

# Hartwood Care (2) Limited

# Sunnybank House

## Inspection report

Botley Road  
Fair Oak  
Eastleigh  
Hampshire  
SO50 7AP

Tel: 02380603120  
Website: [www.hartfordcare.co.uk](http://www.hartfordcare.co.uk)

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on 01 and 07 March 2017 and was unannounced. The home provides accommodation for up to 60 older people. There were 48 people living at the home when we visited, some of whom were living with dementia and some of whom required nursing care. The home was organised over three floors, with one floor dedicated to people living with dementia and one floor designated for people who required nursing care.

A registered manager was not in post at the time of our inspection. 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 service had appointed a new manager whose intention it was to register with CQC. However, the home had had numerous changes in management over the past two years. People and staff felt the frequent changes in management had a negative effect on the quality and running of the home.

The manager had identified areas for improvement within the service and was working towards completing an action plan, which identified where changes were required. People and staff spoke positively about the initial changes the manager had made to the running of the home. The manager had recently implemented a series of cyclical audits, which would monitor and assess the quality of the care and the safety of the home. The improvements needed to be embedded and sustained to ensure people received high quality care over an prolonged period of time.

Systems to safely manage people's medicines were not always effective. People did not always receive their medicines as prescribed and recordings of medicines given were not always accurate. The manager had made changes to the home's medicines management system, which had resulted in improvements being made in these areas; however, improvements were in the initial stages and could not be evidenced as sustained.

People's care plans did not always reflect people's most up to date needs. The manager had identified these issues and assigned staff to complete the areas which were outstanding. The manager had also arranged for staff to complete training which gave them knowledge and skills in effective care planning. People's care plans which were completed were detailed; person centred and met people's needs. Risks to people were identified and incidents were analysed to look for ways to reduce future risks and likelihood of reoccurrence.

People were supported to access healthcare services and were supported to follow a diet in line with their preference and dietary requirements.

The provider had not implemented systems and processes to gain formal feedback from people using the service or their relatives. A questionnaire was due to be sent out to people asking for their feedback about

the quality of the care being provided, but the provider was unable to locate the results of any previous feedback sought. A complaints policy was in place, which the manager followed. Records of investigations were thorough and transparent, with lessons learnt from mistakes and people fed back to about findings.

There were sufficient numbers of staff available to support people. However, there were shortages of permanent staff, which meant that agency staff were required to complete full staff allocation. People, relatives and staff felt that agency staff did not always provide effective and compassionate care. The provider was in the process of recruiting additional permanent staff.

Permanent staff were caring and understood people's needs well. Staff had received training in safeguarding and understood the steps required in order to keep people safe. Staff had also received training in The Mental Capacity Act (2005) and understood how to promote and respect people's rights.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken in the full version of this report.

## 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.

The service did not always have safe systems in place to manage people's medicines

Although enough staff were provided for each shift, there was a high reliance on agency staff who people, relatives and staff did not always feel were suitable.

Staff understood how to safeguard people from abuse. The provider followed recruitment processes to ensure suitably skilled and qualified staff were employed.

Risks to individuals and the environment were managed to ensure that risks were minimised.

### Is the service effective?

**Good** ●

The service was effective.

Staff followed legislation designed to protect people's rights.

Permanent staff received sufficient training and supervision to carry out their role effectively.

People were supported to access healthcare services when required.

People were supported to follow a diet in line with their individual preferences and health and dietary requirements.

The environment was suitable for the people living at Sunnybank House.

### Is the service caring?

**Good** ●

The service was caring.

People were treated with dignity and respect.

Permanent staff knew people's needs well and took time to ensure their welfare.

People's wishes around their end of life care were respected.

### **Is the service responsive?**

The service was not always responsive.

People's care plans did not always reflect their most current needs.

The provider had not obtained formal feedback about the service from people or relatives.

People had a range of activities available for them to participate in.

