Rosecare Homes Limited

Andrin House Nursing 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection that took place on 1 June 2017. We returned unannounced on 14 June 2017 to complete the inspection.

Andrin House provides accommodation, nursing and personal care to up to 37 older people. It is located in a residential area of Derby, close to the city centre. The premises are on two storeys with a passenger lift for access, a range of bedrooms, lounges, a dining area, and a secluded garden. At the time of our inspection there were 30 people using the service.

The service has not had a registered manager since 18 February 2016. 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 told us he was in the process of recruiting a manager for the service who would be registered with CQC. This is necessary as it is a condition of the provider's registration that a registered manager is in place.

The atmosphere at the service was warm and friendly and people and relatives told us the care provided was good. They said they thought the service was well-managed and made many positive comments about the manager. However the provider did not have effective systems in place to ensure that people always received good quality safe care in a suitable environment.

Improvements were needed to the premises. For example, we found unrestricted windows, water in hand basins that was too hot, radiators without appropriate covers, and an unlocked store cupboard containing hazardous chemicals. Improvements were also needed to the way staff were supported and supervised and people's views on the service collected and responded to.

Although people and relatives told us they thought people were safe at the service improvements were needed to the way risk was managed. One safeguarding incident had not been reported to the local authority and CQC and some people's care plans and risk assessments were not fit for purpose. Some improvements were also needed to medicines management.

Staff mostly had the training they needed to provide effective care, although some staff had not completed recommended fire safety training. People and relatives said they thought the staff were well-trained. During our inspection visits we observed staff working with people in a skilled and competent manner.

People told us the care and nursing staff provided good quality care and we saw example of this during our inspection visits. Care plans were personalised to give staff an idea of the person themselves and their likes and dislikes. They contained details to help staff meet people's needs in the way they wanted, for example, how many pillows they liked on their bed and the type of music they preferred. However, some people's care records were incomplete so we could not be sure the care they received was responsive.

People and relatives said they were satisfied with the numbers of staff on duty. They told us staff were quick to come to people's assistance when they needed it and we observed this in practice. There was a constant staff presence in the lounges and staff continually checked on people in other parts of the premises to ensure they were safe.

People made many positive comments about the food served. They told us they had plenty of choice and could have second helpings if they wanted. When lunch was served the food was fresh, nutritious, and well-presented. If people needed support with their food and drink staff provided this.

The service employed both nurses and care staff and people could see their GPs and other healthcare professionals when they needed to. Some people's records showed that their heath had improved since coming to the service.

People and relatives told us they were involved in making decisions about people's care and support. During out inspection visits we saw staff always asked people for their consent and offered them choices before providing assistance and support. Staff had been trained in the MCA (Mental Capacity Act) and knew how to protect people's rights.

People and relatives told us the staff were caring and kind and always found the time to interact with people. There was a calm and relaxed atmosphere at the service with relatives coming and going and having cups of tea with their family members. Relatives told us staff were patient with people and knew how to comfort them if they became distressed.

Staff provided people with dignified care and support. People had access to a range of communal areas, the garden, and their own bedrooms so they could choose whether to have company or spend time on their own. People's bedrooms were personalised and people had brought some of their own possessions to make their bedrooms more homely.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

People using the service told us they felt safe and felt there were enough staff on duty to provide them with safe care.

The registered person had failed to notify CQC and the local authority of a safeguarding incident at the service.

Improvements were needed to the way risks to individuals were managed.

Improvements were also needed to the way medicines were managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were mostly trained to support people safely and effectively although some fire safety training was outstanding.

Staff had the information they needed to enable people to have sufficient to eat, drink and maintain a balanced diet.

People were assisted to access health care services and maintain good health.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and made people and relatives feel welcome and at home.

Staff respected people's privacy and dignity and involved them in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

It was not always clear from records whether people's care plans had been followed.

People had the opportunity to take part in group and one-to-one activities.

