365 Care Homes Limited

Delph House

Inspection report

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Website:

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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**

Overall summary

This was an unannounced inspection carried out on 2 and 3 November 2015. This was our first comprehensive inspection since the service was re-registered on 10 April 2015. On this date we registered a private limited company to take over the running of the existing service. The company had purchased the service from the previous owners who were a partnership. One of the members of this partnership also used to the registered manager. The new owners had arranged for the existing registered manager to continue in their post. We were told that this had been done so that people living in the service did not experience any disruption with the change of ownership and continued to receive the care they needed.

Delph House provides accommodation for up to 22 older people some of whom live with dementia. There were 18 people living in the service at the time of our inspection.

As we have noted above, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The first breach referred to the provision that was in place to support people to eat and drink enough. The arrangements were not robust or reliable. The second breach referred to the provision made to support people who had special communication needs and who could become distressed. They had not always been offered consistent or effective support to reassure and comfort them. The third breach referred to the way in which quality checks had been completed. They were not rigorous or effective and this had resulted in a number of shortfalls not being quickly identified and resolved. These breaches had increased the risk that people would not always safely and responsively receive all of the care they needed. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the back of the full version of this report.

Although staff knew how to report any concerns so that people were kept safe from harm, the arrangements to protect people from the risk of financial abuse were not robust. People had not been fully supported to stay safe by avoiding accidents and medicines had not always been correctly managed. There were enough staff on duty but background checks on new staff had not always been completed.

Staff had not received all of the support they needed and did not have all of the skills that were necessary for them to reliably assist people in the right way. This included caring for people so that they had enough nutrition and hydration. However, staff recognised when people were unwell and had arranged for them to receive the necessary healthcare services.

Staff had helped to ensure that people's rights were respected by supporting them to make decisions for themselves. The Care Quality Commission is required by law to monitor how registered persons apply the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005 and to report on what we find. The safeguards are designed to protect people where they are not able to make decisions for themselves and it is necessary to deprive them of their liberty in order to keep them safe. In relation to this, the registered manager had taken the necessary steps to ensure that people's rights were being protected.

Although people were treated with kindness and compassion staff had not always respected people's choice about the gender of staff who provided them with close personal care. Staff recognised people's right to privacy and they respected confidential information.

Although people had been consulted about the care they wanted to receive, they had not been fully supported to pursue their hobbies and interests. People had been helped to meet their spiritual needs and there was a system for resolving complaints.

Although people had been involved in the development of the service, they had not benefited from staff acting upon good practice guidance. The service was run in an open and inclusive way that encouraged staff to raise any concerns they had.

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?

Requires improvement 

The service was not consistently safe.

Although there were enough staff on duty background checks had not always been completed before new staff were employed.

People had not been fully supported to stay safe by avoiding accidents and medicines had not always been managed safely.

Staff knew how to report any concerns in order to keep people safe from harm but the arrangements used to protect people from the risk of financial abuse were not robust.

Is the service effective?

Requires improvement 

The service was not consistently effective.

People were not reliably helped to eat and drink enough to stay well.

Staff had not received all of the support they needed to develop all of the skills that were necessary for them to reliably care for people.

Staff had liaised with healthcare professionals to help to ensure that people received the medical attention they needed.

People were helped to make decisions for themselves. When this was not possible legal safeguards were followed to ensure that decisions were made in their best interests.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Although staff were compassionate they had not always respected people's choices about how close personal care was provided.

Staff recognised people's right to privacy and confidential information was kept private.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

People who lived with dementia and who could become distressed had not consistently received all of the support they needed.

Although people had been consulted about the care they received, they had not been fully supported to pursue their hobbies and interests.

People had been supported to meet their spiritual needs.

There was a system to resolve complaints.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Quality checks had not consistently identified and resolved shortfalls in the care and facilities provided in the service.

People had not been asked to contribute suggestions for the development of the service so that their views could be taken into account.

People had not benefited from staff acting upon good practice guidance.

Although there was a registered manager he was not always present in the service to check how well it was running.

There were measures in place to enable staff to speak out if they had any concerns.

