

## South West Care Homes Limited

# Kenwyn

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

This focussed inspection took place on 19 April 2018 and was unannounced. We decided to complete this inspection in light of two safeguarding alerts raised by healthcare professionals, a concern raised by a friend of a person using the service and feedback from a mental capacity assessor. They had visited the service to reassess someone who was subject to a Deprivation of Liberty safeguard. Concerns were centred on there not being enough staff to meet people's needs, answering the door bell in a timely way and lack of activities for people. The community nurse team were also concerned about the skills and experience of the current care staff team. There were also concerns expressed about one person who had gone to hospital. Concerns centred on whether they had been assisted to stay hydrated sufficiently and about the cleanliness of water jugs and glasses in people's rooms. During this inspection we found some of these issues were substantiated. We found there were not always enough staff with the right skills for the number and needs of people. We did not find evidence to show people were not being supported to stay hydrated. Water jugs were being changed daily as a result of the complaint made.

In January 2018, we completed a comprehensive inspection and rated the service as 'good'. However, due to there not being sufficient staff available at key times, we judged the 'safe' question as requires improvement'. We did not issue a requirement because we were assured by the provider and manager that they were addressing staffing levels.

At this focussed inspection we looked at three key questions safe, responsive and well-led. No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

Kenwyn is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides care and support without nursing for up to 25 people. Most people are living with dementia and illnesses associated with frailty and old age.

The manager for the service joined the company in January 2018. He is in the process of applying to register 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, 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.

On this inspection, we again found there was insufficient staff at key times to meet people's needs and keep people safe. There were three care staff which included the team leader for 20 people, some of whom had complex needs. We observed people during the morning sitting for long periods with little or no stimulation. One person remained in a transit wheelchair for all of the morning. This placed them at risk of developing pressure sores as transit wheelchairs are not designed for people to sit in for long periods. When we fed this

back to the manager, they agreed this was not best practice and asked a member of staff to ensure the person was transferred to a more comfortable armchair after lunch.

We observed another person becoming increasingly agitated with people around them. They shouted out at people if they came close to them. The sun lounge was exceptionally hot as it was a hot day and the person refused to allow anyone to turn the fan on which was placed next to them. There were no staff available to monitor this situation. We asked the manager to monitor the temperature in this area as people looked hot. At some points this room was registering as over 30 degrees and was unpleasant to sit in. The manager went out to buy more fans, but when these were used they did not have much impact in reducing the high temperature.

The mealtime experience needed improvements. Tables were not set, few had condiments and one table still had breakfast crumbs and debris which was not cleared even when the lunchtime meal was brought out. Some people were sitting in armchairs at the dining table and they were positioned at a parallel to the table, meaning people were eating from a sideways angle. We asked the manager to reposition some people to ensure their comfort and save them from twisting during the mealtime.

We found two pressure relieving mattresses were set at the wrong setting for the weight of the person using them. This placed people at possible risk of pressure damage. A pressure relieving mattress needs to be at the right setting in line with the person's weight in order for it to be effective in reducing the risk of pressure damage.

Two people who were staying at the service for respite care, did not have care plans. This meant we could not be assured staff knew how to meet their assessed needs in a consistent way or if the people had been included in their plan of care. One of these people had complex needs and their health needs had deteriorated since the funding authority assessment had been completed. Therefore the records available to staff to refer to were out of date. Staff used portable electronic devices to record what care and support they had delivered to each person. For those without plans, it was difficult to judge whether their care and support had been tailored to their individual needs. For example staff had ticked they had delivered personal care and they had been given drinks, but without a care plan, staff did not have clear instructions about what sort of support they needed to meet their individual needs.

As it was a very warm and sunny day, the manager encouraged people to spend some time outside. There was a small seating area next to the car park, which was not secure. The seating was too low for people with mobility needs and there was no shade. The area looked shabby and in need of some refurbishment. However, we saw the manager had ensured people had sun cream and a staff member was available to attend to their needs.

