

# St Dominic's Limited

## Birdscroft Nursing Home

### Inspection report

16 Highfields, Ashted, Surrey  
KT21 2NL  
Tel: 01372 274499  
Website: [www.asterhealthcare.co.uk](http://www.asterhealthcare.co.uk)

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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?

Good



Is the service well-led?

Requires improvement



### Overall summary

This inspection took place on 26 February 02 March 2015 and was unannounced on both days.

Birdscroft provides accommodation and nursing care for up to 28 people, some of whom may be living with dementia. Rooms are arranged over two floors and there is a passenger lift. Communal facilities include a large lounge, a small quiet lounge, and a secluded rear garden which is accessed via a ramp with rails. There is parking to the front of the property.

At the time of our visit there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered 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 newly appointed manager was in the process of applying to the CQC to become the registered manager.

Not all of the risk of harm to people had been identified or effective controls put into place to manage them. Areas such as falls from windows had not been managed effectively.

# Summary of findings

The provider did not have a robust recruitment process and there were gaps in information in relation to staff employment files. People and relatives thought there were enough staff to meet their needs. We saw that there were sufficient staff to keep people safe.

The provider had not assessed and monitored the quality of service people received at the home in the absence of a manager. Important areas such as medicines management, staff training and introduction of new policies such as prevention and management of choking had not been put into place until the manager had started. This the new manager had to develop a clear plan that detailed where the service needed to improve. The plan was reviewed and updated as tasks were completed with a senior manager. The quality assurance systems were still in the process of being introduced so were not yet effective at showing how the home was performing against management targets.

People were generally positive about the permanent staff saying they were kind and caring, but they felt the agency staff could be better trained.

People said they were happy with the medicines they received and had it when they needed it. Apart from a few minor issues with recording when they had been given medicines were managed well in the home. People also received appropriate treatment to keep them healthy, or if their health needs changed.

Documentation to enable staff to support people and record the care and support given were not complete. The management was switching to a new system to try to improve the service. Care plan information was available to staff by use of hand written notes at the front of care files, or in people's rooms so staff could access it.

People told us the activities available to them had improved, but those that chose to stay in their bedrooms wanted more to do to keep them entertained throughout the day.

Food and drink was readily available throughout the day. The food was freshly prepared and looked appetising. Those people on specialist diets received the food in the form they needed it.

The home was well maintained and had been adapted to make it more suitable for the people who live here. Floors were smooth and clear of obstructions to reduce the risk of trips and falls, and there was clear signage around the home including words and pictures to denote the use of the room.

Some good interactions were seen between the staff and the people who live here. Staff were friendly, caring and supportive to people and clearly knew them well.

We have identified three of breaches in the regulations. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Not all risks to people had been identified or controlled to reduce the chance of people coming to harm.

The providers recruitment process was not robust and did not have all the information needed to ensure only suitable staff were employed. There were enough staff employed to keep people safe.

People's medicines were not always managed in a safe way however they told us they had their medicines when they needed them.

People told us they felt safe. Staff had a clear understanding of their responsibilities about protecting people from harm.

Requires improvement



### Is the service effective?

The service was not always effective

Staff had been trained in the Mental Capacity Act and Deprivation of Liberty Safeguards, but not all of them were able to explain their role and responsibility.

Staff felt supported and received training to enable them to support people effectively.

People enjoyed the food and had enough to eat and drink and received specialist diets where a need had been identified.

People were supported to maintain good health.

Requires improvement



### Is the service caring?

The service was caring.

People told us that staff were caring, friendly and respected them.

People and their relatives where involved in making decisions around the care they received.

Staff were seen to treat people with respect, and knew them as individuals.

Good



### Is the service responsive?

The service was responsive.

People had access to activities, however some people who spent all the time in bed felt they wanted more things to do.

People told us that staff were responsive to their needs Care planning documentation was under development but information on individual needs was available to staff record.

Good



# Summary of findings

There was a clear complaints procedure in place, and records of complaints were kept. The manager was able to show what actions they had taken to try to solve the issues.

## Is the service well-led?

The service was not always well-led

There were no quality assurance processes in place to monitor the quality of the service.

People were complimentary about the improvements that had been made at the home and felt they had could raise any issues they had with the manager and staff.

