Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Chapel House Care Centre

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**

Overall summary

This inspection took place on 1and 2 June 2015 and was unannounced.

We carried out an announced comprehensive inspection of this service on 8 and 11 November 2014. Breaches in regulations were found during this inspection. We also issued the provider with an enforcement action against one of the regulations.

We undertook a focused inspection on 17 February to check if they had met the legal requirements relating to the enforcement action. Although some improvements had been made, the enforcement action had not been fully met and was subsequently repeated. The provider was told to meet this by 13 April 2015.

This inspection followed up on all the outstanding legal requirements as well as the repeated enforcement action. Although at the time of the inspection we found there were still not enough staff to meet the needs of those using the service, this was improved straight after our visit. We therefore found the service had met all seven legal requirements as well as the enforcement action.

Summary of findings

On 1st April 2015 the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 came into force. We found one breach of these regulations; the provider had not made sure staff had adequate training to equip them with the skills and knowledge required to meet some people's needs, predominantly those who lived with dementia. You can see what action we told the provider to take at the back of the full version of the report.

We also made two recommendations which relate to maintaining optimum staffing numbers and sourcing appropriate support to improve the service's ability to achieve better outcomes for those who live with dementia.

The service predominantly cared for older people who lived with dementia and could accommodate up to 41 people. At the time of the inspection 12 people in total were cared for.

A new manager had started in post four weeks prior to the inspection. They were not yet the registered manager of the service however; they were making arrangements to apply to us. 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.

We found the service had generally improved since the last two inspections. People were safe because risks relating to their health and care had been identified and were appropriately managed. This included the safe use of equipment to meet people's needs. People were protected from abuse and their human rights were upheld. Environmental risks were managed and any shortfalls were addressed. Accidents and incidents were monitored and actions taken to try to reduce reoccurrences. Improvements in staff recruitment practice ensured people were protected from those who may not be suitable to care for them. Improvements had also been made to how people received their medicines and in how staff received guidance for the use of some specific medicines.

The new manager had identified the needs to improve staff training and was making plans to address this as soon as possible. They had made more immediate arrangements to increase the skill levels in the home soon after our visit. The new manager was meeting with staff so they were clear about their roles and responsibilities. Best practice was being promoted and advice was sought from other professionals when needed. People had access to health and social care professionals in order for their needs to be met. People who required support with their eating and drinking had received this. People who lacked mental capacity were protected against discrimination and poor practice because the service adhered to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). A lack of visual adaptions meant some people found it difficult to make sense of their surroundings.

People were cared for by staff who were kind and well meaning. People were treated with respect, dignity and afforded the privacy they were entitled to most of the time. Some staff were better at giving explanations and guidance to people, in a way that they could understand, than others. People who mattered to those who were receiving care were supported and made to feel welcomed. Some people's independence was supported better than others.

Improvements had been made to people's care plans and these now provided staff with better guidance on how to meet people's individual needs. People's individual life histories, preferences and wishes had been explored with people's representatives and recorded. This information was not always used effectively to personalise people's care.

Opportunities for people to take part in activities were provided but with limited resources. The purpose and benefits of supporting meaningful activities were not fully understood or appreciated by all of the staff. This was demonstrated in the approach taken by some staff during the inspection.

There were opportunities for people to express their concerns or to make a complaint and the new manager told us these would be listened to, taken seriously and investigated.

People lived in a service where improvements to how it was being managed had been in place for four weeks.

Summary of findings

The actions being taken by the new manager were therefore either in their infancy or not yet underway. The full impact of these improvements could therefore not be fully assessed.

The culture of the home had improved and staff were happier, generally more supported and included in discussions about how the service was going to be run in the future. The new manager practiced an open and transparent style of management and they were communicating their visions and values to the staff and to people's representatives. People's representatives were to be included in decisions about how the service moved forward and were being encouraged to give their ideas and feedback. There was support for the new manager from the staff and people's representatives.

Local arrangements for monitoring the quality of the services and care provided were to be improved by the new manager so they could develop and implement necessary improvement actions. Support was being given to the new manager by their immediate line manager who was working alongside them to make improvements in how the service operated. It was however also up to the provider to support these actions and to ensure the management team had the necessary resources to sustain future improvements.

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?

Requires improvement

The service was not always safe.

There was not enough staff in number to meet the needs of the people who had been admitted to the home. However this was addressed by the end of this inspection.

Staff recruitment practices had improved and people were protected from people who may not be suitable to care for them.