The programme of activities offered was not always planned in line with people's interests and hobbies. Some people's section of interests and hobbies were not completed and there was no correlation to people's assessed and stated wishes with the activities on offer.

People said staff were kind and caring. Staff interactions were friendly and encouraging.

People and relatives said their views and concerns were listened to.

There were effective staff recruitment and selection processes in place. Staff understood about abuse and who to report any concerns to.

Quality assurance processes and audits helped to ensure that the quality of care and support as well as the environment were monitored, but staff using these systems had failed to pick up key areas for improvement. We have made some recommendations in respect of ensuring

- the accessibility standard is followed.
- Hand gel is placed out of reach of people living with dementia
- the recording of some aspects of medicines management are reviewed, including the process for handwriting additions to MAR charts, the application of external products, and returns records.
- improvements to the outside area to ensure it is suitable for the needs of people living at the service and is a pleasant place to sit.

We found three breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back 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?

The service was not always safe.

Environmental risks had not always been checked to ensure people's safety.

There were not always enough staff with the right skills to meet people's needs.

People received their medicines on time and in a safe way, but improvements were needed in the completion of records

Staff knew about their responsibilities to safeguard people and to report suspected abuse.

Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

Care and support was not consistently well planned or updated.

Activities were not always planned or tailored to individuals' needs and wishes.

People or their relatives' concerns and complaints were dealt with effectively.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well led

Systems were in place to regularly monitor records; training, environment and equipment, but these had not picked up on some key areas of improvements needed.

**Requires Improvement** ●

# Kenwyn

## Detailed findings

### Background to this inspection

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

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 19 April 2018 and was unannounced. The inspection team included an adult social care inspector, pharmacist inspector, a specialist advisor in dementia care 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 service.

The inspection was carried out in response to concerns raised by healthcare professionals about staffing levels and staff skill mix. These were shared with the local safeguarding team, who held a meeting. A multi-disciplinary group of health and social care professionals agreed the concerns did not reach the threshold for whole home safeguarding processes. The CQC judged further reassurance was needed and carried out a focussed inspection.

We spent time observing how care and support was being delivered and talking with people and staff. We met with most of the people living at the home. We spent time in communal areas of the home to see how people interacted with each other and staff. This helped us make a judgment about the atmosphere and values of the home.

We spoke with eight people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with three relatives who were visiting the service. We spoke with four care staff, the manager, the provider quality assurance manager, one housekeeping staff, the handyman and the cook.

We reviewed five people's care plans and daily records, 13 medication administration records, three staff

recruitment files as well as audits and records in relation to staff training and support, maintenance of the building and safety records.

# Is the service safe?

## Our findings

We last completed a comprehensive inspection in January 2018 where we found the service to be overall good, but requires improvement in this key question of Safe. This was because we judged there were not sufficient staff available at key times to meet people's needs and keep people safe. We did not issue a requirement because we were assured by the provider and manager that they were addressing staffing levels. They said they had been short staffed due to staff leaving but with more recruited they were looking at staffing levels and people's needs. At this time there were three care staff available each shift for up to 18 people and they were also responsible for preparing meals some meals. Following the inspection, a cook was recruited so care staff would not need to help with the preparation of the Sunday lunch, but the provider did not consider an increase in care staff was needed.

Prior to this inspection we received two safeguarding alerts raised by healthcare professionals, a concern raised by a friend of a person using the service and feedback from a mental capacity assessor. They had visited the service to reassess someone who was subject to a Deprivation of Liberty safeguard. Concerns were centred on there not being enough staff to meet people's needs, answering the door bell in a timely way and lack of activities for people. The community nurse team were also concerned about the skills and experience of the current care staff team. There were also concerns expressed by a family friend about one person who had gone to hospital. Concerns centred on whether they had been assisted to stay hydrated sufficiently and about the cleanliness of water jugs and glasses in people's rooms. During this inspection we found some of these issues were substantiated. We found there were not always enough staff with the right skills for the number and needs of people. We did not find evidence to show people were not being supported to stay hydrated. Water jugs were being changed daily as a result of the complaint made.

