Ranyard Charitable Trust

Ranyard at Dowe House

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

Ranyard at Dowe House provides accommodation and nursing care to up to 51 older people, some of whom had dementia. There were 40 people using the service at the time of this inspection.

This unannounced inspection took place on 29 January and 5 February 2015. The last inspection of Ranyard at Dowe House took place on 18 July and 1 August 2014. We found then that the service was not meeting the outcomes relating d to the care and welfare of people, respecting and involving people, management of medicines, staffing levels, supporting workers, record keeping, assessing and monitoring the quality of service, and notifications. We asked the provider to take action to make improvements. They sent us an improvement plan which stated that they would address the issues found within six months of our inspection.

At this inspection, we found that the provider had made improvements and were still making progress with implementing their action plan fully. For example, staffing levels had increased, there was now a system in place to ensure staff were supervised and supported, notifications were being sent to us as required, a new manager had been appointed, care planning had improved to reflect people's needs and processes had been put in place to monitor the quality of service provided.

Summary of findings

The service did not have a registered manager. The manager had submitted their application to be registered as the manager of the home with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The environment was not maintained to ensure it was safe for people. There were flammable materials left around. Fire drills were not conducted regularly so that staff could practice evacuation in the event of an emergency.

Staff had not been trained in the Mental Capacity Act 2005 and capacity assessment had not been completed as required where there were doubts about a person's capacity to make decisions.

The views of people were not always obtained when planning the menu and activities. The cultural and religious needs of people were not always met.

People received care and support in a safe way. Medicines were kept securely and people received their medicines as prescribed. The service identified risks to people and had appropriate management plans in place to ensure people were safe as possible.

Staff were knowledgeable in recognising the signs of abuse and knew how to report it following their procedures. People were not unlawfully deprived of their liberty.

There were sufficient staff available to meet people's needs. People told us staff were kind and caring. We observed that people were treated with dignity and respect by the staff. People were supported to communicate their views about how they wanted to be cared for. People told us they enjoyed the food provided. People's nutritional and dietary needs were met.

Training programmes had been developed to ensure staff had the skills and knowledge to provide good care to the people they looked after. Staff received the support and supervision to carry out their duties effectively.

People had their individual needs assessed and their care planned to meet them. People received care that reflected their preferences and choices. Reviews were held with people and their relatives to ensure their support reflected their current needs.

The manager responded appropriately to complaints about the service. Systems had been put in place to check and monitor the service to ensure it was of good quality and met people's needs.

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

We made two recommendations about planning staffing levels and obtaining the views of people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. The health and safety of the environment was not maintained. There were combustible materials stored close to radiators.

Staff knew how to recognise signs of abuse and neglect and how to report it. People received their medicines safely as prescribed.

Risks to people were assessed and managed. There were enough staff to meet people's needs.

Requires Improvement

Is the service effective?

The service was not always effective. Staff were not trained in the Mental Capacity Act 2005 and consent was not always obtained from people in line with it.

Staff understood how to provide care and support. Staff told us they received support they needed to carry out their responsibilities.

People had sufficient to eat and drink and enjoyed the meals at the service. People received appropriate support with their health needs.

Requires Improvement

Is the service caring?

The service was caring. People told us staff were kind and friendly, and treated them with respect. People's preferences in relation to how they wanted to be addressed and how they wanted their care delivered were respected.

Good

Is the service responsive?

The service was not always responsive. People were not supported to follow their interests and participate in activities they enjoyed. The views of people were not always sought when planning activities and devising the menu for the home.

People received care and support which met their individual needs.

Complaints were responded to appropriately and people were asked for their views of the service.

Requires Improvement

Is the service well-led?

The service was not always well- led. The manager in post had submitted their application to register with CQC as the registered manager. Staff told us the manager was approachable and supportive. There were systems in place to check the quality of the service provided.

Requires Improvement

Ranyard at Dowe 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 was carried out by two inspectors, a specialist advisor 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 care service. The specialist advisor was a registered nurse.

Before the inspection, we reviewed the information we had received about the service which included notifications from the provider about incidents at the service. We also reviewed the improvement plan the provider sent us following our last inspection and a monitoring report from the local authority commissioning team. We used these to plan the inspection.

