Cheerhealth (Selsey) Limited

Tenchley Manor Nursing Home

Inspection report

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Date of inspection visit: 3 & 5 February 2015
Date of publication: 09/09/2015

Ratings

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

Overall summary

Tenchley Manor Nursing Home is a privately owned service which provides nursing care and accommodation for up to 37 older people. The service offers short and long term placements, including respite care. At the time of our inspection there were 24 people living at the service.

There was a registered manager in post. 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.

Summary of findings

The inspection was unannounced and was carried out on 3 and 5 February 2015.

People told us they felt safe. However, during our inspection we found that risks had not always been identified, which could impact on people's health and wellbeing.

There were enough staff to meet people's needs. However, staff were not always supported in carrying out their duties to deliver care and treatment safely. The registered manager's approach to supervision was inconsistent and essential training was not always refreshed in a timely manner. We have made a recommendation that the provider research and consider adopting the latest research in developing suitable arrangements to ensure that staff were supported in carrying out their duties.

The provider had a process in place to carry out appropriate checks in respect of the recruitment of new staff.

There were appropriate systems in place for the management of medicines. However, there was no guidance to support staff with the administration of 'when required' (PRN) medicine. People were also at risk of using topical creams after the 'use by' date. We have made a recommendation in respect of PRN guidelines and the management of topical creams.

People were supported to have enough to eat and drink. However, staff were inconsistent in their approach to completing food and fluid charts for people at risk of malnutrition.

Care plans were detailed and reviewed on a monthly basis. However, they did not always reflect people's current needs. There was a structured approach to activities but this approach was not focussed on individuals and their needs.

The vision and values of the providers are set out in the service user's guide, which was available to people in their bedrooms rooms. There was an opportunity for people and their relatives to become involved in developing the service. A suggestion box was available on the desk in reception for use by people, their families, visitors and staff.

The audits undertaken by the manager and the providers to monitor the quality of the service provided were not robust and did not ensure the service continually improved.

Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), which applies to care services. Staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

Healthcare professionals such as GPs, chiropodists and Speech and language therapists were involved in people's care where necessary.

People and their relatives had been involved in the planning and review of their care. Staff used the information contained in the person's care plan to ensure they were aware of people's needs. They understood the importance of respecting people's choice, privacy and dignity. People were encouraged to maintain their family relationships.

Staff had a good knowledge of people, had developed strong friendly relationships with them and were responsive to their needs. Staff interacted with people in a positive and supportive way.

The service was clean and appropriately maintained. All of the bedrooms were individualised and personalised with people's personal effects. People using the service appeared happy and were relaxed in the company of staff.

People and visiting relatives told us they felt the service was well-led and were positive about the registered manager and the senior nursing team. The provider sought feedback from people or their families and there were arrangements in place to deal with complaints. Accidents and incidents were monitored and remedial actions identified to reduce the risk of reoccurrence.

Summary of findings

There were arrangements in place to deal with foreseeable emergencies. A contingency plan had been prepared to ensure care was still provided in the event of disruption to the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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.

Risks to people's welfare and safety were not always identified and managed effectively.

Medicines were managed appropriately. However, there was a lack of guidance to support staff administering 'as required' medicines.

There were enough staff available to meet people's needs and the provider had a recruitment process in place to carry out checks on new staff.

Staff were able to demonstrate an understanding of what constituted abuse and the action they would take if they had any concerns. The service was clean and well maintained.

Is the service effective?

Requires improvement

The service was not always effective

People using the service told us they felt that the service was effective.

However, there were no suitable arrangements in place ensure staff were supported to carry out their duties.

People told us that staff sought their consent when they were supporting them. The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were very complimentary about the food and were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring

Caring and positive relationships were developed with people.

Staff understood the importance of respecting people's choice, privacy and dignity.

People were encouraged to maintain their family relationships. The provider had an open house policy where visitors could visit at any time.

People and their relatives had been involved in the planning and review of their care.

Is the service responsive?