People felt they would be listened to if they made a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service did not have a registered manager and the manager had only one supernumerary day a week to manage the service.

The systems in place to ensure people were receiving good quality safe care in a safe environment were ineffective.

The service had an open and friendly culture and the manager was approachable and helpful.

Andrin House Nursing Home

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 was an unannounced inspection that took place on 1 June 2017. We returned unannounced on 14 June 2017 to complete the inspection.

The inspection team consisted of two inspectors each day we visited.

We looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. They told us the manager was completing an action plan to bring about improvements to the service.

We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We spoke with seven people using the service and two relatives. We spoke with the manager, the deputy manager, a nurse, the activities co-ordinator, a senior care worker and two care workers. We spoke with the provider twice by telephone.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked at five people's care records.

Requires Improvement

Is the service safe?

Our findings

Registered persons have a duty to inform CQC of any safeguarding incidents (when a person is harmed or at risk of harm) that take place involving the people they support. Records showed we had mostly been informed of safeguarding incidents at the service, but on one occasion this had not happened. This was when a person who was not safe to leave the premises unaccompanied had done so, exiting via a fire door, and eventually being brought back by the police. This incident should have been reported to the local authority as a safeguarding incident and to CQC as a notification.

We discussed this with the manager who said that in future the local authority and CQC would be notified of all safeguarding incidents.

People had care plans and risk assessments in place to help ensure they were protected from the risk of harm. However these were not always fit for purpose.

We looked at the care plans and risk assessments for the person who had left the service unaccompanied. These contained a number of errors and omissions. The person's care needs summary included a tick box of risk and staff had not ticked 'liable to wander'. This contradicted the daily notes which showed the person repeatedly being found in different parts of the premises and gardens with entries such as 'wandering in the corridors at times' being made. This meant the person's care needs summary did not include this important information about them.

The person's records showed they had attempted to, or succeeded in, leaving the premises multiple times in the month prior to our inspection. They had usually left by a fire exit and on most occasions staff had brought them back promptly and safely. Following these incidents their care plan had been updated to state, 'Routine changed so that one member of staff is observing [person] at all times especially at night.' However staff told us this was not the case as although they all 'keep an eye on her' they did not have the resources to observe the person on a one-to-one basis at all times. In addition, although staff were told to complete a behaviour chart each time this person attempted to leave the premises, there were no observation charts or other tools in place to monitor this person's whereabouts on a regular basis and ensure they were safe.

Another person's care plan stated they needed bed rails in place to prevent them falling out of bed. However the person's daily notes showed they had attempted to climb over the bed rails and as a result they were no longer being used. We visited this person, who was being cared for in bed, and found the bed rails were down and there was a pressure mat on the floor beside the bed. This meant their care plan was out of date and misleading and if staff followed it the person could be put at risk.

We looked at people PEEPs (personal emergency evacuation plans). We found that not all the people using the service had PEEPs in place. This meant that staff might not how to support people to leave the service in the event of a fire or other serious incident.

These are breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed this with the manager who agreed to update and improve people's care plans and risk assessments where necessary and put PEEPs in place for everyone so it was clear to staff what they needed to do to protect people from harm.

People and relatives told us they thought Andrin House was a safe place to be. One person said, "I feel safe here as there are always staff around. If you want anything you just have to ask the staff." Another person told us, "It's very safe here be." They said this was because the staff 'looked out' for them. A relative said, "My [family member] is definitely safe here."

During our inspection visited we saw people being safely supported. We met one person sitting alone, by choice, in the garden. They showed us a portable call bell staff had given them so they could summon assistance if the needed it. They told us they felt safe because of the call bell and we saw that staff regularly came out into the garden to check on their well-being.

Another person's records showed they were at risk of skin damage due to pressure. Their care plans and risk assessments for this told staff what to do to minimise the risk. This included regular personal care, good nutrition and hydration, the application of prescribed creams, and the use of pressure-relieving equipment day and night. We met the person and saw they were using a pressure relief cushion in the lounge and had a pressure relief mattress on their bed. Daily records showed that staff were following the person's care plans and risk assessments in order to meet their needs safely.

