St. Martin's Care Limited

Washington Manor Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the last inspection of this service in February 2016 we found the provider had breached three legal requirements. These related to staffing levels and training, person-centred care records and quality assurance checks by the provider.

We carried out this inspection on 3 and 4 May 2017. During this inspection we found the provider had made improvements to the staffing levels. The provider had also begun to make changes to personalise people's care records although this was on-going area of improvement. The provider had improved the quality assurance systems although it was too early to assess the effectiveness of the new governance arrangements.

However we found some areas of essential staff training had still not been completed. This included safeguarding training and fire safety training. This was a continuing breach of regulation.

During this inspection there were occasions when people's privacy and dignity were not protected. Also, some restrictions had been applied to people without considering their choice or ability to consent.

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

We found there were no adaptations to help people who were living with dementia to find their way around. We have made a recommendation about this.

Since the last inspection a manager had registered with the Care Quality Commission but had left six months later. A new manager had been in post for four weeks and was in the process of applying for registration. 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.

People told us they felt safe and secure in the home. Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. The provider used a dependency tool to decide the level of staffing.

There were robust checks before a new member of staff started to work at the home, although renewed checks of established staff were not always carried out in line with the provider's own policy. Medicines were administered to people in a safe way but the storage of medicines was not always suitable.

People were supported to eat enough and they had choices about their meals. People were given choices of drinks throughout the day but there were no jugs of drink for people to help themselves. Records about how

much people had to drink were not always filled in fully.

People who could express themselves told us the staff were helpful and friendly. Relatives had mixed views about how staff engaged with people. They felt some staff were friendly and compassionate; whilst others were not. The manager was aware that there were improvements to be made to the overall culture in the home.

There were activities in the home and occasional opportunities for people to go out. Staff felt this would be improved when the second activity staff member was recruited. There was clear information for people and visitors about how to make a complaint or comment and these were acted upon.

People, relatives and staff felt the manager was approachable, open and honest. They had been invited to be involved in discussions about future improvements to the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always stored in a way that was suitably secure or at the right temperature.

Staffing levels matched the provider's staffing tool but the deployment of staff was not always efficient.

Safeguarding concerns were listened to and dealt with in a robust way to protect the people who lived there.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had more opportunities for staff training and support although this was on-going area for improvement.

Assessments about some people's capacity to consent or not to their care had improved but for other people this was still an area for further development.

People's nutritional health was kept under review. But records about people's fluid intake were incomplete so it was difficult to know if people had enough to drink.

There were few design features to help people living with dementia to find their way around.

Is the service caring?

Requires Improvement

The service was not always caring.

There were occasions when staff did not protect people's dignity and privacy.

The way staff engaged with people was varied. Some staff simply monitored people but did not interact with them; other staff were friendly and chatty with people.

People's choice and independence was promoted, where their

abilities allowed.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care plans were being changed to a new personalised format but this was an on-going area of improvement.

There was a timetable of group activities for people to participate in to support their social care needs.

The service had a complaints procedure in place. People and relatives felt their comments would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not fully well led.

The manager had been in post for only four weeks and was not yet registered, though they had begun the process of applying for registration.

The provider's quality assurance processes were more robust and had identified several areas for action. It was too soon to tell if this would lead to improvement.

People, relatives and staff felt the manager was approachable and they were asked for their views.

Washington Manor Care 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 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 inspection began on 3 May 2017 and was unannounced. A second visit was carried out on 4 May 2017 which was announced.

The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We asked commissioners from the local authority and health authority for their views of the service provided at this home. We contacted the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people living at the home and ten relatives. We also spoke with the manager, two senior care workers, five care workers, a catering staff, a maintenance staff, a director of quality and compliance and a director of care.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to

help us understand the experience of people who could not talk with us. We observed care and support in the communal areas and looked around the premises. We also observed a lunchtime meal to help us understand how people were assisted.

