

Cherry Garden Properties Limited

Castle House

Inspection report

Castle Street
Torrington
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Tel: 01805 622233

Date of inspection visit: 8 and 15 December 2014
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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?

Good



Is the service well-led?

Requires Improvement



Overall summary

This inspection took place on the 8 and 15 December 2014 and was unannounced. There were 19 people living at the service. When we last inspected in March 2014 we found improvements were needed in the way the provider ensured there were systems in place for quality assurance. We asked for and received an action plan, which outlined how the provider intended to improve their quality assurance and audit system. This included timescales saying when they intended to be fully compliant. During this inspection, there had been some improvements. The provider had used an external quality assurance company to complete audits in all aspects of health and safety, staffing, records and quality of care and

support being provided. Audit information was made available, but improvements were still required in order to evidence what the provider was doing about the results of audits and recommendations.

Castle House is registered to provide nursing and personal care for up to 33 people. They provide care and support for frail older people and those people living with dementia.

The registered manager had de-registered on the day we inspected and a new manager who had been in post since July 2014 was in the process of applying to register with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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 were not always safe as there were not always sufficient staff with the right skills and experience to meet their needs in a timely way. The service had struggled to recruit and retain qualified nurses and the new manager was covering more than one shift per week, which meant her time was being taken away from management tasks. The provider had not used a dependency tool to review the number of staff needed to meet people's changing needs.

There was an activities coordinator, who worked three days per week. One the days she did not work, people were left for long periods with little or no social engagement. There were several people who called out or made noises which would indicate their distress or need to have social interaction. There were not always staff around to provide this emotional support. In the mornings staff were busy getting people up and assisting them with washing and dressing. This meant interactions from staff were sporadic and task centred, although staff showed empathy and respect to people in all their interactions.

Equipment was not always being stored appropriately which could have been a trip hazard and placed people at risk. There were two available hoists, although staff described one as "not fit for purpose" as the legs of it splayed which made it difficult to manoeuvre around furniture. A further hoist was made available by the second day of the inspection.

Staff were caring and compassionate towards people and were being given updated training to help them develop their skills. However further training was needed to help staff understand the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The manager had been working hard to introduce a more comprehensive induction programme for new staff and to source further training for staff to update their skills in areas of health and safety. Staff understood people's needs and care plan information was being updated to reflect changing needs.

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Equipment was not always being stored appropriately which could have been a trip hazard and placed people at risk. There were two available hoists, although staff described one as “not fit for purpose” as the legs of it splayed which made it difficult to manoeuvre around furniture. A further hoist was made available by the second day of the inspection. The provider had refurbished one of the bathrooms, but the bath installed was not appropriate for people with mobility or frailty issues. This meant people could only use the shower room.

Staff were caring and compassionate towards people and were being given updated training to help them develop their skills. However further training was needed to help staff understand the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The service was not always being well-led. the registered provider was in the process of recruiting a operations manager to support the manager of the homes they owned, but there was no interim arrangements. The registered provider had used an external quality assurance consultancy who had identified areas for

improvement. The registered provider had not acted swiftly to address some of the areas for improvement, such as ensuring electrical equipment was tested for it's safety.

The manager had been working hard to introduce a more comprehensive induction programme for new staff and to source further training for staff to update their skills in areas of health and safety. Staff understood people's needs and care plan information was being updated to reflect changing needs.

People's medicines were being managed appropriately and their health care needs were monitored. Where health care specialist advice was sought, their recommendations were put into action. People were afforded choice and where they were able to make informed decisions about their lives, staff respected this.

People and their families were able to talk to staff and the manager about any concerns they had and were mostly confident these would be dealt with. Two people did mention their concerns had not been dealt with to their satisfaction. The manager agreed to discuss their issues further with them.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. There were not always enough staff on duty to meet the needs of people living at the service.

Equipment had not always been checked or replaced in a timely way, which place people at risk.

