Stone Gables Care Ltd

Stone Gables 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 1 February 2016 and was unannounced. We carried out a comprehensive inspection in January 2015 and rated the service as requires improvement. At the last focused inspection in August 2015 we found the provider was in breach of regulation because they did not always manage risk properly. They did not have an effective system in place for staff to raise concerns about their workplace and the people they cared for. At this inspection we found the provider had taken action to address the concerns raised at the last inspection but they were still failing to appropriately assess and manage other types of risk.

Stone Gables Care Home provides care and support for up to 40 older people. The service did not have a registered manager. A manager had been recently appointed and told us they would be applying to register as the manager of the service. 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 we spoke with told us they were well cared for and were complimentary about the staff who supported them. They told us they felt safe, enjoyed the food and received good support with their health needs. Staff were friendly and kind. Visitors were happy with the standard of care and told us the service was caring. During lunch there were interruptions which were unnecessary and affected the meal experience for people.

Checks were carried out to help make sure some areas of the premises and equipment within the service were safe. However, we found there were some areas of risk that had not been checked, assessed and managed. People's medicines were usually managed effectively.

Staff understood how to safeguard people from abuse and were confident that the management team would deal with any concerns appropriately. Staff felt well supported and received a variety of training sessions including DVD's, external training providers and distance learning workbooks to help their development. However, knowledge around the Mental Capacity Act 2005 (MCA) was varied. Assessments and decision making processes where people did not have the mental capacity to consent did not always meet the requirements of the MCA.

The management team were improving social activities and the care planning process to make sure people's needs were identified and care was appropriately planned. People were being involved in reviewing their care needs.

There were enough staff to keep people safe although sometimes they were sat for long periods with little stimulation; the management team were monitoring staffing levels to make sure they were appropriate. We saw checks were carried out before staff worked at the service but the recruitment policy could not be located so it was unclear what procedure should be followed.

People were complimentary about the manager. The management team were being supported by an external organisation to help make sure they understood their role and responsibilities. Systems were being developed for monitoring the quality and safety of the service. People were informed how to make a complaint if they were unhappy with the service they received.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff knew what to do to make sure people were safeguarded from abuse and knew how to report concerns.

Checks were carried out to help make sure the premises and equipment within the service were safe. However, there were areas of risk that had not been checked, assessed or managed.

Staffing levels were sufficient to keep people safe. Arrangements were being introduced to make sure the levels met people's needs and continued to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and support to help them understand how to provide good care to people.

Key requirements of the Mental Capacity Act 2005 were not fully understood.

People enjoyed the food. Menus were not always followed and plans were in place to review these to ensure people received a varied and nutritious diet.

People received appropriate support with their healthcare.

Is the service caring?

Good

The service was caring.

People told us the service was caring and they were looked well cared for.

Staff were confident people received good care.

Spot checks were carried out to make sure staff were providing care in a safe and caring way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in the care planning process, which was being improved to make sure care was well planned.

People were offered a range of social activities; the provider was looking at how they could further improve these.

Systems were in place to respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

People who used the service and staff spoke positively about the manager.

An external consultancy service was working with the management team to help make sure they understood their role and responsibilities.

The provider was developing systems for monitoring the quality and safety of the service.

Stone Gables 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 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 1 February 2016 and was unannounced. Two adult social care inspectors and a specialist advisor in governance carried out the inspection.

We sometimes ask providers to complete a Provider Information Return (PIR). 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. On this occasion we did not ask the provider to compete a PIR.

Before the inspection we reviewed all the information we held about the service, including any notifications that were sent to us. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of our inspection there were 32 people using the service. During our visit we spoke with six people who used the service, four relatives, nine members of staff and the manager. We looked at areas of the home including some people's bedrooms and communal rooms. We spent time looking at documents and records that related to people's care and the management of the home. We looked at four people's care records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Stone Gables Care Home. One person said, "I have been here a long time and I feel safe." Another person said, "I feel safe." Another person told us, "There is no reason why I shouldn't feel safe; there is always a staff member about." A visiting relative said, "[Name of person] is safe."

Staff we spoke with told us good systems were in place to keep people safe. They told us they had received training to help safeguard people from abuse and training records confirmed this. Staff could tell us how to respond to any allegations of abuse. They were confident the manager would treat any concerns seriously and take prompt action. Information was displayed about 'safeguarding people from abuse' and a notice from the provider was displayed that stated 'any concerns-please contact me'; a mobile number was provided.