Staff understood their responsibilities to keep people safe. They had received training to enable them to recognise when people might be at risk of harm. They told us that if they thought a person was at risk they would report it to the manager or the nurse in charge. One staff member said, "If a person had unexplained marks on their body or were low in mood I would share this with the manager or the nurse in charge. If I felt my concerns were not being addressed I would contact social services." This was an example of a staff member knowing how to report a concern both internally and to outside agencies.

People and relatives told us there were enough staff employed to keep people safe and meet their needs. One person said, "You've only got to put your hand up or call and the staff come. There's always someone around to help." Another person told us, "Staff come quickly if they're needed and there is plenty of staff." A relative told us, "I get the impression that there are enough staff." During our inspection visits we observed that staff were always available to meet people's care needs promptly.

Staff told us they felt staffing levels were good and there were enough staff to support people safely. A staff member said, "I do now feel there are enough staff. Staffing levels have recently increased; there is an extra member of staff on the late shift." Another staff member commented, "We've had ups and downs with staffing levels but it's alright at the moment." We checked the staff rota and saw that it reflected the staffing numbers on the days of our inspection visits. It also showed that at least one nurse was on duty at all times to meet people's nursing needs.

We sampled staff files to see if staff had been safely recruited. Those we saw had the required documentation in place to show that staff were safe to work at this service. These included: proof of identity/photographs; DBS (criminal records) checks; references; employment histories; and health declarations.

People told us staff supported them to take their medicines safely and on time. One person said, "They come round each morning, noon and night." They explained that if they experienced pain staff offered them 'as required' pain killers which helped with this. Another person told us, "The staff bring them [medicines] when you need them." One person told us they looked after some of their own medicines and staff reminded them when to take them. They told us, "The staff get my medicines for me from the chemist and remind me when to take them."

We observed a nurse administering medicines at lunchtime using a secure trolley to take people's medicines to them. The medicines round was carried out in a calm and unhurried manner, with the nurse taking the time to talk with each person about their medicines. They gained people's consent before administering their medicines and ensured they had taken their medicines before moving on to the next person. However, at one point, the nurse poured liquid paracetamol into a measuring cup she was holding, rather than placing it on a flat surface first. This could result in an inaccurate measure being poured out. The manager said she would address this issue.

We checked six people medicines records and found that some improvements were needed. A number of people on 'as required' medicines did not have protocols in place explaining when staff should offer these to them and for what reason. In addition staff had not always recorded the reasons these medicines had been given. One person had been prescribed two strengths of 'as required' medicine. When staff had administered this medicine they had not always recorded which strength had been used. This, and the lack of a protocol, meant we could not be sure if all 'as required' medicines had been given in line with the prescriber's instructions.

Two people's records showed that staff had had not always signed when a particular medicine had been given, although stocks appeared to show the people had had them. Another person had had a medicine signed for as having been administered but it was still in the blister pack.

We discussed these issues with the manager who agreed to take action to ensure medicines were given safely. She told us the service's contract pharmacist was due to conduct a medicines audit in the near future and said she would use this as an opportunity to identify any areas where medicines management needed to improve.

Requires Improvement

Is the service effective?

Our findings

We looked at fire safety training to check that staff knew what to do in the event of a fire. The provider's fire risk assessment, dated 20 April 2016, recommended that, 'All staff should have practical training in the use of the evacuation shed. It would appear from discussions with the staff that this is overdue and should be undertaken on an annual basis and recorded in the fire book.'

Following this, on 8 July 2016, ten staff had fire safety training including the use of the evacuation sled. Since then all staff but two had completed online fire safety training, but this did not include training on the evacuation sled. This meant that at the time of our inspection visits at least eight staff had not yet had this recommended training.