People's medicines were being well managed and staff recruitment was robust to protect vulnerable people.

Requires Improvement



Is the service effective?

The service was not always effective. Staff lacked the skills and knowledge to fully understand and apply the principles of law to fully protect people's rights.

Staff understood people's needs and choices, but could not always offer them their preferences around personal care.

People were not always fully supported to eat and drink when assistance was required. Those who were most vulnerable were fully supported but others who may require guidance and prompting did not always get the right level of support.

People's health care needs were being met and monitored effectively. Health care professionals were appropriately involved in the care and treatment of people.

Requires Improvement



Is the service caring?

The service was caring. People and their relatives were positive about the care they received and this was supported by our observations.

Dignity and respect was maintained for people, although at times care staff were rushed and not always able to offer the emotional support some people needed to reassure them.

Good



Is the service responsive?

The service was responsive. The staff team were working towards making their care plan information more personalised and staff knew people's preferred routines.

People's concerns and complaints were dealt with swiftly and comprehensively.

Good



Is the service well-led?

The service was not always well-led. Although there had been some improvements in the way they monitored the quality of the care and support provided, the provider had not always addressed issues identified as part of the quality assurance process in a timely way.

Requires Improvement



Summary of findings

<p>There was a lack of leadership and support from the provider in respect of supporting the manager to do her job effectively.</p>	
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Castle House

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 15 December 2014 and was unannounced. On the first day the inspection team included two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service. During the first day we spent time observing how care and support was being delivered and talking with people, their relatives and staff. This included 15 people using the service, four relatives and friends or other visitors, and 14 staff. This included care staff, chef, domestic staff, registered provider, manager, nurses and the administrator.

On the second day, one inspector spent time looking in more detail at records relating to people's care as well as

audits and records in relation to staff training and support. We looked at six care plans and daily records relating to the care and support people received. Care plans are a tool used to inform and direct staff about people's health and social care needs.

We also used pathway tracking, which meant we met with people and then looked at their care records. We looked at five recruitment files, medication administration records, staff rotas and menu plans. We also looked at audit records relating to how the service maintained equipment and building.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Staffing was not always maintained at safe levels. There were not always sufficient staff available throughout the day to meet the needs of people in a timely way. One person told us “They all do their best but they’re short-staffed all the time because of the cost of everything...I think the one who’s training them should tell them the most important thing which is if something’s hurting they should avoid that place but they’re always in a rush... in the afternoon its worst...I have to be moved and have my pad changed or I get a sore bum...I’ve waited up to an hour.” Another person said “Changeover times are difficult...I can wait twenty minutes for a drink or a change of pads or sheets.” Staff confirmed there were usually three care staff and one nurse on during the afternoons which meant that when one person who required two staff to safely move them, there would only be one care staff available if the nurse was completing their medication round. Some people were being nursed in bed both on the ground floor and upstairs, which meant staff needed to go between floors to answer call bells and ensure people in the communal areas were safe.

Staff reported there were at least 11 people who required two staff to safely move them. During the afternoon shift there were only three care staff available and one of these needed to help prepare the evening meal and drinks.

The call bell system was not set up to record how long call bells took to be answered. One person said, a staff member would answer the call bell, but they would often be told they would need to wait until staff were available, which could be at least 20 minutes. Staff confirmed that during peak times such as mornings when they were getting people up or later afternoon when they were preparing people for bed, people would have to wait for available staff depending on their need. One staff member said “We try our hardest to make such people get good care, but often because there is not enough staff, we are rushed and people do have to wait sometimes.”

During lunch on the first day, there were several people in the main dining area who required assistance with their meal, either to cut their food up or to encourage them to eat. There was only one care staff available to assist people

in the dining area. People did not get the support they needed to eat their main meal and at least three people did not eat their meal as a consequence of the right support not being available.

