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Firtree House Nursing Home

Inspection report

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Date of inspection visit: 18 and 20 March 2015
Date of publication: 12/06/2015

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



Overall summary

This inspection took place on 18 and 20 March 2015 and was unannounced on both days.

Firtree Nursing Home is registered to provide accommodation for elderly people who require nursing or personal care. The home provides care for up to 35 older people, some of whom are living with dementia. Accommodation is arranged over two floors. At the time of our visit there were 23 people living at the home.

At our previous inspections we had identified a number of concerns at the home. During this visit we saw that some improvement had been made, however from what we saw and were told, it was too early to say whether the home would sustain these improvements.

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 manager had submitted here application to the CQC to become the new registered manager.

Summary of findings

People were generally positive about the permanent staff saying they were kind and caring, but they were concerned about the numbers especially at the weekend when staff did not turn up. The management were looking at ways to manage this.

The provider had plans in place to improve the service and had employed a consultant to put the changes in place. Many of these processes were still being introduced, or had not yet had time to show that they were working.

The management of care and other important records around the home was not consistent. Information such as people's personal histories, recruitment files, and daily care records had gaps, which could mean that staff would not have the correct information available to give appropriate care.

Where people lacked capacity to understand decisions about their care the provider had not correctly followed the requirements of the Mental Capacity Act 2005. Assessments that we were told would be redone at our

visit last July 2014 were not completed correctly to show that where a decision had been made for someone it had been done in their best interests. Where people's liberty may be being restricted to keep them safe, the provider had contacted the appropriate agencies

People told us they had their medicines when they needed them, and since our last visit the management and storage of medicines had improved. The service needed to improve with regards to staff's knowledge of people's special dietary needs.

Staff training had improved. The provider had employed external trainers to provide practical training for staff. Some improvements were required to ensure all staff received training when it was due, and that training had been effective and staff had learnt from it, for example when learning how to use equipment.

We have identified three 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.

The provider did not have a robust recruitment process to ensure new staff were safe to work at the home.

People's risk assessments and care needs relating to mobility had not been updated in relation to accidents and incidents that had occurred at the home.

There were enough staff to keep people safe however relatives and health care professionals told us staffing at weekends was inconsistent.

People felt safe living at the home and staff understood their responsibilities around protecting people from harm.

Requires improvement



Is the service effective?

The service was not always effective.

Mental capacity assessments had not been completed correctly for people that needed them. Where people may be being deprived of their liberty to keep them safe, the provider had acted in line with legislation.

People did not always receive food that met their dietary needs.

Staff received training to enable them to support people. Training had improved at the home.

People received care and support from healthcare professionals when a need was identified.

Requires improvement



Is the service caring?

The service was caring.

People said the staff were caring, friendly and treated them with dignity and respect.

People and their relatives were involved in making decisions around the care they received however not all relatives thought residents meetings were useful.

Requires improvement



Is the service responsive?

The service was not always responsive.

Improvements had been made to activities, but these were group focussed and not based on individual interests or needs.

Care planning documentation was not up to date.

There was a clear complaints procedure in place. The complaints that had been recorded had been dealt with in line with the homes procedure.

Requires improvement



Summary of findings

Is the service well-led?

The service was not always well led.

Management of records was an issue across the home. The provider had not ensured that records were maintained and were in order.

People told us the home had improved, but there was still a long way to go. They said the management consultant was key to the improvements being made.

Quality assurance systems such as audits had been introduced. They were new processes, so there was little information to show that they had been consistently used to improve the quality of the service.

Requires improvement



Firtree House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 20 March 2015 and was unannounced on both days.

The inspection team consisted of one inspector, a specialist advisor and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone who has clinical experience and knowledge of working with people who are living with dementia.

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. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we spoke with four people who used the service, three relatives, two visiting health care professionals, five staff, including the deputy manager and the management consultant that had been appointed by the provider.

We observed how staff cared for people, and worked together. We used the Short Observational Framework Tool (SOFI) to try to understand the experiences of people we were unable to communicate with. We also five reviewed care plans and associated records and two staff recruitment files.

Is the service safe?

Our findings

People were mostly protected from avoidable harm. People told us that they felt safe living at the home.

