Care Quality Commission

Tewkesbury Care Home Limited

Tewkesbury Fields

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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 23 September 2015 and was unannounced.We visited the service again on the 29 September, which was announced, to conclude our findings. Tewkesbury Fields provides accommodation and personal care for up to 73 people, some of whom have nursing care needs. There were 63 people who were living at Tewkesbury Fields on the day of our visit.

There was a manager in place who had worked at the service for two weeks prior to our inspection. The manager was being supported by a regional manager.

The service is required to have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The regional manager explained that once the manager had been fully inducted into the service they would be applying for their registration with the Care Quality Commission.

Summary of findings

People felt safe living at Tewkesbury Fields. Staff knew how to protect people from harm as staff recognised signs of abuse and knew how to report this. Staff made sure risk assessments were in place and took actions to minimise risks without taking away people's right to make decisions. We found that staffing levels did not always reflect the care needs of the people who lived there, while staff minimised risk to people and kept people safe, some of their care needs were not delivered in a timely way due to insufficient staffing numbers.

We found that some medication records were not always recorded accurately to ensure people received their medicines correctly. Concerns had been identified with the timeliness of the monthly stock of medicines from the pharmacy supplier. In September 2015 staff were not given enough time to check that the medicines received were correct. The regional manager told us that a meeting was being held with the pharmacy to discuss a way of improving the service delivery.

People who we spoke with felt that staff were knowledgeable about how to care for them. Staff told us they received training but would benefit from more specific training that was tailored to the people who lived at Tewkesbury Fields. We saw that management had recognised this as an area for development and training had been arranged for staff. Care and support was provided to people with their consent and agreement. Staff understood and recognised the importance of this.

We found people were supported to eat a healthy balanced diet and were supported with enough fluids to keep them healthy. However people raised concerns about the choices of their meals. We found that people were provided with meals which were not what they had originally ordered. The regional manager told us that an external agency was being brought in to work with the kitchen staff to help them create meals and a dining experience people would enjoy. We found that people had access to healthcare professionals, such as their doctor.

People told us that all the staff were caring and respectful. Some people who lived at Tewkesbury Fields were unable to tell us verbally if the staff were kind and caring however we observed that people were relaxed and calm in the home. People told us that they were listened to and were able to make day to day decisions about their care. We saw staff spoke kindly to people and maintained their dignity when providing assistance. People were supported to remain independent and received assistance when they needed it.

We found that people did not always receive care that was responsive to their personal needs. People's personal preferences had not always been sought and we found that staff were guided by a bathing schedule. However staff could not demonstrate how this reflected people's personal choice. We found that the service was not always responsive towards people's individual care needs. Staff did not always recognise that people required further support with their hearing aids or glasses for example.

We found that people knew how to complain and felt comfortable to do this should they feel they needed to. Where the provider had received written complaints, these had been responded to. While there were no patterns to the complaints, learning had been taken from complaints received and actions were put into place to address these. However we found that verbal concerns had not been recorded so the provider could not demonstrate that actions and learning had happened with these.

We found that the service had not fully promoted a positive culture within the home to empower staff and people who used the service. We found that most staff felt that they had not been listened to about certain aspects of the way the home was run, for example with staffing levels. This was because clear leadership and communication had not been maintained. It was recognised that a new manager had been in place for two weeks at the time of our inspection. The provider had recognised that improvements in the service delivery were required.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Staff knew how to keep people safe and how to minimise the risk of harm. However there were not always enough staff on duty to meet people's needs. People's medicines were not always recorded in a safe way.

Requires improvement

Is the service effective?
The service was not always effective.

People were not always provided with food they had chosen or preferred. People were supported by staff who had the knowledge and skills to do. Plans were in place for staff to receive further learning and training that was specific to the people who lived there. People had access to health care professionals and were supported to attend doctor appointments.

Requires improvement

Is the service caring?
The service was caring.

Positive caring relationships had been developed between people who lived there and the staff. People were treated respectfully. People's privacy and dignity were maintained.

