor and chiropodist as necessary. One person said, "If you are unwell they are very quick to make sure you are seen by a doctor." Another person told us, "Someone comes with me on hospital appointments." A healthcare professional who regularly visited the home told us they also visited a number of other homes in the area. They said, "This one is lovely. It is a very friendly and caring place." They told us the staff always reacted quickly to any issues of the suggestions they made. Staff worked with them to ensure people received support to help them improve their mobility and circulation. They also said people always appeared clean and comfortable.

Requires Improvement

Is the service caring?

Our findings

People were supported by staff who were kind and compassionate and demonstrated warmth and understanding to every person.

Colebrook Manor provided end of life care to people if it was their preferred place of death and their needs could be met. The manager and deputy manager assured us people received sensitive and compassionate care at the end of their lives. The home regularly received referrals from local hospitals and hospice teams for end of life care and staff worked closely with these services to ensure people received good care at the end of their lives. They told us that although some people may be near the end of their lives, there were no people who were expected to die in the very near future. We saw that where people may be nearing the end of their lives a specific care plan had been started. However, some aspects of their recording could be improved. For example, the end of life care plan for one person did not contain information about who to contact at the time of their death. We also found there was no person centred information about what was important for the person. Sections about the person's priorities, preferences of how they wished to be cared for in their last days or information about their beliefs and faith, were not completed. This meant that staff may not provide care at the end of the person's life as they wished.

The provider had not ensured the records for this person were accurate, up to date, monitored and had information to mitigate risk. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

We saw staff sitting and chatting with people, holding their hands, and offering friendship and reassurance. Staff told us they enjoyed their jobs and demonstrated a determination to make people happy. For example a member of staff told us, "I like spending time with people. I like making them smile." Staff told us there was a happy atmosphere in the home with good teamwork and support, which meant they did not feel rushed and they were able to give people the time they needed. A member of staff said, "I think it is really good. It's friendly here. Everyone gets on really well."

During the inspection we received mainly positive feedback from people who lived at the home, and their relatives. Comments included, "The care in my opinion is generally good", "Yes the staff are kind" and "They've been angels, as good as gold." One relative expressed, "I'm very impressed with the cheerful, helpfulness of the carers. They seem to really care about the residents." Another relative said, "I really like this place. The care staff are all very good." A community pharmacist told us, "They are very caring. They always welcome you with a smile." They also told us how staff brought in cakes to make people feel 'special'. They told us people were always well dressed, with attention to detail such as nail care, "real personal care" and staff worked hard to do the nice things for people. Staff recognised the importance of welcoming and involving relatives and friends. A relative told us staff were, "Very nice – like family really. I am always pulling their leg!"

During our visit there was a friendly and relaxed atmosphere at the home. We observed staff providing support to people during the inspection in a manner which protected their dignity and privacy. People

appeared well cared for and wore clothing that was clean and well-fitting. People told us care workers also respected their privacy. We observed staff knocking on bedroom doors before they entered as well as staff having genuine, kind and friendly conversations with people over the course of the day. We also heard staff offering people choices, for example choices of foods, drinks and activities.

Staff supported people to mobilise at their own pace and provided encouragement and support. For example, we saw a person walking with a staff member who had a supportive arm on their back to give reassurance whilst they were walking. We saw when staff assisted people to mobilise by using specialist equipment they explained what they needed people to do and explained what was happening before carrying out the task.

Where people needed assistance from staff to eat their meals, they received individual attention from a member of staff. Staff sat with people to ensure they had good eye contact, and spoke clearly to ensure people could hear them and understood what they were saying. Staff gave people the time they needed and did not rush them. In one dining room we saw staff singing with people while they waited for their meals to be delivered. There was a happy atmosphere with laughter, smiles and friendship. There was lots of friendly chatter and discussion around the table, encouraged by the staff, making the mealtime a sociable and happy occasion.

Relatives expressed that they were able to visit the home as and when they wished to. One relative said, "I can visit whenever I want to and feel ever so welcome." Another said, "Totally flexible visiting, you can come anytime you want."

Requires Improvement

Is the service responsive?

Our findings

People did not receive a service that was fully responsive to their needs.