Delph House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons were 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 our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the registered persons had sent us since the last inspection. These are events that the registered persons are required to tell us about. We also received information from local commissioners of the service and healthcare professionals. This enabled us to obtain their views about how well the service was meeting people's needs.

We visited the service on 2 and 3 November 2015 and the inspection was unannounced. The inspection team consisted of a single inspector.

During the inspection we spoke with 10 people who lived in the service and with two relatives. We also spoke with a senior care worker, four care workers, a housekeeper, business manager, deputy manager and the registered manager. We observed care in communal areas and looked at the care records for four people. In addition, we looked at records that related to how the service was managed including staffing, training and quality assurance.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us.

After our visit, we spoke by telephone with a further three relatives and close friends of people who lived in the service.

Requires improvement

Is the service safe?

Our findings

We found that the recruitment and selection procedure had not always been robust. This was because a background check had not been carried out in relation to one of the two newly appointed members of staff whose personnel records we checked. This oversight had reduced the registered persons' ability to ensure that only people who could demonstrate their previous good conduct were employed in the service. However, the registered manager had obtained a disclosure from the Disclosure and Barring Service to show that member of staff in question did not have criminal convictions and had not been guilty of professional misconduct. We also noted that no concerns had been raised about any aspects of the conduct of the member of staff since they had started work in the service.

There were reliable arrangements for ordering, storing and disposing of medicines. We saw that there was a sufficient supply of medicines and that they were stored securely. Records showed that when medicines were no longer needed they were promptly returned to the pharmacy. Senior staff who administered medicines had received training that was designed to ensure that people were given the right medicines at the right times. However, we noted that the guidance had not been followed in relation to a cream that a healthcare professional said needed to be administered. This was necessary to reduce the risk of a person developing sore skin. We saw that the mistake had resulted in the cream not being administered on two occasions during the first day of our inspection. Although the error had been noticed by the second day of our inspection leading to the cream being correctly used the shortfall meant that the person concerned had not received all of the medical treatment they needed.

The registered persons had not always taken all of the steps necessary to reduce the risk of people having accidents. We noted that some people who had significantly reduced mobility needed staff to use special equipment so that they could get into and out of bed and transfer between chairs. Records showed that for all but one of these people the registered manager had not consulted with a healthcare professional to determine how best to use the equipment when assisting these persons' with their mobility. This was the case even though the registered manager accepted that advice from a healthcare professional would have contributed to reducing the risk of accidents occurring.

In addition, we noted that the registered persons had not provided staff with written guidance about how to safely assist people should they need to quickly move to another part of the building in the event of an emergency such as a fire. When staff described to us the action they would take we noted that their accounts were inconsistent and contradictory. This situation increased the risk that people would not receive effective assistance that reduced the risk of accidents occurring if they needed to move to a safer place.

However, records showed that when accidents or near misses had occurred they had been analysed and steps had been taken to help prevent them from happening again. For example, when a person had been unwell and particularly at risk of falling the registered manager had arranged for staff to more frequently call to their bedroom. This had been done to help to ensure that the person was comfortable and safe.

People said that they felt safe living in the service. A person said, "I have no concerns at all about the staff who are all very kind and helpful." Another person said, "I really do get on well with the staff and find them reliable." A relative said, "I never have any worries about my family member being there and I'd know immediately if something wasn't right for them." Records showed that staff had received guidance in how to keep people safe. We found that staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk of harm. This action included contacting external agencies such as the Care Quality Commission, the local authority and the police.

However, we found that the registered persons did not operate robust systems to protect people from the risk of financial abuse. We noted that a number of people had asked staff to hold money for them which was then used to pay for services such as seeing the hairdresser. However, we noted that the records of the various transactions involved had not been completed and audited in a robust way. This had resulted in there not being an accurate account for each person of how money had been spent and how much was left. Although there was no evidence to

Requires improvement

Is the service safe?

show that anyone had been disadvantaged as a result of this shortfall, there was an increased the risk that people's money would not be managed in a transparent and robust way.