The service's fire risk assessment stated that 'the fire evacuation procedure is based on the concept of horizontal evacuation' (i.e. the use of the evacuation sled). As not all staff had been trained in the use of this we could not be sure that people would be evacuated safely in the event of a fire. When we brought this to the manager's attention she said this training would be booked.

People and relatives said they thought the staff were well-trained. One person told us, "The staff know what they're doing. They help me to transfer from my wheelchair to the shower chair. I feel safe when they do this." A relative said, "They all seem to know what they are doing so I assume their training must be good. They all seem very knowledgeable to me."

Training records showed staff had a comprehensive induction designed to give them the skills they needed to carry out their roles and responsibilities effectively. This was followed by ongoing and refresher training. The service had a training matrix which highlighted what training staff had completed and what training was overdue. This showed the majority of staff were up to date with their training.

During our inspection visits we observed staff working with people in a skilled and competent manner. For example, we saw two staff supporting a person who was distressed. They used interpersonal and dementia-care skills to effectively reassure the person and encourage them to take part in an activity. This improved the person's well-being and they appeared happy and settled after the staff had assisted them. We also saw staff support people to move around the service safely. This was done using appropriate equipment, including hoists, where necessary. These were examples of staff providing effective care and support to people.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We look at the records of two people who had restrictions on their liberty authorised by the local DoLS team. Both had care plans in place to instruct staff on how to support them in line with their DoLS authorisations. One person's DoLS authorisations had expired in December 2016. Records showed that the manager had fulfilled her MCA responsibilities by submitting a renewal application to the DoLS team but was still waiting for a response. She told us she had followed this up once and would do so again to ensure the person was being supported effectively.

Staff had been trained in the MCA and DoLS and understood the importance of people consenting to their care and support. During our inspection visits we saw that staff always sought people's consent before they assisted them. Care plans stressed the importance of people consenting to their care and advised staff how best to seek consent. This meant that staff were working within the principles of the MCA and seeking people's consent to care and treatment in line with legislation and guidance.

We looked at how people were supported with their food and drink. People made many positive comments about the food served. These included: "Excellent"; "You can have second helpings if you want"; "We have different things every day"; and "I have just had a lovely dinner." We saw lunch being served and the food was fresh, nutritious, and well-presented.

People told us staff served food in the way they wanted it. One person told us they had their meals in their room as they preferred this. Another person told us, "I like my dinner piping hot and it usually is. I have said, 'Can you take it back, it's cold' and they [the staff] have." Another person said, "The food is quite good. If you don't like what's on the menu, the staff will get you something else."

A relative said they thought their family member's nutritional needs were being met. They told us, "My [family member] has a soft diet, as she does not like bits in her food." Another relative said, "My [family member] doesn't like the noise or the rush in the dining room. The staff recognised this and my mother now sits in the quiet lounge where she always has her meals." This showed that staff had taken steps to ensure these people had a pleasant and suitable dining experience.

We spoke with the kitchen assistant who told us the cook had the main responsibility for preparing meals at the service. They told us they were aware of people's dietary needs, likes, and dislikes. Care staff we spoke with were also aware of people's dietary needs. The kitchen was clean and well-organised, people were asked for their menu choices, and staff kept records of what people had eaten.

Records showed people's nutritional needs were assessed when they came to the service. Staff worked with GPs, dieticians, and speech and language therapists where necessary to help ensure people's nutrition and hydration needs were met. For example, one person was admitted with diabetes and in need of support with their nutrition. Their care plan set out how their nutritional needs were to be met with a view to them gaining weight. It also stated 'any reduced appetite to be reported to nurse in charge'. Monthly weight charts showed the person's weight had increased since coming to the service, which was a positive outcome for them.

People told us they could see their GPs and other healthcare professionals when they needed to. A relative said, "There hasn't been a situation where my [family member] has needed a GP. I am sure they would contact the GP if needed and would let me know if my [family member] was unwell."

