Cumbria Care

Richmond Park

Inspection report

Main Street, Workington
CA14 4ES
Tel: : 01900 325030
Website:

Date of inspection visit: 25th August 2015
Date of publication: 23/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on the 25th August 2015.During our inspection May 2013 we made a compliance action as the environmental standards in the service were non-compliant with the regulations in place at that time. We followed up this inspection in March 2014 and found this standard had been met and the service was fully compliant with the standards we inspected during the two inspection visits.

There is a 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 and associated Regulations about how the service is run.

We found at this inspection that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff to meet the assessed needs of people living in the home and in emergency situations.

We found at this inspection there was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was

Summary of findings

because the registered provider had not made sure that suspected or alleged abuse was acted upon quickly and in line with local safeguarding arrangements to keep people safe.

We found at this inspection there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate arrangements were not in place to demonstrate that people received all their medicines appropriately.

We found at this inspection there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate arrangements were not in place to protect people from cross infection.

We found at this inspection there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the assessments of people's care, treatment and support needs were not in detail to support person centred care and did not include all their needs and possible risks that needed to be managed.

We found at this inspection there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not supported to have adequate nutrition and hydration.

We found at this inspectionthere was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service had not been properly supported to make decisions about their care and welfare.

The Care Quality Commission (Registration) Regulations 2009 require that the registered provider notifies the Commission without delay of allegations of abuse and accidents or incidents that had involved injury to people who used this service. This is so that CQC can monitor services responses to help make sure appropriate action is taken and also to carry out our regulatory responsibilities. The sample of people's records that we looked at showed examples of incidents and accidents that had occurred that should have been reported to CQC. Our systems showed that we had not received these notifications. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

We spoke to people who lived in Richmond Park and they all talked positively about living in the home. They said, "I feel safe you are well looked after here" and "Staff come in regularly during the night to see how you are, and they will have a little chat with you if you are awake." Every person we spoke to told us they felt safe, well looked after, and respected. Relatives praised the attitude of the staff and were happy with the care provided.

We spent time in all parts of the home and observed staff caring for people in a warm and friendly manner.

We found there was a period during the day and also at night when there was insufficient staff to safely care and support people.

We found that some people were not fully supported to take suitable or sufficient nutrition and hydration.

The provider had safe systems for the recruitment of staff to make sure the staff taken on were suited to work with adults at risk.

The records pertaining to topical medicines and creams were not up to date and in some cases not recorded at all. Medicines liable to misuse were recorded and stored correctly.

People knew how they could complain about the service they received and information on this was displayed in the home. People we spoke with were confident that action would be taken in response to any concerns they raised.

Internal audits or checks were completed in order to monitor the service provided.

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 safe.

People were not protected against the risks associated with unsafe use and management of medicines.

Staff had completed training in safeguarding vulnerable adults. However staff had not made sure that suspected or alleged abuse was acted upon quickly and in line with local safeguarding arrangements to keep people safe.

There were not sufficient numbers of care staff at all times to meet the assessed needs of people living in the home and in emergency situations.

People were at risk of infection because appropriate arrangements were not in place to protect people from the risks of poor infection control standards within the laundry area.

Inadequate

Is the service effective?
The service was not always effective.

The requirements of the Deprivation of Liberty Safeguards had not been followed to ensure legal authority had been obtained to restrict a person's liberty where needed.

People were happy with their meals but records showed that nutritional planning and assessments were not always up to date.

Staff training appropriate to people's roles and responsibilities was in place.

Requires improvement

Is the service caring?
The service was caring.

All the people we spoke to told us they were well cared for and supported to lives a full life.

Staff were knowledgeable about the people they supported and treated people in a dignified and caring manner.

Relatives spoke highly of the attitude of the staff and were very happy with the care provided.

Good

Is the service responsive?
The service was not always responsive.

Staff did not always have accurate information to refer to in care plans and some people did not have appropriate risk assessments in place to inform their care planning and the support they needed from staff.

Requires improvement

Summary of findings

There was a system in place to receive and handle complaints or concerns raised.

