

Akari Care Limited

Wallace House

Inspection report

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Date of inspection visit:
21 September 2017
27 September 2017
29 September 2017

Date of publication:
06 December 2017

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 ●

Summary of findings

Overall summary

We inspected Wallace House on 21, 27 and 29 September 2017. This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

At our last comprehensive inspection of this service on 19, 20 and 28 July 2016, we found the provider was in breach of four regulations related to consent to care, dealing with complaints, staffing and good governance. We rated Wallace House as 'Requires improvement' overall at that time. We re-visited Wallace House on 31 January 2017 and found they had rectified the breaches of regulations previously identified.

Wallace House is a care home which provides nursing and residential care for up to 40 people. Care is primarily provided for older people, including people who are living with dementia. At the time of this inspection 36 people were in receipt of care from the service.

The home has not had a registered manager in post since June 2017. 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 provider had recruited a manager and they had submitted an application to the Commission to become the registered manager of the service.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective which placed people at risk.

Accidents and incidents were monitored but we found improvements were needed around how the information was analysed and used to assess risks of falls and injury. We found that the provider was changing the systems they used for monitoring the service and in the transition period the systems in place had not picked up the issues we identified.

Safeguarding and whistleblowing procedures were in place. The manager was currently in the process of reviewing all aspects of the service to check that all previously raised concerns had been investigated and appropriately referred to other agencies. They were also ensuring that the Commission had been notified of these incidents.

A complaints process was in place. However people told us that, up until recently, when they raised issues they received no feedback and action was not taken to rectify their concerns. The manager was currently in the process of ensuring all complaints were identified, reviewed, complainants were responded to and action was taken to reduce the potential for these matters to reoccur.

People's care records were cumbersome, extremely difficult to navigate and we often found it difficult to get a sense of the person's needs. The lack of a detailed written assessment had contributed to the difficulties

around developing the care records as an effective working tool. Also staff needed to ensure the risk assessments in place reflected all of the concerns.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began work. However, the service was reliant on using agency staff and we found the provider's central human resources team had vetted the agencies they used, but they did not always send the staff at the service the agency staff profiles or ensure the ones they did send were kept up to date. We discussed this with the manager on the first day of the inspection and found when we returned they had developed their own system for checking that agency staff remained suitable to work at the service.

The environment on the upstairs nursing unit was not user friendly and both floors were in need of refurbishment. The manager confirmed that they had taken action to rectify this and the provider was to begin a full refurbishment programme before the end of the year.

Although the domestic staff tried their best to keep the service clean, there were insufficient staff to do the day-to-day work. The manager had identified this issue and had requested that the provider ensured additional domestic staff were employed. They were in the process of recruiting a head domestic and more domestic staff.

People told us they felt the care staff did a good job. Staff had been trained to meet people's care and support needs in a wide range of topics, including working with people who lived with dementia and managing physical healthcare conditions.

People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were protected. However the provider template for mental capacity assessments needed to be developed in order to reflect MCA requirements.

People we spoke with told us they felt safe in the home and that staff made sure they were kept safe. Staff respected people's privacy and dignity. We observed the staff team worked well together and with the people who used the service. Staff consistently engaged people in conversations and we heard lots of laughter throughout the visits. We found there was a calm relaxed atmosphere within the home.

Most of the people who used the service and the staff we spoke with told us that there were enough staff on duty to meet people's needs.

We found a range of activities were available and people found them stimulating. We found staff worked with people in ways that delivered personalised care albeit the care records needed to be enhanced in order to demonstrate this expectation.

We reviewed the systems for the management of medicines and found that people received their medicines safely.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to good governance. You can see what action we told the registered provider to take at the back of the full version of the report.

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.

Risk assessments needed to be improved.

Staff were recognising signs of potential abuse and reported any concerns. However, historically some of these concerns had not been reported to the appropriate authority. The manager had identified this issue and was ensuring all concerns were appropriately reported.