People, relatives and staff said there was an open culture in the home which encouraged them to communicate and raise concerns.

**Requires improvement**



# Birdscroft 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 inspection took place on 26 February and 02 March 2015 and was unannounced on both days.

The inspection team consisted of two inspectors, a nurse specialist and an expert by experience on the first day, and two inspectors on the second day. Our expert-by-experience was a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We reviewed the Provider

Information Return (PIR) that had been submitted by the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed information we had received about the service, such as notifications of accidents and incidents, or information sent to us by the public.

During our inspection we spoke with seven people who used the service, two relatives, two visitors, five staff, the manager and a senior manager. We observed how staff cared for people, and worked together. We used the Short Observational Framework Tool (SOFT) to try to understand the experiences of people we were unable to verbally communicate with. We also reviewed care and other records within the home. These included six care plans and associated records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in June 2013 we did not identify any concerns at the home.

# Is the service safe?

## Our findings

People told us they felt able to do the things they wanted, and go where they wanted. They did not feel restricted by staff trying to 'keep them safe'. One person said, "We feel, if we want, we can be anywhere."

Not all risks to people's safety had been identified and acted upon by the provider. For example the risk from not having all upstairs windows restricted to reduce the risk of people falling out of them had not been assessed. We brought this to the attention of the provider who immediately took steps to ensure that this was rectified.

Where people had bed rails to stop them falling from their beds not all of these had been appropriately assessed to minimise the risk of their use. Measurement of the gaps in the rails to check for the risk of entrapment, or the distance between mattress and the top of the rail to reduce the risk of people rolling over the top had not been considered. Not all of the assessments of risk from bedrail use were up to date. The lack of a timely review of risk assessments can put people at risk because the assessment may not reflect their current support needs, and controls put into place may no longer be effective at reducing the risk of harm.

A further risk that had not been identified and managed included the presence of six rat traps around the house in areas that people, staff and visitors used. These contained poison but the risk of harm to people had not been assessed, nor controls put into place to manage the risk.

Where risks of harm had been identified, the controls that had been put into place were not always followed by staff. Equipment provided to reduce the risk of harm to people was not always used by staff. Staff assisted a person to move out of a chair without using a lifting belt. This is a piece of equipment that should be used when a person just needs a little support to stand, rather than being hoisted. The belt reduces the risk of the person getting injured as staff support using the belt rather than holding onto the person. The manager said that lifting belts were available and should have been used. The risk of people being scalded by hot water was also not appropriately managed. Two out of three staff we spoke with said that they would test the water with their skin, such as putting their elbow in the water. Only one staff member said they would use a thermometer to accurately check that the temperature was safe. Testing water temperature by skin is not an effective

way at keeping people safe from the risk of scalding. The taps did have devices on them to limit the maximum temperature so the risk to people was low, but these can fail so accurate temperature checking is an important safety measure.

The failure to identify and manage the risks to the welfare and safety of people meant there was a **breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Risks to people's health were managed and included identifying when people had mobility support needs, and how these would be managed to prevent falls. Staff made sure people had mobility aids to hand in the communal areas. Falls risk assessments were also in place and had been reviewed on a monthly basis. Other areas of risk that had been identified and managed included risk of pressure sores, legionella, slips trips and falls. The assessments covered the hazard and the people that may be affected. Staff were aware of the procedures in place to manage the risk, and an assessment of any additional action that had been taken.

We saw that the environment was regularly checked to ensure it was safe for people. These checks included specialist equipment that staff used to such as hoists and slings. People had individual persona evacuation plans in place to ensure that they would be properly supported in the event of an emergency in the service. Staff were aware of these plans and described to us the actions they would take to keep people safe in the event of an emergency.