Requires improvement

The service was not always responsive

People told us the staff were responsive to their needs.

Summary of findings

Care plans were detailed but did not always reflect people's current needs.

The provider sought feedback from people or their families and had arrangements in place to deal with complaints.

Accidents and incidents were recorded and remedial actions identified.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The quality assurance process adopted by the registered manager and the providers did not always identify issues and drive improvement.

People and visiting relatives told us they felt the service was well-led. The providers provided an opportunity for people and their relatives to become involved in developing the service.

The registered manager understood their responsibilities and the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service.

Tenchley Manor 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 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.

The inspection was unannounced and was carried out on 3 and 5 February 2015. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. A specialist advisor is someone who has clinical experience and knowledge of working in the field of older people and in particular those living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send tell us about by law. We also gathered information from the West Sussex Local Authority Adult Services Team. As a result of the information we had gathered and the short timescale before the inspection, we did not request the provider completed a 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.

We met with the15 people who used the service and seven visitors. We observed care and support being delivered in communal areas. We spoke with 10 members of the care staff, the housekeeper, the head of administration, the maintenance person, the registered manager and the two providers. We looked at care plans and associated records for 14 people using the service, staff duty rota records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The providers registered the service in November 2014 and this was the first inspection under this new registration.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person said they felt happy and safe, "because there is always somebody around". Another person told us "the night watches make me feel safe". A family member said "it is a great weight off my mind" having their relative at the home.

However, during our inspection we found the provider did not have an effective system in place to identify and mitigate risks to ensure the welfare and safety of people using the service.

The surface temperature of a radiator in one of the bedrooms, which was uncovered, was too hot to touch. The person using the room, had mobility issues and a history of falls. Consequently they were at risk of injury should they fall against the radiator which near the bed and unprotected. We pointed this risk out to the registered manager who immediately arranged for the radiator to be covered. The radiators in all of the other bedrooms were covered.

There was a notice in each of the bathrooms to remind staff to check water temperatures before bathing people. Thermometers were in place but staff had not been recording the temperatures. We advised the registered manager about the risks of scalding if the water temperature regulators, which were checked on a monthly basis, failed. They took immediate action to address our concerns and on the second day of our inspection we saw that water temperature checks were being recorded.

One person was receiving oxygen therapy through the use of an oxygen concentrator, which is a machine that filters oxygen from the air in the room and delivers it through a mask or nasal cannula. The use of this machine requires a back-up oxygen cylinder in case the machine breaks down. There were no risk assessments in the person care plan to support staff with the safe use of the concentrator or use and administering of the oxygen should that be required. The Health and Safety Executive (HSE) guidance on 'oxygen use in the workplace' states 'All users of oxygen should know and understand the dangers, and should receive training in the use of oxygen equipment'. We spoke with the two nurses on duty who both told us they had not received any special training to use the oxygen and one said "I don't think we have a risk assessment in the home"

The failure to ensure the welfare and safety of people using the service is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

The provider had identified clinical risks in relation to people's individual health care needs and these included the action to be taken to mitigate those risks. People's care plans contained information regarding risks related to their health care, such as skin integrity and falls. These reviewed regularly and updated when changes occurred. The provider had a series of risk assessments covering other aspects of risk within the service, these included, gas supply, lighting, fire safety and trip and slip hazards.

The provider had an effective system of ordering and stock control and the medicines rooms were tidy and well organised. When medicines required cold storage a refrigerator was available and the temperature checked and recorded daily to ensure medicines were stored according to the manufacturer's instructions. The provider ensured there was also an effective system of recording when medicines required disposal.

Staff administered medicines in a safe manner. The nurses explained what the medicine was for and took time to sit with people until they had taken the medicine. When people had difficulty in hearing or understanding the purpose of the medicine the nurses were patient, unhurried and kind.