Before people moved into the home an assessment of their needs was carried out and a care plan was drawn up to show how those needs would be met. However, people told us they had not been involved in drawing up a plan of their care needs. One person told us they could not remember seeing their care plan. Another person told us they had never seen a care plan. A relative told us they had brought in information about their relative so that staff would be able to get to know them as a person but they had not been involved in drawing up their care plan. The care files we reviewed did not contain evidence to show people had been involved in making decisions around their care and treatment.. The care plans had not been signed by people and it was not possible to tell the extent people had been involved in their care planning and records did not describe what attempts, if any, had been made to discuss people's care with them. This meant the records did not provide evidence that people or their advocates had been involved in planning their care.

People's care records were not always updated when their needs changed or reviewed monthly in order to ensure that information was reflective of people's current needs. For example, one person's records said that they were nursed in bed due to their medical condition. We visited this person in their room and found they were sat out in their chair. Their care plan had not been updated to reflect this change nor did it provide guidance for staff in how to support them with mobilisation. We also found the care plan and risk assessments for one person had not been reviewed since March 2017. We spoke with the manager and deputy manager on the first day of the inspection and they immediately carried out a review of the care plans and risk assessments to ensure they were all brought up-to-date.

People's care records were task focussed and did not give sufficient information to ensure staff knew exactly how each person wanted to be supported and cared for. The information recorded in the care plans gave staff a basic understanding of people's care needs, some risks and support requirements. Without sufficient information to guide staff about people's needs, preferences and risk, people were placed at risk of receiving inappropriate and inconsistent care. Care plans did not reflect people's preferences, or past lives. This meant staff would have limited knowledge about people and events that were important to them, and would limit what staff could talk to people about. This also meant staff may not have provided responsive care, or recognised that people living with communication needs could still be engaged in decision making and interaction. For example, in one person's care plan it had been documented that because of their dementia diagnosis they could become quite anxious and frustrated at times. The guidance for staff was 'to communicate effectively with [person's name] so that they understand what you are saying to them' but there was no detail in relation to how staff should communicate with them, provide reassurance or what types of conversations might help to alleviate their distress.

One person was living with epilepsy. There was no recorded evidence that an assessment of their epilepsy had been completed. Their care plan only referred to their epilepsy in their medical history. There was information guiding staff on what action to take if a seizure occurred, such as to ensure safety by removing

objects and placing the person in the recovery position. There was no information on the type of seizure the person experienced, the triggers and what the seizure might look like. This meant staff did not have the recorded information they needed to support them to recognise if the person was experiencing a seizure.

The provider had not ensured records relating to people's care and treatment was monitored, assessed, accurate and up to date. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

People's social needs were assessed and staff ensured each person was supported in what they wanted to do. A member of staff was employed on a full time basis to assess and plan people's social needs and provide a range of activities to suit people's interests. In addition two further staff were employed on a part–time basis to provide activities. Staff regularly spent time several times each week with those people who remained in their bedrooms to ensure they had individual attention and support with their interests and social needs. This time was spent in a variety of ways such as sitting and chatting with people, reading to them, hand massage and nail care, or playing games such as dominoes and cards. Staff also accompanied people for walks and shopping trips.

A range of regular group activities had been arranged through discussion and consultation with people. There was a planner in place to let people know about future activities such as visiting entertainers, parties and outings. People told us about outings, games, quizzes, exercises, arts and crafts they enjoyed. During our inspection we saw groups of people engaged in board games and quizzes. Some people did not choose to join in, but enjoyed watching and being part of the discussions. We also saw people having their nails and hair done. The activities co-ordinator told us they encouraged people to choose each day the things they wanted to do, and they were flexible to ensure all requests and interests were catered for.

People told us they were happy with the amount of activities available to them. One person told us about a recent trip out to the aquarium they had enjoyed. Another said, "You can make your own entertainment and [activities co-ordinator's name] makes games for us to take part in." A relative told us about a recent activity they saw, "I came in one day and everyone was blowing bubbles around, everyone was having fun and laughing. It was great." A relative told us, "[activities co-ordinator's name] is very good at it. She visits people in their rooms if they don't take part in the group activities. Although when [activities co-ordinator's name] is away, the activities suffer."
A relative also told us about special occasions such as 'themed' meals. They told us, "The last one was Spanish. They [staff] made a tremendous effort, wore sombreros and had a musician playing Spanish music for people. It was great." Other comments from people included, "Staff come and spend time with me", "They have a band that comes in and entertainers. They get everyone going" and "All staff are very friendly and come in and have coffee with people"