Recruitment procedures were completed on contracted staff, but robust checks on agency staff had not been completed. The manager put a system in place to ensure this would always occur.

The service was not clean or well maintained.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff adhered to the requirements of the MCA but the documents for staff to use to complete capacity assessments needed to be improved. Also the DoLS authorisation records had only been obtained since the manager took up post.

Staff received a wide range of training. They also completed refresher training in line with the provider's policies.

People received a nutritional diet and staff took action, when appropriate, to support people who experienced weight loss.

Staff worked closely with other healthcare professionals and ensured advice was sought when needed.

Is the service caring?

Good ●

The service remains good.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care records were overly complicated and did not contain sufficient detail for staff to meet people's individual needs.

People's needs were not comprehensively assessed.

Activities were available for people to take part in.

There were opportunities for people to give their views about the home.

The manager was currently ensuring that all complaints the service had received were being investigated.

Is the service well-led?

The service was not always well-led.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective which placed people at risk.

The manager was taking action to improve the operation of the service but further work was needed.

There was no registered manager at the service.

Requires Improvement 

Wallace 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 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 unannounced inspection took place on 21, 27 and 29 September 2017. The inspection team consisted of an inspector 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 service.

Before the inspection, the provider submitted a Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our planning for this inspection. This included reviewing notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. The information we reviewed also included reports from local authority contract monitoring visits and outlined their views.

During the visit we spoke with 14 people who used the service, eight relatives and a community nurse. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We also spoke with the manager, three nurses, three senior carers, seven care staff, the cook, a domestic staff member and the activities coordinator.

We spent time with people in the communal areas of the home and observed how staff interacted with and supported individuals. We observed the meal time experience and how staff engaged with people during activities. We looked at six people's care records, four recruitment records and the staff training records, as well as records relating to the management of the service. We looked around the service and went into some people's bedrooms, all of the bathrooms and the communal areas.

Is the service safe?

Our findings

We found the provider needed to ensure accident and incident analysis covered the broader picture for people, so, for example, reasons as to why someone was experiencing an increase in falls at specific times could be reviewed, so that consideration could be given to providing additional aides such as pressure mats and extra staff support.

A relative told us, "It always smells badly on this floor and the brass plates on doors are dirty – I worry about hygiene." Another relative said, "Last Sunday at 11.20 am there was still bits of sausage and egg on the floor in the dining room and three or four bulbs were out. I see today the bulbs are all working. I've talked to [Manager's name] and I'm hoping they will bring about improvement."

Although the domestic staff tried their best to keep the home clean there were insufficient staff to do the day-to-day work. It was evident that the schedule for deep cleans was insufficient to ensure the cleanliness of the service was effectively managed. We saw that carpets, floors, tiles and the lift were dirty. We also found there was a malodour throughout the building. The manager told us that they had discussed this with the provider who had agreed to employ a head housekeeper and more domestic staff.

The provider's governance and quality assurance systems had not identified these shortfalls

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

A relative told us, "I don't think there is enough staff and at weekends there is always agency staff that don't seem to know the needs of residents. Floor one always seems to get the agency staff whereas the ground floor, where the manager is, runs smoothly. Just last Sunday an agency staff tried to administer an inhaler to Mam, I asked why, they checked and said it was empty anyway and left. On my way out I enquired again and was told it wasn't for Mam. I told the manager about it."

We found information about people's needs had been used to determine the number of care staff needed to support people safely. We found that generally there were enough care staff to meet people's needs. For the 39 people who lived at the service there was a nurse, a senior and six care staff during the day. Overnight there was a nurse and four care staff. In addition to this a manager was on duty during the week. However, we noted that overnight there was no senior and this meant the nurse had to administer medicines to all of the people, which meant people had to wait to receive their night medicines. We discussed this with the manager who confirmed the provider had agreed to them employing a senior for night duty, also to employing a second nurse for day duty and a deputy manager. The manager also confirmed that they were in the process of filling staff vacancies with the aim of the service not having to rely on agency staff.