The manager investigated complaints thoroughly and implemented change from lessons learnt from mistakes.

**Requires Improvement** 

### **Is the service well-led?**

The service was not always well led.

People, relatives and staff felt that frequent changes in management had negatively affected the running of the home.

There was not a registered manager in place at time of inspection.

The manager had made improvements to the service since joining in January 2017 and had formulated an action plan to make improvements to the service.

Incidents were analysed to look for reduce the likelihood of reoccurrence.

**Requires Improvement** 

# Sunnybank 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 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, which took place on 01 and 07 March 2017, was completed by two inspectors and was unannounced.

Before the inspection, we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events, which the service is required to send us by law. We also spoke with two relatives of people who had experience of using the service, who contacted CQC prior to the inspection. We also spoke to one social worker.

We spoke with 14 people living at the home or their relatives; We also spoke with the provider's representative, the manager, the deputy manager, nine nursing or care staff, two agency staff and a visiting nurse practitioner.

We looked at care plans and associated records for 11 people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

# Is the service safe?

## Our findings

At our previous inspection in November 2015, we found the arrangements in place to record and administer medicines were not always safe and that not everyone received their medicines as prescribed. At this inspection, we found that sustained improvements were required to demonstrate that the service's medicines management systems were safe and robust.

The manager told us how they had changed the medicines management system to respond to an incident that occurred in November 2016, where a person went without their prescribed medicines for five days. The manager told us that the service had experienced supply issues for the person's medicines and they were not available for them to take. However, records showed that the person had missed two doses of their medicines before a senior member of staff was informed and action was taken try to obtain the required medicines. Subsequently, the manager had established positive working relationships with the GP surgery and dispensing pharmacy. They had put in place a protocol and contingency plan to respond effectively in the event that people's medicines were not available. The manager told us that this incident happened before they started working at the home, but felt it was important to put a system in place to avoid a similar incident reoccurring. Since the implementation of the system, there had not been a medicines error at the service. In comparison, there had been 15 reported medicines errors at the service from October 2016 to January 2017, before the implementation of the new medicines management system. The 15 instances include the medicines missed over a five-day period by one person.

The processes in place to ensure that all medicines were accounted for were not effective. There were discrepancies in the amount of medicines the home had stored compared to the expected level peoples' records stated. We counted the amount of medicines stored for three people and found the amounts in stock were different from expected levels. With one person's medicines, there were 12 less tablets then the amount documented in medicines records. This could indicate that the person had been given more medicines then prescribed. Another person's medicines had four more tablets then the expected level. This may indicate that the person had not received all medicines which were prescribed. The third person's medicines stored were found to be of the correct amount, after we recounted the tablets available. We found that staff had made an error in recording the amount of tablets which were carried over from a previous prescription when a new prescription had arrived. The manager had identified this issue and had recently introduced a recording system, which instructed staff to count and record the amount of medicines stored at time of every administration. This was in order to ensure that the amount of medicine stored corresponded with the expected amount. Senior staff checked the records to help ensure that any discrepancies and address these with staff. The manager checked records and audited samples of people's medicines weekly as part of their auditing processes. This system would help to put measures that are more robust in place to monitor levels of medicines stored at the home.

There were suitable systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. However, four people's MAR records for the application of topical creams had missing or incomplete entries. Although other daily recordings confirmed those people

had their creams administered, staff told us it was not always clear that people had received or been offered them. One member of staff said, "It's the night shift and agency who don't complete the records (of administration of topical creams), it leaves the rest of us chasing round trying to work out whether we need to give them (apply topical creams)". The manager had picked up discrepancies and gaps in recording as part of their auditing of the medicines management system. Topical creams kept in people's rooms did not all have a date the cream was 'opened on' to help ensure these were disposed of within manufacturers guidelines. This was discussed with the senior carer at the time of the inspection and immediate action was taken.

