Care Quality Commission

Sanctuary Care Limited

Hatfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 02 and 20 March 2015 and was unannounced. At our last inspection on 07 May 2014, the service was found to be meeting the required standards.

Hatfield Nursing Home is a nursing and residential care home that provides accommodation and personal care for up to 118 older people, some of whom live with dementia. The home is comprised of separate nursing, residential and dementia care units spread over five floors where staff look after people with varying needs and levels of dependency. At the time of our inspection there were 110 people living at the home.

There is a manager in post who is in the process of registering with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers,

Summary of findings

they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection a number of applications had been made to the local authority in relation to people who lived at the home.

People told us they felt safe at the home. Staff had received training in how to safeguard people against the risks of abuse. They were provided with guidance about how to report any concerns which included a 'whistle blowing' procedure. Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs.

People who lived at the home and their relatives expressed mixed views about staffing levels. Our observations found that the effectiveness of staffing levels lacked consistency across different units at the home. In some units we saw there were sufficient numbers of staff to meet people's needs promptly in a calm and patient way. However, in others units, particularly where people's needs and dependency levels were greater, there were often insufficient staff to cope with the demands placed upon them.

We found that people had not been supported to take their medicines on time or as prescribed in all cases. People told us that potential risks to their health and well-being had been identified, discussed with them and their relatives and reduced wherever possible.

We found that staff obtained people's consent before providing the day to day care they required. However, we found that people's consent had not been obtained in line with the MCA 2005 in all cases. We also found that 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions had been taken in relation to a number of people without their proper involvement or consent.

People were positive about the skills, experience and abilities of the staff who looked after them. We found that most staff had received training and refresher updates relevant to their roles. People liked the food provided at the home and enjoyed a healthy balanced diet. They felt their day to day health needs were met and they had access to health care professionals when necessary.

People told us they were looked after in a kind and compassionate way by staff who knew them and their relatives well. Relatives told us they were involved in decisions about the care provided and that staff kept them informed of any proposed changes or developments. We found that personal care was provided in a way that promoted people's dignity and respected their privacy. However, the confidentiality of people's medical histories and personal information had not been preserved in all cases and they did not have access to independent advocacy services.

People told us they received personalised care that met their needs and took account of their preferences. We found that staff had taken time to get to know the people they looked and were knowledgeable about their likes, dislikes and personal circumstances. However, we found that the guidance and information provided about people's backgrounds and life histories was both incomplete and inconsistent in many cases.

People expressed mixed views about the opportunities available for people to pursue their social interests or take part in meaningful activities relevant to their needs. We found the opportunities provided varied and lacked consistency across different units at the home. People and their relatives told us that staff listened to them and responded to any concerns they had in a positive way.

People, their relatives, staff and healthcare professionals were all very positive about the management and leadership arrangements at the home.

At this inspection we found the service to be in breach of Regulations 9, 13 and 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. These breaches correspond with Regulations 9, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.

You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

People told us they felt safe at the home and were looked after by staff trained to recognise and report signs of abuse.

Safe and effective recruitment practices were followed.

People were not always supported to take their medicines safely and when they needed them.

Sufficient numbers of staff were not always available to meet people's needs in all areas of the home.

Potential risks to people's health were identified and effective steps taken to reduce them.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent had not been obtained in line with the MCA 2005 in all cases.

The Deprivation of Liberty Safeguards (DoLS) had been complied with where necessary and appropriate.

Staff received regular supervision and training which meant that people's needs were met by competent staff.

People were supported to eat a healthy balanced diet that met their needs.

People's day to day health needs were not always met in a safe and effective way.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs.

People were involved in the planning and reviewing of their care. However, the guidance provided to staff did not accurately reflect that involvement in all cases.

Care was provided in a way that promoted people's dignity and respected their privacy.

The arrangements for people to access independent advocacy services were inadequate.

The confidentiality of people's medical histories and personal information had not been maintained in all cases.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they received personalised care that met their needs and took account of their preferences.

