HC-One Oval Limited

St Christopher's Care Home

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Christopher's Care Home provides accommodation, personal and nursing care to older people. The care home accommodates up to 168 people in five purpose-built buildings. At the time of the inspection 108 people were living there.

People's experience of using this service
Since the last inspection systems had been implemented to help address the shortfalls, promote safety and improve the quality of care in the home. We found that some of these systems had been effective and some were still a work in progress. However, the atmosphere in the home had changed for the better and staff told us they felt things had improved.

There were mixed views about the management of the home from people and their relatives about the amount of engagement from the management team.

People told us that their care needs were met in most cases. We found that for people less able to request support for themselves, there may be times when care was delayed. Relatives and staff told us that there were not always enough staff. People who were able to request support told us that there were enough staff most of the time.

Care plans were detailed and included enough information for staff to be able to support people with their care needs in many cases. However, they did not all include all elements of people's needs and some areas needed more information. Mental capacity assessments and best interest decisions needed to be completed for some people.

People gave mixed views about the activities available. People who were in their rooms were at risk of being isolated.

People told us that they received their medicines when needed. However, medicines were not always managed safely, and systems needed to be developed to manage this appropriately. People told us that they enjoyed the food. The dining experience had improved in some units but needed further development in other units.

There were systems in place to help ensure staff were trained and received regular supervision and staff felt supported by the management team.

The service met the characteristics for the rating of "Requires Improvement" in all key questions.
We have made recommendations in relation to sharing of examples of poor practice, medicines management, completion of capacity assessments and best interest decisions.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was Inadequate (published 16 April 2019). At this inspection the rating had improved. However, enough improvement had not been made and the provider was still in breach of a regulation.
This service has been in Special Measures since 15 April 2019. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified a breach in relation to governance systems at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will ask the provider to send us an action plan stating how they will make the required improvements. We may meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led

Details are in our Well led findings below.

St Christopher's Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and two Experts 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.

Service and service type
St Christopher's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection:
Our inspection was informed by evidence we already held about the service. We also checked for feedback we had received from members of the public and local authorities.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, the deputy manager, the area quality director, and 15 staff members. We spoke with 14 people who used the service and 12 relatives about their experience of the care provided. We reviewed 12 people's care records, medicines administration records and other records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection the provider had failed to ensure people's needs were met in a timely fashion. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However further improvements were needed to address the concerns some people still had about staffing levels.

- People gave mixed views about if there were enough staff to meet their needs. One person said, "They come quite quickly if people need them but then there aren't many people here now." Another person said, "They don't rush, but they can't waste too much time on one person, so I don't start unnecessary conversations. I let them get on with job." Relatives told us they felt there was not always enough staff, some said weekends were worse. One relative said, "There are not enough day staff, I can't comment on the nights, but they often don't have people turn up. There are 14 or 15 people here and most of them need two people to help them. Lots of them can't ring, and staff are so busy they don't know if they are coming or going. It's not good."
- Some staff said that at times staffing levels were too low. Staff told us that some people's dependency levels had increased and that many more people now needed the assistance of two staff. They said every aspect of people's care needs had increased (eating, assistance in the bathroom, hoisting and those receiving end of life care) which meant everything took longer. Some staff told us they would like more time to spend with people.
- Staff said they tried to cover shifts if a colleague was absent, but it was not always possible to do so. They told us weekends were worse. The provider told us that an additional weekend manager and night manager were been recruited for to help address the concerns.
- People's dependency tools were completed with staff input and sent to the provider who agree the staffing numbers in conjunction with the home's staff team . Although the provider told us that they had taken some actions to address staffing issues there continued to be concerns raised by people, relatives and staff.
- We did not review recruitment at this inspection.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to robustly investigate unexplained bruises and skin tears. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of

regulation 13.

● People told us they felt safe in most cases, some people told us they felt less confident as some staff they knew well had left the home. One person said, "I know I could not cope anymore at home that is why I do feel safe here." A relative told us, "My relative is absolutely safe here." However, we observed two instances that required investigation.
● One person used their call bell and was told by a staff member they would come back after the handover meeting. We saw that their call bell was on the table that was in their doorway and therefore out of the person's reach. We raised this with the registered manager who immediately addressed it with the staff member concerned and raised it as a safeguarding alert.
● One person was displaying behaviours that challenged. We observed a staff member holding the person's wrist while they sat in a wheelchair. Another staff member came to the person and de-escalated the situation. The person's care plan did not include how to support the person in this kind of situation and the registered manager told us that restraint was not an approved technique in the home. They told us they would take immediate action to investigate the concern.