At the last inspection we found the provider did not have policies and procedures in place for staff to raise concerns about the care and treatment of people they cared for so had not done all that was reasonably practicable to mitigate risk. We observed one person was sat separately to other people who used the service. We asked why and were told this related to an incident with another person they lived with that had happened a few weeks earlier. The approach was not risk assessed and did not balance the rights and preferences of the person with their needs and safety. At this inspection we found the provider had taken action to address the concerns raised at the last inspection but they were still failing to appropriately assess and manage other types of risk.

Records showed weekly and monthly checks were carried out by staff at the home to help make sure the premises and equipment within the service were safe. However, we found there were some areas of risk that had not been checked, assessed and managed. Records for checking the safety of bedrails was not available. We looked at a risk assessment for a person using bedrails. This was not signed or dated. Only two sections of the assessment had been completed; there was insufficient information to show the risk was assessed and the person was safe to have bedrails in place.

We saw certificates for areas such as asbestos and fire safety equipment which showed external contractors had carried out tests and servicing. However, the provider was unable to locate the electrical installation certificate. The manager said a certificate had been issued but they could not find this so had requested another electrical installation check. We noted that the entrance from the dining room was used regularly, mainly by staff, to access the designated smoking area. When they went out they locked the door from the outside and this prevented anyone else from exiting the door unless someone unlocked it from the outside.

The manager told us a fire risk assessment had been undertaken in January 2016 and they were waiting for the written report. Records showed that some fire drills had been undertaken including one in January 2016 but we did not see evidence that all staff had participated in these drills. The home had up to date evacuation plans that detailed the assistance people would require in the event of an emergency evacuation. However, when we asked two staff where these plans were located. Neither staff members were able to tell us the correct location.

We looked around the home as part of our inspection, which included some bedrooms, bath and shower rooms, and communal living spaces. We noted that the home looked clean and there was a supply of personal protective equipment available, such as disposable gloves and aprons. In one room we noted a strong odour. The manager said this was being addressed. Some areas were pleasantly decorated whereas other areas looked tired and paintwork was damaged. The manager showed us a maintenance action plan for 2015/2016 which showed plans were in place to decorate and replace carpets, curtains and chairs.

Three internal doors had baffle handles. The doors had two handles fitted, one pushed upwards and one downwards so did not operate in the way people would expect. They were used to keep people safe but they also restricted people's freedom. The doors could be used as an exit route in the event of a fire. Some people would not be able to open the doors, which meant people were at risk of being trapped in areas of the home.

The provider had a number of systems in place to manage risk which included using risk assessments to help identify when specialist support was required. Records showed when people had accidents the service had requested support from other professionals such as the falls teams and occupational therapy services to help reduce the risk of repeat events. We looked at risk assessments within care plans for four people, which covered areas such as falls, pressure care and nutrition. However, we found these had not always being reviewed and updated as people's needs had changed. One person's risk assessment for their pressure area care was incorrectly scored in December 2015 and January 2016 so the risk was incorrectly assessed. Another person's assessment and care plan contained conflicting information around the type of diet they needed and it was unclear which was accurate. We concluded the provider had not done all that was reasonably practicable to mitigate risk. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although this is a repeated breach we have decided on this occasion not to take enforcement action because at the last inspection the breach of regulation 12 related to different areas of risk. You can see the action we have told the provider to take at the end of this report.

In the main, people we spoke with said there was usually enough staff. One person who used the service said, "There is usually someone to ask if I want a cup of tea." Another person said, "Usually there is enough but sometimes not. There is no agency at the moment and they have not had any for quite a while." One visiting relative said, "Always plenty of staff." Another relative said, "Sometimes there is enough staff sometimes not."

Staff we spoke with told us the staffing levels were generally sufficient to keep people safe although concern was raised that sometimes there were not enough staff to monitor the communal areas at all times. The manager said staff presence in the communal areas at all times during the day was recently implemented and they were monitoring this.

We observed staff in communal areas throughout the day although people who required assistance with mobility generally only moved from their chair if they were going to the hairdresser, to the toilet or to the dining table for lunch.