The failure to ensure medicines were managed safely was a breach of regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had plans in place to identify when they needed 'when required' medicines for pain or other medical conditions. The service used a nationally recognised pain assessment tool. This helped to help support people with pain management who were unable to communicate verbally. We observed staff prompt people by asking, "Do you have any pain?", and another person was asked, "Do you need your eye drops today?". People's medicines records and support plans were organised clearly and were easy to follow.

Some medicines needed to be stored at specific temperatures to maintain their effectiveness. A refrigerator was available for the storage of medicines which required storage at a cold temperature in accordance with the manufacturer's instructions. Staff monitored and recorded temperatures for medicine storage areas to ensure that medications were stored at the appropriate temperatures.

There were sufficient staff available to meet people's needs. One person told us, "There seems to be enough staff around". Another person said, "I am never kept waiting when I ring my call bell". The manager calculated staffing levels using a dependency tool, which took into accounts people's needs, and the level of support they required. The manager had introduced additional staffing numbers during the morning and evenings to help people to get up and go to bed. This was in response to feedback from staff that they required additional support during these times. The service had recently employed a clinical lead, whose role it was to oversee the nursing care at the home. The manager told us this was to ensure that each of the three floors in the home had a suitably qualified member of staff supervising and overseeing them.

However, there were shortages of permanent staff and agency staff filled gaps in the provision of staffing on a frequent basis. People and their relatives felt that the level of agency staffing was having a negative effect of the quality of the care being provided. One person told us, "I do not feel comfortable with agency staff, sometimes they send males, sometimes you get the impression they don't care. I feel that the staff (permanent staff) do not like them either". Another person commented, "The agency staff are not as good, they are definitely not as caring". A third person reflected, "The agency staff are nice enough people, but I would rather they didn't send them. They simply don't know how to do things the way I like". A relative stated, "The main issue is the agency staff, there are too many. They do not understand my relative's needs and can be heavy handed. How can they know 20 people's needs or read 20 care plans if they are coming and going? They are not committed and it shows".

Permanent staff also felt that agency staff were not always efficient and skilled enough to meet people's needs. One member of staff remarked, "We are forever picking up after agency staff. They are lazy and don't know what they are doing, you feel like you are doing two people's jobs". Other staff comments included, "When I first started working here it was lovely but it has gone downhill. The changeover of staff is awful. There is not enough staff and too much agency", and, "There is not enough staff and too many agency staff. When there is the right staff it flows nicely, I have complained in the past about the quality of the staff, things

are getting better, I think".

The manager acknowledged that staffing levels for permanent staff had an impact on people and that it was their main priority to address. They told us, "The previous management appointed some people into positions where they were not suitably qualified. We have had to address this. In addition, when I came in I found that the previous management had granted too much annual leave, which has left us relying on agency. We are recruiting now and hope to significantly reduce our agency usage by May (2017)". The manager also had a system in place where competent agency staff were identified by senior staff and requested for regular shifts at the home.

At our previous inspection in November 2015, we found that the provider did not always ensure the security of cupboards containing hazardous materials or make suitable arrangements for the safe storage and disposal of waste. At this inspection, we found that improvements had been made and the home was a clean and safe environment, which had systems in place to ensure that all waste and hazardous items were stored and disposed of safely and securely.

Safe recruitment procedures were in place to help ensure that only suitable staff were employed by the service. Staff files included application forms containing their full employment history, together with reference checks. In addition, the service made checks with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with vulnerable adults. The manager had obtained recruitment and DBS information for agency staff. This helped to ensure that agency staff had relevant experience, training and qualifications.

Risks to individuals were managed safely. Care files contained appropriate risk assessments, which included, use of bed rails, use of lap belts, risk of choking, mobility, falls and use of mobility equipment such as hoists. One person had a risk assessment in place for choking which stated, that the person required the support of a member of staff to encourage them to eat slowly and prompt them to swallow. We observed staff following this guidance during a mealtime. Another person had a risk assessment in place identifying the risk of developing a pressure injury. The assessment instructed staff to support the person to regularly reposition themselves and use a pressure relieving cushion when sitting. We reviewed this person's repositioning chart and their position had been changed as stated in the risk assessment. They were also sat on a pressure-relieving cushion, which further reduced the risk of them developing a pressure injury.