We viewed a range of records about people's care and how the home was managed. These included the care records of six people, the recruitment records of five staff members, medicines records, training records and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in February 2016 we found the provider had breached a regulation in relation to staffing levels. This was because the provider did not have effective systems in place to ensure there were sufficient numbers of suitably qualified staff on duty. This meant people did not receive assistance in a timely way.

Since the last inspection the provider had introduced a new staffing tool to calculate the number of care staffing hours required. Each person was assessed for their dependency in a number of daily activities of living such as mobility, personal care and eating. The dependency formula was then used to work out the required staffing numbers. The manager said the staffing tool was reviewed monthly to account for changes in people's needs.

There had been an increase in care staffing hours since the last inspection. At the time of our inspection 60 people were living at the home. Staffing levels through the day for both floors were two senior care assistants, eight care assistants and one activities co-ordinator. There was also an additional member of staff on duty from 6am to 10am five days a week, and from 6pm to 10pm on one evening a week.

The manager held a morning meeting with senior staff every day who allocated specific tasks to care staff for example, helping to people at mealtimes. We saw there were care staff present around both floors but staff's reaction to call bells was mixed. Some calls were answered quickly but on two occasions call alarms sounded for several minutes before being answered. On one occasion two staff members were sitting in the corridor writing care reports without checking the call alarm board. In this way there were improved staffing numbers but the response by staff on these two occasions was not timely.

People told us there were staff around when they called for assistance. Relatives felt the service was safe but had mixed views about staffing levels. One relative commented, "This is a safe place for [my family member] as they are well looked after and there are staff around if they need anything." Another relative commented, "I feel it is safe, yes, but sometimes there isn't any staff in the lounge or dining room areas. It does worry me a bit in case my family member falls or anything."

The staff we spoke with told us they were happy working at the home, but they didn't always get their full break at times. They felt another member of staff would be beneficial but did not feel the service was unsafe.

There were recorded risk assessments in place about people's needs, for example in relation to moving and assisting, nutrition and skin viability. In some cases the records were incomplete. The director of quality and compliance and the provider's clinical lead had recently carried out audits of care plans and identified there were areas of gaps within the care records. It was planned that these gaps would be addressed by the changeover to a new care record format that was taking place this month. In the meantime permanent members of staff were knowledgeable about people's needs and were able to describe the steps they took to ensure people's safety.

Bathrooms were reasonably decorated but most were cluttered with hoist equipment and laundry trollies, which meant these had to be removed into corridors before people could have a bath. We had pointed this out at the last inspection. The manager confirmed storage space was a challenge and was looking into alternative storage arrangements.

We reviewed five staff recruitment files. We found each file held two completed reference checks and a Disclosure and Barring Service (DBS) check dated prior to the staff member's start date. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults.

The provider's policy stated that DBS checks should be in place before staff were employed and proposed that such checks should be repeated every three years. We found in three of the files repeat DBS checks had not been conducted, which was contrary to the provider's own policy. We noted that this was pointed out at the last inspection. We discussed this matter with the manager who advised it was their intention for all staff to have three yearly DBS checks.

People told us they felt safe and secure at the home. One person said, "I do feel safe in here, because there are people around if I need someone." Another person commented, "I feel very safe in here. What makes me feel safe is that I am not on my own and the staff are here."

The staff we spoke with said they were able to speak about any concerns with the manager and were confident these were dealt with. Safeguarding and whistle blowing were standard agenda items for discussion in individual supervision sessions with each staff so they were frequently reminded of their responsibilities in this area. The provider had a whistleblowing 'hotline' and staff knew how to report any areas of concern or poor practice. It was evident that where staff had reported concerns these were rigorously dealt with by the provider.

All records relating to the maintenance and safety of the building and equipment were up to date and monitored. We saw monthly checks were conducted in such areas as window restrictors, water temperatures, bedrails and wheelchairs. Each person had a personal emergency evacuation plan (PEEPS) which detailed how to support them in the event of an emergency. These were kept in the person's care records and also in an emergency grab bag in the manager's office.

