Oakland Primecare Limited

Woodland Grove

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Woodland Grove is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Woodland Grove accommodates up to seventy two people across three separate floors each of which have adapted facilities. One of the units specialises in providing dementia care in an adapted building. At the time of our inspection, sixty-four people were using the service.

We carried out this unannounced inspection on the 25 January 2018. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. This is the first time the provider has been rated as requires improvement. You can see what action we have asked the provider to take at the back of the full version of the report.

Before the inspection, Essex County Council had notified us that a number of safeguarding alerts had been raised. These had identified a failure in the registered manager duty to raise serious concerns both to the local authority and with the Care Quality Commission. We undertook a comprehensive inspection in response to these concerns.

A registered manager was in post, but because of the nature of the concerns that had been raised; they had been suspended since October 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. In their absence, the provider employed a care consultancy company to assist them with the day to day running of the service. At the time of the inspection, the provider was working with the care consultancy company to review what remedial action needed to be made.

The registered manager had not had an oversight of the number of accidents or incidents that had occurred and they had not worked within the provider's guidance. They did not use information about the service to look at how people's safety could be improved.

The registered manager had failed in their duty to deal with complaints in an effective and responsive way. The provider had a range of audit systems in place, but the registered manager had not used these systems effectively. They did not use information to consider how they could continuously improve the service.

The service was not actively identifying the information and communication needs of people with a disability or sensory loss, and no one at the service had been trained in the accessible communication standards. We have recommended that the registered provider should consider how they identify people who have specific information or communication requirements.

Staff received an induction to prepare them for their role and additional training was provided to support their learning, but the registered manager had not always provided support to staff and supervision meetings had been sporadic. Appraisals had not been carried out.

Risks to people were assessed and management plans were in place to reduce the likelihood of harm, but these were not personalised.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have choice and control of their lives. Care plans contained an assessment of people's capacity but these were not specific. We observed staff supporting people in the least restrictive way possible; the policies and systems in the service supported this practice.

People spoke positively about the service and told us they were listened to by staff that were kind and caring towards them. People could participate in meaningful activities.

There were adequate systems in place for the safe administration of medication and people received their medicines as prescribed.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not always up to date and had not always been reviewed when they should have been.

People did not have their own slings, and at times, these had been shared with others, which could contribute to the spread of infection.

People were protected against the risks associated with the unsafe use and management of medicines by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been trained in how to support people at the end of their life, and staff did not always receive regular supervision and appraisals.

People were cared for by staff who knew them well. People had their nutritional needs met and where appropriate expert advice was sought.

Staff had a good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and how this Act applied to people in the service. However record's relating to people's day to day decision making were not sufficiently detailed.

Is the service caring?

Requires Improvement

The service was caring.

Peoples' right to privacy and dignity was considered and staff were seen being kind and compassionate.

People were encouraged to make choices, and their independence was encouraged according to their abilities.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Appropriate systems were in place to manage complaints, but the registered manager did not always deal with complaints effectively and did not refer some concerns on to external agencies for further investigation when they should have done so.

People had access to a wide range of personalised, meaningful activities.

Is the service well-led?

Inadequate

The service was not well-led.

The previous registered manager had not always supported staff consistently, and they had not been a visible presence in the service.

The service had not always had an effective quality assurance system. The quality of the service people had received had been variable.

Woodland Grove

Detailed findings

Background to this inspection

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

This inspection was partly prompted by a number of incidents that had been reported to the local authority. This information indicated there had been impact on people who was using the service and this indicated concerns about the management of risk in the service.

While we did not look at the circumstances of the specific incidents, which may be subject to a criminal investigation, we did look at the associated risks. We found the provider was in breach of a number of the regulations. Full information about CQC regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The inspection site visit started on the 25 January 2018. We undertook a second visit to the service on the 1 February 2018. Both site visits were unannounced. It included speaking with 19 people that used the service, nine relatives, 12 staff, and the acting manager.