We looked at staffing rotas which were planned in advance and showed staffing levels were consistent. The manager told us they had a new dependency tool to help ensure the staffing levels were correctly assessed.

We looked at how staff had been recruited and found that checks were carried out before staff were employed, this included, proof of identity, references and Disclosure and Barring Service (DBS) checks. The

DBS is a national agency that holds information about criminal records. Staff completed an application form with details of their employment history. Two staff recently recruited did not have a contact of employment on file.

It was unclear what process should be followed in respect of obtaining work and character references. We asked to look at the provider's recruitment policy so we could see what procedure should be followed but this could not be located during the inspection.

We asked about checking criminal records where staff had been employed for a number of years and were told all staff would have had an initial check at the start of their employment but there was no policy in place for follow up checks. The manager agreed to obtain a copy of the recruitment policy and review systems for ensuring the right staff are employed.

People told us they usually received good support with their medicines. One person said, "I am not often in pain but I get medications when I need them." Another person said, "I have medication four times a day and I tell them if I don't get them. I can use my own inhaler." Another person told us, "They would give me extra if I am in pain." One person said they did not receive pain relief because they had been told "there was nothing wrong with me".

We looked at how people's medicines were managed and found, in the main, medicine management was effective. During the inspection we looked at medicine storage, medication administration records (MARs), stock and other records. Staff who administered medicines had received training and their competency had been assessed.

We looked at people's MARs and reviewed records for the receipt, administration and disposal of medicines, and found records were complete. We looked at a sample of medicine stock and found medicines could be accounted for. People had clear guidelines to show staff where any creams needed to be applied.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection some people were receiving controlled medicines. We looked at the contents of the controlled medicine cabinet and controlled medicines register and found some entries were incorrectly recorded. Two entries were unclear as they had been crossed out and one entry was calculated incorrectly. Although we eventually established the balance was correct the recordings had not been carefully checked which could result in medicine errors not being identified.

Medicines were securely stored in the medicines room. However, the medicine fridge was unlocked even though a notice stated it should be locked at all times. Items stored within the fridge did not have dates to show when they were opened. This could result in medicines being used longer than the recommended timescale which can reduce their efficacy.

The temperature of the medicine fridge was being monitored daily but the temperature of the medication room was not being monitored. The record had only been completed for five days during January 2016, therefore, we could not be sure that medicines were always stored at the correct temperatures. The manager said they would review the systems to ensure the problems we identified at the inspection were monitored more closely.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they received good support from the manager and colleagues. They said they had received training that had provided them with the knowledge and skills to do their job well. Staff said they discussed issues as they arose and received regular supervision where they could sit and talk to their supervisor. One member of staff said, "I used to have supervision every six months but it's more often now." Another member of staff said, "They do supervisions and spot checks and are checking and making sure we do our job properly." A supervision matrix showed individual and group supervision was taking place on a regular basis. The manager told us that annual appraisals were up to date.

The service used a variety of training resources including DVD's, external training providers and distance learning workbooks to help develop and train staff. We looked at the training matrix which showed mandatory training such as fire safety, moving and handling, and safeguarding was up to date. Staff had also participated in additional courses such as person centred care and dignity. The manager told us all staff had been enrolled onto a dementia training course and senior staff were booked to attend a full three day first aid course. One member of staff told us, "The training has got much better recently. I have really enjoyed doing it."

New members of staff were completing the Care Certificate, which is an identified set of standards that health and social care workers adhere to in their daily working life. However, a member of staff who was employed in November 2015 had only partially completed their induction even though the induction documentation stated it should have been completed within four weeks. The manager was supporting staff with the Care Certificate and said they were monitoring timescales for completion.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. (The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the inspection in January 2015 we found some people did not have documented records around their capacity to consent to care and treatment so we told the provider they must take action. At the inspection in August 2015 the provider had introduced new documentation including assessments for people who lacked capacity to make decisions, consenting to care summary forms and best interest decision checklists. Mental capacity assessments were completed and indicated what decisions people could make; however, sometimes information did not always match what was recorded in the person's care plan. At this inspection we found similar issues and found the provider had not taken action to ensure where people lacked capacity decisions were made in their best interest and involved their family members.