Staff understood what actions they would need to take if they had any safeguarding concerns. Safeguarding and whistleblowing policies were in place. We found the new manager was making referrals to the local authority safeguarding team and had reviewed all of the information to ensure all appropriate referrals had

been made.

We saw maintenance records which confirmed that the necessary checks of the building and equipment were regularly carried out. These checks helped to protect the health and safety of the people using the service. However, we found that all areas of the service were in need of refurbishment. Most of the paintwork was chipped and we saw a lot of the carpets were stained. A table top within one lounge was extremely loose and some chairs were stained. The manager confirmed that the provider had agreed to the whole service being redecorated and when we asked for timescales the manager confirmed that the estates team had brought this forward so it was to start before the end of the year.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions. The deputy manager showed us information which confirmed checks from the Nursing and Midwifery Council (NMC) for qualified nurses were up to date.

However, we found the provider had not ensured effective monitoring checks were completed to ensure that agency nurses remained registered with the Nursing Midwifery Council, or to check that people had the right to work in the United Kingdom and had completed appropriate training. We discussed this with the manager who immediately altered their processes to ensure that on each occasion agency staff were to be used, these checks were completed.

People who used the service told us they were satisfied with the service and felt safe. One person said, "They know what they are doing." Another person told us, "The girls are lovely, I have no complaints." Another person said, "They always check on us and make sure we are alright."

We observed staff using a hoist to move a person from a wheelchair to an armchair. We saw that this manoeuvre was carried out safely and in line with best practice guidelines. After staff had completed this transfer the person told us they always felt very safe when staff moved them in this way.

We saw evidence of Personal Emergency Evacuation Plans (PEEPs) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

We checked whether the management of medicines within the service was safe and in line with best practice guidelines. Records of the administration of people's medicines were stored electronically. Staff used a hand-held electronic device to monitor all aspects of people's medicines including ordering, administration and disposal. The device showed when people next needed their medicines. The staff on duty were familiar with people's needs and their medicine routines. We found the clinic area of the home to be clean and tidy. Fridge temperatures were taken every day which ensured medicines which were to be stored below room temperature were stored in a safe manner and remained safe for use.

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff had received training in the Mental Capacity Act 2005 and DoLS authorisation. Staff appropriately recognised when people had or did not have the capacity to make decisions around their everyday lives, but they would benefit from more bespoke training around how they were supposed to complete capacity assessments. Also staff needed to be able to access the MCA code of practice in order to ensure their practices were in line with expectations.

We found limited information was contained in the care records to show that capacity assessments and 'best interests' decisions had been completed. The available capacity assessment forms did not support staff to clearly identify, which decision the person was being asked to make. The 'best interests' decision forms we saw did not encourage staff to identify who out of a multidisciplinary team had been involved in the discussion. We found the provider needed to ensure the appropriate capacity assessment and 'best interests' documents were in place for staff to use. The provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care, welfare and finance and if the Court of Protection had appointed anyone to act as an individual's deputy. Also, it did not support staff through the process for referring individuals to the Court of Protection when they objected to being subject to a DoLS authorisation.

The manager told us that although the supervisory body had authorised DoLS, none of the associated paperwork was at the service. The manager confirmed that they were taking action to follow up missing information about the Court of Protection outcome and DoLS authorisations. They had phoned the supervisory body to find out what conditions had been imposed via the DoLS authorisations and documented these whilst they awaited the paperwork in order to ensure staff adhered to any conditions.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People told us that the staff tried to make sure the service met their needs. One person said, "They do their best to spend time with us, they are busy and holidays make it worse." Another person told us, "They are

very friendly here and easy to talk to, very obliging." Another person said, "We all support each other here, it's just natural to do that, we help each other – the staff, the other people we just all get along." Another person told us, "It's canny, alright, the girls are ok, the food is ok, I get my tablets, I'm happy."