The provider had a recruitment process in place to ensure staff employed were suitable to support people however some of the files that we looked at had incomplete or missing information particularly in relation to staff employment histories and references. The provider had completed Disclosure and Barring (DBS) checks before staff started work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff recruitment files had completed application forms which had recorded their education, training and employment histories and proof of identity. This meant that whilst there were some arrangements in place to check that the person was of good character, people were not fully protected against risks as the provider had not

## Is the service safe?

obtained all the information set down in the regulations for each staff member. **This was a breach in regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

During our inspection we saw that there were sufficient staff working to keep people safe, however people and relatives view on this was mixed. One relative said they thought there were not enough staff and said told us they thought that “I don’t think there are enough staff; they are run off their feet.” Whilst another said “I think there are enough staff here, but there has been a high turnover” People said that, “There seems to be enough staff around” and “If they are short of staff they get in agency ones”. We saw that staff responded quickly (within two minutes) to people who had to activate the call bell systems for help or personal care. At the time of our inspection the manager had begun to calculate and update people’s dependency levels against the staff numbers on duty to ensure that people were safe.

People and their relatives told us they felt the home was a safe place to be. One person told us, “It’s definitely safe here, it’s a lovely place.” A relative told us, “My family member has been very safe.” People told us they would be comfortable raising any concerns they had with staff or the manager.

People were protected from abuse and avoidable harm because staff had received training in safeguarding and were aware of what to do to if they had a concern about people’s safety. This was included in the induction training for all staff, and regular refresher training was provided so that staff had a clear understanding of what abuse was and their responsibilities should they suspect, or see it taking place. One said, “I would report to the manager and in

extreme cases I would report directly to the police.” Where issues around safeguarding were raised the manager recorded the action that had been taken. Records of incidents and feedback from people showed that the service had followed their policy when dealing with incidents. This showed that staff put the things they had learned in their training into practice to protect people.

People’s medicines were not always well managed and there were some gaps in the recording of medicines that were identified. After the inspection the provider informed us, ‘The policy of the Home is to not sign the document when medication is not given.’ By leaving blanks in the medicine administration records (MARs) there was no way to quickly identify the reason why a medicine may not have been given. Nor could we get a clear account of why a medicine had not been administered in accordance with the prescribers instructions recorded.

We observed one incident where medicines had not been administered appropriately by staff. They handed the medicine to a person, and then left the room. They did not witness the person take the medicine, but still signed the medicine administration record to say the person had taken their medicine. This was brought to the attention of the manager who immediately took action to ensure there was not a re-occurrence. People told us they had their medicines when they needed them. One person said, “The nurse gives me my medication and they ask if I want a painkiller.” Another said “The nurse always checks that I have taken my medicine.” Medicines identification sheets had people’s pictures on them to minimise the risk of people being given the wrong medicine. Medicines were stored securely in a room so that they could not be accessed by unauthorised people. The medicines trolley was also locked and fixed securely to a wall when not in use.



# Is the service effective?

## Our findings

People told us that the staff were “Good at what they do” and “Well trained”. One relative said that the care was effective and “Since being here he has improved, doing things he didn’t do before.”

Staff offered people choice and asked for their consent before carrying out any tasks. However not all of them were able to show they understood their role and responsibility in relation to the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff had been trained in the Mental Capacity Act and Deprivation of Liberty Safeguards. However those staff whose first language was not English were unable to explain their role and responsibility, which could introduce a risk that staff, through a lack of understanding make decisions for people without their consent, or not understanding when a person’s liberty may be being deprived. It is recommended that the provider reviews the effectiveness of MCA and DoLS training with staff, especially those whose first language may not be English.

People’s consent was recorded appropriately by the manager and when people may have lacked capacity to make decisions about certain aspects of their care there was an assessment undertaken to ensure that any decision was made in their best interests. For example one person had needed bed rails to protect them from falling out of bed, this had been discussed and agreed with them and their relatives and the decision recorded.

The manager had ensured that they followed the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

Staff had not always received effective supervision and appraisals to support them in their roles. Since December 2014 the manager had implemented one to one and group meetings with staff so that they could discuss any training or development needs with them. The staff would also have an opportunity to raise any concerns they might have. Prior to this staff had not had a one to one meeting with their line manager since 2013. This was not compliant with

the provider’s supervision policy that stated staff should have a supervision every two months. Regular supervisions are important to formally record staffs achievements and areas they may need to improve in, and put actions in place where improvement was identified. The supervision process had begun, but at the time of our inspection there was not enough information to show that the system was consistently working, as only two rounds of supervisions had taken place, and some staff had still not received supervision in line with the provider’s policy. We saw that staff had raised issues with equipment that was not working and this had been resolved by the manager as a result. Staff had yet to receive an appraisal of their performance.