Care plans did not always accurately reflect people's involvement in their care or information about what was important to them.

Not everybody was supported to pursue social interests or take part in activities that met their needs, either in the home or wider local community.

People were confident to raise concerns and have them dealt with to their satisfaction.

Is the service well-led?

Requires Improvement

The service has not always been well led.

People, their relatives, staff and healthcare professionals were all very positive about the management and leadership arrangements at the home.

Staff told us they understood their roles and responsibilities and were supportive of the changes made by the manager.

The provider has introduced improved ways to monitor and reduce risks more effectively.

Comprehensive plans are in place to ensure that actions are taken to drive improvement.

However, the systems used to quality assure the services provided, manage risks and drive improvement had not always been as effective as they could have been.

Hatfield Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by four inspectors on 02 and 20 March 2015 and was unannounced. Before our inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with 16 people who lived at the home, three relatives, 20 staff members, the home manager and a regional manager. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to 14 people who lived at the home, 20 medicine records and four staff files. We also carried out observations in communal lounges and dining rooms and 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 due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home and their relatives expressed mixed views about staffing levels. One person told us, "Well, there is not many of them [staff] and food is quite often late and is not always warm." A relative said, "The staff are fantastic but they're so busy. Staffing is sometimes an issue." Another commented, "About six months ago the staffing was bad, lots of agency. They were very short, it's much better now."

Our observations found that the effectiveness of staffing levels varied and lacked consistency across the different units at the home. For example, in some units we saw there were sufficient numbers of staff to meet people's needs promptly in a calm and patient way. However, in other units, particularly where people's needs and dependency levels were greater, we found there was often insufficient staff to cope with the demands placed upon them, particularly first thing in the morning and at meal times. This meant that people did not always receive the care and support they needed in a timely manner. For example, we saw that in some cases people had to wait until 10:30am for breakfast, others did not receive help with personal care until midday and in three units the morning medicines rounds were delayed and continued past 11:45am.

Staff told us they were extremely busy, felt 'stretched' and could not always provide the support people needed in a timely way that met their individual needs and preferences. One staff member said, "There's not enough staff here, people are got up when there's time." Another commented, "We are really very busy and would appreciate more carers during the day." Healthcare professionals with experience of the home told us they had concerns about staffing levels. In particular, they felt there were insufficient nurses available to look after and meet the needs of people with the most complex and serious health needs. They told us this had led to poor communication and on occasions had meant that their guidance had not been followed effectively.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found in all units that people did not always receive their medicines as prescribed or when they needed them. For example, some people needed to take their medicines with food but were not given them until two hours after breakfast. This meant that some medicines may have been less effective in the circumstances. Staff could not always be sure that people had been given the correct amount of medicine they needed. This was because they had not accurately recorded what people had been given in all cases and the stocks of remaining medicines had not been reconciled properly.

People who were given medicines covertly, that is without their prior knowledge, were not always supported in a safe way. For example, we saw that people's tablets were routinely crushed into food without first obtaining expert safety advice from a pharmacist or GP. Some people with limited communication abilities were prescribed pain management tablets to be taken 'as required' (PRN). However, staff had not been provided adequate guidance about how to recognise when they experienced pain, the potential triggers or when they would benefit from the medicine. This meant that people's medicines had not always been managed or administered safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and were happy living at the home. One person said, "I feel safe here." Relatives also felt assured that people were safe and protected from harm by staff who listened and responded positively to any concerns they had.

Staff had received training in how to safeguard people and were knowledgeable about the potential risks of abuse. They were provided with guidance about how to report any concerns and understood how to 'whistle blow' if the need arose. Information and advice about the risks of abuse, including contact details for the relevant local authority, were also displayed at the home. One staff member said, "If I had any concerns I would raise them with the team leader." We found that the manager had investigated safeguarding incidents appropriately and reported them promptly to both the local authority and the CQC. We also

Requires Improvement

Is the service safe?

saw that disciplinary procedures had been used effectively where it was believed that staff may have acted inappropriately in the workplace, either toward people in their care or colleagues.