During the inspection we spoke with 14 people using the service and four relatives and friends. We also spoke with the manager, a consultant, the general manager, three registered nurses, seven care staff and a GP. We looked at 14 care records, 10 people's medicines administration record charts and four staff records. We also reviewed records relating to the management of the service including complaints, quality assurance reports and health and safety records.

We undertook general observations of how people were treated by staff and how they received their care and support throughout the service. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that the service was not safe. People's medicines were not always handled and managed safely to ensure people were protected against the risks associated with unsafe use of medicines. We also found that care plans and risk assessments did not ensure the welfare and safety of people; and staffing levels was not adequate to ensure people were supported safely.

At this visit people told us they felt safe. One person said "At least it feels safe here" another person told us "I feel safe and happy." We saw that medicines were administered and handled safely. Only qualified nurses administered medicines in the home. People's care plans detailed any allergies they had and the support they required with medicines. We observed how nurses supported people with their medicines and saw that they communicated with people and informed them of what medicines were being administered. They checked the prescription and medicine pack to ensure it was the right person, right dose and time. They were patient to ensure people took their time in taking their medicines safely.

Medicine administration records (MAR) we reviewed were clearly and accurately completed. One person said "They get the pills right, I know them." Appropriate codes were used to where required. For example, where people refused their medicines or in hospital, this was recorded using the relevant code; a note made to explain the reason and action taken. This showed that people received their medicines in line with their prescription.

Medicines were stored safely and securely. Medicines were kept in a locked trolley stored in a locked room when not in use. We looked at the trolleys and saw that medicines were neatly organised and arranged with clear labels showing the name of the person each medicine belonged to. All the medicines in the trolleys were within date and in use. Medicines which required storage at a temperature controlled environment were kept in a fridge and the temperature monitored daily to ensure they were safely preserved. Controlled medicines were kept in a secured and locked cabinet. Unused medicines were collected by specialist contractors for safe disposal and a record was maintained for this.

Nurses completed medicine audits daily to ensure all medicines were accounted for. We reviewed the completed audit and it showed they were to account for medicines in and out of the home. We conducted random audit of medicines for five people and found that the medicines supplied and administered tallied with the balance in stock. This showed that people's medicines were managed safely.

The service had put systems in place to ensure that risks to people's health and well-being were identified and managed appropriately. Care records showed that risk assessments had been carried out and they covered issues such as pressure sores, falls, malnutrition, continence and mental well-being. Action plans to manage risks identified were put in place to minimise the risk from occurring. For example, pressure relieving mattresses, body maps and repositioning charts were in place for people at risk of developing pressure sores. We saw that the turning charts were completed as planned. This indicated that the plan was followed by staff.

Appropriate professionals had been involved to devise a plan for a person with swallowing difficulty. The plan stated that pureed food and thickened fluid should be given to reduce the risk of choking. We observed that staff followed this. People at risk of malnutrition and dehydration were supported appropriately. For example, food and fluid intake charts were put in place. They were also supported to eat and drink at regular intervals; and their weight was monitored regularly. These ensured that people were supported appropriately to reduce risks to their health and well-being.

People told us there were enough staff to meet their needs. People told us that staff attended to their call for help quickly. One person said "They come fairly quickly when I ring the bell and they take care when they are washing me." There were suitably qualified staff on each shift to support people safely. We observed staff attending to people promptly. Staff were not rushed and had time to engage with people in conversations. All staff we spoke with told us they were happy with the current levels of staffing. One staff member said "Before I felt like I could not do my job. Now I feel I have time to spend with residents. " Another staff member said "Last time there were not enough staff, but now with the fourth carer I have more time to spend with people. I can hold their hands and have a chat with them."

Requires Improvement

Is the service safe?

A third member of staff said “We are never short and always make sure we have the right number. It has improved over the past year.” Agency staff were used to cover staff shortage where required.

We spoke to the manager about how they planned staffing levels. They told us that they determined it based on feedback from staff about people's needs. The provider had recently agreed increase in staffing levels. At the time of our inspection there were 11 beds vacant. We had a discussion with the manager about how they would ensure that there continue to be sufficient staff to meet people's needs when the home is full to capacity. They told us that there was no specific tool in place currently to analyse and determine staffing levels but they relied on feedback from staff.