During the morning people in the lounge were left for long periods of up to 15-20 minutes without any meaningful engagement. One person was singing out and this was causing some people to become agitated and start to call out for them to be quiet. Several people were asleep or staring into space as there was no meaningful engagement for them. When staff came into the room, they interacted with people and showed kindness and compassion for short periods before they went out again to attend to someone else. Staff said when the activities coordinator was working they felt “better”, because people were safe. One staff member said “When we have activities, it makes our job so much easier because we know there is someone there talking to people and watching them to make sure they are safe.” The activities person worked three days per week, which meant on the days they did not work, there was little social engagement other than care staff providing care and support tasks.

The manager said there had been difficulties in covering nursing shifts as they only had two full time nurses covering the day shifts and two part time nurse covering nights. They were using agency for some shifts, but the manager was also having to cover some of the nursing shifts, which meant she was unable to provide full time management cover for the home.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Equipment was not always being stored appropriately which could have been a trip hazard and placed people at risk. There were two available hoists, although staff described one as “not fit for purpose” as the legs of it splayed which made it difficult to manoeuvre around furniture. A further hoist was made available by the second day of the inspection.

A systematic clear process was followed by the administrator which identified when each piece of equipment needed to be serviced or repaired at a specific time. All expenditure was governed by the provider, which meant that servicing or replacement of equipment was often delayed. For example the matrix showed that PAT testing of electrical equipment was due in 2012 and that as

Is the service safe?

authorisation had not been agreed, testing of equipment was out of date. The provider stated this had now been agreed and could go ahead, but was still out of date at the time of the inspection. Delays in servicing and replacement of items of equipment could present a risk to the safety of people living at the home.

This is in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Appropriate arrangements were in place in relation to obtaining medicines. The home has recently changed the pharmacy. New medication administration records (MARS) forms had been introduced and the pharmacist had provided training to key staff in the handling, administration and recording of medicine. Medicines were delivered monthly following a stock check. On some occasions the pharmacy had been unable to supply a particular medicine. Where this had occurred staff had obtained the prescribed medicine from an alternative pharmacy locally.

Appropriate arrangements were in place for the recording of medicine. MARS charts showed printed details of the medicine supplied, the prescribed dose and the times the medicines should be administered. Errors had occurred on one PRN records and this had been highlighted and followed up the following day by the nurse in charge.

As needed medicines (PRN) protocols stated the date of the next review but were not consistently followed through. Medicines were stored in a locked trolley. Staff checked the MAR chart before taking out the appropriate medicines from a blister pack for each person. The MAR chart was signed after administering each medicine. Staff stayed with the person until they had swallowed their medicine. Where there was resistance gentle encouragement was given to the person with an explanation of the benefits of taking medicines or tablets. We were told that in no circumstances were medicines administered covertly. Where there was a refusal this was recorded on the MARS sheet. Medication policies and procedures were in place which were reviewed and updated by the providers.

Homely remedies were used with a policy in place which was this was due to be reviewed but had yet to be done. Homely remedies administered were recorded in a separate book with quantities of stock checked and recorded.

Medicines were stored safely in a locked drugs cabinet which was kept locked at all times it is unattended. Controlled drugs were stored secured in a locked cabinet, secured to the wall within a locked room. The CD register was maintained, was up to date and accurate. Each entry had a double signature, to help reduce the risk of error. There was a locked refrigerator for the storage of medicines that must be kept cool was available in the treatment room. Fridge temperatures were recorded daily to ensure medicines were being stored at the correct temperature.

Prescribed creams and lotions were stored in a further locked cupboard. Topical creams were recorded and signed for by care staff on a record sheet held in the person's room. A nurse monitored the usage and records on the MARS chart.

The manager conducted monthly audits of medicines. They told us they were introducing a more comprehensive management system to audit medicines devised by the NHS North Devon Commissioning group which would help reduce the risk of error in medicine administration.

Medicines were disposed of appropriately and there are safe systems in place to ensure medicines were returned to the pharmacy when no longer required. No one currently living at the home self-medicates, although this was offered and would be supported if someone wished to do so, within in a risk management framework. This ensured people were safe and competent to administer their own medicines.