Some activities were provided and people could follow their own interests and faiths and maintain relationships with friends and relatives.

Is the service well-led?

Requires improvement 

The service was not well led.

Some notifications of accidents and incidents required by the regulations that should have been submitted to the Care Quality Commission (CQC) had not been notified.

Checks of care plans and reviews used to assess the quality of care planning were not always up to date and did not ensure that people's care plans had all the relevant information.

People who lived in the home and their visitors were given some opportunities to give their views of the service.

Richmond Park

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 checked 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 unannounced inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience in caring for and supporting older people and those living with dementia.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law.

We also asked the local social work team and local health care providers for information about the service. We had contact with staff from health and the local authority that purchase care on behalf of people. We planned the inspection using this information.

During our inspection visit we spoke to 14 people who lived in Richmond Park, eight care staff, the cook and four relatives who were visiting the home. We spent time with the registered manager and the operations manager discussing the running of the service.

We looked at a total of nine care/support plans, four of which we looked at in depth. We looked at the records pertaining to the administration of medicines, staff files, staff rosters and training records and toured the building looking at the environmental standards.

Inadequate

Is the service safe?

Our findings

We asked people who lived in Richmond Park if they felt safe living in the home. We were told, "I feel safe you are well looked after here" and "Staff come in regularly during the night to see how you are, and they will have a little chat with you if you are awake." Every person we spoke to told us they felt safe, well looked after, and respected.

We spoke to two different members of the care staff and both of them had received recent safeguarding training and they were confident that they would know what to do if they witnessed an abusive incident or that somebody told them that they had been abused. They were certain that any concerns they raised would be speedily and effectively dealt with by the new manager. We also asked them what they would do if it was not and they were clearly aware of the whistle blowing procedure and knew who to speak to in such circumstances. The manager told us there were areas she knew training was lacking, one area was that of safeguarding vulnerable adults. This was planned to take place two days after our inspection visit.

We saw in one care plan and corresponding daily notes that one person had been found on the floor at night on two occasions, These incidents had not been reported to CQC and we could not see where steps had been taken to complete a reassessment of possible increased needs. This indicated that there was poor monitoring and steps were not always taken to mitigate the risk of falls. We found that the staff had not identified these falls as possible safeguarding incidents and referred then to the Adult Social Care safeguarding team.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities Regulations 2014. This was the registered provider had not made sure that suspected or alleged abuse was acted upon quickly and in line with local safeguarding arrangements to keep people safe.

We looked at the management of medicines and found that the recording for the administration of creams was poor. The task of applying creams was delegated to care workers. Care plans and body maps for the use of creams were poor or incomplete so that there was no clear guidance for care workers to follow to ensure that creams were used correctly. For example, we saw a skin softening cream that was prescribed "as directed". There was no indication on the records to show exactly what the cream was.

We were told that care staff applied topical medicines and creams but the records were signed by the supervisor even though they were not the person applying the medication. Although the creams were applied by care workers there was no guidance to support their correct use. We discussed this with the registered manager and operations manager during the feedback following the inspection.

The residents we spoke to were happy to have passed on the responsibility for managing their medicines to the care staff and were confident that this was being professionally carried out. However, in the dining room we witnessed a service user being asked if they would like some pain relief and on saying yes this was given out. The supervisor, who was giving out medicines, just put tablets onto the table cloth and only looking back to see if they were gone when he reached the medication trolley rather than being sure that they had been taken.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate arrangements were not in place to demonstrate that people received all their medicines appropriately.

We looked at the staffing levels during our time in the home and discussed these with the registered manager and the operations manager who was visiting the home on the day of our inspection. It was obvious that the staff were extremely busy especially at lunch time. We noticed that during lunchtime the staff in one of the units on the ground floor unit took a long time to respond to call bells (6min and 4min). When we mentioned this we were told that all but four people in the unit eat their meals in their rooms, and mealtimes can put a heavy load on the care staff.

When we asked staff if there were enough staff to meet the needs of the people who lived in Richmond Park they told us, "There is most of the time but if we had more staff we could spend more time with people on a one to one basis just having a chat. Sometimes it is difficult to make sure there is always a member of staff in the communal area of the unit that supports people living with dementia".