We recommend that the provider find current guidance and best practice on how to plan and determine staffing levels.

The environment was not always safe for people. There were signs around the home to show emergency exits and notices showing the day fire alarm system is tested. There was fire detection equipment’ such as fire extinguishers, blankets and smoke detectors. Specialist contractors service and maintained them and we saw records that they were serviced annually. When we walked around the home and saw flammable items left around and some close to radiators which could be fire hazards. For examples, there were packs of gloves, newspapers and magazines on top and by the radiators and windows.

There was no record of fire drills conducted to practice emergency evacuation procedures. We interviewed six staff members in a group about how they would respond in the event of a fire. They knew to wait at the nurses’ station and take instructions. They were unable to tell us about the home’s procedure for evacuation whether they evacuated people or not in the event of an emergency and what method was used. We asked when they last had a fire drill and they said they have not had one in a long time. People were not cared for in an environment that was safe. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had procedures in place to safeguard people from the risk of abuse and neglect. Staff demonstrated they understood the various types of abuse; signs to recognise them and how to report it to the manager in accordance with the organisation’s safeguarding procedures. Staff we spoke with felt confident to use the whistle-blowing procedures to escalate concerns to other authorities if required. Safeguarding concerns were reported to the local authority safeguarding team and notifications sent to the Care Quality Commission.

Recruitment processes were robust and safe to ensure that only suitable staff provided care and support to people. The provider had recently re-checked all staff with the disclosure barring service (DBS) to ensure they continue to be suitable to work with people. The provider also checked that nurses employed had the appropriate qualifications and their professional registration was up to date.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that the service did not adequately support workers to do provide care and support to people. During this visit, we found that the provider had put systems in place to ensure staff had the support they required to do their jobs. People told us that staff provided care to them well. A person told us, "It's alright living here I suppose." Another person said ".It's a home away from home." And a third person said "You have got all the things you could want. They definitely try hard. Everyone does their share of trying."

New staff completed an induction programme which included discussion of relevant policies and procedures, reading through care plans and shadowing an experienced member of staff on the practical aspect of the job. One new staff member told us "I had a good induction. I shadowed for over two weeks which helped." Care staff had clinical supervisions and arrangements were made to hold regular sessions. The provider had recruited an external consultant to develop this system and make it more effective. Staff told us that they were happy with the new supervision arrangements. They shared their learning from one of their sessions with us and how it has helped improved their work.

The provider was working towards an annual appraisal system. Four out of the six staff we spoke with had not received an appraisal in the last year. Staff we spoke with who had completed their appraisal told us they discussed concerns about the people they cared for, issues about their work, and their performance and they found it useful. One staff member said "The new system was much better than before, but could still improve with more discussions on training and goal setting." We spoke with the manager about this and they told us that the human resources team was developing a system to improve this and monitor it to ensure appraisals are carried out regularly and effectively.

The provider had developed a training programme for staff to ensure they had up-to-date knowledge and skills to carry out their jobs well. Training records we looked at showed that had attended training in key areas such as infection control, first aid, safeguarding adults, health and safety. However, these training were due for renewal to ensure staff knowledge were up-to-date. The manager and human resources consultant told us that they were in the process of rolling out refresher courses for all staff and then update the training record.

Staff told us that they had started to attend training to update their skills for the job and they felt there has been improvement in the way training courses were delivered. "Training has improved greatly. We are not just watching a DVD, but going out in groups with an outside trainer." Staff told us they were able to discuss their training needs with their manager and were aware that there was a plan in place to ensure they completed all their mandatory courses required. One staff said "I have requested for end of life care training, and my manager is supportive of this. Although, I know I need to complete the mandatory training first."