The majority of people said that staff were well trained however one person said, “Agency staff could be better trained.” A visiting GP told us that they received a lot of calls from the staff as they “Didn’t have someone who could take bloods”. They told us that the provider had “Employed someone with the skills to do this now”. One person said “The staff are very good at what they do.” Staff told us they felt supported and enjoyed working at Birdscroft.

Staff received training to provide them with the skills to care and support for people. The manager used a chart to record what essential training staff had completed and what they had to do. This covered areas such as fire safety, food hygiene, health and safety, safeguarding, infection control and medicines. There was also specialist training recorded to suit the needs of the people that lived here, for example dementia care, catheter care and pressure sores. Further training had been identified and arranged to support the needs of the people for example in continence care. Nursing staff also received specialist training, for example in medicines management with the local pharmacy.

Since December 2014 the manager had implemented one to one and group meetings with staff so that they could discuss any training or development needs with them and the staff would have an opportunity to raise any concerns they might have. We saw that staff had raised issues with equipment that was not working and this had been resolved by the manager as a result. Staff had yet to receive an appraisal of their performance.

People were happy with the food and drink at the home. One said, “The food is nice, you couldn’t improve on it”.



## Is the service effective?

Another person said, “We get tea or coffee morning and afternoon, but we can have a cuppa anytime.” A relative said, “My family member is on a soft food diet and the chef is very good with his dietary needs.”

Information was on display in the kitchen about various diets that people had. The chef was able to describe who was on specialist diets, and also had this information to hand in nutrition records held in the kitchen. Information about people’s particular needs were on display in their rooms. For example the supplement that they were on and how to manage it if the person was having a ‘good or bad’ day. This gave the information staff needed to support people to have food and drinks to meet their individual needs and took into account their feelings and mood.

Assessments of people’s food and hydration needs were in place. Where these had identified a person could be at risk of dehydration or malnutrition, appropriate guidance for staff was in place to ensure the person was supported to have enough to eat and drink. A relative confirmed their family member was supported to ensure they received

enough to drink. Staff supported people’s independence by use of specialist cups and plates. These enabled people to feed and drink themselves with the minimum help from staff.

Fresh water and juice was available in people’s bedrooms and call bells were to people’s hands so they could ring for assistance if needed.

People felt they were supported to maintain good health. One person said, “I could see the doctor if I needed it.” Another told us, “An optician and a dentist visit.” A relative said their family member had been unable to, “Stand or walk” and had, “Little speech” but had improved since he had been living at Birdscroft.

Where people’s health changed appropriate referrals were made by the staff to healthcare professionals and agencies. For example letters had been sent to specialists asking for reviews of medicines when a person’s behaviour changed. A referral had been made to a dietician when a person’s eating habits changed. The staff had responded to the advice given and had kept a seven day food and drink diary had been kept as per the guidance from the dietician.

# Is the service caring?

## Our findings

People and their relatives were positive about how caring the staff were. One said, “The staff are all lovely, I can’t talk highly enough of them. They always have time to have fun.” Another said, “It’s like a family here, they are all lovely.” A relative said the staff were “Kind and caring”

Staff were seen to sit with people in their bedrooms or in the dining area when supporting them to eat. They talked with them about day to day things as well as encouraging them to eat. One staff member talked about the person’s family with them and about going out on trips. They took the time to talk and really showed an interest in what the person was saying. Staff were seen to be gentle, kind and taking their time when supporting people. One person called for help from their room and staff responded quickly by reassuring them and asking if they wanted anything.

A person said, “Staff are very attentive to my needs.” Another said “They noticed I wasn’t eating and have given me a supplement to my diet.” People told us they had had their care explained to them. Staff took time to listen to what was being said. They then passed on the information to other staff that were involved in this person’s care. This meant that the person would not need to repeat themselves and staff would know about the change that had been requested.

People were able to make decisions about their care and support. Three people told us, “We are aware of our care plans and we do get to see them” A relative said, “I do get told about changes in my family member’s care.”