Good

Is the service responsive?
The service was not always responsive.

People did not always receive care that was responsive to their individual needs. People's formal complaints were listened and responded to, however verbal concerns were recorded in a way that demonstrated that people's concerns were listened to.

Requires improvement

Is the service well-led?
The service was not always well-led.

We found that improvements were required to ensure people, relatives and staff had the opportunity to be listened to and involved in the developing and running of the service. There were procedures in place to monitor the quality of the service and where issues were identified there were action plans in place to address these.

Requires improvement

Tewkesbury Fields

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 23 and 29 September 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection 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. The provider had submitted a Provider Information Return (PIR) which provides information about what improvements the provider has done and is planning to do. We also spoke with external agencies, such as the local authorities and the clinical commissioning group about information they held about the provider.

We spoke with 13 people who used the service and nine relatives. We also spoke with 11 care staff, two nurses, the deputy manager who was also a registered nurse. The home manager and the regional manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed eight people's care records. We also looked audits completed by the provider for the environment, complaints, customer survey results, staffing rota's and dependency charts.

Requires improvement

Is the service safe?

Our findings

We spoke with people, relatives and staff about staffing levels in the home. Three people and three relatives felt there were not enough staff on duty. People explained that they would have to wait for their call bell to be answered, and in some cases this was for long periods of time. One person told us that sometimes they had to wait up to an hour to receive assistance from staff. We found that on the day of our first visit calls bells sounded continuously throughout the home for two hours in the morning. We spoke with management about whether call bell logs were monitored to They told us these were not monitored or reviewed, but would be considered in the future. Therefore management were unable to see how long people were waiting for assistance nor were they able to review staffing levels at busier times in the home.

All of the care and nursing staff we spoke with felt there were not a sufficient number of staff on duty to meet people's needs in a safe way. Staff we spoke with felt that the number of staff on duty did not reflect the needs of the people who lived there. We spoke with staff who worked on the Bushley unit, as this was recognised by staff as an area where people's dependency needs were higher. Staff told us that four care staff were allocated to work on the Bushley unit in the afternoon.

On the second day of our inspection we spent the afternoon in the Bushley lounge to observe how staff worked with people to meet their needs in a timely way. We found that people who needed two staff for assistance, for example, to hoist them, were required to wait. Staff told us this was because there were three staff on duty instead of four. They told us there had been unplanned staff absence and they were waiting for an alternative member of staff to arrive at 4pm. They told us they would be then be fully staffed for the Bushely area. Staff told us that during this time, from 2pm to 4pm people had to be prioritised. We saw that people's individual nursing care risks had been assessed in a way that protected people. For example, there were people who were at risk of pressure damage due to their decreased mobility. Staff recognised this potential risk and ensured people received the appropriate care, such as bed rest in the afternoon, to reduce the likelihood of the person developing a pressure sore. However, we found that two people were required to wait, in both cases, for two hours before staff became available to hoist them from a wheel chair into a lounge chair.

Staff told us there were 27 people who lived on the Bushley unit, 21 of whom required two members of staff to hoist them for all their care needs. We found that staff took actions to minimise the risk of unsafe care for people. However, through doing so, staff did not always meet people's individual care needs. We found staff were having to prioritise people's care based on the number of staff available. For example, one person's care record indicated that one staff member could bath them safely. Staff we spoke with told us that it was a risk to the person to do so with one staff member, as the person was prone to sliding once in the bath. Therefore two staff were required to keep the person safe in the bath. As a result of this the person did not always receive a bath, as staffing levels were not sufficient enough to ensure the person was safe and other people within the home remained safe.

While there had not been any reported incidents, staff felt that there were times people were left unsafe as there were periods of time when there were no staff visible in the communal areas or to answer call bells.

We spoke with management about people's dependency levels and how this reflected staffing levels. Management showed us that staffing levels were based on the information they had about people's dependency levels. However we found that the tools management had in place were not effective as people's care needs were not always met in a timely way.