The service did not always ensure that people gave consent to their care and support in accordance with the principles of the Mental Capacity Act 2005. We saw that mental capacity assessment were not always completed where there were doubts about people's ability to make decisions and best interests meetings were not always held to ensure that decisions made were to the person's best interests. Six of the care records we reviewed indicated that there were doubts about the person's mental capacity to make certain decisions. For example, one person's care plan stated "No mental capacity to make important decisions" but there was no mental capacity assessment carried out in regards to such decisions. We saw that this person's finances were managed by the provider. There was no evidence that they had been involved in this decision or that they consented to this. We discussed this with the general manager and they told us that the local authority made this decision and passed it on to them. We spoke with the person to establish if they were happy with this and they were unable to tell us at the time. Another person's care plan stated they had 'multiple medical problems' and unable to make decisions and express their needs. However, there was no mental capacity assessment completed in relation to their care and support. We were concerned that people may not always have consented to their care and welfare in line with the legislation. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with were clear about the need to obtain verbal permission before delivering care. They told us that

Requires Improvement

Is the service effective?

they respected people's decisions and choices about when and how they wanted their care delivered. However, staff had not completed the Mental Capacity Act 2005 training so we could not be sure that they knew under what circumstances they could or should consult others for making decisions in their best interests.

Care records detailed strategies to communicate with people and to encourage them to cooperate with care and treatment. For example, a person's care plan stated the times of the times of the day they were most alert and ways to communicate with them to ensure they understood the decision being sought. We also saw evidence of written consent in people's files. For example, two cases where bed rails were in place. Risk assessments had been carried out with the involvement of the person's relatives and the relatives had signed the consent form for this.

One person was subject to the Deprivation of Liberty Safeguards (DoLS) at the time of our inspection and the record we reviewed confirmed that appropriate process had been followed in relation to this. The person had the DoLS in place before they moved into the servie. We saw that the local authority safeguarding team was involved, mental capacity assessment was carried out and best interests meeting was held. This ensured that people were not unlawfully deprived of their liberty.

The service supported people with their nutritional and dietary needs. People told us that the food was good. One person said "The food is alright." And another person said "I always enjoy my meals and am happy with the food."

The service used the **Malnutrition Universal Screening Tool** ('MUST') to assess people's nutritional risk. When necessary they were referred to specialists and food supplements were given when appropriate. Care plans were in place to ensure people had the support they required to eat and drink safely. For example, we saw that people with swallowing difficulties had a diet recommended by a speech and language therapist and dietician.

At lunchtime the atmosphere was relaxed. People were a choice of drinks. The food offered had a healthy balance with vegetables and fruits included. People who required assistance were supported by staff. Staff assisted people to cut up food to make it easy for them to pick up. People who had their meals in their rooms were also given the support they required. People were able to request for extra portions. Staff also asked people if they wanted additional food. People were provided with drinks and snacks throughout the day.

We reviewed the menu and saw that there were no alternatives choices on offer. The chef told us that people could request for something different if they wanted. One person said "They make me Caribbean food when I ask them." However, we were concerned that not everyone would be able to do this. For example, people who were unable to express their needs. We spoke to the chef and the manager about how they involved people in planning the menu. The chef told us that the menu changed in the summer and the winter. The chef told us they got feedback from staff about the dietary needs of people and ensured these needs were me. For example, special diets soft or pureed, diabetic or cultural food. There was no system to consult with people and gather feedback from people about what they wanted included in the menu. The manager told us that they would review the menu in consultation with people and their relatives.

People were supported to access healthcare services they required. We spoke with a visiting healthcare professional and they told us that the service liaised with them to ensure people's healthcare needs were met. We saw records of visits from health professionals which indicated any action required. Recommendations made by professionals were implemented. For example, guidelines from a speech and language therapist for a person with swallowing difficulties were followed. We also noted that a specialist nurse was involved in looking after people with diabetes. We saw that staff followed actions from each visit. For example, a person's medicine was increased as directed by the GP. This showed that people received the intervention they required to manage their health and well-being appropriately.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. A person said, ""I am treated with respect and kindness at all times.....I am happy." Another person said, "I get on well with all the staff and they are friendly." A relative told us, "Everyone is so kind and friendly"

We observed good interactions between people and staff. Staff spoke to people politely and nicely. They shared jokes and enjoyed some laughter together. Care staff told us they could recommend the home to family and friends if there was need for it.

Staff understood the needs of the people they looked after. The care plans had detailed information about people's personal histories such as backgrounds, past employments, marriage, religion, children, education and personal preferences. Staff told us it had enabled them understand the people they supported and how to support them.