People were protected from abuse and their human rights were upheld.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected against risks that may affect their health, safety and well-being.

Is the service effective?

Requires improvement

The service was not always effective.

People's needs were not always appropriately recognised or met because staff lacked effective relevant training to gain the appropriate knowledge and skill to do this.

People's rights were protected under the Mental Capacity Act (2005) because staff adhered to the legislation.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

People's health care needs were met because the staff sought advice and input from appropriate health care specialists.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and well-meaning.

Staff were aware of people's likes and dislikes and tried their best to accommodate these.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires improvement

The service was not always as responsive as it needed to be.

Summary of findings

The needs of people who lived with dementia were not fully recognised or understood, so the service was not always able to be responsive to these.

People did have opportunities to socialise and partake in activities but these were not always activities that were meaningful to the individual person.

People were supported to make simple day to day decisions about their care as well as other daily activities. Where people were unable to do this their representatives had been given an opportunity to tell staff about people's preferences in relation to their daily activities.

Care plans were in place for staff guidance and the care was delivered in line with these.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires improvement

The service had not been consistently well-led.

People had benefited from a competent manager being in position for only four weeks. Improvements therefore had already been made but the management team and the provider still needed to demonstrate that these could be sustained.

There were arrangements in place to identify shortfalls. However, some audits had not been completed fully since January 2015 and others needed to be introduced to make the system more effective.

An open, transparent and inclusive culture was being promoted and people and staff were responding positively to this approach.

The new manager was actively promoting best practice and seeking advice to achieve this where needed.

Chapel House Care Centre

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 and 2 June 2015 and was unannounced. It was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. In this case, this person had experience in looking after people who live with dementia.

Before the inspection we reviewed the information we held about the service. This included information about significant events reported to us by the provider. We gathered information from the local County Council who commission the service.

During the inspection we met and spoke with seven people who used the service. Some people we met were unable to tell us much about their experience of the service because they lived with dementia. We therefore gathered information about these people's experiences in other ways. We observed interactions between them and the staff and how they spent their time. We spoke with two visitors and seven members of staff. We spoke to one visiting health professional. We reviewed the care records of nine people. These records included their care plans, risk assessments and medicines administration records. We looked at additional care records such as weight monitoring and food intake charts.

We reviewed four staff recruitment files, the training certificates of two members of staff and the service's staff training record. We reviewed a selection of records relating to the management of the service. These included a selection of audits, maintenance records and accident and incident records. The service's registration certificate and the rating awarded to the service at the last inspection in February 2015 was on display.

Requires improvement

Is the service safe?

Our findings

People did not always receive an appropriate level supervision and support. There were not enough staff on duty to provide this. For example, on one occasion people were left without staff present for 25 minutes. Three people became distressed and agitated and this resulted in verbal conflict between them. Staff were not present to first prevent the situation from happening and then to respond to people's distress. The two staff designated to look after these people had been providing help to others with their personal care. Other people, already up for the day, were also unsupervised at this time. Relatives spoken with said, "We frequently have to find staff if someone is calling out" and "I have looked for staff on many occasions when help is required, they are difficult to find sometimes". A member of staff said, "We don't have time to do the best we can".

One person required additional support from staff. The manager confirmed this was being provided at certain times of the day. However, staff told us this person often required additional support at other times of the day and night. They told us it was sometimes difficult to provide this and ensure other people received the attention and support they required with the numbers of staff on duty. The new manager was aware the staffing levels required a review and there needed to be enough staff to meet people's needs. The day after the inspection visits the manager confirmed that the provider had agreed to an increase in staff numbers during the day time. Adjustments to the person's medication at night had taken place and their needs at night would be further monitored.

We recommend that the service seek advice and guidance from a reputable source, about how to continuously assess for and maintain optimal staffing levels according to people's needs.

People were not fully protected against the potential spread of infection. For example, one member of staff was observed carrying uncovered dirty laundry through a communal area instead of placing it in the appropriate laundry containers. The manager told us staff had already been reminded to use the laundry containers in order to prevent the spread of germs. The manager told us she would continue to ensure staff were provided with appropriate guidance and training on infection control.

People were protected from abuse because the staff had been provided with training on how to recognise abuse and knew how to report allegations and incidents of abuse. The provider's company policy and procedures on safeguarding people was present and accessible to staff. The manager and other senior staff also knew how to report or discuss safeguarding concerns with relevant professionals in the local County Council. Concerns relating to safeguarding people were therefore shared with appropriate agencies who also had a responsibility to safeguard people.