Risks associated with the environment were safely managed. People had individual assessments completed to identify the support they required in the event of a fire and the actions staff were required to take to keep them safe. The manager made checks to ensure that risks around water temperature, maintenance of emergency equipment and infection control were monitored. This helped to ensure a safe environment for people living at Sunnybank House.

People told us they felt safe living at Sunnybank House. One person commented, "I am more than happy here, it's a good place". Another person said, "It's a calm atmosphere here, it's safe". A third person reflected, "I have never considered safety to be an issue whilst I have stayed here".

Staff were knowledgeable about identifying safeguarding concerns and understood how to keep people safe. All staff had received training in safeguarding, which helped them identify the actions they needed to take if they had concerns about people. One member of staff told us, "If I was concerned I would go to the manager or whistleblow (follow the provider's whistleblowing policy)". A whistleblowing policy provides staff with details of external organisations where they can raise concerns if they felt unable to raise them to management in the home. Another member of staff said, "We know all about safeguarding, what is abuse,

what we should do about it, who we should report it to. Firstly, it's your manager, but you can go higher (senior management) if you don't think things are getting done". The manager understood their responsibilities for safeguarding people from harm and had acted appropriately when concerns had been raised to them.

# Is the service effective?

## Our findings

People felt the permanent staff were sufficiently trained and skilled to understand their role. One person said, "The staff here seem to know what they are doing. I have no concerns". Another person said, "If you are talking about the real (permanent) staff, then I would say they are all pretty good at their jobs, some better than others, some really good".

Staff received a training programme, which was suitable to meet the needs of people living at Sunnybank House. This included training in safeguarding, moving and handling, The Mental Capacity Act, health and safety, infection control and first aid. Some people had completed additional training in dementia, whilst other staff were completing qualifications in health and social care. Staff were positive about the training provided. One member of staff said, "I have had lots of training and refreshers", and another member of staff told us, "I have had lots of training since I have been here".

Permanent staff received an induction when they started working in the home, which included time to read care plans, review policies and work alongside experienced staff. One member of staff told us, "When I started I had an induction and was given a hand book and policies to read". Another member of staff said, "I had a two week induction with the deputy manager when I started". Agency staff told us they had spent time with permanent staff when they first started working at Sunnybank House to help enable them to understand their role and duties.

Staff were supported through supervision to build their skills and knowledge. Staff were encouraged to reflect on their work performance during supervision. In addition, concerns and training needs were discussed. The manager also conducted work based observations of staff. This helped to give them first-hand knowledge of staff's working practices and behaviours.

People's legal rights were protected as staff followed the principles of the Mental Capacity Act (MCA) 2005. The 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 MCA 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. When people lacked the mental capacity to take particular decisions, such as the delivery of personal care, the administration of medicines and the use of bed rails, the provider documented why decisions had been made in the person's best interests and who was involved in making specific decisions.

Staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. Staff complied with people's wishes; for example, one person was reluctant to eat their meal. Staff encouraged them and then gave them time until they signalled they were ready to have their meal. One member of staff told us, "You have to do things as people want, in their own time, how they want. It takes patience and understanding".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and if any conditions on authorisations to deprive a person of their liberty were being met. We found staff at Sunnybank House were following the necessary requirements. The manager had applied for DoLS authorisations and staff understood their responsibility to keep people safe in the least restrictive way.

People told us they liked the food and were able to make choices about what they had to eat. One person told us, "Lunch was very nice". Another person said, "I always get a choice about what I have [to eat] sometimes I don't like the menu choice, but they [staff] are very accommodating to give me something else". A third person said, "The food is one of the best aspects here". A fourth person commented, "They always come round to refresh my drinks throughout the day".