Relatives said, "There's been a lot of changes recently and things have improved since [Manager's name] came" and "They have an effective system here for serving meals, my dad is on a special diet and he still gets plenty of choice."

Staff had been trained to meet people's care and support needs in topics such as working with people who lived with dementia and managing physical healthcare conditions. Records showed staff had received training in subjects that the service deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid and this had been kept up to date. Mandatory training and updates were deemed by the provider as necessary to support people safely. We found that staff training had been kept up to date.

Staff had been supported with regular supervisions and appraisals until the previous manager left the service but in recent months, these had lapsed. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The new manager was in the process of designing a plan to ensure all of the staff received regular supervision and appraisal.

People had mixed views about the food. One person said, "I don't like the meals, I don't like soup and sandwiches for my tea, and that is all we get offered at tea time." Another person said, "The food is alright, you get what you are given." Another person told us, "I like the food, it's nice and there's enough of it."

Relatives told us, "They seem to get a lot of sandwiches, particularly tuna sandwiches and it's often the same stuff all the time" and "The food looks nice, they bake cakes for birthdays."

We found the menu offered limited choices, however the cook and manager told us this was being reviewed. They were both aiming to ensure there was more variety and felt this was achievable.

We saw that MUST tools, which are used to monitor whether people's weight is within healthy ranges were being accurately completed. People were seen by GPs and dietitians when concerns arose and attended regular appointments with these healthcare professionals. We saw records to confirm that people had regular health checks and were accompanied by staff to hospital appointments. This meant that people who used the service were supported to obtain the appropriate health and social care that they needed.

We spoke with a community nurse who was visiting at the time of the inspection. They told us that the staff always sought advice when needed and staff had developed a good working relationship with them and other visiting healthcare professionals. A relative told us, "If there are any health issues we get a phone call about it."

Is the service caring?

Our findings

The people we spoke with felt they were well cared for and staff were respectful of their privacy and dignity. One person said "I have been here a while and it's mostly been the same staff, it's like having a family." Another person said, "The girls are marvellous." A third person said, "I think they are very caring here" and a fourth person told us, "They're looked after well."

Relatives told us they thought the staff were very kind. All relatives we spoke with confirmed that they could visit whenever they wanted, were always made to feel welcome and had access to the dining room to make refreshments. One relative said, "Most of the girls are good and [name of carer] is fantastic." Another relative told us, "The girls are good, very caring. Sometimes [person's name] shuffles to the end of the chair and bumps onto the floor. If [relative] has an accident they call my sister straightaway to let her know."

We observed the staff team worked well together and with the people who used the service. Staff consistently engaged people in conversations and we heard lots of laughter throughout the visits. We found there was a calm relaxed atmosphere within the home.

We saw one staff member supporting a person who had taken a shirt from someone else's bedroom, to take the shirt to the laundry where it could be left to be ironed. They provided this support in a sensitive and caring manner. The staff member suggested the shirt go to the laundry and sought the agreement of the person and together they handed the shirt to the laundry. After this interaction we talked with the staff member who told us they felt supported by management and felt they were able to spend time talking with people who used the service. They told us they often take their breaks with people as they enjoyed talking with them.

The staff explained how they maintained the privacy and dignity of the people they cared for and told us that this was a fundamental part of their role. We saw that staff knocked on people's bedroom doors and waited to be invited in before opening the door.

We found the staff were warm, friendly and very respectful. Staff showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history, preferences, likes and dislikes. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs. People were encouraged to remain as independent as possible.

We visited the service early in the morning and found that people were able to get up when they wanted. One staff member told us, "People get up when they want to and there is no rush." We observed staff made sure people were alright and had everything they needed. When staff spoke with people they were friendly and professional.

We saw that information about advocacy services was available, and when needed, the staff enabled people to access these services. Advocates help to ensure that people's views and preferences are heard where they

are unable to articulate and express their own views.