The manager had been in post for two weeks, and had recognised that further work was needed to review each person's care needs and plans were in place to address this as a matter of priority. Management also recognised that further work was needed around the allocation of staff throughout the whole home. They went onto say that this could be better managed to ensure the higher dependency parts of the home were better staffed. However, management had not recognised the impact to people due to the two hours of staff absence and while plans were put in place to bring another staff member on shift, further work around staff deployment within the home had not been thought through.

Requires improvement

Is the service safe?

All of above evidence supported this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We spoke with people about how their medication was managed. One person told us, "Meds are on time every day." Another person told us, "Our medication is on time now; there have been occasions when we've been woken up at 10pm to take them." Another person said, "I know what medicines I take and why I take them, the staff have explained that to me."

We spoke with a staff member that administered medication. They had a good understanding about the medication they gave people and the possible side effects. We found that some of the medication records were not recorded in a clear and safe way. For example, one person's medication dose had been hand-written incorrectly on the person medicines chart. Which meant that there was a potential risk of unsafe medication being administered to people. We spoke with management about the practice around safe recording of medicines who advised that this would be addressed.

The nursing staff told us they had raised concerns with the manager about the pharmacy that provided the medication. They told us that sometimes the pharmacy did not deliver the medication to the home in a timely way for staff to check that all medicines were correct. They told us that when there had been inconsistencies with people's medication, there was not always enough time to correct this before the medication was next due. We spoke with management about the nursing staff concerns. They were aware that timely delivery of medication had not happened for the month of September 2015 and told us that a meeting was being held with the pharmacy to discuss ways to improve the service to ensure the home received a supply of people's medicines in a timely way.

People we spoke with told us they felt safe living at Tewkesbury Fields and told us that staff would check on them to make sure they were okay. We spoke with one person who preferred to stay in their room. We asked them how they felt safe, they told us that there was always staff walking past and whenever they called for a staff member somebody always came to help them. Another person we spoke with told us that staff always came to check on them and ensured at night that their patio doors were locked and windows were secure and that made them feel safe.

We saw that staff supported people to feel safe. We saw how promptly staff responded to help a person when they had started to cough while eating their food. We found that people who were nursed in bed or who may not be able to use the call bell to alert staff for help, were seen regularly. We saw occasions were staff spent time with people to ensure they were comfortable and had what they needed to hand.

We spoke with staff about how they protected people from the risk of harm. Staff who we spoke with showed an awareness of different types of abuse and how they would protect people from harm. They shared examples of what they would report to management if required. We found that safeguarding information was on display at the home which was available to staff should they need this. There had been safeguarding incidents that had been reported to the Care Quality Commission (CQC) and we found that the manager had followed the correct procedures to ensure people were kept safe.

We spoke with staff about how they got to know people and their care needs. The nursing staff explained that they had information available to them from care records and through regular handovers. The care staff explained they gained this by talking with people and their relatives. They also gathered further knowledge over time, by getting to know them. However, they told us that they did not receive regular updates about people through daily handovers. Staff told us how communication was key to ensuring people received the right care. We spoke with management, who were unaware that care staff did not receive a daily handover. On our second day inspection management told us that care staff were now involved in handover meetings. Staff we spoke with confirmed this was now happening and found this was beneficial to them.

Requires improvement

Is the service effective?

Our findings

People's views about the food at Tewkesbury was mixed. Some people said they enjoyed the food. One person said, "The food is quite good, actually". Another person said, "The food is very good, good variety. But they're always ready to be flexible." Another person told us that their meals were good and if they were, "to get peckish later, they bring me a little snack". However some people's views about the food were not so positive. One person said, "The food is alright but it could be better." Another person said, "The food is not good. I have never been asked what I would like to see on the menu. I can't eat pork so when there is pork on the menu, I have to have the vegetarian option which I am not keen on".

We saw that people were able to join others for their meal in the dining room if they wished or away from the main dining area, in their bedroom or lounge. We found that staff who provided assistance to people to eat their food did so in a caring and thoughtful way. We saw one care staff member explain each item of food on the plate and gave the person a choice of this food with each forkful.