The manager showed us a new 'nutritional profile', which had just been implemented. The profile gave a snapshot of person's nutritional needs including; allergies, specialist requirements (food puree, fluid thickening), any assistance required when eating and medical conditions that may affect their nutritional support. The 'nutritional profile' assessed whether people were at risk of malnutrition and helped to give staff a clear representation of people's nutritional needs. The chef was aware of people's dietary preferences and attended a daily meeting with care staff, which provided them with information in relation to people's changing dietary needs. They also visited people who were unwell or had a reduced appetite to encourage them to eat and discuss menu options. This helped ensure that people were being supported to meet their dietary requirements. Some people required their food and fluid intake to be monitored for health reasons. In these cases, staff kept records to monitor that people had received the appropriate food and fluids to help maintain their health.

We observed support staff gave to people over three lunch meals. Some people choose to eat in their rooms, but most people ate in communal dining areas. Where people required support or encouragement to eat, staff were available to help them. People were calm and relaxed in this environment and were unrushed with their meals. We observed staff regularly attending to people in communal areas or in their rooms to offer fluids and snacks. This helped to ensure that they ate and drank sufficiently.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. People had access to doctors, opticians, dentists, chiropodists and other health professionals as required. One person said, "They [staff] always call the doctor if I am under the weather". A relative said, "I think they manage [my family members'] health well". A visiting nurse practitioner commented, "I am called in appropriately. People are clean and appear well looked after".

The provider had made adaptations to the environment to make it suitable for people living with dementia and those who had nursing needs. Toilet doors were painted yellow to clearly distinguish them from other doors. This helped people navigate around the environment. The home had a calm and spacious feel, with lots of natural lighting. Walkways were clean and unobstructed and had signposting to help people navigate to different areas of the home. One of the communal areas on the floor where people living with dementia were accommodated had been designed to look like a homely kitchen. Many people chose to eat in this area and told us that they enjoyed the atmosphere there. The manager told us that they had a policy to only turn on the television if people actually wanted to watch it. This was to reduce background noise, as people living with dementia can be sensitive to sound. Suitable adaptations including overhead tracking hoists in bedrooms and extra wide doors enabled people who were cared for in bed to leave their rooms and join in with activities. People had access to the garden area, which had been landscaped to provide clear,

uncluttered walkways, benches and tables where people could sit. The garden was fully enclosed and the exits were kept locked to help ensure people did not wander out of the garden if they became disorientated.

# Is the service caring?

## Our findings

People told us that they felt the permanent staff were caring and considerate to their needs. One person said, "I have my favourite, [staff member] is lovely". Another person told us, "The staff are very caring people". A third person said, "They [staff] have been kind to me since I have stayed here".

People received care and support from permanent staff that had got to know them well. During our inspection, staff were caring towards people, supporting them in an unhurried manner and engaging them with jokes, humour and light banter. Staff were encouraged to sit with people in the afternoons and spend time with them talking about their day. One person told us that staff supported them to visit her friend in another part of the home on a daily basis. The person required support from staff to mobilise using their wheelchair. They said, "Every afternoon staff wheel me over, I appreciate that a lot". Another person was being supported by a member of staff to try to contact a friend who they had lost touch with.

People were supported to make choices and be as independent as possible. One person told us, "They [staff] let me get on with things as best I can, sometimes I need help. Another person's care plan stated, 'Person is able to dress independently, but needs encouragement to change their clothes'. A third person said, "I like to have my breakfast after getting dressed, always have".

People's privacy and dignity was respected. Staff knocked on doors before entering rooms and doors were closed during personal care. People were given the choice to join others in communal areas or spend time in their rooms. One person told us, "I much prefer staying in my room, staff always offer me to go into the lounges, but I am happy here". People's care plans identified whether they required private time with visiting loved ones and arranged for people to be given privacy during these visits. Where necessary care plans provided guidance for staff as to how best to communicate with people. For example, in one person's care plan we saw guidance that staff should speak clearly and slower than normal in an adult manner. This prompted staff to tailor their communication appropriately to the person and we saw staff following this guidance.

