RedHouse Care Limited

The RedHouse 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 comprehensive inspection took place on 7 and 9 June 2016. The inspection was unannounced following information of concern we had received.

The RedHouse Care Home provides accommodation, support and care for up to 36 people, some of whom live with dementia. There were 26 people living in the home at the time of our visit. The home is built on three levels and there is a lift between the floors. There are three communal areas on the ground floor where people can socialise and eat their meals if they wish.

Although our register shows a registered manager is in place at this home, this person has not worked in the home since March 2016.

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. A new manager had been appointed and commenced work in the home in March 2016. They had submitted an application to become the registered manager. Throughout the report we refer to this person as the manager.

Prescribed creams and as required medicines, lacked clear guidance and recording of their administration. While risks to people were known to staff these were not always clearly assessed and plans developed to reduce the risks. Some risks were known due to staff's personal experience rather than training and guidance. Consent was not always sought appropriately. Staff did not fully understand the Mental Capacity Act 2005 and did not implement this appropriately.

Care plans were not always personalised, although staff knew people well. Staff involved people but this process was not formalised and we have made a recommendation about this. People's nutrition and hydration needs were not effectively monitored and care plans did not always provide clear guidance to staff.

Systems used to assess quality and drive improvement were not effective as they had not been fully embedded and carried out early enough to take prompt action. The systems used by the manager and the provider had not always identified the concerns we had. Records were not accurate and the provider had not notified CQC of authorised Deprivation of Liberty Safeguards.

Staff understood their responsibilities in safeguarding adults at risk. We have made a recommendation that the manager review the way safeguarding investigations are recorded.

Staff had not been receiving the training and support they needed. The new manager was addressing this at the time of the inspection. We made a recommendation about this.

The manager had identified some concerns and had plans to address these. Staff spoke positively of the new manager and the changes they were making.
Staff treated people with dignity and respect. They understood the need for confidentiality. No one we spoke had any complaints but were confident to raise these and feel listened to. Staffing levels were sufficient to meet the needs of people and staff were recruited safely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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.

Medicines were not always managed safely.

Risks associated with people's care were not always assessed and staff were not provided with guidance and training in the management of these risks.

Staffing levels were sufficient to meet the needs of people and staff were recruited safely.

Staff understood their responsibilities in safeguarding adults at risk. We recommend the manager review the way safeguarding was recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not fully understand the Mental Capacity Act 2005 and did not implement this appropriately.

People's nutrition and hydration needs were not effectively monitored.

Staff had not been receiving the training and support they needed. The new manager was addressing this at the time of the inspection. We made a recommendation about this.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect. They understood the need for confidentiality.

Staff involved people but this process was not formalised. We made a recommendation about this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised, although staff knew people well.

No one we spoke with had any complaints but were confident to raise these and feel listened to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems used to assess quality and drive improvement were not effective.

Records were not accurate and the provider had not notified CQC of authorised Deprivation of Liberty Safeguards.

The manager had identified some concerns and had plans to address these. Staff spoke positively of the new manager and the changes they were making.

The RedHouse 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 7 and 9 June 2016 and was unannounced. We visited the home overnight on the 7 June 2016 and during the day on 9 June 2016.

The inspection team consisted of two inspectors.

Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This Information helped us to identify and address potential areas of concern.

During the inspection we spoke with three people. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We spoke to seven staff, the manager and the nominated individual of the provider.

We looked at the care records for four people in detail and sampled the records for a further five people. We looked at the medicines administration records for everyone. We looked in detail at four staff members' recruitment, supervisions and appraisals records. We reviewed the staff training records and the staff duty rota for the past four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

Prior to the inspection we gained feedback from a social care professional.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the home and thought staff cared for them well and knew their needs.