We looked at all the Medicines Administration Records (MARs) relating to all of the people living at the service. We found the MARs were fully completed and up to date. However we identified some issues that did not reflect best practice. The National Institute for Health and Care Excellence (NICE) guidance "Managing medicines in care homes" March 2014 identifies the need for guidance for administering 'when required' (PRN) medicines. This should include the reason for giving the medicine, how much should be given, what the medicine is expected to do, the minimum time between doses if the first dose has not worked and the recording PRN medicines in the resident's care plan. There was no PRN guidance in either the care plans or MAR charts to support staff with the administration of 'when required' (PRN) medication should be administered.

Requires improvement

Is the service safe?

Topical creams need to be used within a specific timeframe after being opened. We found that some prescribed topical creams did not have a record of when they were opened written on them. This is seen as good practice which has developed over time within the health care industry. We raised this with the nurse on duty and they told us told us they had discarded out of date creams the day before the visit. However, they were not able to demonstrate an audit trail for the process. We have made a recommendation in respect of the management of PRN medicines and topical creams.

There were enough staff to meet people's needs. The manager told us that staffing levels was based on the needs of people using the service. The minimum staffing was two nurses and eight care staff on each of the day shifts. The night shift was covered by one nurse and two members of care staff on a waking night. In addition there were separate housekeeping, maintenance and kitchen staff, which meant care staff were not distracted from the day to day care duties. One person told us "staff come if I press the buzzer; if they are busy I have to wait, not long, about 5 minutes". A visitor said "there are enough staff but sometimes they are stretched." They added they thought this was because "staff spend too much time with the residents, which is a good thing". Another visitor told us "from my observations there are enough staff"

There was a duty roster system, which detailed the planned cover for the service, with short term absences being managed through the use of overtime or previously used staff from an agency. The registered manager was also available to provide support when appropriate. Therefore, there were management structures in place to ensure staffing levels were maintained.

The provider had a process in place to carry out Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff and the registered manager had received safeguarding training and knew what they would do if concerns were raised or observed in line with the providers' policy. One member of staff told us "I would report any concerns to the senior nurse on duty or to the manager; I would follow up to see what had been done. We have guidance and telephone numbers in the staff room". Staff had also completed or were in the process of completing Qualifications and Credit Framework (QCF), which is a vocational qualification in care and contains a section relating to safeguarding. Therefore, staff had the knowledge necessary to enable them to respond appropriately to concerns about people. There were also appropriate systems in place to safeguard people's money.

Accidents and incidents were recorded and when an incident occurred the registered manager took action to reduce the likelihood of the incident reoccurring. For example, one person had recently had a series of fall in their room. The person declined to be referred to the falls clinic and the registered manager arranged for an alarm mat to be placed in their room to alert staff when the person was mobilising without support.

The provider had an up to date infection control policy, which detailed the relevant infection control issues and guidance for staff. The training manager was the infection control lead for the service. There were detailed daily cleaning schedules and checklists to confirm when the cleaning had been completed. The communal areas of the service, the kitchen, the bathrooms and people's bedrooms were clean and appropriately maintained.

Personal protective equipment (PPE), such as gloves, aprons and alcohol hand wash were available for staff to use throughout the service. Staff and the registered manager confirmed they had received infection control training. While observing care we saw staff using their personal protective equipment when it was necessary.

There were arrangements in place to deal with foreseeable emergencies. A contingency plan had been prepared to ensure care was still provided in the event of disruption to the service, such as a flood or electrical outage. The plan had been recently up dated and included a reciprocal arrangement with a neighbouring home to provide emergency accommodation when necessary.

We recommend that the provider seek advice and guidance on PRN guidelines and the management of topical creams.

Requires improvement

Is the service effective?

Our findings

People using the service told us they felt that the service was effective and that staff understood their needs and had the skills to meet them. The visitors told us they felt staff were knowledgeable about the care they provided and said their family members needs were met to a good standard.

However, during our inspection we found the provider did not have suitable arrangements in place to ensure that staff were appropriately trained and supported in carrying out their duties to deliver care and treatment safely. Staff did not receive regular supervisions and have the opportunity to discuss their performance, raise concerns or issues and identify learning opportunities to help them develop.