The rotas showed there were only two members of staff on night duty to support the people living on the three units.

Inadequate

Is the service safe?

We were told, and could see from care plans that some people required two members of staff for their personal care and some people required supervision and assistance from one member of staff. This meant that at times two of the units had no staff available to support people.

The registered manager told us they hoped to have the recruitment of the new staff completed within a month. In the meantime night shift staffing levels remained below the number needed to meet people's assessed needs and keep them safe at night. However the registered manager confirmed that three new support staff workers were due to start in October.

We looked at the fire evacuation plans for people in the home and saw that some people required the support of two members of staff. This would not be possible given the current staffing levels and puts people at risk.

This indicated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff at all times to meet the assessed needs of people living in the home and in emergency situations.

When we discussed the staffing arrangements with the registered manager and her line manager they confirmed that new staff had been appointed but were awaiting all the required legal clearances before they started work. This would increase the care staffing hours, in the first instance, by 72 hours per week.

The registered provider for the service had systems in place to ensure staff were only employed if they were suitable and safe to work in a care environment. We looked at three staff files and found that suitable checks had been completed before any applicants were offered a position within the organisation.

We found that the home was tidy and there were no lingering unpleasant odours. The moving and handling equipment we saw in use, such as hoists, were clean and being maintained under annual service level agreements and that people had been assessed for its safe use. We noted that there were areas of the home that needed some redecoration for damaged and chipped woodwork in bathrooms and on corridors and damaged plaster. However we were told by the registered manager that the planned environmental upgrade of the building would ensure this was remedied and all parts of Richmond Park would be a safe and well-maintained home for people to enjoy.

We had been told of the refurbishment and the operations manager told us this should have started in August but the start date for the work was put back until October. Following our inspection visit we have received confirmation from the registered manager that the building work would now start in January 2016. This decision was made following a meeting with the people that lived in Richmond Park and their families who did not want the Christmas celebrations to be held during the refurbishment period.

During our time in the home we saw on more than one occasion washing up liquid was left out on display in the kitchen areas and shampoo and conditioner were left out in bathrooms. We saw that laundry products were left on top of the washing machines when the door to the laundry area was unlocked. This put people at risk of danger from hazardous substances. We spoke to the registered manager about this and she immediately arranged to have all washing products to be safely stored.

Requires improvement

Is the service effective?

Our findings

People we spoke to made many positive comments about the support they received from the staff in the home. One person told us, "Staff ask me regularly how I am" and another said, "They (the staff) know all my likes and dislikes."

Relatives we spoke to were complementary about the care provided to their family members. They said, "The communication is excellent and it has improved with the appointment of the new manager. I requested that my relative come to live here and have not regretted it at all". Another visitor said, "The staff provide really good support and keep me informed about any changes or things I need to know".

In the sample of care records we looked at some people had DNACPR (do not attempt cardiopulmonary resuscitation) forms. There was no evidence to confirm that the correct and legal decision making processes had been followed. There was no evidence of best interests meetings or capacity assessments. This meant that people may not have been properly consulted about their wishes regarding the care and support they would like at the end of their life. Since our inspection visit we have received confirmation from the registered manager concerning the process of dealing with DNACPR forms and those already in place. No future decisions would be made without completing the correct legal procedures.

When we looked at people's care records, we found that people who used this service were not always involved in decision making and giving consent for their care and treatment. There was little evidence to confirm that decisions had been made in people's best interests because they did not have the capacity to make those decisions themselves. We found that the provider and staff at the home had limited knowledge of the Mental Capacity Act 2005 and the deprivation of liberty safeguards.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service had not been properly supported to make decisions about their care and welfare.

We saw from looking at the care files that some nutritional planning was in place but the information was not always consistent. For example we saw in one person's care plan that weight was to be recorded each week but this had not been done. Daily records and food/fluid intake charts indicated there was a poor intake of nutrition but we were unable to see if the person's weight was stable as they had not been weighed since the 23 July 2015. We asked the manager what the home had done about this and she confirmed that the GP the dietitian had not been contacted or been involved in the nutritional planning. This put the person at risk of receiving improper care and treatment.