Records showed that people had been referred to health and social professionals when necessary. For example care records showed that a person had developed some skin damage due to pressure so staff had referred them to a tissue viability nurse for specialist care. Staff had then worked in conjunction with the tissue viability nurse to ensure the person had the equipment, care and treatment they needed.

Care plans were in place for people's healthcare needs. Those we looked at were detailed and included clear instructions to staff on how to support people effectively. Some people's records showed that their heath had improved since coming to the service. Staff told us that if they were concerned about a person's health they would immediately inform the nurse in charge to ensure their medical needs were recognised and met.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring and kind. One person said, "The staff here are wonderful. They seem like family to me and I feel very well cared for." A relative commented, "The staff are as down to earth as the people they're dealing with so that works well. Everyone gets on." Another relative told us, "Brilliant carers and nurses. It's always OK when I come here and the staff seem nice."

People and relatives said staff always found the time to interact with people. One person told us, "I have lots of little chats with them and they take an interest in me. They know what I like to watch on television." A relative said, "My impression is that the staff are very caring. Everyone gets time from the staff. My [family member] sits in the quiet lounge and the staff pop in to see how she is." During our inspection visits we saw staff socialising with people and greeting them by name as they went about their work.

There was a calm and relaxed atmosphere at the service with relatives coming and going and having cups of tea with their family members. One person said, "There are no restrictions on visitors, they can visit when they wish." A relative told us, "I am always made welcome when I visit. The staff bring me a chair and offer me a cup of tea." Another relative said, "It's always a pleasure to come here. The staff are very friendly and you feel part of a big family."

Relatives told us staff were patient with people and responded appropriately if they became distressed. One relative said, "My [family member] can get a bit restless, the staff never shout at her. I am very satisfied with the care she receives." Another relative told us that she had seen staff reassure people on several occasions. They said, "The staff are really, really good. Some of the residents here can be get agitated and the staff always know what to do to calm them down."

People and relatives told us they were involved in making decisions about people's care and support. One person said, "They have got records on me and they talk to me about what I want. They did this right at the beginning when I moved in. It's all down to me what they do to help." A relative told us, "Before [my family member] moved to the home I had a look around and was made to feel welcome. I liked what I saw. I also had a meeting with the deputy manager to discuss my [family member's] care needs and background information such as her likes and dislikes. The deputy manager went to the home my [family member] was in to assess her needs."

During out inspection visits we saw staff always asked people for their consent and offered them choices before providing assistance and support. For example, one person was offered personal care, which they accepted, and then asked to choose how they would like to spend their afternoon.

There was a consent form in people's care records for people or relatives to sign to say they were willing to accept the care and support provided. Some of these forms had been signed by people and relatives, but some had not. These should be reviewed and people and relatives given the opportunity to sign their consent. If they do not wish to sign then staff should record this on the form. This will mean the service has a record of people and their relatives being formally asked for their consent.

Staff provided people with dignified care and support. One relative said, "The staff definitely respect people's privacy and dignity. They never shout across the room if a person needs support with personal hygiene, they are always discreet." People had access to a range of communal areas, the garden, and their own bedrooms so they could choose whether to have company or spend time on their own. People's bedrooms were personalised and people had brought some of their own possessions to make their bedrooms more familiar. One person kept a pet in their bedroom which made their private space more homely for them.

Requires Improvement

Is the service responsive?

Our findings

People told us the care and nursing staff met their needs in the way they wanted. One person said, "The staff are really good and seem to know when I need them and are always there to help me." A relative said, "It's been lovely because the staff make sure my [family member] is clean and well-fed which means I don't have to worry and can enjoy my visits with her."

One person told us they could shower when they wanted and staff assisted them with this. Another person said, "The staff know how I like things done and they're always kind and helpful and ready to help me."

During our inspection visits we saw staff proving people with responsive care. For example, one person in the lounge became distressed, started to get up, and said they wanted to be on their own. Two staff immediately went to their assistance and supported them to walk around the premises, letting the person choose where they wanted to go. The person then asked to go back to the lounge where staff supported them to sit and brought them tea and biscuits. Following the staff intervention the person was more settled and seen content to spend time in the lounge.