We were told that the registered persons had used their experience of how the service operated in practice to establish how many staff were needed to meet people's care needs. We saw that there were enough staff on duty at the time of our inspection. This was because people received the assistance they needed and this care was usually provided in a timely way. For example, staff responded promptly when people used the call bell to ask for assistance. Records showed that the number of staff on duty during the week preceding our inspection matched the level of staff cover which the registered manager said was necessary. People who lived in the service, relatives and staff said that there were enough staff on duty to meet people's care needs. A relative said, "The staff are always on the go that's for sure but people do get the care they need and I think that the service has enough staff in general."

Requires improvement

Is the service effective?

Our findings

Some of the arrangements used to support three people who were at risk of not having enough nutrition and hydration were not robust. None of the people concerned had been offered the opportunity to regularly and accurately have their body weight monitored. This was the case even though the registered manager said that all of them needed this to be done to ensure that they were not losing any further weight. In addition, he said that that staff needed to keep a careful note of how much these people were eating each day so that any significant changes could be notified to a healthcare professional. However, these checks were not being completed in the correct way because the records were not always accurate. In addition, staff did not know how to use the information when deciding if it was necessary to seek advice.

The registered manager also said that staff needed to keep a record of how much each of the three people had drunk each day. This was necessary so that advice could quickly be sought if the amounts were not sufficient to promote their good health. However, the arrangements were not robust. This was because staff had not correctly recorded how much any of the people had drunk each day. Some drinks had not been recorded at all and others had been recorded inadequately so it was not clear how much hydration had been taken. In addition, staff had not been given clear guidance and they were not sure how much the people in question should drink each day to maintain their good health. We saw that no action had been taken even though the amount people had drunk had varied widely between days. In addition, the amounts were sometimes below what a healthcare professional had advised the registered manager were generally necessary to promote people's good health.

Although other care records for the people concerned did not indicate they had experienced any direct harm, the shortfalls had reduced the registered persons' ability to ensure that they were eating and drinking enough to promote their good health.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people who were at risk of choking were being provided with the assistance they needed. This included having their food specially prepared so that it was easier to swallow. In addition, we observed that staff were correctly giving some people individual assistance at meal times so they could eat and drink safely and in comfort.

The registered manager understood the importance of staff receiving guidance and support to enable them to care for people in the right way. Records showed that staff had regularly met with a senior colleague to review their work and to plan for their professional development. However, although new staff had received introductory training, there were shortfalls in some of the refresher training provided for established staff. For example, records showed and some staff confirmed that suitable training had not been provided in relation to supporting people to eat and drink enough. This situation had contributed to the shortfalls we noted in the competencies that some staff brought to this aspect of their work. In relation to this problem some staff were not confident that they could recognise all of the signs when someone was becoming dehydrated or not having enough nutrition. There were further examples of some staff not receiving all of the training that the registered persons considered to be necessary. These included subjects such as basic first aid and infection control. In relation to both of these subjects we again noted that some staff did not have all of the knowledge and skills they needed to promote people's wellbeing. These shortfalls in providing training and support for staff increased the risk that people would not consistently receive all of the care they needed.

People who lived in the service said that they received all of the help they needed to see their doctor and other healthcare professionals. A person said, "The staff are very good to me here and call the doctor straight away even if I tell them not to bother." We noted that on the second day of our inspection visit a person appeared to be unwell and in discomfort. The situation was promptly brought to the attention of the registered manager who immediately asked for a doctor to call to the service. A relative said, "I'm confident that staff do keep an eye on my family member because in the past the doctor has been called several times and I think that the staff err on the side of caution."

The registered manager and senior staff knew about the Mental Capacity Act 2005. This law is intended to ensure that whenever possible staff support people to make decisions for themselves. We saw examples of people being assisted to make their own decisions. For example,

Requires improvement

Is the service effective?

we observed a member of staff carefully explaining to a person why it was advisable for them to see a healthcare professional and why it was advisable for them to use a particular medicine.

When people lack the capacity to give their informed consent, the law requires registered persons and staff to ensure that decisions are taken in their best interests. We noted that the registered persons had the necessary procedures in place to ensure that people's best interests were protected. These included consulting with relevant health and social care professionals and with relatives when a significant decision needed to be made. A relative said, "I like the way staff keep in touch with me and certainly no significant decision is made about my family member's care without me being consulted. I know what they'd want if they could say."

