Ultima Care Centres (No 1) Limited

Green Acres Care Home

Inspection report

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Date of inspection visit:
22 November 2018
23 November 2018

Date of publication:
24 January 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22 and 23 November and was unannounced. Green Acres Care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service is a nursing home registered to support up to 62 people. There were 26 people using the service at the time of our inspection.

There was a manager registered with CQC, however they were not in post at the time of the inspection. A new manager had been appointed who would begin the registration process when the previous manager had deregistered. A registered manager is a person who has registered with CQC 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.

At the last inspection in November 2017, the service was rated as requires improvement, and was in breach of regulations 11 (Need for Consent), 12 (Safe Care and Treatment), and 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, although the service had made some improvements and was no longer in breach of regulations 11 (Need for Consent) and 12 (Safe Care and Treatment), the service remained in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and was also in breach of Regulation 18 (Safe Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have taken at the end of this report.

The service's provider had contracted another provider to manage the service. There had been a number of different providers over a short period of time. This meant there were conflicting records and systems used. Staff told us this had affected morale. However, they were hopeful that the new provider would ensure stability and had invested in the service significantly.

Records were not always managed appropriately. Staff training records were incomplete and oversight of training needs was ineffective and therefore we were unable to assure ourselves that staff were trained appropriately. However, staff told us they received regular training, people told us they were confident staff had the skills to meet their needs and the new provider had introduced an intensive programme of training for staff so they could be assured staff had the right skills to meet people's needs. Archived information was not stored appropriately, and information retrieval was difficult for staff. We also found that people's fluid intake was not always monitored effectively. Other areas of people's health, such as their nutritional intake, skin integrity and weight was monitored regularly.

Quality monitoring processes were not always robust. The manager had introduced quality assurance mechanisms, which were not yet embedded in practice and driving improvement.

Staff did not receive regular supervisions and appraisals. The service had begun conducting group supervisions and intended to conduct regular one to one supervisions in future.

The service did not effectively gather and act upon feedback from staff, people or their relatives. The service had plans to implement this and some meetings had taken place.

Staff were recruited safely and there were enough staff to meet people's needs. Staff were able to describe how they would safeguard vulnerable adults. Incidents and accidents were reported and investigated appropriately.

Medicines were stored, administered and recorded safely. People told us they received their medicines on time. We observed a medicine's round and found that staff ensured people received their medicines safely.

There were appropriate health and safety checks in place, and risks to people were assessed appropriately with clear guidelines for staff on managing risk.

Food was of good quality, and met people's preferences and tastes. The chef kept a detailed diary of compliments and complaints about food and a record of their likes and dislikes.

Staff were kind, caring and compassionate. People and their relatives told us staff were vigilant in protecting people's dignity and privacy and that staff encouraged people to maintain their independence. People's religious and cultural needs were recorded and taken into consideration.

There was a dedicated activities coordinator in post and people were positive about them and the impact this had on their lives. There was a range of internal and external activities on offer, which took into account people's hobbies and interests, and we observed people were visibly engaged by the activities on offer.

Care plans contained person-centred information and guidance for staff on how to meet people's needs. People were assessed appropriately before using the service and the service created a 'this is me' profile so people's preferred mode of address and other things important to them would be documented and respected by staff.

Staff were confident in the manager's leadership and felt that they were approachable and would act on issues raised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed and administered safely. People told us they felt safe and secure in their environment.

Staff told us there were enough staff to meet people's needs. Staff were recruited in a safe way.

Risks to people's safety was assessed appropriately and adequate health and safety checks were carried out regularly. Staff understood how equipment was used to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's fluid intake was not always recorded accurately. We observed that people had good access to healthcare professionals, and people's other health needs were managed and monitored appropriately.

Staff training records were incomplete therefore we could not be assured staff had received a regular programme of training. However we observed staff were knowledgeable and people told us they felt staff had the right skills to meet their needs.

Staff did not always receive regular supervisions and appraisals. However, this had begun to take place.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and compassionate. Staff had a detailed knowledge of people's personalities and preferences and people had a positive relationship with staff.