However, we did find that what people had chosen from the menu, was not what was provided to them on the day. People were not told about the menu changes before-hand and had to ask staff what was the food they had been served. We spoke with management about the change in the menu. The regional manager had recognised that this and explained that they felt that people's dining experience was not to the standard the provider had set. They told us that a recent food survey had been sent out to people to gain their views and thoughts about the food. The provider had also brought forward their plans for using external catering company to advise the service and to enhance people's dining experience.

We saw people were offered hot and cold drinks throughout the day and staff ensured people had drinks to hand. We saw staff ensure people who were nursed in their rooms had assistance with drinks. We spoke with staff about what steps they took to ensure people received adequate fluids. Staff said that people who were unable to express their request for a drink had their fluid intake monitored. This was so that assurances could be gained that staff were offering people enough fluids to keep them healthy.

Staff told us they monitored people's weight monthly and what action they took when they found a person's weight had changed. An example was shared with us about the support and treatment a person received following unexplained weight loss, which had led to a steady improvement in maintaining the person's weight.

All the people we spoke with felt that staff who cared for them knew how to look after them well and in the right way. One person said, "They're well-trained, the staff do what they're supposed to do." Another person told us, "They know what they're doing." Another person we spoke with told us that even when the staff were busy they, "Don't miss out anything at all."

Staff told us they had received training, such as manual handling and nutrition and skin care training. Staff gave examples of how learning and sharing experiences helped them to understand why and how to provide the right care for people. For example, staff were able to share good practice by ensuring people kept their skin healthy. We spoke with management about staff increasing their skills and development in areas specific to the people they cared for. This had already been identified as an area for further development by the new manager. They were able to demonstrate what training staff would receive and when this was planned.

We spoke with a staff member who had recently begun working for the service. They explained to us how they were supported in their role and how their knowledge was developed. They told us that they shadowed an experienced staff member before working alone. They told us they would only work alone when they felt confident to do so.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application

Requires improvement

Is the service effective?

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People we spoke with told us that staff sought their agreement before carrying out any personal care and respected their decisions and choices. Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. For example a staff member told us they would always seek a person's consent before providing personal care.

We found that the manager had begun taking action to ensure that those people who they had deemed to be restricted of their freedom where being done so in the legal way. We saw an example where the manager had reviewed a person's Deprivation of Liberty (DoL) that was due to expire and had submitted an application to the local authority to renew this. The manager told us that they believed other people were being deprived of their freedom and was taking appropriate steps to ensure the Mental Capacity Act (MCA) was being followed. We saw the manager had begun taking actions around this and applications to the relevant local authorities were being submitted where they deemed this to be necessary.

People we spoke with told us they had access to healthcare professionals when they needed to and that visits were arranged in a timely manner when they requested them. We found that when further care and treatment was required by other healthcare professionals, staff had acted promptly in ensuring people received the support. Where the person's doctor had arranged treatment, this was given in line with their guidance. People and relatives told us that they had confidence in the staff and that they were doing what was needed.

Good

Is the service caring?

Our findings

People we spoke with told us staff were kind and compassionate towards them. One person said, “The staff are always most helpful and friendly.” Another person said, “The staff are marvellous. They are kind and genuinely seem to care. They will go the extra mile and give you a cuddle when you are low”. Another person said, “They’re very sweet and very kind.” And, “I’ve never seen a long face, always cheerful.” A relative we spoke with told us that, “You can’t fault the staff they are very good.”

Staff knew people well and engaged with people in a way that made people smile and laugh. We found that staff did not ignore people’s requests for assistance and always took the time to speak with them. We found that staff were attentive and provided reassurance to those who may have become upset. When one person became distressed because they wanted to go out for a walk, staff took the time to take them into the garden, which helped calm the person’s anxieties.