At this focussed inspection, we judged there continued to be insufficient numbers of staff with the right skills to meet people's needs and keep them safe. There was three care staff for 20 people with varying degrees of complexity in terms of their health and emotional needs. We based this judgement on our observations of the day, feedback from people who lived at the service and feedback from other professionals. Our observations showed-

- During the morning people were left unsupervised for periods of up to 45 minutes in the communal lounge.
- One staff member was administering medicine and two others were still helping to get people up. This left people sitting in the sun lounge without supervision. During this time there were two altercations between people which needed staff support, but there was no staff around and no one able to understand how to call for staff attention.
- We saw people were sitting in the sun lounge on an exceptionally hot day. Staff were not available during the first hour to monitor this. Drinks were served after an hour but it was clear one person needed support to ensure they drank; this was not given as staff did not stay in the area to assist them.
- We observed one person becoming increasingly agitated with people around them. They shouted out at people if they came close to them. The sun lounge was exceptionally hot as it was a hot day and the person



refused to allow anyone to turn the fan on which was placed next to them. There were no staff available to monitor this situation.

- There were missed opportunities by staff to interact and communicate with individuals displaying confusion. For example staff walked through the communal areas without chatting to people. This meant people were not stimulated by conversation or reassured.
- One person was brought into the communal dining area and left in a transit wheelchair for all of the morning. Staff did not check and see if they were comfortable or needing to sit in an armchair.
- The mealtime experience needed improvements. Lack of available staff meant tables had not been set, there were few condiments available and the seating arrangements did not consider people's comfort. People were unaware of what the mealtime choice was. The whiteboard which was used for menus had not been completed because staff said they had been too busy and had forgotten to do this. Tables had not been wiped down since breakfast so lunch was served without the debris from breakfast being cleared first.

People said staff were kind but they often had to wait long periods for staff to be available to help them. One person said "Sometimes you ask staff to do something, like take me to the lounge, it takes a long time, they are caring to a certain extent but when their hands are full you have to wait your turn..." Another said "They are nice girls, when I ring my bell sometimes I have to wait 15 minutes or a bit longer, sometimes they come straight away." Relatives also voiced concerns about staffing levels. One said "I don't think there is enough staff, when someone is asking for something staff can take ages to respond. If they are helping someone on the hoist, it takes two (care staff) so that means there is only one staff left for all the rest. Sometimes people are calling out for help and I try to find someone to help them, there isn't enough staff to go around." Another relative said "The staff that were here before were more mature, they would sit with the residents, paint finger-nails, interact, it seldom happens now, the staff have no time. I would like to see smiley staff but I see stressed staff. The staff are inexperienced but they are OK, but hounded throughout the day with too much work, too much pressure."

Healthcare professionals were also of the view staffing levels needed to increase. Concerns had been raised about there not being sufficient staff available to provide feedback to them when they visited someone for treatment. They also said it was sometimes difficult to access the building because staff were busy attending to people or taking a break. One healthcare professional raised concerns directly to CQC, about the fact there were too few staff available when they visited and that people appeared to be left without stimulation or activities.

Low staffing levels may have resulted in staff being very task focussed as they did not always have the time to spend with people individually. For example, one staff member said they had a bath rota and each person had a set day for bathing. They said this meant they needed to bath three people per day. This meant routines were based on staffing levels available rather than on individual needs.

The specialist advisor for dementia care who formed part of the inspection team fed back that staff had limited skills and a lack of specific knowledge concerning the care of individuals with dementia. For example no strategy or working with someone who was becoming increasingly agitated.