There were comprehensive recruitment and selection processes in place. The seven staff files showed completed application forms and interviews had been undertaken. In addition, pre-employment checks, which included references from previous employers, proof of identity, health screening and a valid DBS. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff had received training in understanding about abuse. Staff had a good understanding of safeguarding and one member of staff described the different types of abuse and the potential signs to look out for to ensure people were protected from abuse. Staff were familiar with the safeguarding procedure and said they would have no hesitation in reporting suspected abuse to the manager,

Is the service safe?

the police or CQC. There was evidence of safeguarding training in three of the seven staff files looked at. The manager said there were more training planned including safeguarding vulnerable adults.

Cleaning staff were employed at the home. We spoke with one cleaner who had recently joined the home. They said they had received training in infection control and were clear about their role in preventing and controlling infection. Staff had a good supply of aprons and disposable gloves which were worn when carrying out personal care or cleaning duties. Hand gels were available in various

locations throughout the home to help prevent the risk of infection. Staff were unsure who the lead person was for infection control but one staff member said they assumed it would be the nurse on duty. The rooms, corridors and communal rooms were generally clean. There was a slight malodour in various parts of the home, in some rooms and around some people in particular. This would indicate some people's support needs around personal hygiene were not being met in a timely way and that improvements were needed in deep cleaning some parts of the home to reduce odours.

Is the service effective?

Our findings

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. Relatives were positive about most aspects of care and support. One said “I wasn’t sure I wanted my relative to come here, but they know lots of the people here and although the building is shabby, the care staff understand people’s needs and make sure people are cared for.”

Staff did not understand the MCA and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff were unsure what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, preventing a person from leaving the home to maintain their safety. The MCA provides the legal framework to assess people’s capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

Staff said they were unsure if they had received training in MCA or DoLS. The manager confirmed this is an area she has been trying to ensure staff had updated training on so they understood the act and how to ensure people were fully protected. There were no people currently subject to such safeguards, although one person had been discussed with the county council team who authorise such safeguards, and further applications were being considered for referral following the Cheshire West ruling.

Staff were able to describe how they met people’s needs but their personal preferences were not always met. For example one person had said they wished to have a bath and did not like using the shower. A new Ario bath (with seat) had been installed in the first floor bathroom in July 2014. It could not be used as it had been installed in the wrong position with no space around for staff to support or assist anyone using the bath. The hoist could not be used as it didn’t fit under the bath and would not be safe to use. Where a person was fully ambulant they could use the bath but as the majority of people currently at the home were not ambulant, the bath was not in use. Staff told us

they used the shower/wet room to assist people to wash and were unable to offer an alternative. We fed this back to the provider who said they would need to check why the bath had been installed in the position it had.

Records showed people’s health care needs were being monitored and where needed their GP or other healthcare professionals were consulted. A visiting GP confirmed staff were responsive to people’s healthcare needs and referred people appropriately to the surgery when their health care needs changed. One person had lost a significant amount of weight as they had been unwell with a chest infection. The manager said, they were keeping a close eye on their weight and would refer to the GP if further reduction in weight was noted. The manager said she had been working with the chef to ensure where people had lost weight, fortified food and drinks with increased calorie intake would be considered.

Staff had received most of the training needed to ensure they could do their job safely and effectively. Where there were gaps in staff training and/or updates needed, the manager had identified an external provider to complete this training in various aspects of health and safety. Previously the provider had an operations manager who trained staff on moving and handling, but she has left the company. The manager has offered to complete training to enable herself to deliver training in safe moving and handling, and in the interim, they have external courses booked. New staff received an induction which covered all aspects of care, support and protecting vulnerable people. The induction included working alongside more experienced staff to learn the role. One newer member of staff confirmed they had completed an induction and been given time to work alongside other staff to help them learn the role and get to know people and their needs.