On each floor medicine trollies were securely stored in a small lockable room. Medicines were supplied in blister packs and then stored in the locked medicines trolley. The senior care workers advised only they had access to the room and trolley keys. These storage arrangement presented practical challenges to staff. The downstairs room was so small it was difficult to move the medicine trolley out so senior care workers had to return back and forth to the locked room after administering each person's medicines. Also, care files were also held in the medicines rooms so care staff were not able to access these without asking senior staff to open the door.

We found the room and fridge temperatures in the upstairs medicine room had not been completed every day. When it was recorded we saw it was outside the required room temperature range for the past two months, but no action had been taken to resolve this matter. When we advised the manager of the issue they took immediate action to provide a fan which cooled the room. We also noted any extra medicine supplies were held in a locked cupboard but it was usual practice for the key to remain in the door. We discussed this with the manager who advised that the storage of medicines was to be reviewed.

We saw the medicines administration records (MARs) folder contained a copy of staff signatures for

identification. Each person's medicine's record held a photograph of the person and protocols about when to support with 'when required' medicines. The MARs we viewed showed no gaps or discrepancies. Monthly audits were conducted with actions undertaken when issues were identified. We observed one senior care worker administer medicines. They made sure they had the correct person's medicines and were sensitive when supporting the person to take their medicine. They were able to describe people's preferred method of receiving their medicines.

The controlled drugs cupboard was held in a basement store room. The controlled drugs were correct and a record showed these were checked when given and also during a weekly check.

Requires Improvement

Is the service effective?

Our findings

At the last inspection of this service in February 2016 we found the provider had breached a regulation in relation to staff support. This was because several staff had not been provided with essential training including mental capacity act and deprivation of liberty safeguards, or managing behaviours that challenge.

During this inspection the provider was unable to demonstrate that 14 of the 48 current members of staff on the staff training matrix record had completed safeguarding training. Some of these staff members had been employed for around one year. Also, 10 staff members listed on the staff training matrix record had not completed fire safety training.

This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we pointed out these gaps the manager made sure those members of staff were included on planned training in those areas which was due to take place within the next month.

We found there had been some improvements to training arrangements. The provider now contracted a training agency to manage the training needs of all staff members. There were training plans in place to arrange necessary training for each staff and at regular intervals. For example, since the last inspection all staff had completed updated training in manual handling, training and health and infection control.

The manager had put a supervision schedule in place to make sure each member of staff had opportunities to meet with a supervisor. Arrangements were in place for the deputy manager and senior care workers to carry out one-to-one supervision sessions with staff members. We saw there were induction reviews after one, three and six months for new members of staff and probationary supervision sessions to check whether they were developing sufficiently in their roles. The manager had also started to carry out annual appraisals to assess and support the performance of each staff member in their role. Some staff had already had an appraisal and the remainder were planned. This was an area of on-going development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw 22 DoLS applications had been

authorised by the relevant local authority and other applications were awaiting approval. We found evidence of mental capacity assessments and best interest decisions in most people's care plans.

In others there were not always records of best interest decisions made in relation to equipment that restricted people's movement. For example, staff used lap-straps on wheelchairs when mobilising some people and bedrails were used for other people. But there were not always records in place to show these practices were the result of a best interest decision about keeping the person safe. Several records about people's capacity to consent to sharing information with other agencies were incomplete or unsigned. The director of quality and compliance stated these gaps had been identified at a recent audit and were being addressed during the changeover to the new care records.

During a tour of the building we noted a large number of doors to people's rooms on the dementia care unit were locked. We asked the manager why the rooms were locked and who had access to the keys. They advised that, on the request of people's relatives, doors were locked as some people were going in to other people's rooms without permission. Keys were held in the safe, with staff having access to a master key. We asked if people had been consulted to check if they consented to their room being locked and if they were offered a key. The manager was unable to confirm a discussion had taken place with people living in this unit. This meant that if a person wished to gain access to their room they had to ask a member of staff, or if they did not have the capability to ask they would not be able to access their room.