Two people received their medicines covertly (hidden in food without the person's knowledge). Best

practice guidance states that covert administration only takes place in the context of legal and best practice frameworks to protect both the person who is receiving the medicines and the care home staff involved in administering the medicines. We looked at the care plans for these two people around medication and found they did not contain sufficient information to guide staff on how to manage covert administration of medications safely and effectively. One person had information in their care file from the pharmacist which gave clear written instructions on how to give these medications but this had not been transferred to the care plan.

The provider had two different policies around covert administration; one had recently been introduced and made reference to the Nursing and Midwifery Council (NMC), which is the governing body for nurses. The service does not employ nurses. We also found it made reference to information which was out of date. The policy had an attached 'covert administration pathway' which staff had to complete. These documents had been partially completed for both people who received their medicines covertly but they did contain information about the type of medicine or method of administration.

One person's care records provided conflicting information about their capacity; one section said they were able to consent to care but another section said they were not. There was a record which stated a best interest decision was made in relation to bathing because the person resisted, however, we found there was a lack of information about the agreed decision and what other options were considered. Staff told us the person got distressed during showering and bathing but there was no reference to this in the care records. The person's care plan did not contain guidance for staff and notes around personal care were so brief we could not establish how care was being provided. One care record stated they preferred a bath; another said they had a shower. A Deprivation of Liberty Safeguards (DoLS) application had been submitted but this did not include all the necessary information to inform the application process.

We viewed four other DoLS applications that were pending and found these did not always accurately reflect the specific need of the individuals or how they were being deprived. Two applications related to the use of bedrails. Mental capacity assessments had not been completed to establish whether the person had capacity to make the decision and there was no information to show what other options were considered.

One person repeatedly asked to leave the service. We could not see that a decision specific mental capacity assessment had been completed around this and the DoLS application contained minimal information around what had been done to address these concerns and how staff could support this person so they had minimal distress. The majority of the application was around other aspects of the person's care.

Care records contained information to show the service had gained consent for areas relating to using photographs and care planning, however, often relatives had signed the forms without the service assessing if people could give consent themselves.

All staff had completed MCA training. However, we found staff knowledge around this subject was varied. One staff member told us, "I find it difficult to understand and don't really know what it means." No one was aware they could submit an urgent DoLS application if this was required. We concluded that staff were not acting in accordance with the MCA. This was in breach of Regulation 11 (Need to consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food. Comments included, "Food is nice and you usually have a choice of dinner", "Sometimes I enjoy the food, I love meat and veggies and I have this two or three times a week", "I get what I want. I like salad and I have this nearly every day and it looks nice", "There is plenty and it is hot enough, there is always choice", "Food is fantastic". A relative told us, "[Name of person] has put weight on

and is getting plenty of food. There is juice normally on the table and there are always enough snacks."

At lunch people were chatting between themselves and the atmosphere was pleasant. People enjoyed the food and were asked if they wanted anything else to eat. Hot and cold drinks were offered which included milkshakes. People were asked what they wanted to eat during the morning, however, when staff served the meals they did not always explain what it was.

During lunch there were interruptions which affected the meal experience for people. A staff member pushed a trolley with dirty laundry into the dining area. A staff member brought a vacuum cleaner through the small dining area into the lounge and started to vacuum even though two people were sat in the lounge eating their lunch. A fold up bed and frame were brought through the dining area. It was also very windy and when the door opened, some items blew off one of the tables. The manager said they would remind staff that the meal time should be a peaceful a relaxing experience for everyone.

We looked at the menus which were varied and offered a choice of meals. However, when we looked at the food records the meals served did not always match the menus. There were no teatime food records so we could not establish whether people were being offered the choices that were provided on the menu. The manager and cook told us they had already discussed reviewing the menus and were starting this shortly. The cook had information in the kitchen about people's special dietary requirements.

People we spoke with told us their health needs were checked and they received support from health professionals if they were unwell. One person said, "I go to the dentist sometimes." Another person said, "An optician comes here. I have just got some new glasses. The doctor is called if necessary, they are more safe than sorry." Another person said, "The GP does come." Relatives also told us people's health needs were met. One visiting relative said, "They ring me if [name of person] is not well, one morning they took her to the hospital when she was not feeling well."
Another relative said, "They would call the GP if needed. We have a dental appointment in April."