Three inspectors, an expert by experience and one specialist adviser who had expertise in end of life care carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all the information we had available about the service, which included information sent to us from the local authority. We also reviewed notifications sent to us by the provider. A notification is information about important events, which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection.

The provider did not complete the provider information return (PIR) because they had only been operating the service for six months. This is information we require providers to send us to give us key information about the service, what the service does well, and improvements they plan to make.

We used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed how staff interacted with people who lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

As part of the inspection, we reviewed 13 people's care records, medication charts, seven staff recruitment records; we also looked at records, which monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Staff understood how to keep people safe and knew how to respond and report any incidents or allegations of abuse. However, the previous registered manager had failed in their duty to keep people safe, because they had not reported incidents of safeguarding to the local authority so that these could be independently investigated. These incidents had continued following their departure from the service, which meant the provider had not ensured that people were protected from the risk of abuse. When providers are alerted to suspected allegations of abuse; they should immediately take action to notify the local authority. This had not happened. On three occasions, there had been incidents that should have been reported to the local authority for further investigation. This meant that the registered manager was not responding correctly to concerns of abuse and people might not have always been kept as safe as they should have been.

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. This was a breach of section (1) (2) (3) of the Health and Social Care Act 2008.

Risks to people were assessed and plans were in place to reduce the likelihood of harm, but these were not personalised and some were inaccurate. For example, one person had an assessment in place to monitor their skin integrity but the scores had not been added up correctly so did not represent an accurate picture of the risk.

Some people's records had not always been kept up to date. This meant that we could not be assured that risks to people would always been managed in a safe and effective way. For example, when some people had an accident or incident, their risk assessment had not always been updated so staff did not always have accurate information to understand how to meet people's needs safely.

When people had an accident or incident, the registered manager did not have an accurate oversight and they did not look at ways safety could be improved. For example, there had been a number of accidents and incidents that had been reported in the last 6 months, yet the management information showed a lower number. The numbers of occurrences were vastly different and were not accurate. We were told that the oversight of accident and incident reporting had been delegated to a less senior member of staff. The new manager said, "Accidents and incident reports just used to be slipped under the door, over there. This information comes to me now and I am proactively looking for themes and trends, so that we can look at how we make improvements."

There was no evidence that the registered manager had used information about accidents and incidents to see how safety could be improved. Whilst the provider had systems in place to review this information, the registered manager had not used it accurately or effectively and did not to look at ways they could minimise harm to people. There was no evidence to suggest that the registered manager had retained an oversight of these matters. Whist the registered manager had not managed this appropriately, this also had not been identified by the provider and at the inspection, it continued to be an issue.

Accident reports had not always been filled in so they did not give an accurate picture of the person. Other accidents and incidents should have been reported to external organisations for further investigation and they had not been.

This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section (2) (a) (b) (h) of the Health and Social Care Act 2008.

Not all of the equipment that was available to staff, had been serviced regularly. The provider was unable to evidence that the suction machines had been serviced. Syringe drivers had not been calibrated since they had been purchased in 2015. Syringe drivers help to manage people's symptoms when they are at the end of their life and this equipment needs testing to make sure that they are working accurately and are safe to use. The new manager assured us that new suction equipment would be quickly purchased and syringe drivers would be fully tested.

The provider had carried out maintenance of other equipment at the service and held certificates to demonstrate this had been done. These included hoists, fire equipment and electrical appliances. Plans were in place in case of an emergency, for example evacuation procedures in the event of a fire.

Staff understood how to move and position people correctly and people told us they felt safe when they were being moved. One person said, "I feel safe in the hoist." However, on three occasions accidents had happened due to staff not using the correct sling or the sling not being fitted correctly. We saw that slings were being shared between people and found that people's slings were not always labelled. Sharing slings to move and position people can spread infection. The new manager assured us they would name people's slings and improve infection control practice around this area.

Staff did not always follow good infection control practices to help reduce the spread of infection. For example, the new manager was in the process of applying for notifications of safety alerts and recalls. This is important so that the service can consider if they need to take any action to remove or change the current equipment that is in use.