There was a lack of awareness of people's the psychological needs and how to meet these needs. For example, two care staff were asked about the diagnosis and care needs of a recently admitted person. They were unsure of the level of confusion the person experienced, stating "she forgets". It was clear that this person required assistance with fluids and diet, however they described her as having a poor appetite rather than them needing support to eat and drink. There was no care plan to support staff to meet the persons assessed need. One member of staff described her as "nice and quiet."

The manager said they had a dependency tool which they used to help calculate staffing levels and that this was under review on a daily and weekly basis. He said they were looking to increase staffing but had not assessed in necessary at the time of the inspection.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the manager sent us an action plan based on feedback we gave at the end of the inspection visit. It stated they had increased the care staff to four each day. Bookings were made for agency staff to stay long term to ensure they could cover all shifts until they had recruited more of their own care staff.

Staff said they felt there were enough staff per shift to meet people's needs. One said "We currently have enough staff. When we get extra residents we will get more staff. We have 23 residents, two of them are self-caring so we don't count them in the staffing numbers. Two people are waiting to come in and one is going home... We have a good team, we communicate well, everyone does their fair share. We don't do cooking anymore, we do the laundry by day and the night staff do the ironing. The home has improved a lot, staff are staying rather than leaving, the manager helps at meal times if we are busy."

Some people said they were being well cared for. One person told us "Living here is very good, we are well cared for day and night, this is as good as home". Another said "they are nice girls, I like to stay in my room and the cleaners come in and chat with me."

People were not fully protected from the risks of pressure damage. This was because we found two pressure mattresses set at the wrong setting for the weight of the person. This meant the mattress would not be as effective and may have placed the person at risk of damage to their skin. A person remained in a transit wheelchair for all of the morning period. This placed them at risk of developing pressure sores as these type of wheelchairs are not designed for people to sit in for long periods. When we fed this back to the manager, they agreed this was not best practice and asked a member of staff to ensure the person was transferred to a more comfortable armchair after lunch.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the manager sent us an action plan. This included what measures they planned to put in place to ensure staff were aware and checked pressure mattresses were at the right setting. Most risks had been assessed and where needed measures put in place to reduce risk. For example, where people had been assessed as being at high risk of falls, their assessment looked at whether equipment was needed to support them to be safe. This might include the use of bedrails to prevent them falling out of bed. Where people were at risk of poor hydration or nutrition, universal tools had been used to assess this risk.

We checked the arrangements for looking after medicines. Lockable storage was provided so that people could look after their own medicines if they wished, after a risk assessment to make sure it was safe for them to do this. Trained and competent staff recorded medicines on medicines administration records (MARs). The manager told us that more staff were starting to be trained so that there would be more staff available to give people their medicines. We checked 13 people's MARs and these showed that people were

given their medicines correctly in the way prescribed for them. Most MAR charts were printed by the supplying pharmacy, but there were handwritten entries on four people's charts that had not been double signed as being checked by a second member of staff. This could lead to the risk of errors, and is not in line with the home's policy or with current guidance. However on the charts we checked these entries were correct.

Staff recorded the application of creams and other external preparations on an electronic system. We checked nine people's creams records. Four of these did not have clear directions for care staff as to how and where these preparations should be used, and their records didn't specify the product that was applied. The disposal records for controlled medicines were not always completed in both the register and the records sent to the pharmacy with these medicines.

We recommend that the recording of some aspects of medicines management are reviewed, including the process for handwriting additions to MAR charts, the application of external products, and returns records.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective.

There were directions for medicines prescribed to be given 'when required' to guide staff on when it would be appropriate to give doses of these medicines, which was good practice. There were policies to guide staff on looking after medicines. These were currently being updated. There was a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again.

Safe recruitment practices helped to protect people. Staff recruitment files showed checks were completed in line with regulations to ensure new staff were of good character and suitable to work with vulnerable adults. New staff were required to complete an application form. We were assured that any gaps in employment histories were followed up during the interview process. No new staff were offered employment before all their checks and satisfactory references were received.