Care staff told us that if they found a person had sustained any bruising or other form of injury they were required to report the matter to a nurse or team leader. One staff member said "Any injuries are recorded on a body map and photographed." However, we found two cases where people had unexplained bruising that had not been documented properly or reported by staff. This meant that people may not have been adequately protected from avoidable harm because neither the cause of injury, or potential risks of abuse, had been thoroughly explored or investigated. The manager acknowledged that incidents and accidents had not been dealt with as effectively as they should have been in all cases.

We saw that plans and guidance had been put in place to help staff deal with unforeseen events and emergencies which included relevant training, for example in fire safety. Dedicated maintenance staff carried out regular checks which ensured the home and equipment used, including mobility aids and safety equipment, were safe and well maintained. However, we found that guidance given to staff about how to evacuate people safely in an emergency lacked consistency. This was because evacuation plans tailored to individual health and mobility needs had been drawn up for some people but not others. This meant that the risks had not always been managed in a consistent, effective or safe way.

Risks to people's health and well-being had been identified and closely monitored by staff to ensure they received safe and effective care that protected them from avoidable harm. Staff had access to accurate and up to date guidance about the risks and were knowledgeable about the care and equipment people needed to reduce them. This included areas such as the risk of falls, malnutrition, dehydration and pressure care. We saw through our observations that staff supported people in accordance with the guidance and regularly checked equipment, for example pressure relieving mattresses, to ensure it worked safely.

One relative told us that staff had taken immediate action to minimise the risk of harm to a family member when they had suffered a number of falls. They introduced effective measures to reduce the risks of further falls and injury which included an increased frequency of checks by staff and use of a sensor mat in their bedroom coupled with safer flooring. The relative commented, "They [family member] were so upset they had fallen but I felt [staff] really listened and took responsibility." This meant that risks had been managed effectively to protect people and keep them safe at the home. We also found that effective recruitment practices had been followed which ensured that staff were fit and able to perform their roles safely.

Requires Improvement

Is the service effective?

Our findings

Most people told us that staff obtained their consent before they provided day to day care. One person said, "They [staff] usually ask me before doing anything, it's nice to be asked." However, our observations found inconsistency across the home in this area, particularly during busy periods such as first thing in the morning and at mealtimes. We saw that some staff members asked people for consent before supporting them, whereas others performed tasks, such as hoisting people with limited mobility or putting aprons on them at mealtimes, without first offering an explanation or waiting for agreement.

We also found that consent had not been obtained in line with the Mental Capacity Act (MCA) 2005 in all cases. For example, people's capacity to make decisions had not always been properly assessed, determined or reviewed where necessary. We saw that in some cases, although people had capacity to make their own decisions, relatives had been asked to provide consent regarding medicines and other aspects of care on their behalf, even though it was unclear whether they were legally entitled. In other cases, where people lacked capacity, decisions made on their behalf did not always follow MCA 2005 requirements or necessarily reflect their best interests. For example, in one case a staff member had provided consent for a person who lacked capacity to be given their medicine covertly.

We also found that 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions had been taken in relation to a number of people who had capacity without their involvement or consent. The reasons given for this did not adequately explain why the person had not involved in or agreed to such a fundamentally important decision. For example, we saw in one case that a decision had been taken without a person's consent because of their 'frailty.' In another, the relatives of a person who lacked capacity were not consulted because they were 'not present.' This meant that people's consent to care, support and treatment had not been properly obtained in all cases and the requirements of the MCA 2005 had not always been followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager demonstrated a good understanding of the Deprivation of Liberty Safeguards (DoLS). These apply when people who lack capacity have their freedom restricted, usually when it is in their best interests to keep them safe. We saw that steps had recently been taken to ensure that applications were made in line with MCA 2005 requirements where it was necessary and appropriate to restrict people's freedom of movement in order to keep them safe from harm.