On the day of the inspection, there were enough staff to meet people's needs in a safe way. There was one Registered Nurse based on a unit and one 'floating' Registered Nurse who supported the two other units. Their role was to assess, provide nursing care and support to the non-clinical staff within the care home. One person said, "Some staff are better than others, but on the whole they are okay." One relative said, "There is always someone about, they all work very hard. I have no worries."

The service was using agency staff whilst they were recruiting to vacant positions. They told us that their biggest challenge was recruiting and retaining good quality staff. One senior nurse explained, "It's not about just getting anybody we can do that, it's about getting and retaining good quality staff."

Staff recruitment files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS). This scheme enables the provider to check that candidates are suitable for employment. We did find one staff file where the person had only had one reference. We highlighted this to the new manager who said they would rectify this straight away.

Staff understood their responsibilities around the safe management of drug recording and drug

administration. People's medicines were dispensed correctly and they received their medicines in the correct way and at the right time. Advice was available for staff when people required pro re nata (PRN) medicines. PRN means medicines prescribed to be taken when it is needed. Staff were trained and competent.

All the drugs rooms were chaotic and untidy and when opening the locked cupboards the equipment was not in any order making tracking and checking dates of stock difficult. Some of the shelves and work surfaces were dusty and had stains on them. This was a clinical area and was an infection control risk. We found one example where a person had thickening powder left on their side table, which represents a risk. The new manager said they would arrange for these cupboards to be cleaned and review the staff practice around the storage of thickening.

Relatives said the staff were very good at keeping the service clean and odour free. One relative told us, "The [domestic staff] have been amazing at keeping [Names] room clean; they shampoo the carpet every day to keep it smelling nice.

Requires Improvement

Is the service effective?

Our findings

Everyone told us they were satisfied with the service and that their relatives needs were being met. One relative said, "[Name] is well cared for. It is a big weight off my mind. They are perfectly contented. I know they are safe, warm and well looked after." Despite the positive feedback received from people and their families, we found that some aspects of this service required improvement.

Staff did not always receive support to carry out their roles effectively and supervision meetings had been sporadic. Supervision meetings are one to one meetings a staff member has with their supervisor. One staff member said, "I can't remember the last time I had a supervision session, it was a long time ago." Records showed that staff had not been given regular appraisals. Poor practice had not been addressed by the registered manager because observations of staff practice had been limited. The new manager had recently introduced observational based supervision to look at way's staff practice could be improved. Staff should have received a regular appraisal of their performance in their role from the previous registered manager identifying any training or learning and development needs the staff member may have. There was no evidence that registered manager had carried out a regular appraisal of their performance.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section (2) (a) of the Health and Social Care Act 2008.

Staff confirmed that when they started their employment they had received an induction. Newly appointed staff completed induction training, including the completion of the Care Certificate. The Care Certificate was introduced in April 2015 for all new staff working in care and is a nationally recognised qualification.

People were cared for by staff who had received the training required to meet people's day to day needs. We viewed the training records for all staff. These identified when staff had received training in specific areas and when they were next due to receive an update. All staff received core training which, among others, included; infection control, fire safety, dementia, food hygiene, equality and diversity, administration of medicines and safeguarding vulnerable adults. The provider also offered training suited to the needs of the people living at the service, such as, catheter, pressure sores and percutaneous endoscopic gastrostomy (PEG.)

Some staff told us they had been given limited end of life care training and mentioned that this was an area they would want additional training in. We spoke with the manager who told us this training had been sourced and would be taking place in the next couple of weeks.

People had access to a variety of drinks throughout the day. We saw staff being very patient and encouraging people if they needed additional support. Meal times were flexible and we saw people choosing when and where they wanted to eat and drink. Some people sat together at tables, others chose to stay in their seat. Meals were not rushed. Snack stations had been removed to minimise the risk of infection following a recent outbreak of the norovirus. People told us snacks stations were usually available and had a good range of different foods. One person said, "You can have whatever you want you just ask for it." Menus

in pictorial formats and larger print were not available for people who needed information in this way.