People and relatives told us that staff knew them well and respected their wishes. For example, some people who lived in the home preferred their own privacy and chose to spend time on their own. We spoke with some people who chose to stay in their room. They told us that staff respected their choice, and while they encouraged them to go out, they always respected their decision if they did not want to. We found that people were supported and encouraged to maintain relationships with their friends and family. People told us that visitors were welcome at any time. Relatives we spoke with told us they could visit as often as they liked and were able to take the person out for the day and staff ensured they were ready and prepared to go.

We saw staff spoke to people in a respectful way and maintained people’s dignity. When personal care was provided to people in their rooms or bathrooms the doors were always closed. Where people were hoisted, staff ensured people’s dignity was maintained at all times.

We found that people’s privacy was respected. People had the choice to stay in their room or use the communal areas if they wanted to. We saw staff always knocked on people’s bedroom or bathrooms doors and waited for a reply before they entered. People told us they chose their clothes and got to dress in their preferred style. Where staff were required to discuss people’s needs or requests of personal care, these were not openly discussed with others. Staff spoke respectfully about people when they were talking to us or having discussions with other staff members about any care needs.

Requires improvement

Is the service responsive?

Our findings

Most people felt there were not enough staff on duty to meet their needs in a responsive way. One person said, "The staff are very good but they are really stretched". Another person we spoke with told us that sometimes they had to wait an hour for staff to help and other days they did not have to wait. Another person told us, "I can't find any criticism of the actual staff; the only criticism is that there are not enough of them. They're always rushed." Some relatives we spoke with thought that there were not enough staff on duty to meet their family member's needs. One relative explained that staff were not always available when they had needed help with their family member.

Staff told us that the dependency levels of people were higher than management recognised. Staff told us that that they were not always able to offer people the choice to have a bath or shower as often as they may have preferred. Staff told us that they took steps to ensure people were kept safe, but in doing so meant that people did not receive care that was personal and individual to them.

We reviewed the care records of four people who did not have the capacity to answer our specific questions about how the service delivered personalised care in a responsive way. We found that these records did not reflect people's preferences that were individual to them. For example, the records did not indicate if they preferred a bath or a shower, how frequently and what time of day they would prefer this. We found that a bathing schedule had been put in place, which guided staff of who to bathe that particular day. However staff could not demonstrate how this reflected people's personal choice. In all four care records we reviewed we found that people were not given the option of having a bath or shower and when these were offered this was not a regular occurrence. For example, one person had only received a bath or shower three times over a period of five months. There was no evidence to suggest that the person had been offered the opportunity for more baths or showers over this period of time.

We spoke with one person who was hard of hearing and we had to speak loudly so they could hear us. They told us that their hearing aid was only used when their family member visited as staff did not ensure they had this in place. They said, "I miss a lot". They had a reading book next to them, we asked if they were able to read books they enjoyed. They told us that they had an optician's appointment the previous year and were given new glasses, however said, "They don't work, so I don't use them so I can't read my book". They told us that they were not aware that a further appointment had been arranged. We found other examples where people had not received care that was personalised to their needs. One relative told us about a person's broken hearing aid and glasses and how this had not been resolved in a timely way. They told us, "Staff don't commit to picking up a problem and seeing it through".

All of above evidence supported this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We asked people if they were supported to maintain their hobbies and interests. Most people we spoke with told us that they did not wish to pursue their hobbies and interests as they wanted a more relaxed pace of life. One person told us that they were able to continue their hobby in dress-making and was actively encouraged by staff. One person who was a keen gardener said, "We're encouraged to plant flowers." And went onto say, "There are trips in the coach to the Malvern Hills, the River Severn and also the garden centre".

People spoke positively about the activities co-ordinators. One person said, "There are some nice activities staff but there are not enough of them. It's great when they are around because they spend time talking to us and having a laugh." Another person we spoke with told us that staff knew what they liked, which was crosswords and word searches. They told us that staff ensured they had plenty of these books and brought in new ones when they were finished.

People told us if they had any concerns they felt able to speak with a member of staff. All people we spoke with told us that they would be free to pursue any more serious complaints to management level, if necessary. Most people felt confident that something would be done about it.