The provider had not ensured that safe recruitment practices were consistently followed. Files for staff that had joined the service since our inspection in July 2014 had missing information. There were gaps in employment history in one file which had not been satisfactorily explained, or the reason recorded. Neither file contained a recent photograph of the staff member. A criminal record check had also not been completed for a volunteer who helped when people went out on day trips. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. **This is a breach in Regulation 21(b) 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.**

Over the two days of our inspection there were sufficient staff to safely meet people's needs. However we received feedback that the staffing levels were inconsistent. A relative told us, "Weekends are still an issue. During the week it is not so bad." Staff confirmed this to us. One said, "Before there wasn't enough staff, now we have enough numbers but the issue is staff calling in sick. There is an issue with public transport at the weekends, especially Sunday." A visiting health care professional told us that although people were happy, "The main theme is that there is a lack of staff at times". The manager told us that staff sometimes did not turn up for work and this impacted on the care being delivered. They told us they were looking into this and trying to address the problem.

The deputy manager and management consultant told us that staffing levels were based on the number of people living at the service rather than based on their individual needs. This meant that there was a risk that there were not enough staff to meet the individual needs of people at all times. **We recommend that the provider completes a dependency needs assessment to ensure they have enough staff deployed at all times to ensure people are safe.**

Staff were inconsistent in their approach to keeping people safe from avoidable harm. Whilst we saw some good

practice in relation to staff moving people appropriately using specialist equipment we also saw other occasions where people were moved in wheelchairs without footplates which could have caused an injury. We also saw that one person who wanted to walk around the home was asked by staff to sit down. We brought this to the attention of the deputy manager who said that that was not the appropriate response from staff, they should have supported the person to walk around.

Staff had an understanding of their roles and responsibilities if they suspected or saw abuse taking place. One said, "I would go straight to the person in charge. They would then call Social Services." They also knew that who to contact outside of the service if they could not raise the matter directly. Staff had recently had an update on their safeguarding training and we saw information available to staff on Whistleblowing which was clearly displayed on the wall in the office. Staff described to us how they kept people safe. One said, "I would read up on their needs, and get to know the person by talking with them, I would look at the care plans to see what risks had been identified."

The manager reviewed accidents and incidents. However these reviews did not consistently result in changes to people's care plans.

Assessments had been completed that identified risks of harm to people and then gave guidance on how staff could minimise the risk. Where specific needs of people had been identified an appropriate risk assessment was in place. For example where people required help moving a detailed plan had been completed to guide staff into how to move the person and minimising them being hurt in the process. The detail included information such as the size of sling to use and how to use it. Other identified needs included medical conditions and how the care provided would need to be given to support those needs.

Safety equipment around the home was regularly checked to ensure it was fit for purpose. Items such as fire extinguishers, and equipment used to lift people were all inspected and tested and in date. Staff would then know they were safe to use. Staff knew what to do in the event of an emergency. Personal emergency evacuation plans were in place for people. These detailed people's individual

Is the service safe?

support needs in the event of an evacuation of the building. For example their ability to respond or understand the alarm, and any equipment and number of staff needed help them get out.

People's medicines were managed in a safe manner. A relative said, "The medicine trolley round has improved. The nurse now stays and watches that people take their medicine. The consultant has brought the discipline." People were given their medicines in a safe way. When giving medicines the nurse administered to one person at a time which minimised the risk of people being given the wrong medicine. The nurse explained to the person what their medicine was, why they were there and asked if they would like their medicine. People were given choice to take their medicines themselves.

Information recorded around people's medicines was complete. Records in care plans matched with those on medicines administration records. These showed people received the right medicines, when they needed them, at the right dosage. A small amount of medicines were waiting to be returned to the pharmacy but had not been destroyed so that they could not be used by anyone else. This is especially important with controlled medicines, as their use, storage and destruction has to be strictly controlled to ensure they do not get used by people other than who they are prescribed to. It is **recommended that the provider reviews the NICE guidelines on Disposal of Old Medicines.**

Is the service effective?