We saw from people's care records they had accessed a range of health professionals and included GPs, opticians, speech and language therapy, dentists and district nurses. All staff we spoke with were confident that health professional advice was sought promptly.

Good

Is the service caring?

Our findings

We received positive feedback from people who used the service about the care and support provided. Comments included, "It's alright, I like it. I am looked after well, very well seen to", "I would not be here if it wasn't nice", "I am looked after because they have to put up with me", "I am very happy here. Staff are friends with all the residents and they are marvellous with the people who cannot look after themselves", "I am very happy; I will give it 11 out of 10", "Staff know me well and if I don't appear on a morning they are there to make sure I am ok". One person said they had not been helped to the toilet the previous day when they had asked.

We received positive feedback from visiting relatives. They told us people were well cared for. Comments included, "[Name of person] seems happy enough. I do think she is well looked after and she is always well dressed", "[Name of person has settled in well", "I would have taken mum out before now if anything was wrong, I get on with all the staff", "Twice as happy and twice as good. Physical and mental fitness is 50% better than at home and she is eating and drinking properly". One relative told us, "People have moved round today, but that is very unusual. People sit in the same chair normally."

We observed staff were friendly, kind and generally responsive. One person shouted during lunch "will you come here please". A staff member immediately went to see the person and asked what was wrong. They said they wanted to go to their room and this was arranged by the member of staff.

The service had two lounges which were in close proximity; both were used throughout the day. Some chairs were positioned around the perimeter and others were back to back in a row in the middle of one room. Some people were not able to look at the TV and were facing the window where the blind/curtains were closed. It was difficult for some people to chat and observe what was happening. The manager said they would look at how they could create better seating arrangements.

People looked well cared for. They were tidy and clean in their appearance which is achieved through good standards of care. All the staff we spoke with were very confident people received good care. One member of staff said, "People are well looked after. The team do work hard and we care about our residents." Another member of staff said, "It's a nice place for people to live." Staff knew the people they were supporting very well. Staff were familiar with people's preferences, likes and dislikes.

People told us their privacy and dignity was respected. One person said, "I need help with a shower and staff come into my bedroom and close the door." Another person said, "Certainly my dignity is respected, I am well looked after." Staff told us they had received training to help them understand how to ensure people were treated with respect. Throughout the day we saw staff being respectful. For example, knocking on people's door before entering.

The manager had recently introduced 'spot checks', where they observed staff practice to make sure they were providing care in a safe and caring way. One member of staff said, "The manager checks we are wearing out PPE (personal protective equipment), looks at how we are speaking to residents and makes

sure we explain things. It's a really good way of checking we're doing things right."

Requires Improvement

Is the service responsive?

Our findings

The management team discussed the systems in place for assessing and planning care. They told us they were introducing a new format because the care planning processes needed to improve. They had found some care plans did not clearly identify how people's needs and preferences should be met. They told us people who used the service and their relatives were being invited to reviews and to be involved in the process.

Most people we spoke with told us they had been involved in a recent review. Three visiting relatives told us they had been involved. One relative said, "We had a care plan review last Thursday." Some people who used the service were unsure. One person said, "Not sure about a care plan." Another person told us, "I have a care plan and they make sure it is kept up to date." Another person said, "I think staff would know what I like."

We looked at the new style care plans and saw people had been involved in identifying their needs and choices. The care plans we reviewed contained information that was person centred and outlined how staff should deliver the care to make sure these were met. However, they also contained information about medical conditions and disorders, which was not person centred. For example, the care plan for a person who was living with dementia contained general information about dementia but did not identify how dementia was affecting the person. We saw one care plan referred to 'him' even though the person was female. The manager said they would continue to improve the care planning process and ensure people's needs were identified. They said they were reorganising the care files because it was difficult to locate some information.

We got a mixed response when we asked people about how they were supported to take part in social activities. Positive comments included, "I go out whenever I want to", "They throw a soft ball, have bingo and had a show at Christmas", "There is enough stimulation", "I have my book for stimulation. There is a trolley I can get new books from", "There was a lady in crafting last week and they have been playing games". Less positive comments included, "I just sit here watching the telly and am very bored. I keep getting up and walking around", "Some are like things you would do in infant school", "Activities on the board don't happen. They are there for people like you coming in to see. Once a fortnight a craft lady comes in", "[Name of person] does not join in because of the noise.".