These matters were a breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Records to show where relatives had Lasting Power of Attorney (LPAs) were clearly available for staff to view at the front of people's care records. This meant staff had information about who should be involved in decisions on behalf of people who lived there. We found the home had intervened and supported a person to use the services of an independent mental capacity advocate (IMCA). This had ensured the best interests of the person were considered when the person's family were reluctant to allow an activity.

People who were able to express their views told us they made their own choices over their daily lifestyle. We heard staff ask people for permission before supporting them, for example with personal care or assisting them to mobilise.

Most of the people we spoke to were happy about the quality of food they received and said there was always a choice for their meals. One person told us, "I like the food here, we are well looked after. There is always plenty to eat and drink." Another commented, "We are well fed and watered here. I have no complaints with the food or drink we are served."

People were offered at least two main choices at mealtimes. Some people, who were able to express themselves, had requested for alternatives to the main choices and these were catered for. Staff were familiar with people's abilities in relation to choosing meals and with their food preferences. For example, during this lunchtime one person was provided with a toasted sandwich because staff were aware they preferred finger foods.

There was some positive encouragement by staff for people to eat and drink during the lunch. Some examples of this interaction were, "Are you enjoying that?", "would you like some more juice?", "would you like more dessert?" and "you haven't eaten much today, do you think you might like to try to eat a little more?"

The manager told us people's weight was monitored on a monthly basis. If people were identified as at risk of poor nutrition staff monitored their weight more frequently and any significant weight loss was reported to their GP. Staff told us they used fortified drinks and foods where necessary to support people who were at risk of losing weight.

Staff were keeping a record of the drinks people had on a fluid intake chart. However the targets amounts were general amounts for women or men rather than for individual people. Also the amounts people drank were not totalled to check if they had drunk enough. There was no indication that if people consumed too little this led to any increased support with fluid intake. This meant the fluid records were meaningless and did not result in any action to improve people's hydration. We noted people were offered drinks throughout the day and at mealtimes but we did not see any jugs of juice or water around lounges or in bedrooms for people to help themselves.

The home provided care on the first floor for people who were living with dementia. There were picture menu boards outside dining rooms with photographs of different meal choices. These were intended to help people make informed choices. However, throughout the first day of the inspection the menu board had the wrong date on so the pictures did not correspond to the meal time choices. Also pictures of all meals were crammed onto the board which could be confusing as to which choices related to which meal.

The first floor dementia care unit had a few environmental clues to support people's orientation. For example, bedroom doors were painted different colours. However it would be difficult for people to otherwise distinguish their own room as there were no other objects of reference, such as personal memory boxes or familiar pictures, for them to recognise. There was little in the way of visual or tactile interest for people who walked around the unit other than some hats on a hook outside the dining room and a rummage box on the floor that could not be opened as the lid was jammed. There were two modern pushchairs with a couple of dolls outside one lounge, but these were not used in any therapeutic sense and no-one was engaging with these objects. There were no 'rest-stop' chairs along the long corridors for people who constantly walked around the unit.

The provider had recently developed a 'dementia strategy' for the home although the proposed actions within the strategy had not yet commenced. The manager and quality manager discussed future plans to develop the first floor unit into a more dementia-friendly environment. The plans included redecorating the corridors with memorabilia about the local area, so they would be relevant to people who lived there. Just over half the care staff team had had some training in dementia awareness. The manager said staff would also benefit from 'resident experience' training to raise their empathy and awareness of how it feels to live with dementia.

We recommend the service finds out more about current best practice regarding the design of accommodation for people living with dementia.

People were supported to access health services when needed. People's care records showed when health professionals visited people, such as their GP, dentist, optician, and dietitian. Guidance from health professionals was included in the care records we viewed.

Requires Improvement

Is the service caring?