Our findings

The process for how people's capacity was assessed was inconsistent. Care plans had mental capacity assessments in place which were completed as part of the initial assessment with the person and their relatives. Some recorded as people had capacity, so no further process was needed. However others were generic assessments, rather than an assessment for a specific decision, which did not meet the requirements of the Mental Capacity Act (MCA) 2005. For example where the provider recorded what decision was required that had prompted the assessments of someone's capacity it had been recorded as 'Person is presented with progressive vascular dementia' rather than an actual decision that needed to be made. We raised this issue with the deputy manager and the management consultant. They agreed they would review and update these records as soon as possible. A covert medicine form was seen in one room. However there was no capacity assessment in the file for this to record an assessment had been completed and a best interest decision had been made. Improvement is still needed in this area and the provider **is still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff had an understanding of the MCA. They understood that it was to protect people who may not be able to make decisions for themselves. They knew that other people could make decisions for them in their best interests, and that they could not make a decision for them without this process.

The deputy manager ensured that the Deprivation of Liberty Safeguards (DoLS) were followed to protect people. 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. Applications had recently been made by the deputy manager.

Staff told us that they felt supported by their direct line manager and the management consultant. Systems to support staff were still in the early stages of use so records did not yet detail enough information to show that staff support would be consistent. The majority of staff had at least one meeting with their manager since December

2014. The deputy manager and the management consultant told us that the target was for staff to have a one to one meeting each month however this had not yet been met. The system for staff appraisals had not started and was planned for June 2015. Some improvement is still required in this area to that staff are supported in their role.

People were supported by staff who had the skills and experience to meet their needs. It was noted that training on medicines for the nurses had been completed by all nurses except one on the night shift. The manager had set a number of dates to do this, but each had been cancelled for a variety of reasons. We found that pressure mattresses were incorrectly set which increased the risk of people developing a pressure sore. This had occurred as nursing staff had misunderstood the guidance chart provide for each machine. This shows staff's knowledge of this area needed improving.

Staff told us that the training was "Fantastic" and said "It's just what we need". Training had improved since our last inspection. One member of staff described their induction and how they were supported to become familiar with the people and systems in the service. They told us they had received a good induction which covered topics such as medicines, important documents relating to peoples care and how to manage accidents. Training was also provided to existing staff. Training was underway at the time of our inspection. It consisted of a number of sessions covering both theory and practical elements so staff would have the necessary skills to support people. Topics covered included communication, person centred care, activity and its link to better relationships with people who live here, equality and human rights and safeguarding people from abuse and correct recording skills if this is suspected. The training covered issues we had identified at our previous inspection.

Peoples identified dietary needs were not always consistently met. Where a need had been identified people had a food care plan in place. This gave information to staff on what sort of diet the person needed. Records matched with the initial assessment that had been completed when people first moved into the service, for example a soft food diet. This was seen to be given at the meal times for the people that needed it. However another person had a requirement for a low sugar diet. This was recorded in the care plan, and on the staff handover notes. Two staff and the chef said that no one was on any special diet (other

Is the service effective?

than soft food) when we asked. The person was seen to be served a sweet desert which was not suitable for a low sugar diet. We raised this with the deputy manager. Staff explained how they matched food to people's needs. For example, "If people are losing weight we would look at fortifying their meals, by adding butter and cream to potatoes." "We check people's weights every month. This is always discussed with the chef."

People received enough to eat and drink. A relative said, "The food is excellent and the choice is better now." People were given fruit juice and hot drinks throughout the day. People were asked if they had had enough to eat before staff removed their plates at breakfast. Lunch observation was a positive experience for people in the lounge. Lipped plates were used so people could eat independently and we saw staff sat with people and supported them to eat

where needed. Whilst most of the mealtime was a positive experience for people a small proportion of staff that were supporting people to eat did not interact with people. Staff explained how they ensured people had enough to eat and drink as they completed food and fluid charts. They told us people's changing needs were discussed at handover, for example one person was going to have liver one day a week to help with their medical condition.

Where a change in a person's health was noticed relevant checks were carried out to try to determine the cause. Care records identified that referrals had been made to health specialists to help people. For example specific departments within the local Hospital. Records showed people had regular visits to healthcare professions such as GP, and visits to the chiropodist. In addition people had access to the local dentist and an optician.

Is the service caring?

Our findings

One person told us, “This place is excellent; they keep my clothes clean and really care for me.” A relative told us, “The staff are friendly and personable. They do know my family member as a person.” Another relative said, “Carers are friendly and caring to my family member and me.”