At the time of our inspection people were receiving appropriate end of life care. Staff understood the actions they needed to take to ensure people were supported as they wished.

Is the service responsive?

Our findings

People who were identified to be at risk, had plans of care in place such as plans for ensuring action was taken to safely assist people to eat. However, the 'Client's General Risk Assessment' form contained only basic information and only listed four specific areas, with one section for 'other' risks. The four areas were: walking, sitting, eating and drinking, and bed. There was no specific mention of risks associated with people's needs in respect of areas such as using moving and handling techniques, community access, skin integrity, medication, behaviour, communication and supervision. We accepted that a new care record template was being designed. However, action was needed to ensure the current records were organised so immediate risks such as choking and falls were not lost amongst the paperwork, and may lead to staff not readily identifying the issue.

The manager told us that the provider was in the process of introducing a new set of care records. However, current records needed to be organised so immediate risks and changes in people's presenting needs were not lost amongst the paperwork, and assessment information contained detailed information about people's needs.

We found that moving and handling needs and relevant information was basic and not sufficiently detailed, with an over-reliance on a document called 'Manual Handling Techniques' which was inserted into some, but not all the care plans referencing it. The document was eight pages long, had small print with no diagrams, and contained information that was ambiguous.

The service used a pro-forma care-plan template for a person's needs following a DoLS authorisation, which was a mixture of general guidance and procedural information rather than a person-centred care plan. It was ambiguous in nature and attributed a person's inability to decide where they lived as being due to their short-term memory loss, which would not be the case for all of the people who used the service.

We discussed with the manager how the assessments could be enhanced. The provider only supplied a very limited record for staff to record their full assessment of a person following admission. Other documents they relied upon were tick box assessment forms, which did not allow staff to describe how the person was impacted by their condition. The lack of a full assessment meant crucial information about people's past experiences and risk history was unavailable. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated. The use of care plans in this manner meant the person's priority needs were lost and staff would find it difficult to readily identify when care records were updated. The manager accepted this was a gap and agreed to take action to develop an appropriate tool.

We looked at the complaints procedure and saw it informed people how and who to make a complaint to and gave people timescales for action. Staff were able to explain what to do if they received a complaint but commented that they rarely received complaints. However, the manager and relatives explained that when they had raised concerns previously these had not been addressed. The manager had identified this gap and was in the process of speaking to all of the people who used the service and relatives to determine if all

of their concerns had been looked into and action had been taken to rectify them. However the provider's system for monitoring complaints had not picked this gap up.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People and relatives told us that the activities coordinator was good at their job and people were listened to and engaged in day-to-day activities. One person said, "The activities coordinator is my friend, she takes me shopping and to the pictures." Another person told us, "It's lovely living here, the girls are beautiful they are all very nice to me."

We observed that people were consistently asked to express their opinions about what was on offer and given choices about all aspects of their care and treatment. We found people were engaged in meaningful occupation and the activity coordinator had tailored the programme of activities to stimulate each person and entertain individuals. The activities coordinator was enthusiastic and we saw they organised visits from a friendship dog, church services, dominoes tournament, pamper days and quizzes. We found the care records contained activities lists detailing what people enjoyed participating in.

The activities coordinator told us they were working on pocket histories for each person and intended these to be made available in their care plans. They said, "It's easier to talk to people when you know their background." They also told us they had requested a white board and larger notice board to be installed as this would make it easier for them to promote activities.

We heard that when the activities coordinator was off there were four carers who they found could be depended on to carry out activities. The activities coordinator said, "Often the agency staff don't do any activities when I am away, and some of the staff don't get involved in activities. But the other staff make up for this." The activities coordinator told us that they had joined several local initiatives and were in the process of building a network of activities coordinators who work locally so that they could get together and share best practice in activities. They were an Ambassador for Equal Arts and had developed a relationship with local businesses, which had led to them obtaining monetary and gift donations for activities.