Staff demonstrated knowledge of people's abilities, and likes and dislikes. For example, one staff member talked about a person's daily routine and how they supported the person to maintain it. We observed a new agency staff trying to support this person after lunch but the person was getting frustrated as the staff was not able to communicate with them properly. A permanent staff noticed what was going on and immediately came to help. The staff communicated to the person in the way they understood by speaking to them slowly and lip reading. The staff then supported them to their room for a rest as they preferred. We saw a staff member came to adjust the hearing aid for another person who was struggling to hear what their visitor was discussing with them.

People were involved in making decisions about their day-to-day care and support. Staff asked people what they wanted to do and how they wanted it done. We heard staff ask people "How do you want their coffee today?" "Where do you want me to take you to now?" and they followed the instructions the people gave. We saw that relatives had been involved in care planning where required. One relative said " I haven't seen [my relative's] care plan but whatever [they] want they get." Another relative said, "My relative has been here two years and they never showed me his care plan until a short time ago." We saw evidence to suggest that staff understood the care and support needs of people and how to meet them.

Staff treated people with respect, dignity and empathy. We saw that staff knock on people's room doors and obtained permission before they went in. Staff did not rush people when completing a task and they were gentle with them. For example, we observed a staff help a person who was unable to eat independently. They communicated appropriately and they were patient, allowing enough time for the person to eat at their own pace. We also observed staff support another person to transfer using a hoist. They communicated what they were doing and told them how long it will last to reassure to the person.

The service provided end of life care to people who were at last stages of their life. People's care records detailed the care and support people wanted as they approached the end of life. This included people's decisions about whether they wished to be resuscitated in an emergency. Who they wanted to be informed and whether they wanted to go to hospital if they were unwell. Records showed that people and their relatives had been involved in planning this aspect of their care. Staff we spoke understood people's care and the choices they had made in relation to their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People's care and support were planned in a way that met their individual needs. Before people came to live at the home, qualified nurses met with them to discuss their care and support needs. The information gathered during the assessment process was used to decide whether the service could meet the person's needs safely and effectively. We saw care records which showed that people's personal history such as background, preferences, social and medical needs were discussed as part of the assessment.

The nursing staff developed care plans to cover people's identified needs and how they should to be supported by staff to meet the needs. For example, a care plan detailed the support they required to manage their weight to a healthy range as the person was under weight. We saw that the dietician was involved and recommendations were made which included food supplements, weekly weight monitoring and daily food and fluid monitoring. We checked the records for these and they showed staff followed the plan. We saw that a positive outcome was achieved as the person's weight stabilised within the required range. Two care records of people with diabetes showed that they were supported appropriately to manage their glucose levels. There were accurate records of diabetic monitoring sheet. Their GPs, podiatry and diabetic nurses were involved. This showed that people were supported in accordance to their needs.

Care plans were reviewed monthly or when required to ensure they were up to date and reflected people's needs. For example, we saw that plans were updated when people's needs changed in relation to their mobility. Appropriate moving and handling equipment was available to ensure the person was safe when moving. People had equipment such as walking frames and adapted cutlery and staff supported them to use them appropriately.

There was a plan of activities in place which included group and individual activities at the home which people could take part in if they wished. People knew which activities were available. One person said "We have activities; there's a notice on the door" However, not everyone was happy with the type and level of activities on offer. One person said "They won't take you out to the shops or help me with my exercises. They have some activities: 'Bingo' and 'Colouring which is demeaning when you are an adult." Another person said they paid someone to come to visit them to do the activity they enjoyed. Another person said "It can be lonely here…. Nothing much to do."

We saw staff giving people hand massages and manicures at the time of our inspection. We saw staff support a person to feed the birds as stated in their activity care plan. The person said they enjoyed doing it. We observed that people who were less able or who received care mostly from their bed had little activities to engage them apart routine checks from staff to make them comfortable. We asked the manager how they consulted with people to plan activities. They said the activities coordinator spoke with people and developed a plan based on what people were interested in. We did not see evidence of the consultation done with people about activities and people we spoke with could not tell us how activities were planned for the home.