The manager said she was in the process of ensuring all staff had regular support and supervision to enable them to review their practice and discuss training needs, but this had been delayed due to the fact they had been short staffed and she had needed to spend time covering shifts or arranging cover.

People were not always supported to eat and drink and maintain a balanced diet. Systems were in place to ensure those who were at most risk of poor nutritional intake, were monitored and supported to eat and drink at regular intervals. Records were kept of the amounts people ate and drank, and those who were assessed as most vulnerable,

Is the service effective?

received staff support to eat their meals. However there were a number of people who struggled to eat their meal on the first day of the inspection. They were not offered support to cut up their food or encouragement to eat, and at least three people ate very little of their main meal due to the lack of support available.

The chef confirmed there were always two options for people to choose from and that they knew people's likes

and dislikes and could cater for specialist diets as needed. Two people said they did not like the food being offered and one person said their food was always cold and had been told they could eat in the dining room if they wanted their food to be hot. There were condiments on one table and these were not offered to others on other tables. One person asked for salt for his chips, but his request went unheard.

Is the service caring?

Our findings

People spoke highly of the staff and the care they received. Comments included “They’re marvellous here, they do everything for me” and “I’m very happy and well-looking after here.” Relatives were also complimentary about staff and their approach. One relative said “Mum is very happy here and the staff do their best. I come in two or three times a week and it’s always fine at any time of the day... I pop up to her room and it’s always beautifully kept.”

Staff were kind and professional in their approach with people. One person was distressed and wandering around and staff remained calm and patient. One relative said “Mum gets frustrated so can be a bit aggressive as she’s always been strong-minded and independent and now has dementia... but staff here calm people down and talk to them if they’re upset.” Staff were sensitive towards the behaviour of one person talking to them gently as they were was trying to get out of the front door.

Staff said they understood people needed time to respond to any requests. One person was crying out and staff spoke

gently with them asking them various questions to try and understand what might be causing them distress. One staff member said “I’d like my Mum to live here” and another said “I know a person is happy when there are lots of smiles. We have lots of laughs here.”

Staff were able to describe ways in which they supported people to make decisions about aspects of their care. For example staff said they checked with people where they wanted to spend their day, gave choices about what they wished to wear and assisted people in aspects of care they were unable to do for themselves. Care plans included information about how to support people in making choices. Staff provided care and support to people in a way which upheld their respect and dignity. For example when staff noticed someone clothes had food on them, they gently asked if they would like support to change. When people were being assisted to transfer using hoists, staff worked in pairs and one staff member explained each step of the process to the person. They checked they were comfortable and covered them with blankets to maintain their dignity.

Is the service responsive?

Our findings

People did not comment on whether they had been involved in the review of their care plan, but several people were able to recall being consulted about what their likes and dislikes were. One relative said the manager had visited the person prior to them being admitted to discuss their needs, wishes and preferences and this had also involved family. The manager said they were working towards making care plan information much more detailed and personalised. She said she would also ensure the process included recording how and when people were involved in their care plan process. There were details in some plans about people's preferred routines for getting up and going to bed. Staff were able to demonstrate a good understanding of people's needs and their wishes. For example staff knew who liked to get up early, who liked a lay in bed and what each person enjoyed drinking.

One person had been referred to speech and language therapist for a swallowing assessment. The speech therapist had recommended a pureed diet, but the person refused to eat the food pureed. The service was responsive to the person's needs and as they did not lack capacity, they have continued to offer more manageable foods, but have respected the person's wish for their meals not to be pureed.

Plans and daily records for people showed how staff supported people with their specific needs, including equipment to move around the home safely and independently and what aids were needed to ensure people can hear and see to the best of their abilities. Where

people's faith or beliefs were known, this was recorded. There was monthly services held at the home and visiting clergy could be arranged if people wanted a visit from a specific faith.