People's confidentiality was respected and upheld by staff. People's care records were stored securely away from communal areas, so were not in view of visitors or other people. Staff handed over information to each other away from communal areas. This helped to ensure that personal or sensitive information about people was kept private.

People's wishes around their end of life care were respected. People's care files documented people's preferences around the care they wished to receive leading up to them passing away. These included following any cultural or spiritual beliefs that would affect the care provided. Some people had advanced wishes, which were documented, and where appropriate, people's relatives were involved in developing these care plans. Staff had received training to understand the principles of delivering compassionate end of life care.

## Is the service responsive?

### Our findings

Not all care plans reflected people's most up to date needs. The manager had undertaken an audit of care plans in March 2017. This showed that 11 out of 18 care plans for people on one floor required either updating, or were due for a review. Some people required a periodic review, which was in line with the providers policy, whilst others needs had changed after periods of illness and others had sections of care plans, which were incomplete. One person's care plan did not have information about their daily routines and preferences. This meant that new or agency staff may find it difficult to support them effectively with their personal care routine. The deputy manager told us how they were planning to ensure all people's care plans reflected their current needs. They told us, "We are working through them (outstanding care plans), we have prioritised those with risks or highest needs. Whenever a senior staff member is on, their responsibility is to update one person's care plan". The manager showed us training documentation they used to give guidance to staff to provide them with the skills and knowledge to effectively update people's care plans. They told us this training was ongoing.

Where care plans had been reviewed, we found they were informative, detailed and personalised. These care plans included; personal care needs, eating and drinking, communication needs, elimination and continence, breathing, cognition, sleep, social and emotional needs and mobility needs.

Care plans, which were completed, detailed information to enable staff to monitor people's health and wellbeing. One care plan informed staff about how the person's medical condition affected them emotionally, the steps staff could take to reassure them and when the symptoms escalated, how a doctor should be contacted. Another person's care plan detailed the support they required around their diabetes and signs staff needed to look out for to recognise they were not well. The person's care plan stated that they required three sweeteners in their tea and were to be given diabetic options at meal times. Their care records reflected that staff followed this guidance.

The provider was developing ways in which to gain feedback from people about the service. They planned to send out a questionnaire to people and relatives to ask them to reflect about the quality of the care provided and competency of staff. This was due to take place in May 2017. At time of inspection, the manager or regional manager were unable to provide any feedback obtained from the previous management from people or relatives about the quality of the service provided at Sunnybank House. The manager told us they planned to implement regular meetings with residents and families to discuss issues and gain feedback about the home. The previous manager held the last resident's meetings in May 2016.

The manager investigated complaints thoroughly and tried to implement learning from mistakes that had been made. One person told us, "I am quite happy to make a complaint to the manager if I have one". The manager had documented investigations that took place because of complaints people had made. Findings of investigations were fed back to people and learning points embedded through staff supervision and changing procedures or systems to make the running of the home more effective.

People were supported to take part in a range of activities, which were in line with their interest. These

included games, walking groups, visiting external entertainers and movie screenings. People were supported to join in with household tasks and meal preparation. This enabled people to continue with routines and activities they enjoyed. On the first day of inspection, an external singer came to entertain people. Staff encouraged over 20 residents to congregate in a large communal space and engaged people to sing and dance whilst listening to the singer. One person said, "Yes, it's really rather good isn't it". Another person said, "I love to have a dance with staff, it keeps me feeling young".

## Is the service well-led?

### Our findings

At the time of our inspection, the home did not have a registered manager in post. The manager had started working at the home in January 2017, and told us it was their intention of applying to be registered with CQC as manager.