We saw people's care plan stated their religious and cultural needs. One person who liked to practice their faith was supported by their relatives to attend their place of worship. There was information on the notice board about times of service at the local church. We asked the manager how they ensured people religious needs were met. She told us that they were not actively doing much about it currently but they were looking into making links with the community to ensure this area was addressed.

We saw that there were no forums in place to meet, consult, involve and gather feedback from people and their relatives about the service provided. For example, people were not consulted about the menu; the views of people were not always obtained when planning activities, and about the service provided. The manager told us that they were in the process of organising meeting for people and their relatives.

We recommend that the service find ways to consult and gather the feedback of people about the service provided.

We saw that the service addressed complaints effectively. The complaints records showed that complaints were investigated promptly and action taken to resolve them. People who had made a complaint received a written response to concerns they had raised. We tracked some recent cases and saw that the service had taken steps to rectify the issues raised. For example, one person had received reimbursement for damaged property.

Is the service well-led?

Our findings

At our last inspection, we found that the service was not well-led. The management was not visible as the registered manager was part-time at the service. We also found that the quality of the service provided was not assessed and monitored regularly; notifications were not sent to us as required and records were not maintained or kept up-to-date.

At this inspection, there was no registered manager. The previous deputy manager had been appointed as the manager and had made application to CQC to register as the registered manager. A new deputy manager who knew the home well had also been appointed. The provider had also recruited two external consultants, a human resource consultant and a clinical consultant to support the implementation of the action plan following our last inspection.

The service had developed and introduced various systems to monitor the quality of service provided. For example, health and safety audits, infection control, care plan audits, quality of documentation audit and staff files audit. These systems were currently being implemented at the time of our inspection. The manager told us that they would complete full implementation throughout the service by the end of February 2015.

Care records were maintained and up-to-date. We saw that repositioning, weight, wound management; blood sugar monitoring, food and fluid intake charts were maintained, accurate and up-to-date. Care plans were up-to-date and reflected people's needs. Staff training record was being updated at the time of our inspection. We saw that record keeping training was being organised to improve staff skills in this area.

The service ensured that lessons were learnt from incidents. The service kept a record of incidents and accidents such as falls, and medicine errors. Action plans were put in place to minimise and reduce future occurrence. For example, a daily medicine audit had been introduced to pick up issues with medicines before it became a problem.

The manager complied with the conditions of its registration and sends notifications to CQC, as required.

Staff told us they were supported and motivated by the new management. One nurse said "My manager is approachable and very supportive." Another care staff said "She listens and wants to get it right." The new management including the consultants met with staff regularly to obtain their views about the service, service users' concerns, and issues affecting their jobs and to update them on progress on various matters such as recruitment, policies and procedure. Minutes of meetings we saw confirmed that actions were taken to address suggestions made. For example, a clinical consultant had been recruited to provide clinical support and supervision to staff. Also, staffing levels had been increased following concerns raised by staff and equipment and items required for the home had been bought.

Registered nurses also held monthly meetings with the manager where they discussed the care and welfare of people they supported and reflected on relevant policies. We saw that actions were taken to address issues. For example, medicine audit system was introduced to improve the medicine system.

All staff we spoke with told us that the service had improved and they felt positive and confident that new management team will help bring the service to the required standard. One member of staff said "Since last time it has got a million times better." Another staff member said "I feel relieved. Things have improved, it is not perfect, but there have been marked improvements." We have our own manager on site and the support is much better." And a third staff member told us "The culture has changed. Team morale has lifted. It is so much nicer coming in to work. I feel like I can knock on the office door any time and they will listen." Staff demonstrated they understood their roles and responsibilities and they showed enthusiasm throughout the day as they supported people.

The commissioning authority carried out regular monitoring visits and made recommendations for improvement. The recommendations from the most recent report in January 2015 were being actioned. However, some of the issues raised had not been addressed. For example, the combustible materials around the home and general health and safety issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered provider did not take proper steps to ensure that people consented to their care and treatment delivered to them in accordance with relevant legislation. (Regulation 18).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not take proper steps to ensure that people were protected from the risks associated with unsafe or unsuitable premises. (Regulation 15 (1) (a - c)).**