People were also protected from those who may be unsuitable to care for them because staff recruitment records showed that the appropriate checks were carried out on staff before they started work.

Assessments were carried out in relation to people's health risks. For example, the level of people's risk of developing pressure ulcers had been assessed. Depending on the outcome of the assessment, people had been provided with the appropriate care and treatment. For example, a pressure relief mattress, cushion and help to reposition themselves so pressure ulcers did not develop. No-one had a pressure ulcer at the time of the inspection. Some people had specific risks which staff needed to be aware of in order to keep them safe. For example, the risk of falling or falling out of bed. These risks had been identified and appropriate actions had been taken to reduce potential harm to people. Bed rails had been removed and alternative actions taken where it had been assessed bed rails were not appropriate to keep people safe. For example, as an alternative to bed rails they had been provided with a bed that almost lowered to the floor and safety mats. These were placed alongside the bed to break any potential fall from the bed.

Accidents and incidents were monitored by the manager in order to identify patterns and trends. This included, the circumstances leading up to someone's fall, the time and location of the fall or incident. This information helped staff put strategies in place or alter current strategies to help avoid a reoccurrence.

Arrangements were in place to minimise risks from the environment and from the equipment used. For example, a fire safety risk assessment had been completed and appropriate contracts were in place with external companies to check fire fighting equipment and fire detection systems. Moving equipment such as hoists were

Requires improvement

Is the service safe?

regularly checked and maintained by appropriate contractors. There was no contingency plan for untoward emergencies which the management team were aware of and told us they would address.

People's medicines were managed and administered safely. We found an improvement in how the medicines were received into the home and in how they were stored. Stock levels were monitored and any excess stock had been returned to the Pharmacy. Records were maintained accurately. The manager had carried out two medicine audits which we reviewed. Actions required to further improve the system had been identified and the manager was addressing these. These had already included; staff who administered medicines had been reminded of their responsibilities in relation to accurate record keeping and best practice during and after administration. Medicines which had been prescribed to be used "when required" now had additional guidance in place for their use. For example, some of these medicines had a sedative or calming effect. The guidance prompted staff to consider other interventions before they resorted to administering the prescribed medicine. The manager intended to continue the medicine audits, which were fortnightly, until they were confident that improvements had been fully sustained.

Requires improvement

Is the service effective?

Our findings

Staff were not provided with an appropriate level of training or support to meet the needs of the people in their care. In particular the needs of people who lived with dementia and some people's more complex needs. The training record showed the majority of the 26 staff had received basic training in subjects such as safe moving and handling, health and safety, food safety and safeguarding adults. This training had been delivered through a combination of workbooks with some face to face training. However, the new manager confirmed that most staff had not received an adequate induction training.

Although staff had recently received a training session on dementia care, we found their awareness of the support people who live with dementia require was poor. For example, the verbal conflict between three people in the lounge was triggered by a day time television program known for its content of verbal conflict and strong language between the people taking part. Staff had not considered, prior to leaving these people unsupervised, that the content of this program may potentially act as a trigger for distress. No-one in the room was engaged in watching the television program but it was left on. Subsequently people reacted and responded to the conflict they could hear around. This in turn triggered responses from others seated in the lounge.

Other basic subjects required by staff to be able to carry out their tasks safely had only been signed off as completed, at a satisfactory level, for a few staff. For example, only seven staff had completed infection control training, six had completed first aid training, and eight had completed fire safety training. Only six staff had been signed off as completing training in managing challenging behaviour and four staff in studies relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. The manager was aware there needed to be an urgent improvement in the provision of staff training. Specific gaps in training and knowledge were already being identified by the manager working with staff and would be further explored in staffs' one to one support sessions. The manager had already started to plan how to implement the new Care Certificate (a nationally recognised set of standards designed to support care workers at the beginning of their care careers to deliver to provide compassionate, safe and high quality care and support). They told us all new staff would be supported to achieve this as well as some existing staff who required support to improve their basic knowledge of care.

This evidence demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia

People unable to provide consent for their care and treatment were protected under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission monitors the implementation of the Mental Capacity Act 2005 and DoLS. These safeguards ensure that people who lack mental capacity are lawfully deprived of their liberty in order for them to be kept safe or to receive the care and treatment they require. Staff explained that people's ability to give verbal consent varied. Some people gave implied consent, meaning, rather than verbally giving consent they demonstrated consent through their behaviour or actions. Where people had been unable to provide consent for significant decisions, such as being admitted to the care home, records showed that the appropriate process had taken place to do this lawfully.