People were positive about the skills, experience and abilities of the staff who looked after them. One person told us, "Staff are very good here, they look after you and when you need help they are there". However, the manager told us, and our inspection confirmed, that training provision had not been as effective as it should have been. This was because staff had not always been kept up to date in areas such as moving and handling, medicines, person centred care and the MCA 2005. We saw that significant steps had been taken to roll out improved training, timely refresher updates and practical instruction in the workplace relevant to the various roles performed. A staff member told us, "Training used to be very 'hit and miss' but it's really improved since the new manager arrived. We are now well supported and get more 'face to face' and practical training."

Staff told us and our inspection confirmed, that they had not always been adequately supported to develop their skills and abilities because the induction, supervision and appraisal arrangements lacked structure and were not effective. The new manager was aware of this and had already made significant improvements over a short period of time.

An induction programme had been introduced which meant that new staff members were properly supervised and not allowed to work alone until assessed as competent in practice. Staff had also benefitted from the introduction of regular group and individual meetings with senior colleagues [supervisions] to support their personal and professional development. A staff member commented, "We are getting much better support now. The manager is hot on supervisions and giving us the tools we need to do our jobs properly." This helped to ensure that people's needs were met by competent staff who had been supported to develop relevant skills.

People were complimentary about the standard of food provided at the home. One person said, "The food is nice."

Requires Improvement

Is the service effective?

Another person commented, “Food is always quiet good here.” However, people also told us, and our observations confirmed, that there were often delays in serving meals. This meant that food was sometimes left on trollies for long periods and became too cold to eat or enjoy properly. A person who had eaten lunch in their room told us, “Dinner was quiet nice, but a bit cold.” People were able to choose from a menu that offered healthy and nutritionally balanced meal options and had access to a good supply of hot and cold drinks of their choice.

We found that people at risk of not eating enough had been provided with supplementary drinks and fortified food appropriate to their needs. Advice, guidance and support had been obtained from health care specialists such as dieticians and speech and language therapists (SALT) where necessary. Staff were knowledgeable about people’s food and drink preferences and who needed additional support to help them eat and drink. However, we found that the level of support provided to people at mealtimes lacked consistency across the home. In some areas people were provided adequate support to help them eat and drink in sufficient quantities but in others, where people’s dependency needs were greater, staff struggled to cope with the demands placed upon them. The issue of inadequate staffing levels has been addressed under ‘safe.’

People told us that their day to day health needs were met in a timely way and they had access to health care professionals when necessary. One person said, “I am looked after well.” Another person commented, “The staff always ask the doctor to see me when I am worried, they are good to me like that.” We saw that appropriate referrals were made to health and social care specialists when needed and there was regular contact with and visits from the local mental health team, dieticians, dentists, chiropodists and opticians. We saw that GP’s from a local surgery attended the home regularly to review people’s care and ensure they received safe treatment that reflected their changing needs and personal circumstances.

During our visit we saw that a GP reviewed a number of people in one unit who had been identified as having the most significant health needs. These included people who lived with diabetes, complex medical conditions, limited mobility and risks associated with pressure ulcers, malnutrition and dehydration. We also saw that people and their relatives were involved in discussions about care and treatment options during the reviews. This meant that people had been supported to access appropriate healthcare services and maintain good health. However, some GP’s and health care professionals told us that their medical advice and guidance was not always communicated properly between staff on duty or at shift handovers. This meant that it was not always used in a way that met people’s changing needs effectively. The manager was aware of this and has taken immediate steps to improve the communication of medical advice.

Requires Improvement

Is the service caring?

Our findings

People told us they were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs and how they wanted to be supported and cared for. One person said, "Staff are friendly and they look after me well. They speak to me in a kind manner." Another person commented, "I love it here you couldn't beat this place if you tried. Staff are caring. I am happy here."

We saw that staff had developed positive and caring relationships with the people they looked after. They provided help and assistance when required in a patient, calm and reassuring way that best suited people's individual needs. We saw a number of positive interactions between staff and the people they cared for during our visit. For example, we saw that when one person became distressed, a staff member distracted them and provided appropriate levels of comfort and reassurance.