Staff knew how to protect people's privacy and dignity, and relatives told us staff were sensitive to people's needs when delivering personal care.

People were supported to maintain a level of independence and the service took account of their religious and cultural needs.

Is the service responsive?

Good

The service was responsive.

People were assessed appropriately before being admitted into the service and care plans contained person-centred and detailed information on how staff should meet their needs.

There was a complaint's process in place, and people and their relatives told us they were confident they knew how to raise a complaint.

The service was implementing an electronic care plan system at the time of the inspection.

Is the service well-led?

Requires Improvement

The service was not well-led.

Records were not managed appropriately. Staff training records were incomplete and archived information was not stored and organised appropriately.

Quality assurance mechanisms were not always robust. However, the new manager had begun to address this and implement new quality assurance measures.

The service did not effectively gather and act upon feedback from staff, people and relatives of people who used the service. However, this was being implemented by the manager.

Green Acres Care Home

Detailed findings

Background to this inspection

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

This inspection was conducted by an inspection manager, an adult social care inspector, a specialist advisor with a nursing background, 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.

Prior to the inspection we reviewed information we held about the service such as statutory notifications (notifications about events the provider is obliged to send to CQC), information from the local authority and local Healthwatch. Healthwatch is an independent national champion for people who use health and social care services. We asked the provider to submit a Provider Information Return (PIR) prior to the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who used the service and five relatives of people who used the service. We reviewed records and documents relevant to people's care and the management of the service, including five people's care plans, medicines administration records, health and safety documents and governance audits. We also spoke with nine staff, including the manager, registered nurses, the head chef, maintenance staff, the activities coordinator and care staff.

Good

Is the service safe?

Our findings

At our last inspection in November 2017 we rated the service as requires improvement. The service was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not used properly or safely. At this inspection we found the service had made the required improvements and was no longer in breach of the regulation.

People we spoke with told us they felt safe. Comments included, "I have only been here a few days but feel safe enough and that the building is secure", "I feel safe", "I like this house, it nice." Relatives said, "[Name] is in a secure room and there are people around", "The place is clean and [Name] is well looked after. I keep asking [Name] about it and they say it's alright."

At this inspection, we found that medicines were managed safely. We reviewed eight people's medicine administration records (MARs) and found that medicines were recorded appropriately, with no errors or unexplained omissions observed. MARs contained photographs of the person, any known allergies, and separate topical MARs or TMARs with accompanying body maps to record any creams or pain patches that were prescribed. There were clear protocols in place for the use of 'as and when' or PRN medicines which described the amount that could be administered and the reasons why. Medicines were stored safely and securely. Medicines which had been opened were labelled with the date of opening, and 'thickener' powder for fluids was stored in the secure medicines trolley to ensure it could not be accessed by vulnerable people. Controlled drugs are those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. We observed a medicine round and found that time was taken to ensure people had taken their medicines. No medicines were left for people to take later.

People we spoke with told us they received their medicines on time. People's medical devices such as catheters were managed safely, and there was relevant information from healthcare agencies and monitoring conducted to ensure they were looked after and maintained appropriately.

There were enough staff to meet people's needs in a safe way. Staff we spoke with confirmed this. One member of staff said, "I think we are alright. If somebody calls in sick we can get agency staff to recover. It's not dangerous. If we work together residents are happy." People and their relatives gave mixed feedback on staffing levels but did not feel that it was unsafe. Comments included: "Sometimes they are a bit pushed for staff, now and again. It doesn't affect [Name] too badly", "They look busy but are always around and have time to chat", "They give me my stuff and just go".

Staff were recruited safely. We reviewed three care worker and two nursing staff personnel files and found that they included interview notes, photographic ID, proof of the right to work in the UK and a disclosure and barring service (DBS) check. The DBS is a national agency which uses the police national database to help employers make safer recruitment choices when working with vulnerable people.

We saw that there were disciplinary policies and procedures in place, and that they had been implemented proportionately and effectively.