Best interest decisions had been made and recorded in people's care records. In the case of two people best interest decisions had been made by suitably qualified people that they needed to remain living at the home so that they could receive the care and treatment they required. Referrals for DoLS authorisations had subsequently been applied for. In the case of one other person, who had previously required a DoLS authorisation, staff explained this person had settled and was no longer expressing or showing a wish to leave the home. This authorisation had not been extended by professionals from the local supervisory body (the County Council). The manager was aware of her responsibility to constantly review people's levels of supervision and control and to complete a DoLS referral if needed.

People had access to health care professionals and other specialists when required. For example, one person had been reviewed by a speech and language therapist (SALT)

and the type of diet they had received had been reviewed. However, for one person, a thickener for drinks had been recommended to be stopped by SALT but had still been given by the staff. This lack of communication about a change in a person's care delivery was fed back to the manager who told us they would find out why this had happened and address it. Another person was waiting for a review by a SALT. An occupational therapist had helped staff review the use of bed rails for some people. One person had additional equipment put in place to stop them being injured by bed rails which, in this case, had been assessed as still being appropriate.

People were receiving regular visits from their GPs as well as additional visits when required. A GP visited one person to review the current state of their mental health and to alter their medicines. This person had transferred from one mental health team to another and a lack of communication between the two teams had resulted in a delay in this person being reviewed by mental health specialists. The staff had identified this and had made efforts to get this addressed. The manager and GP discussed this during the inspection and better arrangements were to be put in place so people could more quickly receive the reviews they required in the future. In the meantime the person's GP was attending to the person's immediate needs.

People had been given the support they required with maintaining a health nutritional intake. Risks relating to people's nutrition had been identified and addressed. People's weights were monitored and GPs were made aware of any nutritional concerns. We spoke with the cook who was also aware of who was losing or gaining weight. Food was fortified with additional butter and cream when people needed extra calories and snacks were provided in-between meals. People had access to frequent drinks and those who required their intake to be monitored more closely were having this done. Meal times were relaxed. However there were no visual clues about what was on offer to eat or what had just been chosen. For example, pictorial menus that could be used to support people to make choices and then help them remember what they had chosen. One person gave their food order but after the staff member left asked if they had chosen something nice. Other people around them could not remember what they had ordered or what the person had ordered.

Some adaptions to the environment were in place to help support people. For example, each bedroom was fitted with a motion sensor. If people were at risk of falling or being disorientated at night, the sensor would alert staff for example, that the person was up out of bed. Staff could then respond and potentially prevent a person from falling or becoming distressed.

The area of the care home designated for the care of people who live with dementia was not "dementia friendly". For example, it offered very few visual clues to help people orientate themselves and make sense of their surroundings. General adaptions had been made, for example, as in other parts of the home; the bedroom doors displayed a picture of the person and their name. Toilet doors had a pictorial sign as well as the word 'toilet' on them. On this floor, in people's personal toilets, a more specific adaption had been made; a different coloured toilet seat helped those with poor eye sight and altered perception to distinguish the white toilet seat from the white toilet pan and the floor. However, the main toilet area on this floor, used in the day by most people, did not have an adapted seat. A member of staff told us that this did impact on one person's ability to use the toilet appropriately.

A seating area between these corridors had nothing to encourage a person to break their journey when walking through the corridors and partake in an activity. There were no items of nostalgia to look at or touch, no pictures of interest or other artefacts that would encourage investigation or which could be used for an activity. The lounge again, lacked any items that could offer a different sensory experience or activity apart from a television. A few books on a book shelf were all in small print and no games or other items of interest were on display. One member of staff who had some good ideas on how to improve this said they had been "blocked" when they had suggested having artefacts about and putting more meaningful pictures on the walls. Another person asked on many occasions "what day is it", a simple orientation board to provide such information, in different formats, such as the date, day and what the weather was doing may have helped to reduce their repetitive anxiety over this.

Information on a board in the dining area appeared to be more for the staffs' benefit and not representative of current thinking in dementia care. It referred to 'wandering' and people who required feeding. A poem had been put up

Requires improvement

Is the service effective?

on the wall but it was in very small font with continuous text. It was unlikely that the older people in the unit with poor eyesight and cognitive impairment could have read this.

Good

Is the service caring?