People and staff felt that frequent changes in management had a negative effect on the quality of the care and running of the home. One person said, "There have been so many changes, I just can't keep up". Another person commented, "There have been so many comings and goings at the top (management). One manager only lasted a few months, then I found out they had gone". One relative reflected, "Managers keep leaving, there must be something going on". One member of staff told us, "I have had about seven different managers in the past couple of years, it's ridiculous". Another member of staff commented, "No one takes charge of the shift, we don't work as a team. I don't think anything is going to change". A third member of staff remarked, "Staff issues have been reported but no one ever does anything".

People spoke positively of the new manager. One person said, "Yes, she certainly seems good, organised". Another person commented, "The new manager is approachable and friendly, I hope she stays". Staff spoke positively about the new manager, but were concerned that their tenure may be a short one and were worried about the effect this may have. When asked about the new manager a member of staff said, "I'm not going to comment, let's see if they stay, we have had so many, I hope they stay". Other staff comments included, "I have confidence in the new manager, she is approachable and I think things are going to improve", "I like working here and things are really improving", and, "We now have some leadership and the new manager is approachable".

The manager had recently appointment a deputy manager who had previous experience working at the service. They told us they understood the challenge of instilling a positive culture within the home. The manager said, "I think the staff need some support. There have been many changes and it has been difficult". The deputy manager added, "There have been several different managers here over the past couple of years, we need to earn the staff's trust".

The manager had recognised the challenges of making the improvements which were required at the home. They had received support from the provider to carry out a 'quality outcome review' of the home. The review assessed the quality and safety of the service. The manager and deputy manager were open and honest about areas which required improvement and had formulated an action plan, which detailed how they would make changes to the service. The deputy manager told us, "We know there are issues, we know you will find them, one of the main issues is care planning. The main thing is to teach and mentor staff, staff will not know all they need to know unless we support them and show them". The action plan for the service detailed 22 areas which were identified as needing development or changing. The action plan included areas which required improvement highlighted during our inspection including; staffing, medicines and care planning. At the time of inspection, the manager and staff had completed 16 actions and were working towards completing the remaining outstanding areas. The manager had recently held a staff meeting where they had addressed some performance issues with staff and had shared plans going forward to improve the

service.

The manager showed us plans to introduce a computer system in the home that staff would use on a daily basis to record, monitor and update people's care plans and daily recordings. Staff would use mobile phones given to them by the provider to update the computer system whilst they were on shift working with people. The manager told us the system would allow them to have a live insight into people's health and wellbeing in the home and would allow them and clinical leads to notice trends and concerns, giving them a broader oversight of the care being provided at the home.

The manager had also introduced a programme of scheduled cyclical audits that looked at the quality and safety of the home and the care being delivered. These included; infection control, health and safety and the maintenance of emergency equipment in the home. An infection control audit was being completed at the time of inspection, where no concerns were found.

There was a system in place to record and analyse incidents in order to reduce likelihood of reoccurrence. The manager collated all incidents reports together monthly. From this information, they produced an 'incident analysis'. This looked at where incidents took place, how often they took place, who was involved and any measures that could be taken to reduce the risk of reoccurrence. The manager had recently introduced an incident recording form for staff, which asked them to reflect on why incidents happened and what they could do to avoid them happening again. Records of incidents were detailed and had been used effectively when monitoring people's health to review their care needs.

The manager had notified CQC about significant events that happened in the home. We used this information to monitor the service and ensure they responded appropriately to keep people safe. Previous inspection ratings were clearly displayed in a communal area of the home. This showed openness and complied with the registration regulations. The provider had a duty of candour policy in place, which set out the responsibilities of the manager to inform people or their legally appointed representatives when mistakes occurred.

Clear improvements had been made in the past few months under the new management structure as they worked through their action plan to address all of the outstanding areas. However, the leadership of the service had yet to demonstrate that the improvements had been embedded and sustained to deliver high quality of care over a prolonged period.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider failed to ensure they had an effective system in place to manage people's medicines