The provider shared information with people about how to raise a complaint about the service provision. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome. We looked at the provider's complaints over the last nine months and saw that six complaints had been received. We found that these, with the exception of a more recent

Requires improvement

Is the service responsive?

complaint, had been responded to with satisfactory outcomes for the person who had raised the complaint. There were no patterns or trends to the complaints raised. We spoke with the manager about verbal complaints that are raised, where people may not want to raise a formal complaint. The manager told us that verbal complaints were not recorded. This meant it was difficult to identify patterns or trends with these types of complaints to demonstrate that lessons had been learnt. It was agreed by management that this was an area for improvement.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection a new manager was in place who had worked at the service for two weeks. They were working closely with the regional manager at this time. We spoke with them about the opportunities for open communication with people, relatives and staff. The manager told us that conversations happened regularly with relatives and staff and that their door was always open to people if they wanted to talk. However, we found that the relatives and staff who we spoke with were not aware of the manager's open door ethos.

People and relatives we spoke with said that there had been many changes with the management of the home and felt this had impacted on the care standards delivered in the home, such as staffing levels. One person told us, "I know there is a new manager, there have been lots of managers but I haven't met them." We asked one relative about the leadership of the home. They told us, "Adequate. There have been lots of staff and management changes. I have no idea who the manager is." Another relative told us, "There is no continuity, the manager does not respond and I don't feel we are listened to".

Staff we spoke with acknowledged that the manager was new in their post and that time was required for them to be able to make changes and improvements. Staff felt hopeful that this would happen. Some staff told us that they had approached the manager to raise their concerns about staffing levels. Other staff told us that they had not met the manager as meetings had been arranged however had then been cancelled. It was acknowledged that staff morale was low as staff told us they did not feel valued or listened too. One care staff member told us about some improvements that would like to recommend, but felt they did not have the opportunity to do this.

We found that steps were being taken to improve the culture of the home and saw that the regional manager had recently introduced 'flash meetings'. This is where a range of different staff attend to discuss different aspects to the running of the service. Staff were also given the opportunity to raise any concerns they may have.

The manager spoke about how they worked with the regional manager to support each other to continually improve the home. The manager told us that they felt well supported by the provider and had many contacts within the provider's services to discuss any matters that arose.

The regional manager told us that questionnaires had been sent out to people who use the service recently, however the results of these were not yet available. We looked at the results from a questionnaire sent to people in April 2015. Overall this showed positive comments from people and did not identify any patterns or trends. The results did highlight a lower score for the food at the service. This had resulted in the provider organising an external catering company to advise the chef around menu plans and people's overall dining experience.

The provider had completed checks in areas such as staff training, environment and care records. This identified areas where action was needed to ensure people's individual needs were met. For example, through reviewing some people's care records it was identified that these needed updating and written in a way that was more person-centred and that the person's wishes were reflected.

People we spoke with told us they had not had any accidents or incidents while they were at the home. We looked at how incidents and accidents were monitored that occurred in the service. Records showed that each incident was recorded in detail, describing the event and what action had been taken to ensure the person was safe. Accident forms had been reviewed so that emerging risks were anticipated identified and managed correctly.

The provider is required by law to notify CQC of serious incidents that have happened in the home. We found that the provider had notified us when there had been an incident. This showed they promoted an open culture and met the legal requirements.

Following our inspection on day one, management had responded to our initial concerns and had drafted an action plan that had commenced immediately. On the second day of our inspection, it was acknowledged that management had put measures in place to begin to improve the quality of the service. Management acknowledged that further work was required to improve the quality of care in the home and expressed their passion for getting this right for people. While management has

Requires improvement

Is the service well-led?

provided positive assurances to improve the service, it was recognised that time was needed to embed these changes and future tests to check the sustainment of this would be required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who used the service did not always have their care needs met in a timely way because there were not always sufficient numbers of staff deployed in the service. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services did not receive care that met their needs and reflected their preferences. (1) (b) (c) 3() (a) (b).