Staff demonstrated a good knowledge and understanding about the people in their care, this included preferred names, backgrounds, preferences and interests. One person told us, "They [staff] are very busy but do take time to get to know us and what makes us tick." A staff member said, "I always read [people's] care plans, for me it is important to know the person." People told us that staff listened and made them feel valued. One person commented, "Staff are really kind and try their best to give us what we want and make us feel at home." This meant that people had their needs met by staff who treated them with kindness and compassion.

People and their relatives told us, and our inspection confirmed, that they had been involved in planning and reviews of their care. One person said, "The staff asked me about what I like and what I need." We saw that reviews of the care and treatment provided had taken place on a regular basis and that people and their relatives had been invited to take part and share their views.

However, we found that written confirmation of people's involvement in planning their care had not always been consistently or accurately recorded in the guidance provided to staff. We also found that people did not have adequate information or guidance about how to access local advocacy services should they need to do so. The confidentiality of information about people's medical histories and medicines was not always consistently maintained across the home. In some units we found that personal information was locked away securely, but in others it had been stored in offices that were frequently unlocked, insecure and unattended. This meant that arrangements put in place to maintain confidentiality and make sure people were listened to and involved in their care were not as effective as they could have been.

Personal care and support was provided in a way that promoted people's dignity and respected their privacy. For example, we found that staff knocked on doors and asked for permission before entering people's bedrooms. One person told us, "Staff are caring and respect my dignity." We saw that one person declined the offer of an apron to protect their clothing during lunch. The staff member concerned respected their wishes and took the apron away. Another staff member told us, "I always knock on people's doors before entering their rooms. I communicate what I am doing and always respect the person's choice." This meant that people were looked after by staff who treated them with respect and dignity.

Requires Improvement

Is the service responsive?

Our findings

Most people and their relatives told us they received personalised care that met their needs and took account of their preferences. One person told us, "My cup of tea will be here shortly, I love a biscuit with my tea. I am very well looked after here, as you can see." A staff member then gave the person concerned a cup of tea and offered them a selection of biscuits from a tin.

We saw that most people's rooms had been personalised with decorations, family photographs, flowers and ornaments of their choice. People and their relatives told us they had been able to contribute, share their views and make decisions about how care and support was provided. One person's relative said, "Staff keep us informed and went through it all [care plans]."

Care and treatment was delivered in a way that was responsive to and met people's individual health and support needs. This included where risks had been identified in areas such as pressure care, mobility and nutrition. We saw that staff were knowledgeable about the people in their care and how they preferred to be looked after and supported. A relative commented, "I am happy that [family member's] needs are being met in a way they prefer and like things to be done."

However, we found that guidance provided to staff about people's likes, dislikes, backgrounds and preferences lacked consistency and did not accurately reflect their changing needs and circumstances in all cases. For example, we saw people had not always been asked about their employment, important life events or relationships that were important to them. This meant that the guidance provided may not have accurately reflected people's views and preferences. The manager was aware of this and had taken steps to improve the quality of information and guidance to ensure that it was person centred and responsive to people's needs.

People expressed mixed views about the opportunities available for people to pursue their social interests or take part in meaningful activities relevant to their needs. One person said, "It's alright but a bit boring." Another person commented, "This week I went to a 1960's concert and it was good. I like to read and the home has lots of books and I like to knit."

Two full time activity coordinators were employed at the home Monday to Friday but not on weekends. Information about scheduled activities, which included bingo and a vintage themed tea party, was displayed in the home but not everybody we spoke with was aware of what took place or when. We noted that the information was not displayed in formats appropriate to everybody's communication needs. The activity coordinators also used a shopping trolley to visit all units in the home which gave people the opportunity to purchase toiletries, sweets and fruit.

Main group activities were scheduled for 2:30pm each weekday in one particular unit. This meant that staff from the four other floors were required to support people who wanted to attend from their unit. Care staff told us this was difficult to manage and achieve because they were often too busy providing support to people who remained on the units and either couldn't or did not want to attend. This meant that some people, particularly those with limited mobility, were not always able to attend or take part in the activity.