In the daily diary of the 9 August pertaining to one person it stated that they had a sore mouth and was reluctant to wear dentures. They also complained of having a sticky mouth and a feeling they were going to choke. We asked the registered manager about this but she could not provide an explanation about what had been done regarding these concerns. We saw that there was nothing recorded in the supervisor's book to confirm a GP, dentist or a speech and language therapist had been involved or a nutritional assessment completed.

Another nutritional plan showed one person had lost a considerable amount of weight since June and whilst it said to offer a high calorie diet and fortified drinks this was not mentioned in the care plan. We spoke to the cook who had worked at Richmond Park for many years and she was aware of the people requiring high calorie meals and drinks.

Food and fluid intake should be accurately monitored on applicable charts and kept up to date at all times. We did, however, see on another care plan we looked at evidence there had been referrals to the dietician and speech and language therapist (SALT). This evidenced that up to date and accurate information was not consistently recorded on each care plan.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not supported to have adequate nutrition and hydration.

We spoke to staff about the training they had completed in order to fulfil their role as a support workers. Staff told us that training had been completed in safe handling of medicines, end of life care, mental health awareness and moving and handling. Training in respect of safeguarding of vulnerable adults and the Mental Capacity Act 2005 (MCA 2005) had been arranged for the week of our inspection.

Requires improvement

Is the service effective?

One member of staff confirmed she had booked a place on the courses. The operations manager confirmed she was in discussion with the registered manager to ensure all staff training was brought up to date as soon as possible.

The staff files showed that each member of the staff team received regular appraisals. Staff told us that they received regular formal supervision from their line manager during which they discussed the professional development. They also said they could approach the registered manager at any time if they had a concern.

We toured the building to look at the environmental standards within the home. We saw that the upper floor was in a better state of repair than the ground floor. In some parts the building looked shabby although clean and with no unpleasant odours. The laundry area was in need of a complete refurbishment. It was extremely small and did not allow sufficient space to separate clean and soiled items of clothing and bedding. This meant that people were put at risk because they were not protected from the spread of infection. The registered manager confirmed that when the refurbishment of the building was complete the laundry would be twice the size allowing separate areas for soiled and clean linen and clothes.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate arrangements were not in place to protect people from cross infection.

The operations manager confirmed that Richmond Park was due for a major refurbishment covering the whole building. This work was due to start at the beginning of October and it was because of this that there would be no admissions to the home until the work was completed. The people we spoke to were aware that the care home was looking a little worn but were very glad that it was going to be refurbished and kept open as they wanted to continue living there. Since our visit we have been advised by the registered manager that, following a relatives meeting it had been decided to postpone the start date for the refurbishment of the home. This would allow the people who lived in Richmond Park to enjoy their Christmas festivities without the disruption of building work and redecoration.

Good

Is the service caring?

Our findings

We asked people and their relatives if they were happy with the care and support provided by the staff at Richmond Park. All the replies we received were positive and people were only too pleased to have their comments recorded. Relatives said, “The staff are nice people who always make you welcome” and “We are asked for our opinion and made to feel that it matters”. Other family members told us, “We looked at lots of care homes and Richmond Park was the one that really felt like a home”. Other family members said, “we have two relatives living here and the staff are brilliant with both of them”.

People who lived in Richmond Park said, “My visitors like coming here as it’s so friendly” and “It’s like inviting someone into your own home.”

We were told that the care staff always made clear what they were doing and why, which made the residents feel involved in their care. They told us, “They (the staff) always knock if the door of your room is closed” and “The girls always tell you what they want to do and ask if it’s alright.”

The family members we spoke to told us that they were very pleased with the quality of the communication provided by the home and felt that they were part of any decisions made about the care arrangements of their relatives. We were told that they were always kept up to date with how their relative was and were contacted immediately there was a concern about health issues.

From our observations there was an excellent, warm relationship between the staff and people who lived in the home. Staff knew the people they supported well and we saw they responded well to their support needs.