Whilst staff were described as caring by people and relatives on the first day of the inspection there was limited interaction between them and the people that lived in the service. Some staff did not engage people in conversation however this improved on the second day of the inspection. The permanent staff knew people as individuals. Staff said they got to know people by talking to them. One said, “I speak to people, although some choose not to talk.” They were able to describe the history and interests of the people they supported. A visiting social worker said, “There seems to be a bit more interaction with staff and residents now.”

People’s needs were reviewed daily by staff during handover meetings. These discussed each person, their mobility, continence, risk, help needed and any notes that staff need to be aware of (for example changes in health).

People received caring support from the staff. When staff supported people into the lounge they moved at a pace appropriate to them. Other times staff asked if people would like anything to eat or drink, their order was then put into the kitchen. Staff went back and updated people on how long their food would take. Staff had a friendly attitude to relatives. They were seen to feedback to relatives about how their family member was. Two staff responded to a person’s request to wrap a present for someone’s birthday. They had got the wrapping paper and helped the person wrap the present which was given to the person on their birthday. During the celebration everyone made a fuss of the person and sang happy birthday to them. People were smiling and laughing and were really enjoying the event.

A ‘resident of the day’ system had been introduced which involved a review of an individual’s care records, and their

room being checked by staff. This would help ensure that people’s personal preferences and choices would be constantly updated, and that they were happy with their room.

Memory boxes have been attached to doors, along with pictures of people. Family have been requested to bring items in to populate the boxes to help people recognise their own rooms, and also tell a little about the person as an individual.

People said that they were more involved in expressing their views about the care and support but were unsure if they achieved anything. A relative said, “We have house meetings now, once per month. We have had four now. We can air ours views. However I keep hearing the same old thing, and am not sure how constructive they are, I have not yet seen much change as a result.” Staff told us how people were supported to express their views. One said, “I would talk them through what we were doing and ask if they were OK with what I was going to do.”

Information was given to people in a number of ways. Pictures of the staff were on display in the main lounge so that people knew who was looking after them that day.

Relatives told us they were able to visit whenever they wanted. They could see their family member in their bedroom if they wanted privacy, or go into the conservatory if they wished to talk away from the main lounges.

Staff explained how they would protect people’s privacy and dignity. Examples included closing the door and covering people when giving personal care, making sure curtains were closed in rooms so people outside could not see in. They also understood about protecting people’s confidentiality, for example by not talking about the people they support to others outside the home. Other examples of people being respected were seen when staff took the time to explain to someone why it would be good for them to use a clothing protector at lunch.

Is the service responsive?

Our findings

People told us that the service had become more responsive to their needs, however they did have concerns. One said, “I think the home is slowly improving. The new consultant manager is definitely the driving force, but I’m concerned that her days are being reduced.” Another relative said, “The consultant has introduced a better system of care planning documentation, but the documents are still a bit sketchy at the moment”.

People were involved in the planning of their care. Initial assessment forms were completed with important information such as family contacts, medical history, medical history, family history, dietary information included and assessed. This was done to ensure the home could meet the person’s needs.

Some care plans had been reviewed in January 2015. They recorded how each person was doing against each completed section. Care plans, had information such as people’s personal hygiene and dressing support needs. They talked about dignity and self-respect and ensuring people’s choice and opinions were considered. This was the only review at the time of our visit so there was not yet enough information to show that this would continue and be effective. A visiting health care professional told us, “The life story information and other information is still not quite there yet. We could see the person was involved in the care planning due to the answers that had been recorded.”

Staff gave us examples where they had responded to people’s changing needs. One said, “A person had stopped eating (gone off their food), so I sat down by them and ate my lunch. They picked up on this and did the same. I knew they could feed themselves.” This showed the staff member had responded to the change and worked with the person to maintain their independence.

People had organised activities on offer on Wednesday and Fridays, with a trip out to the coast or other community activity every month. People we spoke with confirmed that this had happened. A relative said, “We’ve been to Chessington for a cream tea; we’ve been to the garden centre. They have also been out with the home in a mini-bus. The next outing is to Crystal Palace.”

People enjoyed the activities when they took place. People smiled, laughed and sang along with the singing activities provided. ‘Pat the dog’ also proved popular with people.