Our findings

Staff did not always consider people's dignity and privacy. On two separate occasions over the two inspection days we saw staff accompany a person into a shared toilet in the corridor outside a lounge. The person was in a state of undress without the door being closed. On one of these occasions the person was left unattended on the toilet with the door fully open while the staff member observed from the corridor. This significantly compromised people's dignity and privacy. We did not see senior staff, who were nearby, correct this staff practice to make sure that the culture in the home was one where people were always supported in a dignified way. Also one agency care worker (not employed by the home) made an insensitive remark about finding one person's behaviours amusing.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and quality assurance director told us this was not considered acceptable practice and were aware that the values and attitude of some staff needed to be addressed. They told us, and disciplinary actions confirmed, they were taking rigorous steps to address any reports of inappropriate or disrespectful approaches towards people who lived at the home.

Staff interaction with people was variable. We noted some members of staff, mainly agency staff, spent long periods standing in the doorways of lounges or dining rooms monitoring people but not interacting with them.

Other members of staff, notably senior staff and catering staff, were chatty and friendly towards people. They engaged people in conversations and encouraged them to make choices. A couple of people who were agitated with each other were gently diverted onto light-hearted conversations to diffuse the situation. We saw staff supported people who needed assistance with their food in a sensitive and caring manner and at the person's own pace so they were not rushed.

Relatives also felt there was variation in the manner of staff. Some relatives said some staff were "lovely" with people, but felt other lacked compassion and didn't interact with people. One relative gave an example of a staff member just putting drinks in front of people without talking to them. Another relative commented, "I do think there are some nice staff here but others I do not feel are."

People who were able to express their views were positive about the care they received from staff. One person commented, "I am happy here. The staff are nice and help me." Another person said, "Staff are kind and lovely." A third person told us, "The staff are good and look after me."

The people we spoke with said their privacy was respected if they needed any help with personal care, bathing, or other assistance. They described how staff closed curtains in their bedroom for privacy and dignity. We observed staff knocked on bedroom doors and asked for permission before entering. For example, they would say to the person, "Hello, I am here, can I come in?"

Staff encouraged people's independence where their abilities allowed. For example, some people who used walking frames were encouraged by staff to the dining room with supportive words such as, "Here we are, nearly there". We saw that staff were patient and took time to ensure people's safety when supporting them to transfer and get around in wheelchairs.

Most staff had a good relationship with the people living at the home and with relatives and other visitors. Relatives' comments included "the staff are great" and "they will always help if there are any queries".

There was information in the home about advocacy services for people and one person had been supported to use an independent advocate to help them make a decision in their best interest.

Some care records were kept in an unlocked cupboard in the corridor. These included daily care reports and food and fluid records. This meant staff had easy access to the records but it also meant they were not stored in a confidential way. The manager stated they were looking into suitable storage space for records.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in February 2016 we found the provider had breached a regulation relating to person-centred care. This was because care records did not contain personalised information about how people liked or needed to be supported.

Since the last inspection we found improvements had been made. Care records were being changed to a new format that included personalised information about each person. In the care files we viewed there was detailed guidance for staff about the support people needed throughout their daily routine. Six people's care records had changed to the new format and there was a planned timetable for the remainder to be completed within the next month.

The new records included a one-page profile of the person that included personalised information titled 'how best to support me'. For example, one person's profile stated, 'I like to be smartly dressed every day. Staff should encourage and promote my independence.' Another person's stated, '(Person) worries she's lost her belongings. Staff must reassure (person) that their belongings are safe.'

The new care records also included a section titled 'staying in control'. This clearly outlined how to enable people to make decisions in their preferred way and to ensure people were given choices. It detailed how information was to be given to the person to meet their cognitive needs and what time of day was best for them to make choices.

The people we spoke with did not comment on their own care planning but felt they had control over their daily routines and lifestyle. They told us they were "happy" with the care and support they received at the home.

In discussions, staff who were permanently employed at the home had a good knowledge of each person and were familiar with their needs, health, daily living skills and preferences. Relatives felt informed about any changes to their family member's well-being. For example, one relative commented, "Staff always call and let us know if there are any changes to discuss. They are great like that." Another relative said, "They do call if there is a problem or anything is wrong."