Records regarding the application of prescribed creams for people were unclear and inconsistently completed. For one person their records stated the cream was to be applied 'as required', and then stated 'needs to be completed daily.' The Medication Administration Record Sheet (MARS) indicated at times that this was applied twice a day. On a second person's MARS we saw they were prescribed a cream to be applied twice a day. However there were days when no one had signed to say they had applied the cream. For a third person who was prescribed a cream to be applied three times a day, a note on the record stated '[name] will only allow once daily after shower.' There was no evidence to show that this had been reviewed in light of the person's request. For two more people we saw they had been prescribed creams. Their MARS recorded 'to be used as directed'. There were no directions on the application records on how often staff should apply these creams or under what circumstances.

People were prescribed when required (PRN) medicines however protocols to guide staff on when these medicines may be required, their use and possible issues associated with using the medicine were not in place. For example, one person's MARS showed they were prescribed a controlled medicine for pain however there was no guidance for staff in the person's records about this. For a second person who was prescribed a medicine for the management of behaviours there was no guidance for staff in the person's records about this.

There were daily checks of both the medicines room and fridge temperatures, these were completed every day except for ten days between the 21 March 2016 and the 9 June 2016. Staff we spoke with were aware of the temperature ranges and these were displayed on the wall.

The lack of clear guidance and consistent recording of the administration of medicines and the temperature of medicines storage placed people at risk of not receiving medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely in a locked area. Staff told us that when medicines were changed or prescribed by the doctor either by phone or in person that two members of staff always listened to the instructions given to ensure there were no issues with communication. If the new information required a change to the records both members of staff signed to confirm the changes. Staff told us that medicines arrived each month and any partly used medicines were returned. There was a returned medicines record and the pharmacy signed and checked returns.

Risks associated with people's needs were not always assessed and plans developed to reduce these. Whilst staff knew people well and some were able to describe what to look for this was through personal experience rather than training and guidance. Care plans for people with diabetes contained no information on the person's normal blood sugar. They contained no guidance about what signs and symptoms staff should look for to indicate the person may be unwell. They gave no information to staff about any action

they should take if they felt people were experiencing ill health due to their diabetes. Some staff spoken with were able to describe this to us, however they told us this was based on personal experience rather than clear guidance and training. This placed the person at risk of not receiving the correct treatment.

A second person was being treated by the local community nursing team for a health condition. They received daily injections to prevent blood clots forming. Due to the medicines being given there was a potential risk of excessive bleeding should the person cut or hurt themselves. There were no plans available to identify the risks associated with this medicine or the action staff should take if the person was bleeding. Some staff spoken to were able to describe this to us, however told us this was based on personal experience rather than clear guidance and training. This placed the person at risk if staff did not recognise concerns and take appropriate action.

We identified some concerns regarding the fire safety of the building. A previous fire safety audit identified a number of actions that were needed but the provider was unable to demonstrate that these had been completed. We were concerned about one fire door which when closed did not provide sufficient seal. A second fire door, when it was opened for access did not close properly afterwards meaning it had the potential to be non-fire resistant. We referred our concerns to the fire safety service.

The lack of clear assessment of risks for people and measure to reduce these placed people at risk of receiving unsafe care and support. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other areas of risk management for people were much clearer although records needed to be improved. For example, for one person who was identified as a high risk of falls, accident sheets were being monitored and the manager advised that a referral to the community falls team had been made for advice. Two staff were observed supporting this person who wanted to maintain their independence, to mobilise using walking aids. At the same time they discreetly ensured a wheelchair was behind the person should this be needed. Whilst we saw staff taking this action the care plan did not state this. It stated that one staff member was needed with transfers but was not specific about the support needed for mobilising

For people who were at risk of skin breakdown, the care plans identified the risk but the actions to reduce the risk were not always clear and asked questions without providing answers. For example, one person's record said "one or more of the following should be considered". It then referred to inspecting the person's skin weekly or daily "as required", review mattress and seating surface and replace with pressure reducing alternatives as appropriate". This was not specific to the person. However, on discussion with staff they knew this information and what to do. They were able to confirm that pressure relieving equipment was being used. They showed us daily records which demonstrated the settings of these were checked.

Prior to our inspection concerns were raised with us about moving and handling practices in the home. The manager told us they had identified training in this area as a concern. All staff had since completed this training and equipment had been serviced and was safe to use.