People were given information at the time they needed it. For example staff gave people the time of day when asked. When a person asked about a piece of equipment that staff used, they took the time to explain what it was. Other information was in the form of clear signage to tell people what was in a room, such as the downstairs toilets. Signs on bedroom doors identified a person’s keyworker and gave a little piece of information about the person, such as an interest they may have. When we talked with people the information on the door was correct.

People said staff treated them with dignity and respect. One person said, “They just don’t wander in (to my room), they always knock and ask if they can come in.” Another said, “When washing us they close the door and draw the curtains.” A relative told us, “They do knock on her door and they are always kind when dealing with her.” People were seen to be dressed in the clothes of their choice, and happy to talk to staff and visitors.

Staff respected people’s privacy and dignity in a number of ways. They were seen to knock on doors and wait for a response before going in. Doors were closed when personal care was given. When a person who was independently mobile called for help from a toilet, a nearby member of the domestic staff immediately responded. They asked if the person was alright without opening the door. Staff not directly involved in the care of people knew about people and their needs.

Information on dignity and respect was available to staff and people that lived here. It was on display on the wall by the lounge. Relatives said they could visit their family members when they wanted. One said, “There are no restrictions to my visiting.”

# Is the service responsive?

## Our findings

People and relatives thought the care was focused on their individual needs. One said, “The care I get is especially for me, they are all wonderful.” A relative said, “The care she is having is fine” and, “Her personal care is marvellous”. Other comments made by people included, “They leave me alone and when I want them to come when I call.” And, “If I wanted to get up staff would help me, they are very helpful.”

Prior to a person moving into the home a pre-admission assessment was completed to ensure people’s needs could be met. This assessment covered all aspects of the care that was to be provided. Support plans were developed. These recorded what the person wanted to achieve, not just around care needs but also their social needs. They detailed what support would be needed, who would support them (including the number of care staff) and when. Dependency assessments had been recorded every two months to look at changes that may have taken place and to identify if additional support was required.

Support plans were in the process of being updated to a new format at the time of our inspection. This meant that a lot of the information was generic care and support guidance, and not individual to the person. However action had been taken to give staff information about individuals until the plans were finalised and included when a change had been identified such as a change in the person’s mobility and what equipment was required to help the person move safely. Staff updated care records in people’s room as the care had been given. This gave an accurate and up to date picture of what had been done for each person.

Spiritual needs of people were known, however at the time of our visit one person had not had the opportunity to practice their faith. The manager was already aware of the situation and had arranged for a regular visit to take place.

Important calendar dates were celebrated at the home. For example at the time of the inspection the home was celebrating St David’s Day. Decorations had been put up and fresh daffodils were placed around the home.

Activities were on offer to people during the day. People said they could join in with activities if they wished and the coordinator would go round checking if they were keen to join in. The manager had taken on feedback they had received from people about the activities and introduced new events. However some people who spent all the time in their rooms felt there could be more individual activity offered for them, or maybe some more company from people during the day. The manager was already aware of this and was working towards improving this.

The majority of people felt their concerns were listened to and acted upon. One person said, “I can’t remember if I ever had to complain, but they know us all very well and they know how to treat us all.” Another said, “There are residents and relatives meetings” where they could raise any issues they had. Another said, “I’ve no complaints, but I would if something was not right.” A relative said, “I’ve got no complaints” and “I’ve no reason to complain about the management, the manager is welcoming and friendly”.

A record of complaints was kept and the manager recorded what action had been taken to address the issues. For example where a person had complained about a cold room a heating specialist had visited the home to see if this could be improved. There had been six complaints recorded since the beginning of 2015. These included feedback from external agencies that had been recorded as complaints and these had been responded to in line with the complaints procedure.

A relative confirmed that when they raised an issue the staff had responded quickly to address the concern and made sure they were happy with what had been done. Information on how people and relatives could make a complaint was clearly on display in the reception areas. There was also a suggestion box where people could give their views on what could be improved.

# Is the service well-led?

## Our findings

The provider was unable to demonstrate how people received safe and good quality care during the time there was no manager at the home. Areas such as audits of health and safety practices, infection control, staff supervisions and receiving feedback from people who use the service by way of residents meetings had not been in place.