We recommend that the provider ensures staff are all made aware of these examples to ensure this is not accepted practice.

● Safeguarding information was clearly displayed around the home and staff were reminded about their responsibility to recognise and report any concerns relating to abuse.
● Staff knew how to report any concerns they had within the home and reported any concerns they had to the management team.
● There was a monitoring system for unexplained bruises and skin tears. However, we noted that unexplained bruising still occurred for people who were totally dependent on staff and were nursed in bed. The registered manager was analysing this information and acting as needed. This included training staff, supervision and using their disciplinary processes. We discussed the need to have a better oversight to help them swiftly identify themes and trends.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure that infection control was promoted, fire records were completed, medicines records were accurate and risk assessments were followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People had their individual risks assessed and the assessments were clear in most cases. However, assessments for choking needed more detail. For example, to give staff guidance on what to do if someone choked.
● Risk assessments were incorporated in care planning for risks such as pressure care management, falls and mobility. Staff were seen to be working safely. People identified at risk of falls had sensor mats in place to alert staff if they needed help.
● A fire risk assessment had been carried out in 2018 and the actions identified had been recorded as completed.
● Staff had attended fire drills and knew what to do in the event of an emergency. People's individual evacuation plans (PEEPS) were easy to follow.
● Accident and incident forms were collated to help the management team review for any themes and

trends and help ensure remedial action was taken.
● People who had bedrails in place had the protective bumpers on to help prevent them from injury and bedrail checks were in a place. The home was trying to reduce the use of bedrails through an assessment process.

Preventing and controlling infection
● The home was clean on the day of the inspection. The housekeeping staff were moving around the home and cleaning all areas. People and relatives told us that the home was kept clean.
● Staff had received training and were seen to use gloves and aprons in most cases.

Using medicines safely
● People's medicines were administered, stored and recorded safely in most cases. We counted a random sample of medicines and found that while most of the records and quantities were correct, one was not. The daily counting and recording systems had not identified this and records were wrong.
● A new electronic records system was being rolled out through the home and this had some issues that needed to be addressed. For example, who was responsible for reviewing and addressing alerts on the system which flagged missed entries. The management team told us this role had not been allocated yet.

We recommend that the provider seeks advice from a reputable source to ensure good practice and the safe management of medicines.

● People received their medicines when they needed them, including time specific medicines.

Learning lessons when things go wrong
● We reviewed staff meeting notes and found that management and staff had discussed some areas of practice, such as outcomes of inspections and what was needed to address these areas.
● The management team had implemented some systems as a result of things going wrong previously. For example, body map monitoring.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's care plans were written in a way that reflected care that was in their best interests and explained why care was needed. However, capacity assessments and best interest decisions had not been fully completed for everyone. Staff we spoke with told us they knew it was needed but they had not yet had time to complete them.

We recommend that the provider ensures there is an effective plan in place to ensure that capacity assessments and best interest decisions are completed promptly.

●Staff received training relating to the MCA.
●DoLS applications were made when needed, authorisations had been granted for some.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us that they liked the food offered. One person said, "Food is very good here, I do enjoy all meals here. I know what I will have today, they came and asked me yesterday, I made a note in my diary."
● Food choices were taken the previous day, and, on some units, visual choices were shown to people to help them choose at the mealtime. There were no menus on the tables as the menu was displayed in the room on a stand. People could not access this easily.
● People living in the home had a range of dietary needs. These were known by the staff team supporting them.

● People's care plans contained information about their dietary needs and some likes and dislikes. However, for one person it stated staff should sit to the person's left, but there was only space in the room for staff to sit on the right.
● Most people were supported in a calm and patient way when being assisted to eat. The atmosphere varied across the units. Staff could take more opportunity to speak with people when supporting them.
● Food and fluid charts were completed for those assessed as being at risk of not eating or drinking enough.
● Drinks were always available for people. We saw hydration stations around the home and staff assisting people to drink. People told us they missed the hostess team coming around with drinks and snacks as this had been stopped by the provider. Some people felt they missed out because of this.
● Where people were at risk of losing weight, there were management plans in place to address this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff told us that people, and their relatives where appropriate, were involved in planning care.
● Care plans reflected people's input and that of their relatives where appropriate.
● People told us that staff asked them before support was given.