There were people living in Richmond Park who had complex needs and saw that the care staff knew these needs and understood how best to manage them well. We observed, throughout our visit, friendly and warm interactions between the care staff and people they cared for.

We observed the way staff dealt with people living with different medical conditions. We saw staff who dealt patiently and sensitively with the people they supported. We saw people living with dementia responded well to the staff group.

Visitors were always made welcome when they visited the home and they told us, “We are looked after like members of the family and there is always a cup of tea for us while we are here.” They did, however, sometimes have concerns because the staff were always seemed so busy although they were quick to say it never seemed to be detrimental to the care provided by the staff team.

Requires improvement

Is the service responsive?

Our findings

All the people we spoke to told us they thought the staff were responsive to their needs. Comments included, "They (the staff) know what you need and get it for you" and "They (the staff) soon notice if you feel a bit off." One person said, "It is nice to get your hair done as it always perks you up a bit".

The people we spoke to were confident that their likes and dislikes were known by staff and acted upon. However they had little concept of what 'care plans' were. None of the people we spoke to saw them as working documents, that they had ownership of, and which encompassed their total care whilst in the home. They told us they were quite happy with their care and didn't really want to see their care plans. "I leave that to my family" one person told us.

We asked relatives who were visiting the home if the staff discussed their relative's care. One person said, "I have a lasting Power of Attorney in respect of my [relative] and the staff keep me well informed. I attend the review meetings and any residents' meetings. I am always made very welcome when I visit".

We saw that all the care plans were currently being reviewed. The registered manager had only been in post since June of this year and told us that was the first job she started when she came to work in Richmond Park. She found there were issues with the care plans such as limited details being recorded and a lack of personalisation. She had recently appointed care plan champions to take a lead in the care planning process. Staff were now being encouraged to write in the care plans and to discuss any changes in the care provision with the supervisors and/or the registered manager.

Although most care plans had been reviewed we found that some information in them was missing or not up to date. Care management plans did not always reflect the strategies and actions needed to support people with more complex care needs. These strategies were needed to ensure the care staff knew exactly what level of care to provide. For example the daily notes in a care plan showed that the person could sometimes show aggression towards other people and required careful monitoring. There was little information about how the care staff should deal with this other than to record the lounge on the unit should never be left unattended.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the assessments of people's care, treatment and support needs were not in sufficient detail to support person centred care and did not include all their needs and possible risks that needed to be managed.

As there has been no new people admitted to the home we were unable to see any new pre-admission assessments but we did see, in the care plans, copies of the ongoing assessments after admission. We saw that people had access to appropriate health care professionals to meet their individual health care needs. We saw records in the care plans of the involvement of the community mental health team, district nurses and specialist nurses as well as opticians, chiropodists and dental services.

Richmond Park did not have an activities co-ordinator but there had been some activities organised for people which had included armchair aerobics and music which most people enjoyed. Cream teas had been organised by two of the local supermarkets which everyone enjoyed. There were monthly church services, with communion in between, on the activities plan as well as visits by the hairdresser. People we spoke to told us they welcomed the opportunity to attend the church services when they felt able to do so.

We spoke to one family member who told us she was good at organising activities and fund raising and was helping the home in this way and enjoying it. She said, "I will look forward to doing this as it would help the staff and benefit the people who lived in Richmond Park".

We asked people if they knew what to do or who to speak to if they had a complaint. We were told, "Well I have never had to complain but I would speak to the new manager or any of the girls. I am sure I would be listened to". There was a copy of the complaints procedure on display for people to read. Staff told us they had not received any complaints but if they did they would immediately go to the registered manager. Relatives told us they were impressed with the recently appointed registered manager and were confident she would deal with any complaints or concerns in a timely manner.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post on the day of our inspection visit who was appointed in June of this year. She was previously a registered manager in another service with the provider Cumbria Care. We saw during our inspection that the registered manager was accessible and spent time with the people who lived in the home and engaged in a positive and open way with them.