Staff we spoke with demonstrated a good awareness of safeguarding and whistleblowing. They were able to articulate potential signs of abuse and what steps they would take to ensure this was escalated and investigated appropriately. One staff member said, "If someone is abusing the person, maybe their family, we have to report them and have to first tell the nurse. Could be staff doing something wrong, or giving poor care".

We found that aspects of the service's tidiness could improve. There was an alcove which contained various pieces of equipment and full bags of soiled linen that were waiting to be moved. We observed a person's crash mat was unclean. The sluice room door which was supposed to be locked when not in use was observed as unlocked on multiple tours of the estate. We raised these issues with the manager who changed the lock and ensured it was locked at all times, the equipment cluttering the alcove was removed when we brought it to the attention of the manager and the crash mat was cleaned. Other aspects of the service were clean, and people and relatives we spoke with said they felt the service was clean and that they observed cleaning staff were always busy.

We reviewed the service's health and safety measures and protocols. We found there were certificates in place for electricity and gas safety, appropriate checks of hoisting and lifting equipment, a fire risk assessment and a legionella check. There were a range of daily and weekly checks conducted such as window restrictor, wheelchair and fire extinguisher checks. There was a fire drill every month which recorded the response time of staff. If this was deemed to be too slow, fire drills were brought forward to ensure the response time improved, for example on 1 June 2018 the response time was seven minutes, so there was another fire drill three days later where this improved to four minutes.

People had risk assessments in their care plans covering a range of areas such as falls and weight loss, and the service used nationally recognised tools such as the falls risk assessment tool, Waterlow skin assessment tool and the malnutrition universal screening tool. There were also personalised risk assessments with clear guidance for staff on how to avoid risk, for example there was a smoking risk assessment with protocols for staff in order to avoid burn injuries and maintain fire safety.

People had 'personal emergency evacuation plans', and there was a business continuity plan with a scheme of delegation for staff and key contacts in the event of a significant disruption to service delivery such as a natural disaster or power cut. Accidents and incidents were recorded and reported appropriately, with actions taken to investigate issues and learn lessons.

Staff received training on preventing infection, and there were measures in place to prevent the spread of infection. Nursing and care staff were observed to wash their hands before and after aspects of care. There appeared to be sufficient supplies of gloves and aprons available. All people and relatives we spoke with felt the service was clean and that staff wore gloves and aprons where appropriate. Cleaning records in the kitchen were well maintained and food temperatures were recorded before service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2017 we rated the service as requires improvement. We also found the service was in breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider could not be sure that care and treatment was provided with consent of the relevant person. At this inspection we found the service had made the required improvements and was no longer in breach of the regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Care plans demonstrated that capacity assessments were carried out in line with the MCA and that best interest's decisions were made which included multiple stakeholders such as health professionals and family members. Staff received MCA training and demonstrated an awareness of the principles of mental capacity and limited awareness of the act. DoLS applications were made and tracked appropriately.

Documents we reviewed indicated that consent had been sought from people for permission to access records, deliver medicines and care as well as using restrictive equipment such as bed rails. People and their relatives told us they were asked permission before care was delivered.

Fluid intake was not always recorded. There was one person who was required to have their fluids monitored but the records were incomplete across several days. No total intake was recorded. This meant that staff could not be assured the person had enough to drink. Another form we reviewed had a target intake of 1,620 mls of fluid each day but frequently the person did not reach this target, and it was unclear what action had been taken or whether this had been analysed as a result. We also found one person with conflicting information in their care plan. One document said that their food and fluid intake was to be monitored, and another document said that it was not. After further investigation and speaking with nursing and care staff it was found the person did not require their intake to be monitored. We observed that fluids were offered regularly throughout the inspection.

Training was not up to date. We could not be assured that staff had received the right training because of poor records management. The provider had developed an action plan to address this. Records demonstrated all staff had completed an induction and fire safety training. Only 37% had completed first aid and 6% completion of end of life care training. The manager told us that all relevant training would be completed by staff in January 2019. A staff member we spoke with said "We've had three days of courses.