We looked at people's care plans to see how staff met people's needs. Care plans were personalised to give staff an idea of the person themselves and their likes and dislikes. For example, one person's stated, '[Person] does not like being on their own for too long, she enjoys the company of others, staff to ensure she is sat with residents she can interact with.' We went to meet this person and found them seated with a group of other people in one of the lounges. We saw they were conversing with the people they were with and appeared content. This showed staff were following the person's care plan in order to provide them with responsive care.

Another person's care plan stated that should they become distressed staff should 'play soothing music, stroke [the person's hands] and offer verbal reassurances'. Staff told us these measures worked well for the person and helped to reassure them. Other care plans contained details that helped to ensure people received responsive, personalised care. For example, one person's bed time routine stated 'Likes to go to bed at 7pm […] likes to sleep on two pillows and to have an extra blanket on his bed […] prefers the wall light turned off.' This meant staff had the information they needed to support the person in the way they wanted.

However some people's records were incomplete so we could not be sure that responsive care had been provided. This was because observation and safety checks and charts had not always been completed in line with instructions in people's care plans and risk assessments. For example, staff had been instructed to complete a nightly sleep chart for one person but when we looked at a sample week in May 2017 we found that only two out of seven charts had been completed. The same person was meant to have daily bed rail checks but these were recorded as being done only eight times in April and nine times in May 2017. This person's fluid charts were also incomplete so we could not be sure they had had enough fluids on the days when only partial records had been made.

We discussed this with the manager who said she thought staff had carried out the observation, safety checks and care as instructed but had not always made a record when they did this. She said she would ensure that staff did this in future.

Some people were satisfied with the activities the service provided but others said they would like more. One person said, "Yes there are activities if you want them and we have entertainers coming in." Another person said, "We could do with more activities. The staff sometimes ask what activities we like but not much seems to happen." This person told us they would like more visiting entertainers and the opportunity to attend a sporting event. Another person said they would like to sit in the garden more often and go to the city centre with staff.

We discussed these suggestions with the activities co-ordinator who said she would try and arrange these activities for people.

We looked at records for the group and one-to-one activity programme in the month prior to our inspection. Group activities had included belly dancing with a visiting tutor, ice-cream tasting, baking, a religious service, and visiting entertainers. One-to-one activities included hair and beauty, dominoes, and a trip to the shops. This showed that people had access to a range of group and one-to-one activities if they wanted them.

The service had its own spacious and well-resourced activities room for people to use. Photos of people taking part in various activities were on display. The activities co-ordinator told us that when people first came to the service she completed an activity profile with them so staff knew their likes, dislikes, hobbies and interests which helped staff to provide responsive and personalised care.

People and relatives told us they would feel comfortable making a complaint if they needed to. One person said, "I've not had to make a complaint, but feel they [staff] would listen if I had a grumble." A relative told is, "I've not had any information on how to make a complaint. But I feel confident if I had a complaint it would be dealt with."

The provider's complaints policy was displayed on a notice board at the service. It included the information people needed if they wanted to complain and explained how their complaint would be dealt with. It also explained the role of the local authority and CQC in investigating and responding to complaints. Records showed the service had received two complaints since our last inspection and both of these had been addressed with improvements made in line with the complainants' wishes.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led and we identified a number of areas where improvements needed to be made.

The service had not had a registered manager in post since 18 February 2016. It is a condition of the provider's registration that a registered manager is in place. The provider told us he was in the process of recruiting a manager for the service who would be registered with CQC. This must be done as a matter of urgency or CQC may consider taking regulatory action against the provider.

At the time of our visits the manager, who also worked as a nurse at the service, had only one supernumerary day per week to manage the service. This meant that the manager might not have always have had the time necessary to fulfil her management responsibilities.