More individual activities were on offer included knitting encouraged by the activities co-ordinator. However we found periods of time where no activities were available to people. People were sitting and staring with no one paying attention to the television or radio.

Staff told us they felt that activities for people could still improve. One said, “People had organised activities two afternoons a week, but very little else for the rest of the time.” They told us they wanted to be doing more with people. The management team said, “We have tried to encourage staff to think of activities that are more age appropriate, for example music that is played, but we are still at the stage of constant reinforcement of this message with staff.” Relatives also suggested that more physical exercise activities would benefit the people that lived here.

The service was responsive to people’s beliefs and religious needs. Staff were able to tell us the religious beliefs of the people they supported, and how these were met, for example visits by local religious groups so people could practice their chosen faith. Religious worship information was on display in the house which detailed when services would be held in the home. People would be able to take part if they wished.

Improvements had been made to make people’s rooms more homely. More people now had pictures on their bedroom walls and other sentimental items. The provider has purchased and installed specialist’s beds for everyone since our last visit. These better suit the needs of people that live here, as they are able to be raised and lowered to enable easier access into and out of the bed.

People were asked about how their complaints were dealt with. A relative said, “My concerns are the same as last time, but not as grave as they were due to the management consultant that has been bought in. The management of the home is key here.”

Care records showed when information had been shared with relatives, or relative’s feedback about the care, and the action that would be taken as a result. For example one person had highlighted an issue with their hearing aids and glasses. The response from the home was recorded along with the comment on what they would do to improve. This was being done when we looked.

Staff understood their responsibilities about dealing with complaints. One said, “I would ask what was wrong, and what we could do better, then discuss this with the person

Is the service responsive?

in charge. They would see the person and talk about how we could make things better. We have a book outside by the front door where people can write suggestions and we talk about issues at handover meetings.”

Information on how to complain was displayed for people to see. The complaints policy was posted on the wall in the

reception area. A record of complaints had been kept. These matched with incidents that relatives told us about. They recorded what action had been taken, for example meeting with the person who complained, and any action taken to try to resolve the issue.

Is the service well-led?

Our findings

The service did not have robust records in place. Across the home we found documents that were incomplete or had not yet been updated. For example care records had not all been updated to a new format. Information such as personal histories had not been completed and sections were left blank which included social activities, significant life events, and 'my appearance.'

Not all risk assessments had not been reviewed and updated. For example a care plan identified an issue with mobility, but the risk assessment section was blank on the new documentation. An earlier risk assessment was found at the back of the large file but the information had not yet been transferred over. Checklists used to record when a task had been completed were inconsistently completed. For example gaps were seen in daily care notes, and records of when cleaning had been completed.

Accidents and incidents have been reviewed. A checklist was in place to give staff the information to be able to complete the form correctly. However more recent accident forms had no entry by the manager to say they had been reviewed. Prior to the end of February 2015 they had been reviewed but no one had taken over in the manager's absence. This meant patterns of incident that may indicate a change in people's care needs could be missed.

The issues with the documentation meant there was a breach in **Regulation 20(1) 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.**

People felt the quality of care was improving however they still had concerns. A relative said, "So little has been put into the house over a long period of time, but it is definitely getting better. But if the consultant goes, I feel it will go bad again." A social worker said, "Improvements have included new flooring being put into a bedroom, and a sensor mat to alert staff when people get out of bed."

The consultant explained how they were working to improve the service. "We did a gap analysis when we started to find out what needed to improve. We have begun

to update the care plans, and these should be done by staff sitting with the people. We are now focussing on monitoring that things we have put into place are getting done."

Weekly reviews were held to see how the service was working. This generated a manager report which covered a number of areas of the home, such as admissions, accidents/incidents, pressure sores, safeguarding, and complaints. This enabled the management to see on a weekly basis a summary of what had been happening. The complaints review included checking to see if actions carried out had been effective. Records showed the action that had taken place, for example if a response letter had been sent, what the desired outcome was.

Quality audits were carried out or planned for medicines, the kitchen and other areas of the home, as well as people's weight charts, care plans, staff files. However not all of these had started at the time of our inspection.

Improvements that have been made since our last inspection included having an emergency box now in place, and having minutes of meetings on display. They had also updated and improved the induction programme for new staff. The complaints procedure had been further developed and improved. Important information such as the local authority procedures on safeguarding vulnerable people and choking were now to hand.