Some is online, which has started up again, but some is practical. The training we did before has all gone." Another member of staff said, "We do get good training, practical and online. Moving and handling, fire safety, first aid. We get reminded about it all the time."
Staff received supervisions, however these were themed around topics such as fire incidents in another home and a reminder for staff to get their flu jabs. There were no supervisions recorded where staff discussed issues they wanted to talk about or training needs on a one to one basis. The manager told us they planned to bring in more one to one supervisions as new practices were embedded, with the aim that staff received six supervisions per year. There was also no annual appraisal for staff. Staff we spoke with told us they felt well supported by the manager but that they had not received individual supervisions or an annual appraisal.

We have concluded that the above evidence demonstrates a breach of Regulation 18 (Safe Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt that staff had sufficient skills and training to meet their needs. Comments from relatives included, "They know what they are doing and I have seen them use the hoist", "They transfer [Name] well from the chair to the Zimmer frame", "They know how to transfer and to turn people in bed."

We observed two midday meals at the service. Food looked appetising and of good quality. The kitchen had a five-star rating for food hygiene from the Food Standards Agency at its last inspection in November 2017. The head chef kept a log of compliments, complaints, and conversations with each resident about their likes and dislikes. We observed that there were plenty of fluids available and a twice daily snack trolley with cakes, biscuits and healthier options on offer. Comments about food included, "The food is alright, I have put on weight since I have been here", "The cook will come around to see what you want, there's too much food. You can have a plate of fruit in the afternoon". Relatives said, "They get nice meals. My relative has blended food and energy drinks. There is plenty to drink and people get drinks whenever they want."

Staff received an induction to the service which included training, 'shadowing' senior staff on shifts and a three-month probationary period. One staff member who had recently undertaken their induction said, "Senior staff will help you all day long. Training here is good."

The service ensured nurses were up to date in relation to revalidation with the nursing and midwifery council, and kept a file which included details of their registration and PIN number.

People and their relatives told us people had good access to healthcare professionals and referrals were made to them appropriately. People told us they had seen chiropodists and optometrists when needed. One relative told us their loved one had pressure sores on admission which had not been looked after effectively, but staff knew to reposition them every two hours and that the person's sores had healed. A visiting health professional we spoke with told us that they had no concerns with clinical practice at the service. We saw that there were detailed logs of visits by professionals with information and advice for staff. Where people had injuries such as pressure sores there was a detailed diary of care to monitor progression with guidance for staff on how to aid the person's recovery. The service used nationally recognised tools to monitor people's health such as the Waterlow skin assessment tool and malnutrition universal screening tool.

Good

Is the service caring?

Our findings

At our last inspection in November 2017 we rated the service as requires improvement. At this inspection we found the service had made the required improvements.

People and their relatives told us they thought staff were kind and caring. One person said, "They are nice staff, always pleasant with you". A relative we spoke with said, "The staff are very competent, caring and know everyone on a personal level, residents and visitors. They know the residents and their families really well. It's more of a vocation than a job to them, and they go the extra mile." Another relative we spoke with said, "It's a warm, caring environment, the staff are amazing and you never feel they are just here to do a job".

Staff we spoke with were very knowledgeable about people's personalities and preferences, telling us about their hobbies, life histories, favourite foods and the way they preferred to present themselves. This indicated that staff had a good relationship with the people they cared for. We observed that people's body language was relaxed and that they enjoyed positive relationships with staff. During mealtimes staff were polite, patient and warm towards the people they cared for.

People and their relatives we spoke with said that staff treated people with dignity and respect. One relative said, "Staff are very caring and helpful. They always ask how I am as well. They leave the door open so they can check on [Name], but they close it when doing personal care. They explain what they are doing all the time so that he knows what is happening." We observed staff knocking on people's doors before entering their rooms, and closing doors to toilets and bathrooms for people when in use.
People we spoke with said they were encouraged to be independent. One person we spoke with said, "Staff take me to my room for private things, encourage me to wash what I can and I choose what clothes I will wear." Two relatives we spoke with told us staff did their best to encourage people's independence, and as one person's health had improved they were encouraged to move from their bed to a wheelchair so they could reduce social isolation and do things for themselves. One staff member said, "[Name] was very poorly when they came to us and couldn't get out of bed, but we've helped encourage their independence so now they are always in the lounge with people".