In addition, the registered manager knew about the Deprivation of Liberty Safeguards. We noted that they had applied for the necessary permissions from the local authority when it was likely that five people may need to be deprived of their liberty to keep them safe. This helped to ensure that only lawful restrictions were used that protected people's rights.

Requires improvement

Is the service caring?

Our findings

The registered manager said that people had been consulted about the gender of the staff who provided them with care and that only one person had expressed a definite preference. However, when we spoke with six women who lived in the service four of them said that they were concerned about the lack of choice they had in relation to this matter. One of them said, "I don't think us ladies should be expected to have a male member of staff in our room while we are receiving care that involves being undressed." Another person said, "I would object when there's a male member of staff doing my care but I don't want to be difficult, especially if there's only one female staff on duty and she's busy doing something else. I don't think it's right as we should be able to choose." This situation had occurred because the registered manager had not effectively consulted with people to enable close personal care to always be provided in a way that respected their wishes.

However, people were positive about the quality of care that was provided. A person said, "The staff are very kind and can't do enough for you." Another person said, "The staff are always willing to do extra things for you and I never feel I'm being a nuisance." A relative said, "I chose this service carefully because it felt right for my family member. It has the feeling of being like a family."

During our inspection we saw that people were treated with respect and in a caring and kind way. Staff were friendly, patient and discreet when providing care for people. We noted how staff took the time to speak with people as they assisted them and we observed a lot of positive interactions which supported people's wellbeing. For example, we saw a member of staff chatting with a person while they assisted them to walk from the lounge to their bedroom. They both spoke about life in the nearby villages where they had both lived for many years.

We saw that staff were compassionate and supported people to retain parts of their lives that were important to them before they moved in. For example, we observed a member of staff asking a person questions about the various jobs they had done in the past and then helping them to recall those which they had found to be the most fulfilling. Another example involved the way in which staff helped people to celebrate special events such as giving cards to mark a person's birthday and preparing a special cake for them to enjoy.

We saw that there were arrangements in place to support someone if they could not easily express their wishes and did not have family or friends to assist them to make decisions about their care. These measures included the service having links to local advocacy groups who are independent of the service and who can support people to express their opinions and wishes.

Staff recognised the importance of not intruding into people's private space. People had their own bedrooms that were laid out as bed sitting areas. This meant that they could relax and enjoy their own company if they did not want to use the communal lounges. Staff had supported people to personalise their rooms with their own pictures, photographs and items of furniture. A number of people had chosen to have their own telephone installed in their bedroom and other people could use the service's business telephone without charge.

Bathroom and toilet doors could be locked when the rooms were in use. Staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. A person said, "When staff help me in my bedroom they close the door so I can be private which is what I want." Another person said, "I suppose I take it for granted that the staff are courteous because they've always been that way with me."

People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted to do so. A relative said, "When I call to see my family member I usually sit with them in the lounge but if I wanted to speak in private there'd be no issue about us going to their bedroom to have a chat."

Written records that contained private information were stored securely and computer records were password protected so that only appropriate staff could access them. We saw that staff understood the importance of respecting confidential information and only disclosed it to people such as health and social care professionals on a need to know basis. A person said, "The staff don't talk about other people's business in front of me which is how it should be I suppose."

Requires improvement

Is the service responsive?

Our findings

The registered persons had not ensured that there were robust arrangements to support people who lived with dementia and who could become distressed. Although the registered manager said that staff needed to receive training in how to improve outcomes for people living with dementia records showed that most staff had not completed the training. The majority of staff we spoke to told us that they were not confident about their skills to support people who lived with dementia and we noted that they did not have some of the basic knowledge and skills they needed. For example, they were not familiar with how best to provide support so that people with reduced comprehension could be comfortable and settled in their surroundings. Furthermore, we noted that when staff spoke about how they cared for people who became distressed they described care that was inconsistent and contradictory. One member of staff said that they would spend time with the person to reassure them but another member of staff thought it was best to leave people with the time and space they needed to become more settled. This situation increased the risk that people would not receive the consistent and predictable assistance they needed.