Care staff were also responsible for supporting people with their social interests and 'one to one' activities at other times. However, staff told us, and our observations confirmed, that they did not have the time to support people with activities as they were too busy providing personal care and support. During our inspection we noted an absence of meaningful activities provided, either group or on an individual basis, and saw that most people sat around in communal lounges or slept in their bedrooms.

We also found that people had not been given adequate opportunities or supported to access and pursue social activities in the local or wider community. The home had a mini bus to help people go out but we were told it was not used as much as it could be due to limited staffing levels and other demands. One person told us, "I am not mobile but would like to go outside but I am never taken." This meant that some people, particularly those who lived with dementia, had not always been provided with adequate support to pursue their social interests or take part in activities that met their individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because care and support had not always been planned and delivered in a way that met people's individual needs

Requires Improvement

Is the service responsive?

or took full account of their preferences and personal circumstances. This breach corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staff listened to them and responded to any concerns they had in a positive way. One person said, "If I have any worries or concerns I just speak with [staff] and they help me sort it out. I have no complaints." The manager told us, and our inspection confirmed, that people's complaints and concerns had not always been responded to or dealt with as effectively as they should have been.

However, we saw that the new manager had taken immediate steps to improve the way in which complaints were received, handled and responded to. We also saw examples of where complaints had been properly recorded, investigated and resolved by the manager and senior staff in a timely way. For example, the manager had arranged to meet with family members to improve lines of communication and look into concerns they had about the standard of care provided to a relative.

They used the issues raised to improve awareness, care quality and to share good practice among all staff at recently introduced daily team leader and information sharing meetings.

The manager has held meetings with people who used the service and their relatives to provide an opportunity for them to raise concerns, suggestions and to provide feedback. Although at an early stage in development, information generated at these meetings will be used to influence, inform and develop plans of action to help improve the quality of services provided.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives, staff and healthcare professionals, were all very positive about the management and leadership arrangements at the home. They were complimentary about the new manager in particular who they felt demonstrated visible and strong leadership and had made significant improvements in the relatively short time they had been in post. One person who lived at the home told us, "The new manager is very nice, we see them all the time and they often stop to say hello."

The manager had been in post for three months and was in the process of registering with the CQC at the time of our inspection. We found they had been well supported by the provider, a regional manager and senior colleagues from within the organisation. For example, a senior care development manager had reviewed the circumstances of every person who lived at the home to ensure that, where it had been necessary to restrict their freedom of movement in any way, the necessary DoLS applications had been made to the local authority.

We saw that this review had also included checks to make sure sought consent was always obtained in line with MCA 2005 requirements, particularly where people may have lacked capacity to make their own decisions, which had not always been the case previously. The manager told us that the review would be widened to include all DNACPR decisions. This was in light of the problems identified by our inspection in terms of people's lack of involvement and agreement in some cases.

A new role of 'clinical lead', in the shape of an additional deputy manager, has also been introduced to provide further management support and drive improvement in terms of the quality of care and treatment provided. Healthcare professionals with experience of the home told us they had confidence in the post-holder's abilities and felt the role would not only provide much needed additional leadership, but would also improve how staff communicated and managed information and guidance about people's care.

We found that the provider and senior management team, having worked in close cooperation with local authority commissioning and monitoring teams, had made significant improvements in a number of areas. For example, we saw that additional care and nursing staff had been recruited and the reliance on agency staff reduced considerably, training provision had improved and staff felt more valued as a direct result of supportive and consistent leadership. One staff member commented, "The manager is very supportive and approachable, things have really improved."

We saw that the manager and senior colleagues met regularly with staff to discuss the importance of training updates, how to safeguard people and raise concerns, practical implications of DoLS and the MCA 2005 and the need to deliver person centred care. Staff were also encouraged to raise issues important to them and make suggestions about how working conditions and care practices could be improved.