Our findings

When we asked people to describe how the staff were towards them. Comments included, “The staff are very kind”, “They do their best” and “They are good girls”. We found staff were kind and well-meaning in the way they approached people and in how they interacted with them. Staff were respectful towards people and they recognised people’s needs in relation to their age and frailness. For example, some people required more physical help than others; some required patience and things done in a slow pace.

Staff spoke to people in a kind and caring manner. They gave people time to answer and sometimes adjusted the way they spoke to them in order for them to understand what they were trying to explain to them. One member of staff made a particular effort to alter how they spoke to a person when they needed to explain something. In this case they spoke in the dialect of the region the person had grown up in. This resulted in the person showing signs of visibly relaxing and smiling broadly in response.

We found staff usually ensured people’s privacy when for example they delivered personal care by keeping bedroom and bathroom doors closed. Staff knocked on doors and waited for a response before entering. If people did not respond staff entered in a polite and respectful way. However we did observe, a person who had expressed a wish to have a shave being brought his razor into the dining room, and being prompted to shave in view of other people. This compromised this person’s privacy and dignity. Relatives were provided with space and privacy when they visited. They and friends were able to visit at any time unless restrictions were in place to safeguard a person. Guidance was in place for staff to follow in these situations.

Staff were familiar with people’s likes, dislikes and preferences and they generally aimed to support these. Staff involved people in making simple day to day decisions, for example, about what they wanted to wear, eat and do. Where people wanted to be alone or independent they were supported to do this safely. Staff were equally aware of the risks of social isolation and had arrangements in place to address this. For example, one person had spent most of their time in bed in the past. Over a period of time staff had encouraged the person to join others for a meal and to sit with others. The person had grown to enjoy this but on some days still wished to remain in bed. On these days the staff accepted this as being the person’s choice on that day.

People who mattered to those that were receiving care were made to feel welcomed. They had opportunities to eat with their relative and join in activities with them. This helped to give them quality time with their relatives.

Requires improvement

Is the service responsive?

Our findings

One of the provider's stated aims and objectives within the service's literature was to "provide a variety of meaningful activities for all clients". One member of staff was responsible for the provision of activities. They were very enthusiastic about improving this provision and include activities that were meaningful to individual people. We found they were trying hard to provide activities with limited resources and other staff had a limited understanding about the benefits of meaningful activity. This resulted in some people's needs in this area being better met than others. For example, one person was given support to enjoy the wider community, such as visiting the shops and hairdresser. It was documented in their care plan that this would take place in order for the person to have some independence and improve their well-being. However, another person who lived with dementia, wanted to wash up the tea cups that had just been used. This person said twice, "I can do that for you". Staff responded by diverting the person to go and sit down. Staff missed the opportunity to engage this person in an activity that was meaningful to them and which would have given them a sense of purpose and self-identity. There was one good example of a small memory box which contained some of a person's favourite items collected over the years. The person enjoyed, several times over, emptying this, touching the items and putting the items back in the box. This however had been provided by a relative in order to prompt conversation and give the person a meaningful activity. This relative was concerned about the lack of stimulation available.

The manager was aware of a need to review how activities were organised and promoted in the home. They were aware of a local forum, which is held for staff who have responsibilities in co-ordinating activities. They told us they planned to support the activity co-ordinator's involvement in this forum. This would provide the activities co-ordinator with support in helping other staff to understand their wider role in providing meaningful activities. People were being supported by the activities co-ordinator to plan personalised activities and outings. One relative visiting at the time was engaged in supporting their relative to be involved in this.

People had care plans which outlined their needs and how support and treatment would be given to address these needs. The care plans were stored electronically and staff had access to these. Staff confirmed they read people's care plans. Improvements had been made to the content of these since our last inspection in February 2015. One specific member of staff had been responsible for improving the content of the electronic care records. Care staff confirmed that this member of staff had consulted with them about people's needs before they had completed this process. Where people were not able to contribute themselves, because they lacked the mental capacity to do so, their representative had been involved on their behalf.

Settings within the electronic system had been altered so staff were now alerted when a monthly review of someone's care plans or additional health assessments was due. Monthly reviews of people's needs were expected by the manager however, reviews were carried out earlier if there was a change in need or risk. For example, if a person's health needs altered and their care needed changing or if they had a fall. This ensured the guidance for staff about how someone's care or risks should be managed remained current. Relatives told us they were unclear as to the process for generally reviewing their relative's care plans, but they confirmed staff kept them well informed of any changes in their relative's health or needs.