During our SOFI exercise we observed the care that was given to two people who lived with dementia and who were being cared for in their bedrooms. We noted that over a period of 40 minutes both of the people increasingly made sounds that indicated they were uncomfortable or distressed. Although at various times staff were nearby in the hallway they did not call to see either of the people. When we glanced into their bedrooms one person was indicating their distress by pulling sharply at their clothes. The other person appeared to be uncomfortable because their arm had become dislodged from a sling that a healthcare professional said they needed to use. We immediately brought both matters to the attention of staff who agreed that the people concerned were distressed and who then provided the care and reassurance they needed.

Shortfalls in the arrangements to support people who lived with dementia had reduced the registered persons' ability to ensure that these people's special needs for care were reliably met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not fully supported people to pursue their interests and hobbies. We saw that although there was an activity held in the lounge every morning records showed that the majority of people did not attend these events. In addition, there was no one to coordinate and evaluate how well people were being supported to engage in activities. Records showed that during the five weeks preceding our inspection on most days the majority of the people living in the service had not been offered the opportunity to become engaged in a social activity. For example, the activities recorded for a person who lived with dementia for the period 9 September 2015 to 30 September 2015 only involved four occasions when they, 'watched television'. When we visited this person who was being cared for in their bedroom we found that the television was switched on but it was screening a news programme to which the person could not relate.

Although some of the people who used the lounge read their newspapers and chatted with each other most people sat in their armchairs without anything in particular to do. In addition, records showed that most people had not been supported to leave the service to enjoy community resources. None of the staff could recall when people had last been supported to visit a place of interest. We were told that no visits had been planned and staff did not anticipate that any would take place. A person said, "We have someone who comes to play music and things like musical movement in the lounge but apart from that there's not much else." Another person said, "Time can hang a bit here and it sometimes seems to be a long day waiting for meal times." A relative said, "I do think that there could be more activities for people to do because sitting around too much isn't natural and it can make people go into themselves."

These shortfalls had reduced the registered persons' ability to ensure that people were adequately supported to pursue their interests and hobbies.

We saw that staff had consulted with people about the practical assistance they wanted to receive and they had recorded the results in a care plan for each person. People said that staff provided them with all of the everyday assistance they needed. This included support with a wide range of everyday tasks such as washing and dressing, using the bathroom and getting about safely. In addition,

Requires improvement

Is the service responsive?

staff regularly checked on people during the night to make sure they were comfortable and safe in bed. A person said, "I really find it nice to know I'm checked on at night because it makes me feel safe."

We saw a lot of examples of staff being kind and supporting people to make choices. For example, we saw a person who was standing in a hallway and hesitating because they were not sure about where they wanted to go next. A member of staff gently reminded them that they could go on a little bit further to their bedroom or return to the lounge. We saw the person point to the lounge after which the member of staff assisted them back to that room and then did not leave until they were comfortably seated in an armchair.

We saw that the catering arrangements provided people with choice. There was a written menu that provided a different choice of meals each day. We saw people choosing different meals for their lunch on both days of our inspection and people praised the quality of the food they received. A person said, "The food is very good and I've no complaints." A relative said, "I've been in the service when it's been a meal time and I've noted the food to be very good.

People were supported to meet their spiritual needs. For example, people were offered the opportunity to participate in a regular religious service. In addition, the registered manager was aware of how to support people who did not have English as their first language including being able to make use of translator services.

People and their relatives said that they would be confident speaking to the registered manager or a member of staff if they had any complaints about the service. A person said, "I've not had to complain yet because I can just mention if there's something I want changed and the staff are very helpful." Another person said, "If there was something I wanted to raise I'd just speak to the staff and get things sorted out, but to date it hasn't been necessary." A relative said, "There have been problems in the past and it's taken some time to get them resolved but things are better now and issues get sorted out more quickly."

We saw that each person who lived in the service had received a document that explained how they could make a complaint. In addition, the registered persons had a procedure that was intended to ensure that complaints could be resolved quickly and fairly. Records showed that the registered persons had not received any formal complaints since the service was registered.

Inadequate

Is the service well-led?