We spoke to people who lived in Richmond Park and relatives who were visiting on the day of our inspection and asked them for their comments about the management of the home. All the comments we received were favourable. People said, "I have seen the new manager she always seems to be round and about. She seems very nice indeed". Visitors told us, "There is a huge difference since the new manager came. She is so responsive and helpful". One relative said, "My [relative] came in for respite and was so happy I requested this home when she had to move into full time care".

The staff we spoke to were very supportive of the new manager and said she was willing to listen to them. One member of staff said, "I find the new manager very different but very supportive and fair". The staff we spoke to said that the morale of the staff was higher than it had been for some time and they felt that everyone was pulling in the same direction. One member of staff said, "It can only be good for the people we support and who live in the home". It was clear from all the staff we spoke to that the Richmond Park was run on a person centred model. Staff told us that the changes that had been implemented since the new manager was appointed were all positive and with the residents in mind in particular for the people living with dementia.

We spent time with the registered manager and she told us she knew there was much work to be done to improve the standard of support provided to the people who lived in Richmond Park. She said, "I know the actual care provided by the staff team is good but our paperwork and recording needs much improvement".

We found that the registered provider had not ensured that CQC had been notified of incidents and accidents in the home that they were required to inform CQC by law. We looked at records for the last 12 months and found that there had been a failure to notify CQC about injuries people had sustained following falls and not reporting two possible safeguarding incidents. This meant CQC had not been able to check that the registered provider had taken appropriate action at the time of these incidents and accidents so that, if needed, action could be taken to protect the person or their rights. We told the registered manager they needed to do so.

This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009. This was because incidents that could affect the health, safety and welfare of people who used the services were not always being notified to CQC.

We discussed with the registered manager and the operations manager about this failure and the breach of regulation. We informed them that that we would deal with this breach separately and take further action if future notifiable incidents were not reported to CQC without delay.

Cumbria Care, the registered provider had systems in place to assess and monitor the quality of the service provided and internal quality audit staff visited Richmond Park in December last year. There was a number of requirements and recommendations highlighted and the registered manager was working through the list to ensure all these were met. Two of the requirements were in respect of incomplete recording in the care plans and another was in respect of manual handling assessments not being up to date. The registered manager confirmed that these had been addressed during her review of the care plans.

The operations manager also visited the home on a monthly basis to do service checks and monitor quality. We saw that some internal auditing did take place for example on the care plans, medication records and people's personal finances. An infection control audit had been carried out by the registered provider. The registered manager confirmed that a monthly health and safety and environmental check now took place. In future some of these checks would become part of the role of the supervisors.

We looked at the records detailing people's personal finances and saw that these were correct with the amount of cash held tallying with the written records. The operations manager also audited these records during her monthly visits.

Requires improvement

Is the service well-led?

Satisfaction surveys had not been sent out this year but the registered manager said these would be sent out as soon as possible. In the meantime she would arrange a meeting for people who lived in the home and their relatives to discuss the service provided.

All the staff we spoke with told us that they now had regular staff meetings, formal supervision and felt they were more supported in their work.

During our inspection we spent some time with the operations manager and she confirmed she visited the home more than once a month whilst the new manager was settling in. She said, “It has been a difficult time for the new manager but she has settled in well and is working with the staff to support them through the changes”.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Person centred care** **The assessments of people's care, treatment and support needs were not in detail to support person centred care and did not include all their needs and possible risks that needed to be managed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.** **Need for consent.** **Practices were inconsistent when people were having their decision making capacity assessed and so did not consistently promote their best interests in line with legislation and recognised guidance.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014** **Safeguarding service users from abuse and improper treatment.**

This section is primarily information for the provider

Action we have told the provider to take

The registered provider had not made sure that suspected or alleged abuse was acted upon quickly and in line with local safeguarding arrangements to keep people safe.

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (f)(g) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 Management of medicines. Appropriate arrangements were not in place to demonstrate that people received all their medicines appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 Cleanliness and Infection Control Appropriate arrangements were not in place to protect people from cross infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 CQC (Registration) Regulations 2009. Notification of other incidents. The registered provider had not made sure that incidents that could affect the health, safety and welfare of people who used the services were always being notified to CQC without delay.
	Regulation 14 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. This was because people were not supported to have adequate nutrition and hydration