Staff understood the types of abuse that could occur and how to report concerns. Staff had received training in understanding abuse which was updated annually via a DVD. The manager understood their responsibilities in working with the local safeguarding team when needed. There had been recent safeguarding alerts raised in relation to possible poor hydration and staff not having the skills to provide care and support for people with complex needs. The manager had addressed all issues raised and relatives also concurred the manager was very responsive to any concerns raised. One said "The manager gave me his mobile phone number and told me I could phone him at any time, he is on the ball, he does watch, he does respond, he has an easy manner." Another relative said "I can't criticise the manager, he is understanding, he listens, you can just go and knock on his door and tell him your concerns, he's trying his best."

Emergencies were planned for. For example, each person an emergency evacuation plan and regular fire safety checks were being done, including testing of alarm bells. Fire equipment such as extinguishers had been serviced and maintained on an annual basis. We noted a carpet which was lifting near a fire exit. When we fed this back, the manager said they would remove it immediately. The action plan they sent stated this had been completed on the same day of the inspection visit.

Staff understood infection control procedures. Staff explained that infection control training was

undertaken via DVD learning. At mealtimes staff were observed wearing gloves when assisting people to eat. There was no clinical indication for doing this so was unnecessary and may not contribute to the ambience of enjoying a meal. Hand antiseptic gel was in ample supply.

We recommend consideration should be given to where hand gel is situated as it was on surfaces within easy reach of confused people, posing a possible risk of ingestion.

## Is the service responsive?

### Our findings

People did not always receive personalised care that was responsive to their needs. Two people who were at the service for more than two weeks for respite care had no care plan to detail to staff how they should support them in a personalised way. The registered manager said they had completed risk assessments and daily task lists but had not completed care plans. He agreed this meant staff did not have clear instructions about how the person liked to be supported nor any details about their preferred routines. It was clear from our discussion with staff they were unclear about the needs and wishes of at least one of these two people. They were unable to describe their level of need. The assessment and care plan which had come from the funding authority had not been updated since the person's health had deteriorated. This meant staff could not rely on this information to help inform how to care and support the person.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people did have care plans to guide staff about how to best support them. These were not always linked to risk assessments. For example one person's record showed an assessment that identified a high falls risk, this was not linked to a care plan. Moving and handling was identified as a moderate risk but again this was not linked to a care plan. Staff said the person was mostly self-caring. Staff were aware of identified risks and discussed how they would work to ensure these were minimised so the impact for people was low. For example using hoists and slide sheets for people who had mobility issues and were at risk of falls if equipment was not used to safely transfer them.

A healthcare professional expressed concerns about staffs knowledge of end of life care. It was said that a member of staff made the decision to stop one person medicines because they were deemed at end of life. This was discussed at a recent safeguarding meeting. The manager disputed this and said this was a miscommunication. He added they always worked closely with the GP and community nurses to ensure the right care and support was provided.

We looked at how provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Most care plans included where staff needed to consider people's sensory or hearing impairment. Staff were mostly able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. For the two people without care plans, it was unclear if staff did know their communication needs.

Areas of the service were sign posted to help people find their way. There was a large white board available for staff to record important information such as the menu for the day and the date and day to help people remain orientated. On the day of the inspection this had not been completed. We fed this back to the quality

manager and staff then completed the whiteboard information with the following day's date and menu option. It was written up in green pen, which would have been difficult for some people to read. The board should have accurate information about the actual day to help people living with dementia stay orientated.

It is recommended that the service looks at best practice in ensuring any information is clear and follows the assessable information standard.

The provider had invested in an electronic care planning system. Staff used hand held devices to record what care and support was completed for each person. Plans were easy to navigate around and when completed.