There was an activities coordinator who worked three days per week and offered sessions around games, discussions, reminiscing and quizzes. She also arranged to do shopping for people and on occasion trips out to the local shops for people. People said they enjoyed the activities on offer. There was no notice about what activities were offered when although there was some old information about a paid entertainer visiting the home.

People who were able, said they could make their concerns known to staff and most were confident these would be followed up. Two people said they had raised concerns about the food but were not confident this had been followed up on. We fed this back to the provider who said they had regular meetings with people and their relatives where things like the menus had been discussed. They had not received any negative feedback, but said they would do a survey around food and menu choices to see if people had views and suggestions.

The complaint's policy set out the procedure to be followed by the provider and included details of the provider and the Care Quality Commission. Where complaints had been made, these had been appropriately followed up and actions taken to resolve the issues. For example one relative had raised concerns about laundry and this had been looked at by the manager and a response given to the relative about how things would improve to ensure their relative got their laundry back in a timely way.

Is the service well-led?

Our findings

At the last inspection in March 2014 a compliance action was set as improvements were needed in the way the provider responded to the results of audits where risks had been identified. An action plan was received from the provider showing how they intended to become compliant and by when. The areas that were outstanding have been addressed, such as windows needing replacing and the completion of a new bathroom. However, there have been other identified areas which had been identified as part of the auditing process, where the provider has not acted as their action plan indicated. For example the action plan stated “Issues identified which cannot be dealt with in house will be referred to head office and depending on the risk element they will be dealt with within the following timescales: High risk – immediate or within 7 days depending on severity, Medium risk 28 days depending on issue, Low risk timescale will be agreed with manager timescale for action or action plan developed for managing risk. The electrical testing of portable equipment was not actioned within any of the timescales stated. This showed that improvements were still required to ensure quality audits were used to improve the service within a timely way.

The bathroom which had been refurbished was considered by staff as not fit for the purpose of bathing older people with moving and handling needs. Staff said they had not been consulted on the right equipment needed in the new bathroom. The provider said he had consulted with the previous manager and no objections were made, but there was no evidence of the provider having consulted with healthcare professionals such as occupational therapists in the design and layout of the new bathroom for people with complex healthcare needs. This showed a lack of vision to

improve the service in light of best practice and in consultation with staff who knew the people’s needs and would have been able to contribute to ensuring the right equipment and bathing facilities were in place.

The manager was in the process of registering with CQC. The previous registered manager had only recently de registered. The provider normally had an operations manager who visits the service on a regular basis and provides support and supervision to the manager. This post was vacant, so the provider said he had been making visits to the service and was available via phone for the manager to raise any issues or discuss any ideas. The provider had no clinical experience and the manager said she had not had clinical support and guidance since she began her role in July 2014. We fed this back to the provider who said there was support available for other managers from homes they also own. There was no formal process for his, but the provider said the manager could call himself or another manager at any time.

Staff and relatives gave positive feedback about the new manager’s approach and leadership skills. One staff member said “She is very approachable and is trying her best to make this home work well.” Staff said the manager was very accessible and they felt they could speak with them at any time. She had organised regular staff meetings to ensure all staff had an opportunity to voice their opinion about all aspects of the running of the home and about the care and support they provide to people. The manager had some concerns about how they would recruit the right staff with the right skills and qualifications, but was positive about the remaining staffs’ skills and abilities. There was a lack of vision and openness from the provider which meant that the manager and staff were not always clear about what the future plans for the service were. The provider said they had been very open and transparent about looking at future options for the service and remained committed to the service being a good nursing home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>How the regulation was not being met: The registered person had not taken steps to ensure the health and safety of service users as there were not always sufficient numbers of suitably, skilled and experienced persons employed for the purpose of carrying out the regulated activity.</p> <p>Regulation 22</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment</p> <p>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>How the regulation was not being met: The registered person had not made suitable arrangements to ensure people were protected from the risks of unsafe equipment as they had not made suitable arrangements to ensure they were properly maintained.</p> <p>Regulation 16(1) (a)</p>