People were at risk of receiving unsafe care because staff were not always up to date with the latest developments and best practice in the care and treatment of people. For example, nursing staff were unaware of the latest guidance with regard to the use and storage of oxygen. Although there was a system to place record the training staff had completed and to identify when training needed to be updated. We saw that some essential training, such as, health & safety, fire safety and control of substances hazardous to health (COSHH) training was not always refreshed in line with current best practice guidelines. We have made a recommendation in respect of supporting staff through effective training and supervisions.

The provider did have arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS are the standards employees working in adult social care should meet before they can safely work unsupervised.

People were supported to have enough to eat and drink. Meals were appropriately spaced and flexible to meet people's needs. People were very complimentary about the food and told us that someone came round every day and explained what was on the menu. They said if they did not want the choice, an alternative would be provided. One person said "the food is very nice, three choices, or you can just have soup or sandwiches if you want a smaller portion". A visitor told us their friend "likes Stilton cheese, they get it in especially for him". Their friend, who was living at the service, said "they will swap food if you want something else".

Kitchen records showed that people's likes and dislikes, allergies and preferences were recorded. During the afternoon we observed the chef going round asking people what they would like for supper. The minutes of the 'Residents Meeting' showed that people were consulted about menu choices and were able to provide feedback on the food provided.

People who had been identified as being at risk of choking, malnutrition and dehydration had been assessed and supported to ensure they had sufficient amounts of food and drink. A nurse told us they used a malnutrition universal screening tool (MUST) to identify people who may be underweight or at risk of malnutrition. Food and fluid intake was monitored and recorded.

However, in seven food and fluid charts we tracked, there were omissions in signing and staff had not fully completed the forms to record how much of a meal was eaten. There were no totals being kept of how much fluid intake people had over a 24hour period. As a consequence people were at risk of malnutrition or dehydration because staff could not be assured that people had had sufficient food and fluid to meet their needs. We pointed this out to the manager who undertook to review all of the food and fluid charts to ensure they were completed correctly.

People told us that staff asked them for their consent when they were supporting them. They said staff encouraged them to make decisions and supported their choices.

The Mental Capacity Act 2005 (MCA) provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

The registered manager and staff understood their responsibilities in relation to the MCA. They were able to explain the principle of capacity and how it applied to people using the service. For example one person had been advised to have a low sugar, low fat diet by their dietician. The person had full capacity to make decisions around their own lives and had chosen to disregard the dietician's advice. Staff supported this person's choice.

Requires improvement

Is the service effective?

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. There were two people subject to DoLS at the time of our inspection. Staff were knowledgeable about the safeguards people had in place and were able to describe their restrictions. One member of staff told us "DoLS are used when someone has to have some kind of restraint like a locked door, so that an application has to be made to make it legal, we just cannot decide it ourselves". Records showed staff regularly reviewed people's DoLS and considered the least restrictive option. Staff responded effectively to ensure people's freedom was not unlawfully restricted without authorisation.

Healthcare professionals such as GPs, chiropodists and Speech and language therapists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care. One person told us "I can see my doctor if I am worried about anything". A visiting relative said "My mother had a cough soon after she arrived. I told staff that she was prone to chest infections, they got a doctor to look at her, and he prescribed antibiotics".

We recommend that the provider seek advice and guidance on developing suitable arrangements to ensure that staff were supported in carrying out their duties.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and visitors told us they did not have any concerns over the level of care provided. One person said "the care here is very good". Another person told us "The staff are very nice, they are always kind and have a laugh and a joke with you". A third person said "I have lived here a long time, it is very nice and a pleasant place to live. The staff are very good, always polite".