The activities coordinator told us that since the manager had taken up post they had been able to re-commence residents' and relatives' meeting. The activities coordinator chaired the meetings but the manager intended to get involved in the near future.

We saw that staff promptly responded to any indications that people were experiencing problems or their care needs had changed. The staff discussed the action the team took when people's needs changed to make sure they did everything they could to make the home a supportive environment and ensure wherever possible the placement still met people's needs. We found that people and relatives were actively engaged in reviews of the placement and consulted about the care proposed.

Is the service well-led?

Our findings

At the time of our visit, the manager had been in post for four weeks. Although they had been reviewing the service and making changes we saw little evidence of good governance or leadership being in place beforehand. We found prior to the manager taking up post there was little evidence to show effective processes were in place to monitor the service. For example, the provider had not identified that there were insufficient domestic staff, there was no senior on nightshift and this meant the nurse had to administer all of the medication, the building needed a full refurbishment, care records were disorganised and lacked important detail and DoLS authorisation documentation was not in place. This demonstrated that there had been a lack of regular auditing of standards of care.

Although the provider had introduced a new computerised system [Care Block], we found staff were still in the process of imputing the information. Thus, they had ceased completing many of the paper-based audits and were transposing information onto Care Block. This meant during this period of transition the provider could not be assured that oversight of the service remained robust.

We found the quality assurance procedures in place lacked 'rigour'. Although some auditing and analysis was carried out, this was not always effective. For instance the tool the provider had supplied for monitoring accidents and incidents did not assist staff to look at wider issues than a fall, so they were not considering if there were patterns or trends. We found the quality monitoring systems had not picked up that vetting system for agency staff was not appropriate or that care records were inaccurate, lacking in detail and difficult to navigate.

We looked at how the provider monitored and checked medicines to make sure they were being handled properly and that systems were safe. We found that the previous manager had not completed monthly audits so any areas for improvements had not been highlighted. The new manager had completed a review and identified areas that needed to be addressed.

We found that the provider's monthly visits by the previous regional manager had not picked the issues up that we found at this inspection. The provider's governance system was not effective in identifying and addressing shortfalls.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (regulated activities) Regulations 2014

The manager took up post in August 2017 and had applied to become the registered manager of the service. Staff were very positive about the manager and told us they found them to be approachable and committed to delivering a high quality service. One person told us, "[Manager] is brilliant and is really starting to make positive changes to the home." The community nurse also told us that they found the manager was competent and had made some really positive changes to the service, they said, "She is a breath of fresh air and each day I see the home getting better."

The manager told us that the provider was supportive of the action they were taking and were providing them with the resources to allow this to happen. Since coming into post the manager had been able to increase the number of hours nurses worked, recruited new staff and a deputy manager and brought forward the timeframe for completing the refurbishment of the home. We found that the manager had identified breaches of regulation and many gaps in practice. They had developed an action plan, which we found planned to address the issues.

All of the staff and visitors we spoke with were positive about the steps the manager had taken and the improvements they were witnessing. Staff said, "[Manager's name] has implemented things which the previous manager refused to do." Another staff member told us, "The new manager is approachable and acts on requests, recently I asked for a new mattress for a resident and it was done, she is now happy with her bed."

People said, "The new manager listens and has acted on my issues." Another person told us, "I've not been here long but it seems well managed." Relatives told us that until the manager came into post they would raise things such as the offensive smell in the service but nothing was done about it. However, they were now seeing improvements and felt the manager took on board their comments.

The manager told us that since starting work at the service they joined in a charity event with staff, which involved roller skating for five kilometres, and this had raised £600. They were also planning funding raising events for the service.

The manager was in the process of setting up meetings with all the staff so they could give their views about the service. We saw that the staff team were reflective and all looked at how they could tailor their practice to ensure that the care delivered was completely personalised.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured the systems and processes in place to oversee the service were effective. Regulation 17 (1)