Staff were knowledgeable regarding the risks posed to people who needed additional support to eat and drink in a safe way. Risks to people's nutritional health were assessed and recorded but these had not always been updated to reflect people's current needs. For example, one person had been prescribed a dietary supplement however; their risk assessment had not been updated to include the supplements in the person's management plan. People's weights were regularly monitored and information from speech and language teams (SaLT) was recorded.

People told us their day to day health needs were being met and they had access to healthcare professionals. The provider worked with other health services to make sure that people could access the care, support and medical treatment they required. One person said, "The GP came on Monday, I had the bug but all clear now." Another person said, "I go out to the Dentist and Nurses come and give me my medication in the morning and evening. The nurses are really nice."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes is 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 were being met. The provider had policies and procedures in place and staff had received training on the MCA and DoLS. Care plans contained an assessment of people's capacity but these were not specific. Mental capacity assessments were of a poor quality. MCA's were generically applied and needed to be specific. For example, care plans lacked information regarding decisions that were made in the people's best interest and there was a lack of information recording other's views. The new manager was reviewing all the care plans and records and assured us that the quality of the information being recorded would be reviewed and improved.

Some people had been assessed as not having the capacity to consent to their care arrangements. They were also subject to continual supervision to ensure they were safe and their needs met. The manager and staff had recognised this amounted to a deprivation of their liberty and had submitted applications to the appropriate authorities.

Staff actively encouraged people to make their own day to day choices and decisions. We saw they asked for people's consent before providing care and support, gave them options to determine what they wanted to do, and, respected their decision if they changed their mind.

Woodland Grove is a purpose built care home. At the time of the inspection, the décor had been maintained to a good standard throughout. People had safe access from the building to the grounds and there was a mixture of different lounges and communal spaces so that people were able to choose where they would like to spend their time. Relatives were encouraged to spend time with their family member's and they were offered meals so that people could eat with their relatives if they wanted to. People and their families, told us that their relatives had been involved in personalising their bedrooms and they were satisfied with the

standard of the décor.

Requires Improvement

Is the service caring?

Our findings

Whilst staff were caring and people told us, their experience of the service had been good. The provider was not always caring, as they had not ensured that people were safe and well cared for in a culture that promotes a caring environment.

Everyone we spoke with told us they were happy with their care and said staff were kind and caring towards them. One person said, "The staff are very kind. They are a 9 out of 10." Another person said, "The staff are very kind, they are the best." Another person said, "I have been asked who I prefer and I always prefer female staff members to help me, and that is what I have."

At times, staff were busy but we observed that staff interactions with people were positive. There was a calm and relaxed atmosphere throughout and people had good relationships with staff. Staff spoke in a caring, warm and respectful manner. They did this by kneeling or sitting next to people and they took the time to listen to what people were saying. One relative said, "There is good communication with staff. Everyone is friendly. They come and say hello to mum and chat for or wave when they go past."

We saw people being able to get up when they wanted to and people told us they were given choice over when they went to bed. People and their relatives told us they were able to visit at any time, and were able to dine together if they wanted to. One person said, "I enjoy breakfast in bed, no rush to get up."

One member of staff described how they interacted with a person who was non-verbal. They told us, "[Named person] doesn't speak but understands everything; they put their hand up to indicate yes so we show them things like clothes and ask them to put their hand up to indicate their choices."

People were encouraged to make choices, and their independence was encouraged according to their abilities. We saw that staff knocked on bathroom doors and waited for a response before entering. We saw people being spoken to discreetly about personal care issues. For example, helping people to go to the toilet so as not to cause any embarrassment.

People were supported to maintain relationships with family and friends. Visitors and family members told us they were always welcome and were able to visit at any time. One relative said, "I really praise how well they have made [Name] feel." Another relative said, "Staff has got to know [Names] likes and dislikes very quickly."

Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments. Doors were always kept closed when people were being supported with personal care and staff knocked and waited for a response before entering a person's room.

People's care records included an assessment of their needs in relation to equality and diversity. The provider looked at ways to meet people's cultural and religious needs. Staff could explain that they understood the importance of maintaining people's privacy and human rights.