Prior to our inspection we had received concerns that the staffing levels provided were not sufficient to meet people's needs. However, we found sufficient numbers of staff were available for people. People said they felt staff responded quickly if they needed them. Observations during both the day time and night time visits showed staff responded quickly to people's needs and requests, and had time to spend with people. The manager confirmed that if required additional staff would be provided to ensure people's needs were met. Rotas seen reflected a consistent level of staff was provided. The manager said they were recruiting and the number of staff working during the day had recently increased. The manager and provider confirmed a

dependency tool was not used to assess the number of staff required to meet people's needs. The manager confirmed they would be looking at introducing a dependency tool and staffing level policy.

Recruitment records showed that appropriate checks had been carried out before staff began work. Potential new staff were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place. People could be confident that they were being supported by staff who were safe to work with adults at risk.

Training records showed that only four of 34 staff recorded on the rotas had received training in safeguarding adults at risk. Staff did not understand the term 'safeguarding', however they were able to describe the types of abuse, the signs to look for and the action they would take if they suspected abuse was occurring. They were confident to raise concerns with the manager or provider and if they felt they were not responded to appropriately stated they would raise their concerns with external agencies. The provider policy provided clear guidance although this referenced old legislation.

We had received recent concerns which we shared with the local authority responsible for safeguarding. The manager was able to discuss with us how they had responded to this and the action plan they had started to develop and were continuing to work with the local authority around. This included training, record keeping and meetings with external professionals. We saw that the manager had made some changes to the daily recording charts to help improve this. However, this was not fully embedded into the home.

We recommend the manager review how they record any safeguarding matters and implement clear, measurable action plans following these.

Requires Improvement

Is the service effective?

Our findings

People told us they were given choices and felt staff knew how to support them well. They spoke highly of the staff and were complimentary of the food provided.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). 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 this inspection 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.

Staff demonstrated an understanding of the need for consent, although their understanding of the Mental Capacity Act 2005 was poor. Staff had not received training in this area and were not able to tell us what this was about.

Capacity assessment had not been undertaken and records of consent were in conflict with the principles of the Act. For example, one person's care plan described how they were aware of their rights regarding consent and withdrawing this, but then described how their advocate had given consent to sharing information and the use of photos. The advocate was not named. No signed consent forms were found. Their care records stated that they had fluctuating capacity and were unable to make certain decisions however no evidence could be found that this person's capacity to make these decisions had been assessed. An application for a DoLS had been submitted but no assessment of capacity had been undertaken first. Only a person with the legal authority can consent on behalf of another person. This person's records stated that there was legal authority for another to make decisions about this person's health, welfare and day to day care. The manager thought this was in place however, no evidence that any other person held the appropriate legal authority to make these decisions could be found. The manager told us they had audited this information and had asked relatives to bring in evidence if they have been granted power of attorney.

For a second person their care plan also stated that they were happy to share information with others but also stated their advocate had consented to this. The person who held legal authority had signed a consent to care, treatment and sharing of information form on the same date that the person themselves had signed a consent form regarding disclosing their information. If a person has capacity to provide consent, this should not be sought from others. This person was diagnosed with dementia and their care plans stated they had fluctuating capacity but these consent forms had not been reviewed since 2013.

This meant that the information recorded about people's ability to make decisions and provide consent could not be relied on, placing people at risk of not receiving the care and treatment they wanted or was in their best interests. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the unclear and conflicting records we did observe staff offering people choices and allowing them to make their own decisions. For example, at night some people refused to get undressed. Staff respected this, made people comfortable and told us how they would support them in the morning.

We saw a list of 21 Deprivation of Liberty applications (DoLS). It was not clear which had been authorised. Two people's care records recorded that they were subject to an existing Deprivation of Liberty safeguard. They recorded under the details section that a referral has been made to local authority but provided no other information. It did not describe what the DoLS related to or how this was to be managed by staff. For one person whose records confirmed their DoLS had been approved, the care plan gave staff no guidance about what this meant and what they should do. Staff we spoke with were unable to tell us what was meant by DoLS and did not know if they had been authorised. The manager had not notified CQC as per the Registration Regulations 2009, of the DoLS applications at the time of our inspection.