Although the provider had notified CQC of serious incidents at the service, one safeguarding incident had not been reported. It is a condition of the provider's registration that CQC is notified of all serious incidents that occur at the service.

There was no system in place to determine how often staff member's DBS (criminal records) checks needed to take place. One staff member, who had worked for the service for over 15 years, told us they had only ever had one DBS check during that time. This meant the provider could not sure that the staff employed continued to be suitable for their roles.

Some staff members told us they had not had regular staff meetings or supervisions and records confirmed. Consequently we could not be sure they had had the support they needed to carry out their roles.

The provider had a quality assurance policy in place which included giving people using the service, relatives, and staff the opportunity to complete quality questionnaires. However these had not been distributed since 2015. This meant we could not be sure people had had the opportunity to share their views on the service.

There was no effective system in place to ensure the safety of the premises. On the first day of our inspection visit we identified a number of safety and maintenance issues that put people using the service at risk.

Not all windows were appropriately restricted. For example the aperture in the window in Room 25 opened to 23 cm and was fastened with a chain that could easy be broken. Two windows in the corridor in Zone 5 had no restrictors. This meant there was a risk that people could fall from windows resulting in serious injury or death.

The front door could only be opened from the inside by a key which a designated staff member held. This could cause a delay in evacuating people during a fire or other emergency. The issue with the front door, and the possible delays unlocking it might cause, were not referred to in the provider's fire risk assessment.

Consequently it was unclear whether this was seen to present a risk, and if so what staff were meant to do to minimise this.

We found an unlocked store room on the first floor containing COSHH products, for example bleach and other cleaning fluids. There was no facility to lock the door of this room. This meant people using the service could have access to substances that might put their health and safety at risk.

Some radiators were uncovered which meant people could be at risk if they were hot when being used. When we ran the water in some people's hand basins we found it became too hot to touch. This could put people at risk of scalding.

These are breaches of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these issues with the manager and provider who agreed to make improvements where necessary. When we returned for the second day of inspection some improvements had been made to the premises. For example, water temperatures had been adjusted to a safe level and some new window restrictors had been fitted. A lock had been fitted on the COSHH storeroom door, although this room was still unlocked as staff were yet to be given keys. The provider told us he had appointed someone to carry out a health and safety audit of the premises and they would be coming the following day to do this. The provider said he intended to carry out all the necessary improvements once the audit had identified what they were.

The manager, who worked at the service as both a nurse and the manager, also told us that following our inspection visits staffing levels were being increased. This will allow her more supernumerary time to fulfil her role as manager and address the shortfalls we identified.

The atmosphere at the service was warm and friendly and people and relatives told us the care provided was good. One person said, "This home is well-managed – it must be because I'm looked after very well here." Another person told us, "There's nothing wrong with this care home. I'd recommend it to anyone." A relative commented, "We are very pleased with this home and [my family member] gets excellent care here."

People and relative said they had confidence in the manager who was approachable and available to talk with. One person told us, "[The manager] is in charge, she is always here. If I had a problem I'd go to her." Another person said, "The manager is excellent and she's not just in the office. I would absolutely talk to her if I had a problem." A relative told us, "The manager is brilliant. She always seems to be here and she's very dedicated to the residents. I trust her totally."

Staff told us they were supported by the manager. One staff member said, "Since the manager has been in post, morale amongst the staff team has improved. She has been very supportive when you raise issues with her." Another staff member told us, "The manager will do what she can do and has been supportive. The deputy manager has also been very supportive."

The manager told us she was in regular contact with the provider who gave her support and advice. She said if she needed clinical support she was able to approach the registered manager of another home run by the provider for this.

The manager carried out some audits to help ensure the service was running effectively. For example, records showed accidents and incidents had been audited and action taken to reduce risk to people as a

result. The manager said that she was planning a system of audit for all aspects of the service, including health and safety, but due to time constraints had not been able to implement this yet.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that risks to the people using the service were mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that systems or processes were operated effectively to ensure compliance with the requirements.