Requires Improvement

Is the service responsive?

Our findings

Whilst people and their relatives told us, the service responded to their needs, we found that this required improvement. This was because the registered manager had failed in their duty to deal with complaints in an effective and responsive way.

There had been a number of complaints made in the months running up to the inspection. Whilst the provider had a robust policy and procedure in place to deal with complaints, the registered manager had failed to work within these guidelines. For example, some complainants had raised concerns that their relative had been neglected, but the registered manager had failed to seek advice from the local authority.

Information from complaints had not been used to improve people's experience of the service and the registered manager had failed in their duty to allow people and their relatives to complain without fear of reprisal. For example, in correspondence to one complainant, after having a meeting with the registered manager, they were told that they could always move their family member elsewhere if they did not like it.

This was a breach of Regulation 16 Receiving and acting on complaints Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section (16) (1) (2) of the Health and Social Care Act 2008.

The new manager told us, "We have been proactively trying to meet with these people who had previously complained to make sure that this is now being dealt with appropriately. One family member told us that the complaints process had improved they explained, "[Name of Manager] has listened to us and dealt with our complaints professionally."

Each person had care plans in place that identified how their assessed needs were to be met, but these lacked detail and were not person centred. For example, a number of care plans had recently been reviewed but the responses were generic, and not personalised. The new manager explained that everyone was currently in the process of having their care needs reviewed and their care plans update. They advised that once these had been reviewed they were going to be electronic, which would support staff to obtain the information they needed in much quicker way.

Staff we spoke with were able to demonstrate that they knew people well and provided care and support how people liked. One staff member told us, "[Name] likes a lay in; we give as much choice as possible; they can get anxious but respond well to reassurance; they also love dessert."

Policies were in place in relation to equality and diversity, and accessible communication when making care and support decisions, but the provider had not yet put this into practice. For example, care records did not identify who may have additional communication needs relating to a disability, impairment, or sensory loss, and did not flag up when people required accessible information and communication support.

Some relatives told us that communication could be improved and they were not always kept informed

about their family members. One relative said, "Communication has been poor." and, "They were not so forthcoming when [Name] got poorly." We saw that a relative's contact sheet was kept in people's care records, which logged when staff had contacted relatives to update them. We saw that these were not always completed. For example, where a person had fallen, the records indicated that relatives had not been informed of the incident.

Where appropriate, the information about people's preferences at the end of their life was recorded, but we found that staff did not always have the correct tools in place to support them. For example, staff were not using a recognised pain assessment tool, and nurses were using their own. Using a pain assessment tool as part of end of life care is important as part of the overall pain management. A good assessment tool should assist staff to assess some ones pain, pain relief, and mood. At times, staff was expected to administer the correct dose of analgesia that supports the patient's pain score and therefore appropriate training was essential.

People with a palliative care diagnosis had advanced care plans in place, but they lacked depth and detail and there were gaps in the essential information. There was no evidence of documentation of any personal wishes for the individual and the documentation was generic in its content rather than person-centred. Staff did not routinely discuss planning future care unless the person had been given a palliative diagnosis.

We recommend that the provider obtain reputable advice and support to ensure that people's wishes and preferences are recorded in detail, so that people's pain can be robustly and consistently assessed and staff are trained and competent in this area.

Over recent weeks, leading up to our inspection, nursing staff reported they had started to work alongside care staff by observing them delivering personal care to people who were at the end of their life.

The service had good links with the Specialist Palliative Care team in the community at the local Hospice. If people had been given, a palliative care diagnosis staff knew how to refer to specialist services if this was required.

Staff supported people in activities to maintain a fulfilled day-to-day life. One person said, "I am going to two birthday parties this afternoon. It was my birthday in November and I had six guests come for lunch. It was very good." Another person said, "The activities are very good here. They email my daughter every Sunday, so that they can plan their visits around what I am doing.

Inadequate

Is the service well-led?

Our findings

In response to the seriousness of the allegations, the registered manager had been suspended from their duties, pending an investigation. A few weeks after this, the operations manager also left the role. In the interim the provider had commissioned a consultancy company to help manage the service.