We observed care in the communal areas of the service and saw staff had a good knowledge of people and had developed strong friendly relationships with them. Staff interacted with people in a positive and supportive way. For example, we saw one member of staff helping someone to eat. The staff member positioned themselves close to the person and maintained eye contact; they assisted the person to eat, waiting until they were ready for the next mouthful of food. The staff member was smiling, spoke calmly and was mindful of the person's dignity. On a different occasion two carers were supporting a person to transfer from a wheelchair to a lounge chair using a hoist. They were both very patient, continually explaining what was happening and providing reassurance. When the manoeuvre was completed they checked the person was comfortable and whether they needed anything else. On another occasion the maintenance person was observed going from room to room to inform people who stayed in their rooms that there would be a fire alarm test and not to be worried.

People were encouraged to maintain their family relationships. The provider had an open house policy where visitors could visit at any time. One group of visitors told us they were family orientated and often visited their relative in groups of up to seven or eight family members. They said the manager and staff always finds space for them to socialise together as a family. Another visitor told us staff encouraged them to come and eat their meal with their relative if they wanted to.

Staff used the information contained in the person's care plan to ensure they were aware of people's needs. They understood the importance of respecting people's choice, privacy and dignity. They spoke to us about how they cared for people and we observed that personal care was provided in a discreet and private way. People's movements were unrestricted and they were able to choose where they spent their time. We spoke to some people who chose to spend their time in their own rooms. They said the staff respected this and offered them opportunities to join others if they wished. There were dignity posters displayed throughout the service, which informed people and their relatives of the provider's expectation with regard to the standards dignity and privacy they should receive.

People and their relatives had been involved in the planning and review of their care. One person told us that they and their daughter had both participated in their care plan together and added "I can review it anytime". There was a separate care plan for different aspects of a person's care and support needs. Each plan detailed the preferred or desired outcomes the person wanted from the support. For example, one person's personal care, care plan identified how much support the person required to promote their independence and respecting their dignity.

All of the bedrooms were individualised and personalised with people's personal effects. People using the service appeared happy and were relaxed in the company of staff.

Requires improvement

Is the service responsive?

Our findings

People told us the staff were responsive to their needs. One person said, "I am very happy here, I get good attention, I only have to press the buzzer and they are here. If I had any problems I would talk to the manager and she would listen". Visitors told us that people received good care and personalised support based upon their individual needs. A visiting relative said staff had offered to support their mother to eat their meal because her dinners were getting cold. They added their mum was pleased to take up the offer because they did not like eating cold food. Another visitor told us their relative was "well cared for, the food is good and he is very clean".

Care plans were detailed and reviewed on a monthly basis. They included areas such as, personal care needs, spiritual and psychological wellbeing, and skin integrity. Although care plans were detailed and of a medical model, they did not always reflect people's current needs. For example, one person's care plan recorded they suffered with depression. However, their care plan did not detail how to identify what signs might be displayed or how to support the person's mental state. In two other care plans the person had been identified as having skin damage however, there were no wound care plans in place to support staff in understanding what action to take to manage the wound and prevent it developing.

There was a structured approach to activities and included activities lead by an activities coordinator, such as arts and crafts, reminiscence quizzes or bingo. There was also a programme of visiting entertainers and musicians. These were held in the lounge area of the service and were also attended by day care visitors. This provided an opportunity for some people to socialise with other people from outside of the home environment. A relative told us, "There is always something going on, they [people using the service] are encouraged to do things".

However, there were no activities available which focussed on the individual and their needs. One person using the service said, "It's very nice here, sometimes like this morning we do have activities but there is not much else to do". People did not have individual activity plans, particularly for those people who stayed in their rooms. One person told us they did not do activities because "the activities that I can do are restricted because of my poor sight".

People's daily records of care were up to date and showed care was being provided in accordance with their respective care plans. One person's care plan showed the support they required when eating. During our inspection we saw staff supporting the person in line with their care plan and as recorded in their daily record of care. The person told us "I had pork for dinner. I always take my time. They [the staff] cut up my food for me".

Staff were responsive to people's needs. One person asked a staff member for a snack during the morning, the staff member asked what the person would like and they said 'peanut butter on toast'. The staff member went immediately and provided the snack. Another person with poor verbal communication was trying to communicate their wishes to a staff member. The staff member used a pictorial sheet to ascertain the person's wishes. The person wanted to go to bed and this was actioned straight away.