People told us they enjoyed the food and we observed that if people did not want what was on the menu they could choose something else. Where needed staff provided support to people to eat their meals however this support was not always consistent. For example, one person was not eating their meal and did not seem to know what to do with their cutlery. A member of staff offered them help which they accepted, however after helping with half of the meal the staff member left the room. The person then stopped eating their meal. Another member of staff entered the room and placed the person's pudding in front of them. The person started eating the pudding with their knife and fork and pushing it onto their dinner plate. After a significant period of time a member of staff offered this person support. This demonstrated that staff did not always provide the support people needed when eating their meals.

People had care plans in place regarding their nutrition and hydration needs. These detailed preferences, for example, traditional foods but lacked specific guidance for staff. For example, one person's plan described a small appetite and for food to be fortified. Monitoring records for people's food and fluid were used when staff were concerned about people, however they did not provide guidance to staff about people's ideal nutrition or fluid intake. They did not record any evaluation or action when fluid intake was a concern. For example, one person's fluid intake records showed minimal intake for a period of six days. There were no records to suggest any action had been taken to address this. The food records did not detail the amount eaten. Staff told us how they checked people's weight monthly and if they were concerned they would do this weekly. However records of people's weight were only available for the previous month. The manager told us that they had looked at people's weight from three months prior to them starting work at the home and had referred people to their GP where there had been a loss in weight, however they could not show us records confirming this.

A lack of clear guidance and effective monitoring meant people were at risk of not receiving the personalised support they required. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we had received information which raised concerns about staff training. The manager was open and transparent with us when discussing training, supervision and appraisal of staff. They told us how when they had started they had found this was not being completed. Training records showed minimal training had been given to staff to help them in their role. Staff had not completed mental

capacity training and they demonstrated a lack of knowledge in this area. The majority of staff had not completed any training about safeguarding, leaving people at risk of this abuse not being recognised and acted on appropriately. The manager told us how they were booking training for staff as a priority. They had arranged for all staff to complete first aid and moving and handling training. Records showed this was completed. They had engaged a college to work with all staff to undertake the Care Certificate and diploma qualification in health and social care. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Other training the manager had arranged since they had started their role included fire training, pressure ulcer prevention, urinalysis and constipation management. The provider advised us of an ELearning system they were purchasing which had not yet been set up for staff. One staff member told us about the lack of induction under the previous manager and the training they had undertaken recently since the new manager had started work at the home. They told us the new manager was trying to "catch staff up".

We recommend the provider formalise a plan to prioritise training for staff ensuring they receive this in an appropriate timescale.

Staff files we looked at showed no supervisions or appraisals had taken place in the last year. The manager said they had started to complete these and two staff said they had had supervision the previous month. They said they were able to talk about their feelings related to work, any issues, training and the care plans. The manager had produced a plan outlining the month staff were to receive a formal supervision for the rest of the year.

We found that other professionals were involved with people at the home for example a community psychiatric nurse visited two people, one for medicines to help them manage their mental health and the second because they were having trouble settling at the home. Staff told us how they would access the GP if needed for people. The manager told us how they had made referrals to the falls team for advice.

Good

Is the service caring?

Our findings

People spoke highly of the service they received and of the staff. They described staff as kind, caring and respectful.

People were treated with kindness, compassion and respect. Most staff in the home took time to speak with the people they were supporting. For example, one member of staff showed an interest and chatted to a person while supporting them with a jigsaw puzzle, while a second member of staff did not communicate with the person and appeared disinterested. We saw many positive interactions and people enjoyed talking to the staff in the home. Most observations showed staff had a caring attitude towards people. For example, overnight one person came into the lounge fully dressed and quite upset, the staff settled them in a chair, staff knelt down to be on their level, comforted them and offered them food and drink. They had a hot drink and drifted off to sleep, staff covered them with a blanket.