The manager had developed, and was in the process of introducing, new staffing arrangements to ensure that there were always sufficient numbers of suitable staff available at all times to meet people's needs. For example, staff absence from the workplace was managed more effectively with the introduction of an 'absence coordinator', together with more robust sickness monitoring and formalised breaks. Staff had been consulted and invited to make comments and suggestions about proposed changes to working patterns. We also saw that staff disciplinary procedures had been used to good effect where appropriate to tackle poor attendance, inappropriate conduct and performance issues.

The manager had also improved training provision and told us they had moved the emphasis away from online e-learning, to classroom style teaching and practically based workplace instruction and assessment. This was because they felt that 'face to face' training was more effective in some areas as trainers and staff had the opportunity to explore subjects more thoroughly and in a practical context. We saw that additional training in areas such as infection control, medicines and dementia and person centred care was also planned. The manager had introduced checks to make sure that agency staff were not used unless satisfied they were properly trained, experienced and could deliver care safely.

Staff told us they understood their roles and responsibilities and most were supportive of the changes made by the manager. We found that the management team and staff at all levels recognised the challenges that remained and acknowledged the need for sustained improvement in a number of areas. For example, the

Requires Improvement

Is the service well-led?

manager had arranged for a review of the support, care and treatment provided to every person who lived at the home. This was to make sure that the guidance used by staff was accurate and reflected people's family history, preferences and other information about how they wanted to be cared for. The manager told us, and staff had been made aware, about their vision to embed a culture of care throughout the home based on respect, dignity and person centred care that took account of people's individual circumstances and met their needs.

The senior management team have linked in with a reputable professional care provider's association to obtain additional support, training and guidance. They have also worked closely with other healthcare specialists and organisations to obtain additional training and development for staff in areas such as pressure and palliative care. The manager has also met with GP's who treat people at the home and nursing staff from a local hospice to improve both the exchange of information and knowledge about how to improve the overall quality of care.

The provider has introduced improved ways of helping the manager to monitor and reduce risks more effectively in areas such as infection control, medicines, accidents, injuries, falls and pressure care. Arrangements had also been made to improve the way in which complaints were handled and feedback about the quality of services provided was obtained from people, family members and health and social care professionals. It was acknowledged that significant improvements were necessary in this area because for example, investigations about complaints and the circumstances surrounding falls and injuries, had not always been carried out effectively. We saw that the manager had taken immediate steps to address outstanding complaints and had personally met with people and their family members to discuss and resolve on-going any concerns.

We saw that comprehensive plans were used to make sure actions were taken and completed in a timely way to reduce identified risks and drive improvement, particularly where problems had been previously identified by the local authority and CQC. These plans were reviewed and scrutinised by the provider on a regular basis to ensure that satisfactory progress was made and to improve accountability. The manager met with members of the management team and senior staff from all departments on a daily basis. This was to review and discuss any significant changes to people's health or care needs and to share information about good practice, performance, risks, training needs and monitor the progress of action plans.

This meant that people and staff have benefitted from an open and supportive culture that has started to deliver improvements in the quality of care, support and treatment provided. However, both the provider and manager recognised that further sustained improvements were required to ensure that people received high quality care that met their needs safely at all times.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Care and welfare of people who use the service. How the regulation was not being met: The registered person did not take proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. This was because care had not always been planned and delivered in a way that met people's individual needs. This breach corresponds with Regulation 9 (1) (b) & (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Management of people's medicines. How the regulation was not being met: The registered person did not take steps to ensure people were protected against the risks associated with the unsafe administration of medicines. This breach corresponds with Regulation 12 (1) & (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.

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 Consent to care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Staffing arrangements. How the regulation was not being met: The registered person did not take steps to ensure there were sufficient numbers of suitable staff available at all times to meet people's needs. This breach corresponds with Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.
	How the regulation was not being met: The registered person did not take steps to ensure that people's consent to care and treatment was obtained in line with the MCA 2005. This breach corresponds with Regulation 11 (1) to (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.