Our findings

Some of the systems used to assess the quality of the service people received were not robust. For example, we were told that the care provided for each person should have been reviewed and audited at least once a month. However, records showed that these audits had not been completed as planned in relation to three of the four people whose care we reviewed. This shortfall had contributed to problems we noted in the delivery of care not being robustly addressed. These issues included the provision made to support people to have enough nutrition and hydration, the management of medicines and in supporting staff to develop all of the skills they needed to promote positive outcomes for people living with dementia.

In addition, we were told that a regular check was completed to ensure that defects in the accommodation were quickly identified and addressed. However, no one could find the records of the most recent audit and we noted a number of defects in the accommodation that had not been quickly put right. These included an area of worn carpet that increased the risk that someone might trip and fall. When we brought this defect to the attention of the registered manager they confirmed that the problem had not been previously identified. However, they assured us that the carpet in question would be immediately repaired or replaced.

We noted that lack of robust checks had also resulted in us not being told about an accident that had happened in the service. Records showed that the mistake had not resulted in the person concerned experiencing direct harm. However, the registered manager's mistake in not telling us about the event had reduced our ability to promptly establish if additional steps needed to be taken to keep the person safe.

We were told that one of the directors of the company that had recently been registered to run the service regularly called to check that people were receiving all of the care they needed. However, there were no records or other evidence to show us which aspects of the service they had reviewed, how well the checks had been completed and what improvements had been made.

Shortfalls in the completion of quality checks by the registered persons meant that the systems and processes in place were not operating effectively to ensure that people were suitably protected from the risk of inadequate and unsafe care.

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

People had not been fully supported to contribute to the development of the service. The registered manager said that there were regular 'residents' meetings' at which people were invited to suggest improvements to the service. However, the registered manager could not find the record of the most recent meeting and could not recall what people had said. We asked four people about their attendance at residents' meetings and none could recall having been invited. In addition, they could not give us an example of action having been taken to respond to a suggested improvement. A person said, "Most people wouldn't go but it might be a good idea because we live here and we might come up with some good ideas.

We were also told that people who lived in the service and relatives had been invited to complete a quality questionnaire each year. However, records showed that the system was not robust because the most recent questionnaires dated back to 2014. These shortfalls in the way people had been consulted had reduced their ability to contribute to the future development of the service.

In addition, the registered persons had not provided the leadership necessary to enable people to benefit from nationally recognised good practice guidance. For example, the registered manager had engaged with an initiative that is designed to promote high standards of care for people who are at risk of not having enough hydration. However as we have noted, this involvement had not resulted in the service offering an effective response to always ensure that people had enough to drink. Another example involved the deputy manager who had subscribed to an initiative that is designed to champion positive outcomes for people living with dementia. Again as we have described, this involvement had not consistently benefited people who lived in the service who had special needs for care relating to dementia.

People who lived in the service and relatives said that they knew who the registered manager was and that they were

Inadequate

Is the service well-led?

helpful. A relative said, “The registered manager is very easy to talk to and is genuinely a kind person who wants the best for the people who live here.” However, we noted that the registered manager was only present in the service for three days each week and that the deputy manager ran the service on the other days. We noted that the registered manager’s reduced contact with the service corresponded with them not having a detailed knowledge of the care each person was receiving. In addition, they were not fully aware of most of the shortfalls we identified in the care people were receiving.

However, there were arrangements to develop good team working practices that were intended to support staff to provide the right care. These measures included there being a named senior person in charge of each shift. In addition, there were handover meetings at the beginning and end of each shift so that staff could review each person’s care. There were also regular staff meetings at which staff could discuss their roles and suggest improvements to further develop effective team working. These measures contributed to supporting staff to be able to care for people in the right way.

Staff said that there was an open and inclusive approach to running the service. They were confident that they could speak to a senior colleague or to the registered persons if they had any concerns about another member of staff. In addition, they were reassured that the registered persons would listen to them and that action would be taken if there were any concerns about poor practice. A person said, “They have their off days of course but in general I think that the staff do get on quite well and you hear them laughing and chatting together which sets the tone for the place.”

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	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered persons had not ensured that there were safe systems to meet people's nutritional and hydration needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered persons had not ensured that care was designed with a view to ensuring that positive outcomes were promoted for people who lived with dementia.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered persons had not protected people who lived in the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided.**