The provider sought feedback from people or their families through the use of a quality assurance survey questionnaire. We saw the results from the latest questionnaires which were sent out in November 2014. The responses from people, which were predominately positive, had been analysed and where issues were identified these were responded to. There were also regular 'residents meetings'. One of the people using the service co-assisted with organising the meeting. They told us the meeting provided an opportunity for people to speak about any concerns or small complaints without staff being there.

The provider had arrangements in place to deal with complaints and provided detailed information on the action people could take if they were not satisfied with the service being provided. This was published in the 'Residents' Handbook' which was available in each person's bedroom and there was also a copy published on the notice board in the foyer. Since our last inspection there had been one complaint. This had been investigated appropriately and the complainant had signed to say they had been updated with the result. People and visiting relatives knew how to complain. One person said "I would complain to the manager and action would be taken. I don't complain much, there is nothing to complain about because everything is always done". A relative told us "When mum first arrived here, her mattress was thinner than the one she was used to, we spoke to the manager, it was replaced in days".

Requires improvement

Is the service well-led?

Our findings

People and visiting relatives told us they felt the service was well-led and were positive about the registered manager and the senior nursing team. One visiting relative said "I think the care is excellent, the staff are caring and nothing is too much trouble. I can go to the office any time and they keep me well informed of any changes. If I am not happy about anything they listen and do something".

The vision and values of the providers are set out in the service user's guide, which was available to people in their bedrooms rooms. Posters reinforcing the provider's expectations with regard to people's experiences of the care provided in the home. Regular staff meeting provided an opportunity for the management team to engage with staff and reinforce the providers' value and vision. They also provided an opportunity for staff to provide feedback and become involved in developing the service.

The providers provided an opportunity for people and their relatives to become involved in developing the service. 'Residents Meetings' were held on a monthly basis to which people using the service and their relatives were invited and could raise concerns, make suggestions and provide feedback. Items actions raised at a previous meeting were considered by the management team and the outcome fed back at the following meeting. For example, the choice of activities or entertainers. There was also a suggestion box available on the desk in reception for use by people, their families, visitors and staff. The registered manager told us that it was rarely used.

The registered manager had an open and inclusive style of leadership, developing a positive culture within the workforce. One member of staff told us the registered manager was "very approachable and she will listen. Staff morale has improved and I know that if I need help they will help me". Another member of staff said "the nurses in charge are very supportive and they thank you for your work. The manager is very approachable and helpful". The manager who holds a level five vocational qualification, interacts regularly with other managers and the providers to ensure they keep up to date with best practices and can drive forward any improvements to the service.

However, apart from the formal staff meetings there was a lack of a structured approach to staff engagement. As a consequence the lack of regular staff supervisions meant there was no structure opportunity for the registered manager to engage with staff on a one to one basis and ensure they felt supported, motivated and understood their role in developing high quality care.

The registered manager carried out a series of reviews and audits on different aspects of the service as part of their quality assurance process. This included checks on infection control and cleanliness schedules, fire safety, accidents and record keeping. Some of the audits were carried out by external organisations. However, the review process adopted by the registered manager did not always identify issues and areas for improvement. For example, all of the care plans had been reviewed but had not identified any of the omissions in food and fluid charts we found during our inspection.

The providers had an informal approach to monitoring the quality of the service provided by the home, which was based on what they saw when they visited. They told us they accepted their approach was 'fragmented at the moment with a focus on financial viability, dependency and cost benefit analysis'. The informal approach to quality assurance adopted by the providers was not robust and did not provide them with sufficient evidence to drive continuous improvement within the service.

The registered manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of their registration. They told us that support was available to them from the providers. There was also an arrangement with the registered manager of a sister service who was available to provide ongoing mentoring and support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 People were at risk of receiving unsafe care because the provider did not have an effective system in place to identify and mitigate risks relating to the health and safety of people using the service.