There were systems in place to ensure people knew how to raise a complaint or make a comment. Most people we spoke to were reasonably happy with the service. We asked people if they had ever complained. One person said, "No I haven't" and another person said, "I have not had cause to complain." They said they felt if they had a problem they would be listened to. Most people knew who to go to if they had a complaint. A relative told us "If we find anything we want changed, we do say." One person told us if they had any complaints they would not hesitate to speak to the new manager and said, "She is very good." The new manager had taken formal complaints seriously, investigated them fully and ensured actions were taken to prevent recurrence. In the entrance hallway there was a folder with forms for people to complete if they wanted to make a formal complaint. There was also a box for people to make suggestions. In each bedroom there was a copy of the residents' information booklet which provided information about many aspects of the home including how to make a complaint.

In the entrance hallway there was a book in which people were invited to make comments. However, the book was not checked on a regular basis. We saw comments raised in 2016 which had been checked and acted upon. However, the new manager did not know about the book and there was no evidence to show the previous manager nor any staff had checked the book in recent months. Comments had been raised during the summer of 2017 included comments about some aspects of the cleanliness of the visitors' toilet. The comments had been written a few weeks and months before the new manager was appointed, and when we showed them to the manager she confirmed the issues had not been brought to the staff's attention and had not been investigated or actioned. The manager assured us they would review their systems to encourage people to raise complaints and comments to ensure these would be acted on immediately in future. During our inspection the cleanliness of the visitor's toilet was checked and was found to be satisfactory.

Inadequate

Is the service well-led?

Our findings

At the last inspection of the service on 27 and 28 October 2015 we rated this key question as 'requires improvement'. This is because we found there was no evidence to show how the provider had monitored the service or ensured people received a good quality of service. At this inspection we found people received a service that was not well-led. The provider had systems in place to monitor some aspects of the service but these were not effective and did not ensure people received a safe, effective, consistently caring or responsive service. During this inspection we found issues that should have been picked up and addressed through regular monitoring processes. The lack of robust monitoring systems meant the provider had failed to identify the problems and ensure they were addressed promptly.

The provider completed a report following their monthly visits to the home. The headings included a section to report on interviews with service users and or advocates and representatives, and interviews with staff. We looked at copies of the reports completed by the provider's representative following visits to the home in November and December 2016, January, June, August and 2017 which showed no service users or advocates had been spoken with. The reports also showed the only conversations with staff had been with the previous manager, the new manager and the deputy manager. The reports contained evidence of inspections of the premises and maintenance areas identified, although the reports not include issues we noted during our inspection such as the storage of building equipment including a cement mixer in the lower ground corridor, or faulty doubled glazed window panes. The reports did not cover areas such as staff rotas, staff recruitment, staff training or staff supervision. There was no evidence of any discussions relating to the management of medicines, food, activities or other important areas of people's care. Complaints had been listed, but there was no other evidence to show how people's views on the service had been sought, listened to or acted upon. The monitoring reports focussed on income, and on planned maintenance and improvements to the building. There were no systems in place to monitor all aspects of the service fully or to identify areas for improvement, other than the improvements to the building listed in their monthly report.

Before this inspection five concerns were raised with CQC and the local authority safeguarding team by relatives, whistle blowers, and by anonymous members of the public. The concerns related to staffing levels, moving and handling procedures, procedures to be followed after a fall or serious injury, and behaviour and attitude of individual staff members. When these were brought to the attention of the new manager they took prompt actions to investigate the matters and they had taken actions to address them. However, some of the issues and concerns could have been prevented if more robust systems had been in place to monitor and improve the service.

Before the inspection we received concerns that staffing levels were not sufficient to meet the needs of people living there. The manager had taken prompt action when the concerns were brought to their attention to improve the staffing levels. The provider had agreed to increase the staffing levels both day and night. This meant that at the time of this inspection there were sufficient staff to meet peoples' needs. However, the provider did not have systems in place to determine safe staffing levels or ensure staffing levels are adjusted promptly in future if people's needs increase.

During this inspection we found that staff had not received regular supervision. Systems to plan and monitor staff training needs and ensure staff competency were not fully effective. Staff training records had not been updated and the new manager was unsure if the records were correct. The records showed that many of the staff had not received training on topics such as safeguarding, the Mental Capacity Act 2005, dementia or equality and diversity. This meant that the provider did not have effective systems in place to assess staff practice and staff knowledge, or to improve practice promptly for example through monitoring, observations, training and support. It also meant poor practice may not have been recognised, challenged, reported or addressed, for example through disciplinary processes. Recent concerns raised relating to poor practice had not been identified by the provider in a timely way and this meant there was a risk poor practice may not have been addressed promptly for example through disciplinary procedures, monitoring, supervision and training.