Staff knew people well and were aware of their preferences and needs. For example, staff knew how people liked to have their drinks and food. They knew what activities people enjoyed and who liked to win games. They told us this was important to enable them to get as many people involved as possible and to ensure people enjoyed themselves. When speaking to people staff got down to the same level as them and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them. People were encouraged to personalise their room. Relatives and friends were able to visit at any time.

Staff were knowledgeable and understood people's needs. We observed staff supporting people in the communal areas of the home and they interacted well with people. Staff explained what they were doing and gave people time to decide if they wanted staff involvement or support. Staff recognised when people required support and offered this discreetly. They spoke to people kindly and quietly, offering reassurance and respecting their choices. For example, we observed one person who was clearly uncomfortable in their chair. Staff quickly recognised this and offered the person support to their room. The person did not verbally communicate but indicated that they wished to walk. This was clearly difficult for the person and staff remained with them, offering gentle encouragement and reassurance. This approach helped ensure people were supported in a way that respected their decisions, protected their rights and met their needs.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in the handover records and discussed at staff handovers which were conducted in private.

People were not aware of their care plan and did not recall being asked how they liked to be supported. They did tell us staff always asked them before helping and gave them choices. People felt staff involved them. The manager confirmed that resident meetings had not been taking place and that this was something they planned to introduce to the home. Staff described how they knew people preferences, likes and history which enabled them to ensure care was delivered in a way that people wanted this.

We recommend that the service seek advice and guidance from a reputable source, about supporting people and their relatives to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

People felt cared for by knowledgeable staff. They said they got the help they needed and were able to see a doctor promptly if required. Staff had a good knowledge of person centred care and were able to tell us what this meant. They knew the people they cared for and the support they needed. They were able to explain what care and support was required for individuals.

Observations showed that people were involved in making decisions, however care records did not demonstrate how people had been involved in the development of their plans and people did not know they had a care plan.

People were confident staff knew how to support them and knew their preferences.
Care records included information about people's history, including their personal and medical history. Information about people's likes and dislikes was also maintained.

The new manager had introduced a new care planning system which had only recently been rolled out. They told us this was because they had found care plans and risk assessments to be non-existent or of poor quality when they started. They were unable to show us any preadmission assessments that had been undertaken and used to inform care planning.

The computerised system that had been implemented pre-populated care plans following completion of the individual assessments. The assessments had not been printed so staff were unable to see the content of these. The pre-populated care plans had not always been fully individualised to give sufficient guidance to staff. For example, two people's care plans regarding their personal care needs was worded exactly the same and had not been personalised. For another person a care plan regarding behaviour management said "[name] occasionally presents behaviour that can be predicted and managed by trained staff that are able to maintain a level of conduct." Staff could not tell us what this meant.

The manager told us that now they had implemented information onto the computerised system they would be spending time with senior members of staff to ensure these were personalised. They also explained their plans for regular reviews of care plans, to be undertaken monthly by the senior members of staff and every six months, a full review involving the person, their family and their keyworker.

The lack of detailed and accurate records placed people at risk of receiving care that did not meet their needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were occasions when the care plans had been personalised and we saw staff knew these and followed them. For example, one person had a health condition which could cause them discomfort. Staff recognised when the person was showing signs of discomfort quickly and took appropriate action in line with their care plan. This person was at risk of falls as well and we saw staff discussing with the manager how a move of rooms may support the monitoring and reduction of the risk for the person. Staff spoke

about the need to discuss this with the person and their relatives and planned to do this. We observed one person spent time gardening. Staff told us how this person enjoyed this activity especially during the nice weather. It was very hot outside the day we visited and staff ensured this person had plenty to drink and was wearing sun cream to protect them. Overnight we observed how staff supported people in a way that met their needs and wishes. This showed staff acted in a person centred way to ensure people were receiving individualised care and support.