The registered manager and operations manager had been responsible for monitoring the quality of the service, but we found that this had been ineffective because the governance processes had failed to proactively identify and address issues that we had found during this inspection.

Before the inspection, Essex County Council had told us that a number of retrospective safeguarding alerts had been raised. These had indicated there had been a failure in the registered manager's duty to report serious concerns to both the local authority and with the Care Quality Commission. We found evidence that on at least sixteen occasions the registered provider had failed in their duty to report serious concerns for further investigation to the local authority or the CQC.

The provider had a range of audit systems in place, but the registered manager had failed to use these systems effectively. They did not use information to consider how they could continuously improve the service. For example, the audit system had not identified the improvements needed to improve people's health and safety around accident and incidents, complaints and the correct reporting and handling of safeguarding. The registered manager had failed in their duty to operate an effective governance system. Whilst the provider had ensured that audit systems were available to the registered manager, the audits and checks had failed to identify or address the concerns we had found.

This was a breach of Regulation 17 Good Governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section (17) (1) (2) of the Health and Social Care Act 2008.

The registered manager did not fully understand their duty under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had failed in their duty to notify the CQC on at least seven occasions. These notifications inform CQC of events happening in the service.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Registration regulations 2009.

The new manager was providing support, to stabilise the service, and had been looking at ways the governance structure could be strengthened. They had recently introduced a range of checks and balances designed to improve the service people received. Some of these included; spot checks, observational assessments, audits, meetings with staff, relatives and people, risk governance and oversight meetings, developing and strengthening the existing team. Positive feedback indicated that they were managing the service in a way that disrupted people, their relatives, and staff as little as possible, whilst working to make improvements.

Whilst the provider had audit systems in place, the registered manager had failed in their duty to look at ways they could minimise harm to people or escalate safeguarding matters to the Local Authority for external investigation. There was no evidence that the registered manager had retained a sufficient oversight of these matters and dealt with them effectively.

Historically there had been a lack of information sharing across the organisation resulting in disjointed working and low morale amongst staff. The service had recently introduced a morning meeting with heads of department and senior members of staff to improve communication and include staff in the running of the service. We observed a morning meeting and saw it was used constructively to share information about people and the service. Actions were agreed and followed up to improve the quality and safety of the service people received.

Most people and their relatives did not know who the registered manager was. One person said, "No, we have never really seen them around. I am not sure who they were or are really." This sentiment was echoed by most of the people we spoke with.

Staff said that work had been unsettling due to all the changes in management however, they were positive about the new changes. Comments from staff included, "The last few month's things have improved" and "The management now includes us in the running of the home, the morning meetings are very helpful, we get information about residents and what's going on in the building." Some staff had said some negative comments about the registered manager's lack of acknowledgement or emotional support.

A few weeks prior to our inspection, the new manager had produced a detailed action plan, which specified how the service would improve and provided clear timeframes for improvement. We were notified that shortly after our inspection, the registered manager had resigned from their post.

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 12 HSCA RA Regulations 2014 Safe care and treatment Whilst the provider had systems in place to review this information, this system had not been used accurately or effectively to look at ways they could minimise harm to people. There was no evidence to suggest that the registered manager had retained an oversight of these matters. Near misses were not considered. Some accidents and incidents should have been reported to external organisations for further investigation and they had not been.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The previous registered manager had failed in their duty to keep people safe, because they had not reported incidents of safeguarding to the local authority so that these could be independently investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Information from complaints had not been used to improve people's experience of the service and the registered manager had failed in their duty to allow people and their relatives to complain without fear of reprisal. The registered manager had failed in their duty to

seek advice from the local authority when some complaints should have been raised as safeguarding alerts.

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 The provider had a range of audit systems in place, but the registered manager had failed to use these systems effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive support to carry out their roles effectively and supervision meetings had been sporadic.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered manager had failed in their duty to notify the CQC on at least seven occasions.

The enforcement action we took:

Notice of proposal