There was a new manager in post who was a nurse. There was no clinical supervision in place to support the manager to ensure they were following best practice at all times. This meant the provider could not be certain the management team and staff had followed safe practice at all times. The manager told us they had begun to consider their future support and training needs but had not had opportunity to plan these fully yet.

The provider had failed to identify the issues we found relating to poor care plans and risk assessments. They had failed to ensure staff had sufficient recorded information and knew how to meet people's needs. People told us they had not been consulted or involved in drawing up a plan of their care needs. Care plans did not specify if relatives wished to be contacted at any time, day or night, in the case of illness or accident. This put people at risk. We found risk assessments did not always provide sufficient information on the risks or the actions staff must take to minimise the risks. For example, where people were at risk of pressure sores, the risks had been identified and pressure mattresses put in place. However, there was no guidance to staff on the correct settings for the mattresses. This means the provider had failed to ensure good practice was being followed.

The manager was unable to find some policies we requested. Therefore we were unable to establish if policies and procedures had been reviewed or updated regularly. For example, staff did not have sufficient guidance on when to contact NHS emergency service for advice immediately following a fall, or when to notify the person's next of kin immediately. Their policy on action to be taken after a fall had not been reviewed to ensure it reflected current national good practice guidance. This meant staff had not been given sufficient information either in their policies and procedures, or in each person's care plan, to ensure they followed best practice after a fall or incident. We also found policies and procedures to protect people from the risk of financial abuse were not fully effective. The provider did not have systems in place to check that the records of cash held on behalf of people were accurate, and to ensure records of all transactions were correct.

The provider had failed to have effective governance systems and quality assurance processes to assess, monitor and drive improvement. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

There was a new manager in post who had not yet been registered. Everyone we spoke with praised the new manager for their caring management style. Comments from staff included, "[Manager's name] is doing a fantastic job. She is approachable. She is getting things sorted." Comments from people and relatives included: "I know [manager's name] very well, she is a very nice person. Everything works well", "There's a manager that comes in every day to make sure we are all happy" and a comment about the manager stated, "Always seems very much on the ball".

There were clear lines of responsibility. A management structure was in place with a manager and deputy manager who worked closely together. There was an 'open door' management style and people, visitors and staff felt confident they could approach the manager or deputy manager at any time.

The new manager had begun to make some positive changes to the way staff worked to make the home run more smoothly and improve the care people received. For example, they were in the process of splitting the staff into two teams (these were called the red and the blue teams) who would each work more closely with a group of people. They had decided that smaller teams of staff working with a small group of people would enable staff to get to know people better, and to ensure their needs were fully met. Each team had their own line management structure. The manager and staff explained how they expected this would improve the level of personalised care each person will receive. For example, they hoped that staff would be more aware when people were running out of toiletries or personal items, and would be able to do shopping for people. The manager and staff were not aware of the provider's visions and values for the service. However the manager said, their own was to, "Give people lots of love. To treat people as individuals."

There was a warm and happy atmosphere within the home and staff demonstrated a determination to ensure people's social needs were met. People were supported to maintain close links with family and friends and with the local community. Staff escorted people to visit shops and facilities in the local community. Group and individual outings were arranged.

On the first day of our inspection the manager's office floor was covered in files. They told us they had realised the recording systems were not fully effective and they were in the process of reviewing and improving them. Therefore some records could not be located easily, and the manager was not sure if some records had been fully maintained. However, we were assured that they had already recognised the records were poorly organised and they were in the process of addressing this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to fully protect people who use the service from unnecessary or disproportionate restraint. The provider has failed to ensure staff understand their legal requirement to act in accordance with the Mental Capacity Act 2005 for those people who lack capacity to consent.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider has failed to ensure people received safe care and treatment. Risks to people's health and safety had not been fully assessed and measures to reduce risks were not fully effective.

The enforcement action we took:

NOP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

The enforcement action we took:

NOP positive conditions

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	The provider had failed to establish effective systems to assess, monitor and improve the quality of the service

The enforcement action we took:

NOP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider has failed to ensure staff received adequate support, professional development, supervision, and training to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

NOP positive conditions