The service had a complaints procedure. People knew who to talk to if they had a complaint and said they felt comfortable and confident to do so. No one we spoke with had any concerns. Staff knew how to support people to make a complaint and said they felt confident the new manager would listen and act on these. The manager and provider stated no complaints had been received in the last year and no records of any complaints having been made were in place.

Requires Improvement

Is the service well-led?

Our findings

Staff spoke positively about the service and the manager. They described the service as one which aimed to give people the best possible care.

Although the Commission's register shows a registered manager was in place at this home, this person had not worked in the home since March 2016. A new manager had been appointed and commenced work in the home in March 2016. They had submitted an application to the Commission to become the registered manager.

The manager showed us a care plan audit they had undertaken shortly after joining the service in March 2016. The care planning system had since changed and a further audit of care plans had not been undertaken. We identified some issues with care plans that an effective audit should have identified. We were not assured of the effectiveness of medicines audits. For example, the medicines audit dated 4 June 2016 identified no concerns with the recording of creams. However we had identified a lack of clear guidance and recording of these medicines.

Records were not accurately maintained and did not provide clear guidance to staff. For example, one person's care plans guidance about the support they required was not up to date. This person had been assessed as requiring care in bed. However, some records stated they were to be encouraged to join others at the table for meals and 'is now being assisted into chair to eat meals in room.' Another record described how the person would forget to use their walking aid. Although we saw staff caring for the person in bed to meet their needs any new member of staff reading the care plans would not be sure of what support the person needed. Whilst other health professionals were involved and accessed for people, their involvement was not well documented.

The manager told us about concerns they had identified since starting their role, including a lack of training for staff, the need for additional staff, unclear, inaccurate and poor records. We spoke with the nominated individual of the provider about how they assured themselves the manager was performing and using quality systems effectively. The provider confirmed they did not carry out any audits of the service although they visited at least twice a week. If they had they carried out effective audits they would have identified the concerns the new manager had at an earlier stage and could have taken action sooner to address these concerns. The provider expressed their confidence in the new manager and said they would look at the quality assurance systems. The manager had started to take action to address some of these concerns and make changes to the running of the home. They had sourced training in some areas for staff, had recruited additional staff, including activity staff and changed the system used for care planning. They had developed a plan for the year which included training needs, support and supervisions for staff, monitoring of people's weights and referral to other professionals where needed, six monthly review of peoples care needs and a move of their office to ensure they were visible to staff and people.

The lack of effective auditing and clear and accurate records placed people at risk of not receiving the care, support or treatment they required. This was a breach of Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Registered providers are required to notify the CQC of a range of significant incidents, which occur within the home. The provider did not ensure they notified CQC of authorised Deprivation of Liberty Safeguard applications. The manager confirmed that some of the application had been authorised. We had not been notified of these. The manager was not aware of the need to notify us and said they would ensure this was done in the future. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff described an open and positive culture in the home. We saw records of team meetings that had taken place since the manager had commenced their role which discussed changes to be made. Staff spoke positively about the changes being made. One said "Changing for the better." "We have had a lot of training we did not get that before. There have been a lot of staff changes for the better, my job is a lot different now, I am not just a carer, I have responsibilities.....I am really enjoying my job now, really brilliant." Staff told us that the manager made suggestions about changes and involved staff. One staff member told us how the manager had discussed the introduction of daily work/allocation sheets with staff. They then trialled the new record and staff fed back their thoughts. Staff said "We have work sheets in the morning now; staff are allocated to specific roles .....". Staff described the manager positively. They said the manager was supportive, listened and was open to suggestions. They all said they would not hesitate to talk to the manager or raise any concerns if they needed 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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission of authorised deprivation of liberty safeguards. Regulation 18 of the Care Quality Commission (registration) regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured all care needs were planned and delivered in an individualised manner. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured consent was sought appropriately. The principles of the Mental Capacity Act 2005 were not understood and applied appropriately. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured medicines were managed safely. They had not ensured risks associated with people's care had been assessed and plans developed to mitigate such risks. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured records were accurate and systems to assess quality and drive improvement were effective. Regulation 17(1)(2)(a)(b)(c)