When the new manager had started they had to put a number of systems into place to ensure people had a good standard of care. This included pressure mattress checks to make sure they were set correctly for people to minimise the risk of a pressure sore developing; putting into place a policy for dealing with choking and ensuring staff had read and understood how to keep people safe; audits of medicines to ensure these were managed safely; and ensuring that staffs training was up to date. These should have been monitored and managed by the provider prior to the managers appointment.

Quality assurance checks to ensure people received a good standard of care, and to check on the effectiveness of the systems the manager had put into place had not yet started at the time of the inspection. Monthly provider visit forms had been generated but not yet used. The operations manager explained that the provider had recruited someone to carry out checks on the quality of the service, however they had not yet started with the organisation. The operations manager explained they would review any issues that had been identified when they visited, but this was not currently being done.

The failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service was a **breach in regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Records were in the process of being updated. This meant that care files had old and new information mixed which was potentially confusing to staff. There were also gaps seen in weight recording and MAR charts. The manager told us that there was “A lot of work to do”. To do this there was now a clear plan in place and they had been “Focussing on the care while I make improvements.” A number of new

initiatives and reporting methods were introduced by the manager. These had not been in use for a long enough period at the time of our inspection to demonstrate that they were being used effectively to improve the service.

People and relatives said the manager and staff checked that they were giving a high quality of care. One person said, “We could approach the management about anything and they would tackle it.” A relative said, “There was a questionnaire on food recently” and “There was also a questionnaire about the home.” A visiting healthcare professional said, “There has been a change for the better in the last six to eight months. There was a high turnover of staff before. Feedback from relatives is more positive now.”

The manager was aware of the need to review accident and incident reports to look for patterns, and to check that action taken was effective. There had been no accidents recorded for the manager to review since they joined the service. The operations manager explained that they would be receiving a monthly report from the manager beginning next month. This would summarise what had been happening in the home and what had been done.

People said the management were approachable and they were made to feel welcome. One person said, “The manager comes round every day.” Another said, “I do know the management”.

A relative told us, “The staff make me feel welcome.” Another person told us how they had a meeting arranged with the manager to feedback any issues they or others may have about the service. She felt she could raise any concerns or issues with the manager.

Staff said, “The culture is very open here. We are encouraged to talk and raise concerns.” Another said, “Yes we have team meetings, and I am able to raise concerns if I have any.” Group meetings with staff had discussed staff empowerment and a discussion on who does what within the home. This included checks that needed to be completed around the home and who was responsible for completing them. This gave staff a clear understanding of what was required of them.

Information was on display in the reception area, which described the values of the service, and what people could expect, for example treating people as individuals. Information on how the service would achieve this was displayed for people to see. The values of the service were

## Is the service well-led?

about treating people as individuals and listening to their comments and requests about the running of their home. Staff were seen to work to these values during the course of the inspection.

Residents meetings were planned to start in March so that people could be more involved in how the service ran. Invite letters had been sent out and people were offered a choice of times that they might prefer.

Information on whistleblowing was clearly on display in the reception area to guide staff if they needed to raise concerns outside of the service.

People were complimentary about the manager and the home. Most thought the home was managed well and the staff worked as a team. One said, "The manager is very good, she has made changes which are for the good." Another said, "I think this place is managed well, they keep it lovely and clean." A relative told us, "I would be definitely confident that I could approach the management and they would sort any issues out".

There was not a registered manager in post at the time of our inspection. The manager that was in place had just begun the registration process with CQC to become the registered manager. They were aware of their responsibilities as the manager for example how and when to report incidents and to which agencies.

The manager had a clear vision for the home but realised that improvement was needed in several areas in particular the updating and completion of peoples care records.

The manager had an action plan that covered a period of six months. They had identified areas that the home needed to improve and had given timescales and responsibilities for each. The plan covered areas such as staff training, care plans, pressure mattress checks / monitoring, consent forms, medication audits, and maintenance checks.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services <b>Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services. This corresponds to regulation [12(2)(a) Safe care and treatment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b> The planning and delivery of care did not always ensure the welfare and safety of the service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers <b>Regulation 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation [19(3)(a) Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b> The provider had not ensured that the information specified in Schedule 3 was available in respect of persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision <b>Regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Quality Assurance. This corresponds to Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance</b>

This section is primarily information for the provider

## Action we have told the provider to take

Quality Assurance checks of the home by the provider had not yet started.