Supporting people to live healthier lives, access healthcare services and support
● People were supported to have access to outside health and social care professionals. A relative told us, "They noticed a chest infection not long ago, she would be very sleepy and that alarmed them."
● A chiropodist, dentist, tissue viability nurse and optician all visited the home on a regular basis. The home had a visiting hairdresser who also went around people's rooms if they were cared for in bed.
● We saw that all changes in health were documented.

Adapting service, design, decoration to meet people's needs
● Some bedrooms were personalised, and people had their personal items around them. The home is designed in a way that people can move around easily whether independently or with the use of mobility aids. The home was clean and odour free.
● There was ample communal space, and we saw people using the main lounges and dining room.
● There was a pleasant garden area which people used if they were able to access it by walking or wheelchair. The home supported a number of people who were end of life or being nursed in bed, further thought could be given to how those people could access the garden.
● Development was needed to ensure the environment was more dementia friendly. For example, items around for people to find interesting or stimulate their senses. Also, to make the lounges homely for people. In addition, some room number arrows did not correctly reflect the room numbers on each corridor.

Staff support: induction, training, skills and experience
● Staff were happy with the training provided. One staff member said, "We have eLearning (online training) and face to face training and it's enough." A relative told us, "They do have better knowledge of her condition, proper medical training because she is often poorly."
● Staff said they had regular one to one meetings with a line manager.
● Records showed that training was ongoing, and most staff had attended all training. Some was now due to be refreshed and we saw that more training sessions were planned.
● However, training for staff to recognise the symptoms of sepsis was needed as some nursing staff did not know the signs to look out for.

Staff working with other agencies to provide consistent, effective, timely care
● The home was visited by the clinical commissioning group and the local authority to help improve care for

people. There was an action plan in place which the management team were working through. Some progress had been made, for example, ensuring people had access to drinks and call bells and to promote better teamwork.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported

● People and their relatives told us that they felt the staff were kind and respectful. Many people told us that they were sad to see staff they knew leave the home. One person said, "I like my carers, they are friendly, and I like when they have time to stop and chat." A relative told us, "[Person] can't talk so if something is not right they (staff) can only read from their facial expression and I think they are very good at that." However, we noted that one staff member argued with a person when they tried to request food that was cooked in a way they liked. This did not encourage people to voice their choices.

● People and relatives told us that staffing issues had a negative impact on people's wellbeing. One person said, "Seems like nobody cares, really cares. I am saying that because they rush around, I can hear them going up and down corridor and unless I ring nobody will come and ask do I need anything. Doors are always open, it will take few second just to say hi, do you have everything. I am tired of telling people how I would like things done." A relative said, "Staff are very good, it's a shortage they have which is a problem."

● People's life histories, religion or cultural beliefs, hobbies and interests were recorded in people's care plans. Some staff were familiar with these and some staff knew people well.

● Most staff were attentive and stopped and chatted with people. We also heard some staff chatting with people while they supported them. Staff knew visitors well and they stopped to welcome them into the units. There were no restrictions on visiting time and we saw relatives supporting people at lunch time.

●However, activity staff didn't notice people were cold during the tea party. Another care staff noticed and brought blankets out. We saw that one staff member knew how to approach and interact with people who were displaying behaviours that were challenging. However, other staff members were not as knowledgeable in this area.

● Staff were smiling and positive in their attitudes towards their duties which helped to make the atmosphere light.

Supporting people to express their views and be involved in making decisions about their care

● People told us that they felt involved in planning or reviewing their care. Relatives told us that they were involved. However, the systems used did not allow staff to be flexible and explore if people had any specific wishes or routines they wanted to continue with after they moved to the home. For example, people were not really asked when they wanted to get up. They were asked about their preferences for male or female carers but not about routines.

● People gave mixed views about if they got to choose what care they received and not everyone felt they could speak up about additional support they wanted. One person said, "I choose what I wear, they ask, and I choose, I like that." However, others told us that they took what care was on offer and did not want to ask

for extra care.
● We heard staff asking people's choices throughout the inspection and gave people options to help them choose. For example, "Would you like to sit by the window, so you can look out at the garden, the weather is bright and sunny."