People's likes, dislikes and preferences were incorporated into people's care plans making the care records more personalised. Staff were aware of people's likes and dislikes and responded to these when meeting people's basic needs, for example when delivering personal care or supporting their dietary needs. Staff however had not fully considered the information they held about one person. For example, some of this person's behaviours were linked to actions and routines they had carried out as part of their working life and more lately in their own home. Although some staff recognised this, arrangements and adaptions had not been implemented to support some of the person's particular activities in a way that was meaningful to them.

The service had a complaints policy and procedures. The manager had not received any complaints since starting in post four weeks prior to the inspection, but was made aware of a relative's concerns during the inspection. They told us people's concerns and complaints would be listened to, taken seriously and addressed. They said these

Requires improvement

Is the service responsive?

would be appropriately recorded. The relative's concerns had included staffs' abilities to meet their relative's needs. The manager had acknowledged these concerns and had booked a meeting to discuss these with the relative. Before the end of the inspection they had already considered how they were going to increase the level of staff skill in the home. There were no other records of any concerns or complaints having been raised since the last inspection in February 2015. A representative of the provider confirmed they were unaware of any having been received by the previous manager.

Requires improvement

Is the service well-led?

Our findings

Relatives told us the appointment of the new manager had been a good improvement to the service. They said, "She is so easy to talk to" and "She seems like a lovely lady". The staff were confident in the new manager's abilities and felt she was going to be an effective leader. Two staff members said, "She is going to be good, I hope she stays" and "I hope they (referring to the Directors of the Company) listen to her, I want her to stay".

We found the new manager to be passionate and determined to promote good practice, to make improvements to the service and move it forward. They were suitably qualified to understand the services needs and challenges.

The manager had begun to share their values and expectations with the staff. They had already met with staff and had booked a formal staff meeting. They operated an open door policy and people and staff had direct access to them. The manager's personal values and expectations were that all staff worked in an ethical and professional way and followed the rules. They considered it to be important to be honest and to be able to "hold one's hands up when something goes wrong or when you are unsure". They informed us people were entitled to know if things had gone wrong and to be given an explanation and have mistakes addressed. They told us the staff in the home, the management team and the provider needed to be able to reflect on mistakes and use them positively for further learning and for making improvements. They told us this was the way they intended to operate and would expect the same back from those they worked with. The manager demonstrated they therefore understood the requirement of needing to be open and transparent in the way they operated.

People were to be more involved in the running of the home. The manager was keen to get people together, to hear their ideas and to get feedback on the services already being provided. They planned to hold meetings and be in regular contact with people who used the service and their representatives. One such meeting had already been booked. Relatives were looking forward to attending this and the manager told us they had received a positive response to this meeting being held.

One of the provider's aims and objectives was to "promote useful social contact with other members of the local community". Links with the local community had not been actively promoted. The manager explained they intended to utilise the support of local agencies to improve the support and care provided by the home. They said they would also be developing links within the local community to improve opportunities for social activities both inside and outside of the home.

The manager discussed the provider's audit system with us. Audits on various areas of the home were present both electronically and in paper form but had not been fully completed since January 2015. The manager therefore told us they were going to start from scratch. Audits which focused on the monitoring of health and safety and maintenance systems were part of a rolling annual program of monitoring. These were completed and returned to the provider. The manager was also expected to complete a monthly report which was effectively an information gathering tool for the provider. This included a request for information on complaints received, pressure ulcer development, notifications such as accidents, incidents, safeguarding issues and deaths. It also requested updates on other systems such as personnel records, medicine management, staff training and care plans. The manager told us she would be introducing some more detailed audits for her own monitoring purposes and for compiling this information.

The monthly report was then discussed with the manager's immediate line manager each month. Identified shortfalls were then incorporated in to a working action plan which the Directors also had sight of. Both the new manager and the provider were therefore fully aware of the service's progress to date and what still needed to be addressed. The new manager told us they were receiving good support from their immediate line manager. The manager discussed with us one of their main challenges, which was how to successfully embed the required improvements in order to confidently be able to increase the homes occupancy levels. Their plan was to not rush this process and only to admit people with the needs that the current staff skills could meet. People with more complex needs would be admitted as and when the staffs' knowledge and skills increased. It was expected by the manager that the provider would support this approach.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe and appropriate way for service users because the provider had not ensured that staff had the qualifications, competence, skills and experience to do this. Regulation 12(1) and (2)(c).