An activity board displayed in the dining room had a range of activities displayed which included, jenga, musical activity, movies, ball games, quiz of the year, chair exercise, fit as a fiddle, board games, sing along with staff, music for health, skittles, bingo, board games and dominoes. On the day of our inspection we saw that a movie was playing in the main lounge and some people listened to music. A religious service was being carried out by members from a local church. A visitor from the church told us, "We come every other Monday."

Although some activity was organised, during the day we saw some people were sat for long periods with little stimulation and activity. The manager said they were in the process of recruiting an activity co-

ordinator and would be offering a more varied range of social activities.

People generally told us they would discuss any concerns or complaints with staff or a member of the management team. One person said, "I would tell the senior who is on and would tell them it is an official complaint and they should take it up with [name of manager]." A visiting relative said, "I would hope someone would do something if I made a complaint." Another relative said, "I would speak with the girls in the office." One person told us, "I'm not really sure I know what to do if I have grumbles."

When we looked around the home we saw that information was displayed to inform people about what they should do if they had any complaints although some contact details were not up to date. The manager was familiar with the complaint policy and told us they had not received any formal complaints in the last six months.

We saw the home had received some written compliments which included the following comments: 'A very heart felt thank you to you all', 'Thank you very much for the care you provided to [Name of person], especially the kindness and care you showed in the last few days. It is very much appreciated. It helped us enormously to know he was so well looked after'.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection the service did not have a registered manager. A manager had been recently appointed and told us they would be applying to register as the manager of the service. A new position of 'principle senior care worker' had been created to support the manager. An administrator also worked at the home. The manager and staff told us the providers visited nearly every day and, since the last inspection, had a more "hands on approach".

We received positive feedback about the manager from people who used the service and visiting relatives. Comments included; "[Name of manager] comes to talk to you and I am sure she is doing a good job", "The manager is approachable", "[Name of manager] is very good, she always chats, she knows who you are and who you have come to see", "The manager is lovely".

Staff we spoke with described the manager as approachable, hardworking and helpful. One member of staff said, "[Name of manager] is trying really hard and discusses everything with us." Another member of staff said, "The management changes are working out; they are doing well."

During the inspection the manager discussed changes they had introduced and went through plans they had to improve the service. In some areas it was evident the management team had a clear plan for development. However, it was also evident there were some knowledge gaps around other key areas. For example, the management team were unsure what events should be notified to CQC. There was a lack of understanding relating to some specific health and safety issues, and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The manager said they were developing these knowledge areas and were being supported by an external consultancy that specialised in social care. They said a consultant visited every two weeks to provide guidance and had helped devise an action plan. The manager said this support was "extremely useful".

Before the inspection we reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home since the last inspection. We noted the provider had notified CQC about some significant events such as deaths, safeguarding and serious injuries, however, they had not sent a notification of an authorised Deprivation of Liberty Safeguards (DoLS). The manager agreed to make sure any further authorisations were sent.

We looked at how accident and incidents were managed at the service. We found that records were comprehensive around accidents and a new form had been introduced that looked into trends. They used a different system for monitoring incidents. The manager told us that incidents were recorded straight into people's care files. This could include incidents between people who used the service and incidents where people went missing. There was not a system to identify any trends but the manager said they would introduce a similar system to the one they used for accidents.

The management team were completing regular audits which included mattresses, slings, care plans, medicines, accidents, environment and infection control. A Health and Safety audit had been completed by

an external consultant but the service did not have a copy of the health and safety audit. This meant they could not fully demonstrate the level of progress they had achievedalthough it was evident actions were added after the consultant carried out a visit. We could see that action points for all audits were being worked on by the management team.

The manager said they were developing opportunities for people to share views about the service. A weekly 'manager's surgery' had recently been introduced. A notice was displayed stating anyone could discuss their issues. We saw minutes from 'resident and relative' meetings where people had been asked to comment on the service although most people we spoke with said they had not been involved. A notice advertising a meeting in February 2016 was displayed. A notice asking people to comment on an external website was also displayed. The provider had issued surveys to people in March 2015, however, no action was taken with the returned surveys. The manager said they would carry out a new survey and ensure results were analysed and actioned.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure care was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risk.