Respecting and promoting people's privacy, dignity and independence
● People were dressed appropriately in most cases. However, we saw one person in a state of undress while in bed when we arrived as their bedroom door was open. The care plan stated that the person removed their blankets. Consideration is needed to find ways to better promote the person's dignity.
● Staff knocked on doors before they entered.
● Care plans were stored in a secure office. The office had a board with important information about people for staff. This was covered by a blind to promote confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.
At our last inspection the provider had failed to ensure that care was delivered in a person centre way and opportunities for activities required improvement. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were mostly happy about the care they received. One person told us, "I am very comfortable and happy here - everything I need I will get." Relatives gave mixed views about care received, this was mainly because of staffing issues where they told us people waiting for support to get washed and dressed. However, one relative said, "What also makes me feel they know what they are doing its reporting back to me - if anything, however small thing happens - they will call me to tell me and they will be ready to explain if I have any additional questions." Some relatives told us that teeth and dentures cleaning was sometimes not done.
- We reviewed care entries and found in most cases these were completed. However, there were some gaps at times. We discussed with the manager about making these charts personalised to prompt staff about key areas, for example, thorough care of hands if they were contracted.
- Care plans were detailed on some units and included enough information for staff to be able to support people for care needs. However, this varied across units and they did not include all elements of people's needs in all cases.
- Staff knowledge and responses to the needs of those living with dementia was positive in most cases. We heard staff giving encouragement and support to someone who was becoming distressed during personal care. This calmed the person and they were able to have their needs met.
- Baths and showers were not always offered in a person-centred way, but as part of a weekly bath rota. One person said, "I have a bath once a week, but they missed it last week, so I didn't have one. I don't like that so I'm going to have one this week."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People who were able to participate in group activities told us that they enjoyed those provided. One person said, "I went out this morning for a walk around, I was up early, and the carer was able to wheel me for a bit of sunshine - I picked up some lavender." However, another person told us, "There is never anything interesting to do here, it is very, very boring, but I watch my TV so that's alright."
- People in their rooms had little stimulation. We saw people lying in bed, and they were not always involved in activities, especially if they were planned to happen in other units. One person said, "I don't

know anything about them (activities), nobody comes to tell me what is going on or bring any leaflets, it might be on the main board but how can I go and read it - even in the wheelchair I can see anything that high...I spent my day listening music, but even that is problematic because my hearing aid is not working properly." The provider told us that there was a activity planner and newsletter circulated in the home, including to those who were in bed.

● Staff told us that they felt activities in the home had improved since the last inspection but staffing issues did limit people attending. They felt this was a work in progress.

● An activity poster was displayed on communal area notice boards. We saw that these activities offered were generic and did not consider people's individual preferences. However, the registered manager told us that these had been planned in accordance with people's preferences.

● There were no tactile objects around the home for people living with dementia to hold or see. For example, blankets that could be used by people who spent time in bed to stimulate their senses.

● On the day of inspection, we saw there were limited activities taking place. There was a tea party between two units but when observed, people were cold and just sitting with little interaction. The deputy manager told us that prior to our observation people had been singing.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There were no aids available to support people with communication when they were unable to verbalise choices. Staff did not show visual prompts to people. We discussed the need to develop these tools to assist people with communication.

● The management team told us that for people whose first language was not English, they put staff who spoke the same language on the units to support those people while they were on duty. However, tools needed to be in place for when those staff were not available. One person's family had written some sentences for staff to use for their relative.

End of life care and support

● The service offered end of life care. When people were nearing the end of their lives, care plans were put into place for supporting people. However, the plans did require more detail about how staff could provide comfort and reassurance to people.

● We received mixed views about the care people received at the end of their lives. One relative told us that they felt their relative did not receive attentive care. Another relative told us, "[Person] is in that stage where she needs good health care and she has that here. We discussed end of life care, which was upsetting for me, but staff and carers were so supporting and after chatting with them it felt better , I know they will do anything possible."

● Plans were completed in detail when people approached the end of their lives and they stated if a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) was in place. The person's preferred place of death was noted and to keep people comfortable. Just in case medicines were prescribed for people nearing the end of their lives. This meant that people were supported to die in a pain free and dignified way.

Improving care quality in response to complaints or concerns

● Records indicated that complaints and concerns had been investigated and responded to.

● People and their relatives gave mixed views about the response to complaints. One person said, "I would speak to the senior carers if I needed to." Relatives told us that they did not always feel responses were sincere and that they did not bring about the changes needed, such as improvements to staffing.