People's rooms were painted in a neutral colour, so that if they wanted it painted a different colour maintenance staff were able to accommodate this. If people wanted their rooms decorated differently they were enabled to do so, for example a person had wallpaper matching their own home put into their room. People who wished to smoke or drink alcohol could do so, as long as they had capacity and these activities were properly risk assessed.

Care plans contained information about people's cultural and religious wishes and how they wanted them to be respected. There was a local vicar who performed religious services once a month, and people were supported to attend a church coffee morning. We saw one instance where the chef had contacted a person's family for recipes on how to cook food from their cultural background.

Good

Is the service responsive?

Our findings

People were assessed appropriately before admission. This included information about people's social networks, healthcare professionals involved in their care, medical history, discharge notes and a bit about their life histories.

Although care plans contained various forms and paperwork from multiple providers, they nevertheless contained sufficient detail and person-centred information on how to meet people's needs. Care plans contained a 'this is me' document which included information about their preferred mode of address, life history, previous work and interests, things that make the person upset and things that make them feel better, and how they preferred to receive their medicine. Care plans contained information on how staff should meet people's needs across key areas of care such as diet, mobility, continence, communication and medicines support. Care plans also contained hospital passports, so that if a person needed to go into hospital staff there would have relevant information important to the person.

Care plans were reviewed each month with details of any changes to people's needs being recorded to ensure that care plans remained effective. They were also changed in response to any deteriorations in health or other changes in circumstances.

Care plans we reviewed did not contain any record of conversations about people's end of life wishes, or any record of a conversation having taken place about what people wanted to happen in the event of their death.

We recommend the service seek support or guidance from a reputable source in relation to enabling conversations about end of life care wishes.

There was a policy and procedure in place for managing complaints. We saw that complaints were responded to appropriately and in a timely way. People and their relatives we spoke with were confident they could go to the manager with complaints. The chef kept a log of complaints and compliments they received about meals so that they could continually monitor and improve catering provision.

There was a dedicated activities coordinator, and activities were planned on a weekly basis. These included in-house activities as well as activities and entertainment from external providers. For example, students from a local university organised fashion shows, trips to pub quiz nights and coffee mornings at a local church. We observed local school children come in to do a bingo afternoon with people. People were very lively and engaged by the activity. Staff were enthusiastic about activities provision. They considered people's interests and hobbies when planning activities, for example a 'knit and natter' session for people who liked knitting, a session at a local art group for people who had an interest in art, and a discussion session about London because a person was from there and was able to discuss their hometown with others. Activities were planned and advertised on the activities board, along with photos of people enjoying previous social events.

People and their relatives gave positive feedback about activities and the activities coordinator. One relative said, "Activities are good under [Staff Name] and have improved since they took over, but before that people would just sit in the lounge. Staff have encouraged my relative to get involved and take part. They take him to the pub on an afternoon sometimes. They did a birthday party for him".

The service was in the process of implementing electronic care plans, and had begun training staff to use mobile phones to input information and retrieve people's care plans. The service was still using paper care plans because the manager was not assured that all staff were proficient in using the new system. One member of staff said, "We are trying to go paperless. At the minute we are using both paper and electronic. Care plans contain good information. If I'm unsure about the electronic plan nurses are always able to help".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017 we rated the service as requires improvement. We also found the service was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective governance systems in place and because records relevant to care and treatment were not always accurate or complete. At this inspection, although the service had made some improvements and was no longer in breach of the regulation, the service was still rated as requires improvement.

There was a manager registered with CQC however they were not in post at the time of the inspection. A manager had been in post since August, however they were not registered with CQC.