The programme of activities offered was not always planned in line with people's interests and hobbies. Some people's section of interests and hobbies were not completed and there was no correlation to people's assessed and stated wishes with the activities on offer. There were some regular activities such as yoga, music and pet therapy. Most people were unable to comment about activities but one person said they were bored and there was very little for them to occupy their time. On days where no entertainers were planned, activities were more sporadic. For example on the day of the inspection there were no planned activities. Most people sat in the sun lounge with the TV on and no other stimulation. Care staff did have some awareness of the residents' recreational needs. Fund raising had been carried out, they organised an Easter celebration and a Dementia Day, making cakes and holding a raffle with the funds raised they had arranged a trip to Dartmouth Zoo on 9th May, which is what some people had requested they would like to do.

The manager was encouraging people to sit outside as it was a very sunny day; he ensured people had sun cream. People were accompanied by the manager or the handyperson as the garden area was not secure and did not keep people living with dementia safe. The seating outside was not suitable for people with mobility difficulties as it was too low and not cushioned. The area had a look of neglect for example; flower pots were full of weeds. This was an area where staff could involve people in activities such as planting bulbs.

It is recommended that the service looks at improvements to the outside area to ensure it is suitable for the needs of people living at the service and is a pleasant place to sit.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments. This was through on-going discussions with them by staff, and the manager. People and relatives said they would feel able to raise any concerns and would be confident they would be resolved.

## Is the service well-led?

### Our findings

Systems and audits were used to ensure the environment was safe and well maintained, records were kept accurately. However, these had failed to pick up the issues we identified at the inspection. This included lack of care plans for people on respite, improvements needs in medicine records and pressure relieving mattresses being on the wrong setting. Their tool on staffing levels and people's dependency had not been effective in ensuring there was always sufficient staff available to meet people's needs. The provider stated following this inspection "we had a plan in place (previously agreed as acceptable at the safeguarding meeting) to increase staffing and add the extra person (staff member) all day from 20th May. All parties to the meeting accepted that as a satisfactory plan, and that is what we were working to."

The checks and systems used had failed to pick up the excessive heat in the conservatory. We asked for this to be monitored and when the manager saw the temperature was at unacceptable levels he took actions to purchase more fans to try to cool the area. They were no monitoring this on a regular basis as there was no thermometer in the room.

The manager said they gained people's views by talking to them, having family meetings and an annual survey. He said they had not complained about the staffing levels to him. Two relatives said the manager was very responsive and they had been able to discuss their concerns and felt these had been acted upon quickly. One relative said there was a constant problem with the laundry which they had raised many times but that this was an ongoing issue.

The quality assurance deputy manager said the provider had recently increased the quality assurance team and they were looking to improve their quality assurance tools. They had been working closely with Devon County Council quality improvement team to develop better ways of auditing.

There were weekly and monthly medicines audits being carried out. Some actions were identified from these audits to help improve medicines management in the service; however some of the issues we picked up had not been identified.

People and relatives expressed confidence in the manager. They felt his approach was responsive and that he listened to any concerns and where needed made changes to provision of care delivery. For example one relative had raised the issue of cleanliness and water jugs not being kept clean and renewed with fresh water. We saw the manager had instigated a system of ensuring water jugs were changed each day as staff had to label when they had been changed. Similarly staff expressed a high level of confidence in the manager's ability and professionalism. One said "Things have really improved since this manager came here. He is focussed on the residents and getting it right for them."

The manager was not yet registered with CQC; they had been in post for four months. A registered manager is a person who has registered with the 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.

The manager and provider understood their responsibilities in respect of duty of candour. Where they had reviewed incident reports or complaints and concluded the service could have done things differently, they acknowledged this.

The rating from the last inspection report was prominently displayed in the front entrance of the service and on the provider website.



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 9 HSCA RA Regulations 2014 Person-centred care  People did not always receive personalised care that was responsive to their needs. This was because not everyone had a care plan for staff to follow.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  People were not fully protected against the risks of developing pressure damage.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There were no always sufficient staff with the right skills to meet people's needs