● Many of the complaints received were about staffing. The response was that the dependency grid would be reviewed. However, feedback on the day of inspection was that improvements had still not been made to staffing.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to bring about improvements in a timely manner and identify concerns found on inspection. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

- At the last inspection in March 2019 the appropriate checks and systems were not in place to ensure people received safe and appropriate care, or ensure regulations were complied with. At this inspection we found that action had been taken to address many of the shortfalls found.
- The systems used to promote the expected standards in the home included a manager twice daily walk round, unit manager walk round, nightly and weekend walk rounds. These were not used consistently until very recently when it was highlighted by an internal inspection. September 2019 had regular checks completed.
- The management team had used the internal governance systems to help them identify issues in the home. An action plan was developed. However, some issues remained.
- The management team had not ensured that the principles of the Mental Capacity Act had been adhered to. The systems in place did not identify that the correct process was not always being followed and some records were not in place.
- A 'Resident of the Day' system was carried out daily by staff in the units. Each day a person's care plan was reviewed and their room deep cleaned. All heads of department were required to visit the person and discuss if anything had to be done regarding their room as well as talk about their meal time experience, menu, likes, dislikes and preferences. Although these were done daily, there were differences between the quality of each audit. For example, there were occasions where the person's room had not been deep cleaned and there were no records of them meeting with the chef. The registered manager told us they had identified this issue and they were reviewing every resident of the day record to ensure they could give feedback to staff where improvements were needed.
- The management team were planning to introduce an additional management structure at weekends and night time to try and address the issues that had been raised in relation to staffing. Feedback from people, relatives and staff was that at times they felt the provider did not respond to their concerns or take on board their feedback. The management team shared with us the ways in which they were trying to engage with

everyone and the additional ways planned, for example, a manager's surgery when time was blocked out for the registered manager to meet with people.
● Audits and checks had identified the areas of improvement needed for mealtimes and they were working with staff to achieve this.
● There was a new electronic medication system being rolled out in the home. We found that there were some issues with the new system and staff needed to become more familiar with their responsibilities. However, no one had been appointed to review the daily alerts which flagged missed entries. 80 entries were showing as being missed over the previous few days. The management team acknowledged that this was something that was needed.

Continuous learning and improving care
● The learning from the home's recent issues and ongoing performance issues had been shared with the staff for any required actions to be taken. This had a positive impact in relation to the care people received and atmosphere in the home, there had also been improvements in relation to governance and provider monitoring.
● However, some people and relatives still felt that the management team were not invested in the home and the changes were brought about by the care staff. One relative said, "The real care comes from carers only."

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
● Not everyone who lived at the home knew who the registered manager or provider was. One person said, "I never seen manager. I know it's a woman, but she never came to introduce herself, so I didn't know her."
● We were told by some people, relatives and staff that the management team were not always visible. One relative said, "I do know all senior staff, but I don't know any managers. Maybe they come when I am not there, although I do come every day." Another relative said, "Management could be more present on the floor. You would think they would like to see how people who live in place they manage are but its look like they are not really interested. I saw the manager today for first time in long time - they should show more interest in people."
● A staff member told us, "The management are better now, it dipped when HC One took over, but things are starting to improve now."

Engaging and involving people using the service, the public and staff
● People and their relatives had meetings to discuss the service. Heads of department were also meant to meet with people as part of the resident of the day process. However, one person said, "I don't know any of office people, this lady who just came now introduced herself as deputy I never seen before, it's nice she popped in, shame she is not in more often, and cook came today first time, never happened before. I did attend one of meetings it was some time ago and I can't remember what was discussed."
● The resident meetings looked at activities and menus and gave some information about the home. This included recent inspection visits or contact from the CQC and local authority. However, one person said, "I don't think management wants to know opinions of people who live here. I am not scared to say what I don't like but in the same time - nobody pays attention, they say I am a bit fussy and get on doing it same way so no point of saying. We had a lot of meetings, they just talk and talk and no action." Another person said, "We do have residents' meetings, but I don't bother to go, they never listen to you anyway."
● A relative told us, "We hardly ever have one. They aren't useful when they do happen and the last one was a big one after you lot came in last time."
● Care staff meetings included reminders of good practice. A staff member said, "Communication is much better, we talk at meetings, handovers, and we all share what we are told. If each of us tell five people (staff),

everyone will get to know what they need to." Results of a recent staff survey about how they felt working at the service were positive.

Working in partnership with others

● The management team had been working with other agencies to help make improvements. They had reported concerns in relation to allegations of abuse and reported serious injuries appropriately.

● The provider was working with the local authority to improve the service provided. A recent drop in visit had resulted in actions. We noted that some of these actions had been addressed.

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 17 HSCA RA Regulations 2014 Good governance Systems developed to improve the standards in the home were not yet fully embedded and some issues remained.