People told us that the culture of the home was improving, and they were able to give feedback about how the service was doing. They told us about relative and residents meetings that had now taken place, but said that it was too early to say if the provider listened to what they said and would take action.

A staff member said, "We are getting help. We have the consultant, who is great, and the deputy manager, who will listen. The culture is open and we all talk now. We all communicate at handover. We don't want this place to sink, we all feel the same."

The management consultant told us, "When I first came here there appeared to be a fear in reporting. I have put in a new accident and incident folder. We now seem to get much more reporting of incidents by staff, especially around pressure areas and looking at people as a whole

Is the service well-led?

(for example noticing changes). Staffs responsibility to report issues has been explained to them.” Staff we spoke with said they felt they could raise any issues with the manager.

Staff had a clear understanding of the values of the home. The deputy manager said, “During staff handovers and team meetings we talk about the values of the home. Staff are part of the family, and how they need to get to know the residents. Another staff member said it was everyone’s responsibility to “Treat everyone with dignity and respect. Give a good quality of life and respond to the needs of the people here. To give the life they deserve and want.”

Staff received feedback from managers so they knew what actions they needed to take. Staff meeting minutes showed that results of internal quality audits had been discussed. They highlighted the good things found, as well as the areas that still needed to improve, for example completion of records such as turning charts and key worker notes. Staff described how the consultant and deputy manager, “Have a walk about” to see what is happening and feed back to staff if they see something that needs to be changed.

An incident had taken place where an allegation had been made that staff had acted inappropriately. The provider had taken appropriate action to protect everyone involved while an investigation was undertaken. This sent a clear message to staff that honesty and transparency were important in the service.

The service had encouraged communication and feedback from people that lived here and their relatives. They had sent out a questionnaire asking for people’s feedback. People had responded but the results had not yet been analysed at the time of our inspection. The management told us that the intention was to also send a questionnaire out to staff, but this had not yet been done. A plan was in place to review the feedback that had been given, and send out the forms to the staff so they could give feedback on how well they thought the service was run, and where they thought it could improve.

People told us they thought the management consultant was doing a good job. The new deputy manager had only recently started so they had not yet formed an opinion of them. The manager, who had submitted their application to become the registered manager, was not at work at the

time of our inspection. One relative said, “The home just needs someone to manage it properly, be here every day, and have a proper routine and proper supervision. Sometimes there’s just no organisation.” Another said, “The new consultant manager is just the job. We need her here seven days a week.”

People said they were concerned that the home could easily slip back into its old ways without the presence of the consultant. One relative said, “If the consultant is allowed by the provider to finish the job by putting in the correct management structure and systems, we will be all right here. If she goes, I feel the home could go backwards to what it was before.” They raised concerns that the days the consultant visited had been reduced by the provider from five to one day a week. This was before the new systems and processes they had introduced were fully embedded and working in the home.

There were processes that had been handed over from the consultant to staff that were not effective. For example a review of care plans carried out by the consultant found a very low level that had been completed correctly. A later review carried out by a member of staff showed a very high level of care plans being completed correctly. The care plans we reviewed on the days of our inspection all had large amounts of information missing, so did not match the findings of the staff check. This shows that the management of the home still needs improvement as the systems to improve the home had already begun to not be effective as the consultants time was reduced at the home.

The deputy manager had been bought in for their knowledge and experience to assist the manager and to ensure that when the consultant was not there, standards were upheld. However the manager was not currently at the service so the deputy manager had to drive improvement as well as ensure day to day care was given. The issues we have found over the course of our inspection have shown that although the home has improved in areas, it is still struggling with management and leadership.

Staff told us about the meetings they had. They were able to raise concerns or suggestions to improve the service. This was recorded in the meeting minutes that we saw. They had only had two meetings so far and they said it was, “Early days to see if the provider responds to our suggestions.”

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 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	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>Regulation 21(b) Requirements relating to workers of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider had not ensured that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment</p> <p>Regulation 18 Consent to Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is corresponds to Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p>

This section is primarily information for the provider

Action we have told the provider to take

Regulation 20(1) Records of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17(2)(c) In Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured an accurate up to date record in respect of each service user was kept. Nor other records that were appropriate to the management of the regulated activity.