One activities coordinator was currently in post and the service had recently interviewed for a second full-time post. The service had an activities board which displayed the planned events for the week ahead. During this inspection some people were taking part in a parachute game. This was enjoyed by the participants who were laughing and encouraging each other to throw the balls higher. Some people were having their nails manicured.

The service provided a number of group activities including quizzes, craft and bingo. At this time there was no indication of individual activities with people who spent time in their room or specific activities based on people's previous interests. The manager stated this would be improved by the recruitment of the second activities co-ordinator.

There were some opportunities for people's social inclusion in the community. For example, some people were supported to the shops and some were accompanied to a local tea dance. During the two sunny days of this inspection there was no opportunity for people on the first floor dementia unit to access the gardens for some fresh air. Some people on this unit spent long periods walking the corridors and may have found the chance to go outside more purposeful and fulfilling.

In discussions people and relatives said they knew how to raise any issues. They told us they had no current reason for any complaints but if they needed to they would have no problem addressing this with staff or management.

There was information in the home's brochure about how to make a complaint. The complaints policy and procedure was also on display in the entrance to the building. The complaints records showed that one complaint had been received and had been fully investigated.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection February 2016 we found the provider had a breached a regulation relating to the governance of the quality and safety of the service people received. This was because the provider's systems had not been effective in assessing, managing or improving the safety or quality of the care service provided to people who lived there. During this inspection we found the quality assurance systems had improved, although it was too early to assess the effectiveness of the provider's new governance arrangements.

A director of quality and compliance had been appointed to support quality assurances processes. In March 2017 they had carried out a comprehensive audit of all aspects of the service which resulted in a 65-point action plan for areas requiring improvement. The action plan was being updated by the manager as corrective action was taken and would be reviewed each week by the director of quality and compliance to check continuous progress.

The director of quality and compliance had also put in place a schedule of audits for the manager to check the quality and safety of the service. These included audits of care records, medicines management, infection control, nutrition and dementia care. The manager had only been in post for four weeks so these audits had not yet taken place but were planned. The provider had also appointed a director of care who supported the management of the home, and a clinical lead who advised on health care.

The manager and senior staff completed a 'clinical governance report' each month that included an analysis of people health and well-being including any incidents, weight loss, hospital treatment and pressure care. The manager had introduced daily meetings with senior staff to ensure key information about people's needs was passed on and acted upon. Staff told us this had improved communication within the home.

Since the last inspection the previous registered manager had left and a peripatetic manager had covered the post until the new manager was appointed. The new manager had begun the process of applying to the Care Quality Commission for registration.

Staff told us the manager was approachable and accessible. They also commented positively on the improvements the management team were beginning to make. One staff member told us "I am happy with the new manager. I like working here." Another commented, "I really enjoy it here and have been here many years. We have had a lot of manager changes recently but I am happy with the new manager so far."

Relatives felt the manager was open and honest with them about staff practices, the staff mix and planned changes. The manager had held a meeting with people and relatives to introduce themselves. They had also involved relatives in discussions about changing the colour-scheme in the home and new carpets and floors were to be replaced as part of the long-term decoration plan. Relatives were positive about the planned improvements although felt the "proof is in the pudding".

At the time of this inspection new surveys for people had been developed by the provider and were to be sent to them soon. Relatives' surveys were also due to be sent out.

Staff meetings had been held for senior day staff and for night care staff. The minutes of the most recent meetings showed the manager had set out expected standards and practices around care records, use of agency staff and mobile phones. The provider had introduced 'policy of the month' messages so that all staff were regularly reminded of pertinent information. For example the most recent policy of the month was whistleblowing and bullying. Staff told us they felt able to raise issues and that these were listened to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected and promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Restrictions were in place that people had not consented to or assessed as in their best interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate training to ensure the health and safety of people who used the service.