We found that there were issues with records management at the service, and that there was confusion between the systems used due to the fact that there had been multiple changes in leadership and changes in leadership over a short period of time. The service's archive room was heavily cluttered and disorganised, and the manager informed us this made retrieving information difficult and time consuming. Care plans, although adequate, contained different paperwork from multiple providers that had operated the service over a number of years. This was evident in other areas of the service, for example in one nurse's room where a whiteboard listed each person on that corridor and their needs, a red dot was used to signify that the person was not for resuscitation, whereas in another room a butterfly was used to indicate the same thing for people on a different corridor. It was explained to us that they were different systems used by two previous providers which were never reconciled. One member of staff we spoke with understood what the red dot was for, but not the butterfly. Another member of staff said, "With records it's difficult always changing company. It's the transfer of records that is really stressful and the changing of all the forms. We have been here many times before."

We reviewed quality monitoring arrangements at the service. The provider was unable to ascertain exactly what training staff had taken due to poor records oversight, and had therefore begun an intensive programme of training all staff to meet its own requirements. However, this was not completed at the time of the inspection. The manager told us they were unable to find records of fire extinguisher checks or emergency lighting checks. However, records of the checks were now in place and evidenced that checks were being completed regularly.

We saw care plans were audited in April and May 2018, but none had been audited in June and July. Since July, we saw the service had begun auditing care plans again, as well as a catering audit. We saw improvements had been actioned and as a result, for example, a deep clean was carried out and new chopping boards purchased. Prior to August 2018 there was no evidence of any analysis or audit of accidents that had taken place. However, this had begun to take place in a limited way. Pressure mattress audits had also not been conducted prior to August 2018, but these were now in place.

The provider had not conducted a quality inspection of the service since February 2018. The new leaders in

post had implemented their own quality visits to identify areas for improvement and generate associated action plans as a result. We saw that some improvements had been noted but there were a number of outstanding actions remaining.

An annual survey of people using the service did not take place. This meant that the service did not proactively seek and take into account people's feedback in developing the service. However, the manager showed us a draft of an annual survey that was to be sent to people by the end of the year. The manager had conducted a residents' and relatives' meeting in July 2018 where they discussed topics such as refurbishment and the proposed takeover of the service. The manager made people aware of their weekly drop in sessions if people had any issues for discussion.

We concluded that the above evidence was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the manager approachable and that they were confident in their leadership despite a period of low morale and frequent changes of leadership. Comments included, "The manager is brilliant, he introduced himself to staff. He has daily meetings with staff, any problems you go along and say your point", "I like their approach. More approachable. I feel confident in their leadership. They would listen to our issues and sort them out", "He is approachable, he is welcoming and is trying to make this home better." Staff told us that because the provider had changed so frequently, staff were apprehensive but positive that the new provider would make improvements. One staff member said, "Morale got really low at one point. It (the service) went from one provider to the other in a short period of time. The new manager came in with a completely different approach and it's getting better. Staff felt really ground down but it's going in the right direction". Another member of staff said, "I think morale has been better recently and everything has calmed down since all the changes. Some staff have gone who weren't helping. Staff are good now. We can work together and help each other".

The manager conducted daily walkarounds of the service, looking at medicines administration, call bell response times, cleanliness of the service and speaking with people to ask how they were. Issues identified and actioned included mopping of floors and a conversation with staff around call bell response times.

The manager also held daily 'flash meetings' where the heads of each department (estates, clinical, catering and domestic) could be kept informed and bring issues to the attention of the manager to be actioned, for example, with people's nutrition, activities organised and any equipment, which needed replacing. One staff member said, "We have daily flash meetings, where all heads of department get together. If they've issues they raise it with the manager. He doesn't mess about and he sorts things out straight away."

There had not been a staff meeting since January 2018. However, we saw that more regular meetings had taken place since the new manager was appointed. Meetings had been held in response to issues such as safeguarding incidents. One staff member said, "We had a team meeting about an incident. It wasn't pleasant, but it was handled in the right way. The manager doesn't mention names. He's not here to be a witch hunter. The incident wasn't reflective of practice I've seen now".

The manager appropriately submitted notifications of incidents and changes which providers are obliged to send to CQC where necessary.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and oversight of the service was not robust, there were concerns with records management and the service did not gather and use people's feedback effectively to develop the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff training records were incomplete and we could not be assured that staff had received the right levels of training and support. Supervisions and appraisals did not take place. People's fluid intakes were not always recorded correctly.