

Care Home Consultancy Services Limited

Rushey Mead Manor Care and Nursing Home

Inspection report

30 Coatbridge Avenue
Leicester
Leicestershire
LE4 7ZS

Tel: 01162666606

Date of inspection visit:
22 July 2021
23 July 2021

Date of publication:
06 September 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Rushey Mead Manor Care and Nursing Home is a care home that provides accommodation for persons who require nursing or personal care including those living with dementia related needs, physical disabilities or end of life care. The home is multicultural and Asian languages are spoken as well as English. The home can accommodate and care for up to 50 people.

The service comprised of three floors. The upper floor was undergoing extensive refurbishment and was not being used at the time of our visit. At the time of our inspection there were 26 people using the service. Two people were in hospital at the time of our visit.

People's experience of using this service and what we found

The management of people's medicines needed to be strengthened to ensure people received their medication safely. We found some areas of medication administration did not follow best practice.

Further improvements were needed to the risk assessments and care plans to make sure they contained detailed guidance for staff to follow. We were informed that these were being transferred onto a new electronic system and so not all of them had been reviewed and improved.

Although staff rotas showed there were sufficient staff on duty, we found people were left unsupervised for long periods and they often had to wait before staff attended to their needs in a timely manner.

We have made a recommendation about safe staffing levels.

Although staff wore appropriate Personal Protective Equipment (PPE) we found that PPE was not always well managed, and some areas of the environment required improvement to ensure they were easy to clean and to keep people safe from the spread of infection.

We found that systems in place to ensure people's oral healthcare needs were met needed to be strengthened.

We have made a recommendation about the management of people's oral health care needs.

Systems in place to meet people's nutritional and hydration needs were not adequate to ensure people's dietary needs were met. We found a lack of choice, poor staff knowledge about people's dietary needs and inadequate nutritional screening.

Staff training records showed there were some gaps in staff training. They showed that training in areas necessary for a staff member's role had not always been undertaken. For example, the staff rota showed there were two 'nutritional assistants' employed but the training records showed they had not completed training in relation to nutrition and hydration. The provider had put plans in place to make improvements to

staff training.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

We found there was a lack of choice in relation to people's meals and activities. We observed staff taking people from one area of the home to another without asking them if that was what they wanted.

There was a wide range of quality checks in place to monitor the quality of the service. However, these needed to be strengthened to ensure they identified areas where improvement was needed.

People and their relatives felt that Rushey Mead Manor Care and Nursing Home was a safe place to live. Staff we spoke with had an understanding about how to recognise abuse and the steps they needed to take to report any concerns.

Staff received an induction when they first commenced work at the service. Most staff felt well supported by the management team, and in particular the registered manager.

The registered manager and the provider had identified that further development was needed and had implemented numerous improvements. They were in the process of developing an action plan detailing their priorities to bring about change.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 22 October 2020).

Why we inspected

The inspection was prompted due to whistle-blowing concerns received about poor staffing levels, a lack of choice, and the management and leadership of the service. A decision was made for us to inspect and examine these risks. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rushey

Mead Manor Care and Nursing Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified three breaches in relation to the safe administration of medicines, risk management and infection control, meeting peoples nutritional and hydration needs and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Rushey Mead Manor Care and Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by two inspectors, a specialist nurse advisor, an interpreter and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type

Rushey Mead Manor Care and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection the provider had employed an area manager who had registered with the Care Quality Commission (CQC) as the manager for Manor Care and Nursing Home. This was to be a temporary arrangement until a new manager had been recruited.

This means that they and the provider are legally responsible for how the service is run and for the quality

and safety of the care provided.

Notice of inspection

We gave the service short notice of the inspection on the first day of the inspection. We telephoned and spoke with the provider and informed them of our inspection 15 minutes prior to entering the service. This was to help the service and us manage the risks associated with COVID-19.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group (CCG) who commission with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with 12 people who used the service and two family members about their experience of the care provided. We had discussions with 11 members of staff including the two directors, six care and support staff, the home's administrator, a part time cook and a catering assistant. In addition, we spoke with a visiting health care professional. We used the Short Observation 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.

We reviewed a range of records. This included five people's care records and five medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including monitoring of quality and risk, policies and procedures and service certificates were also examined.

After the inspection

We continued to seek clarification from the provider to validate evidence found. This included information in relation to staff training, induction, supervision, accident and incident reporting, staff rota's and other records relating to the management of the service.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- We examined medicines records and found a qualified senior staff member had signed for a controlled drug (a patch) before it was applied and had refused to accompany a senior care worker to administer the medicine so that two staff could be present as per best practice guidance when administering controlled drugs.
- Records showed that one person had refused their diabetes medicines and high blood pressure medicines over a three-day period. Staff had failed to undertake any blood glucose monitoring or blood pressure monitoring and there had been no referral made to their GP. We brought this to the attention of the provider who ensured a check of the person's blood sugar and blood pressure was carried out immediately.
- Records showed that different codes were being used to those set out on the Medication Administration Records (MAR). For example, we saw one staff member used the code R for 'refused' rather than the letter 'A' as directed on the MAR chart. This meant that staff would be unsure why a person's medicine had not been administered so actions could be taken swiftly.

Assessing risk, safety monitoring and management

- We spoke with a visiting health professional who told us they were providing training to staff to provide better mobility support for people. They told us that over the last few months staff had been observed not using walking frames at the correct height and some walking frames had been lost. This put people at risk of inappropriate moving and handling procedures.
- Risks to people's mental and physical well-being had not monitored when they regularly refused their medicines.
- The care plan for one person showed they had mental health needs and required support with their behaviours when they became distressed. There was no evidence of an effective behaviour management plan that related to ensuring they took their medicines and the level of support they needed to help them manage their anxieties when they became distressed.
- We observed on the plate of one person who was on a soft diet, a large hard piece of food which put the person at risk of choking if they had eaten it. We brought this to the attention of a staff member who removed it from the person's plate. This placed the person at risk of choking.
- We observed one person in a wheelchair whose feet were bare and there were no foot plates on the chair. A staff member was pushing the person and they banged their foot. When we raised this with the staff member, we were told this was their choice as putting their feet on the foot plates was uncomfortable for them and bare feet was a cultural preference. This information was not recorded in the person's care plan and their feet were not monitored for potential injury.
- The provider was in the process of changing all care plans and risk assessments from a paper-based

system to an electronic system. We looked at three care plans with associated risk assessments that had been reviewed and moved onto the electronic system. We saw these were detailed and comprehensive.

Preventing and controlling infection

- Some areas of the environment required improvement to ensure people stayed safe from the spread of infection. For example, the dining room floor was not cleaned swiftly after each meal and we saw wheelchairs that were dirty. In one toilet we saw the tiles at skirting board level had come off and the area was dirty. The soap dispenser didn't work so people were not able to wash their hands.
- Although we saw staff wearing Personal Protective Equipment (PPE) we found that PPE was not always managed effectively. For example, we observed on the first and second floor, store areas were generally untidy, and the sinks were dirty. There were open boxes of PPE on worktops and on the floor. In the corridor, where they had designated PPE stations, aprons were laid over the handrails and not in any sort of container.
- We observed some staff with long painted nails and some wearing stoned rings and various bracelets. These could be a source of cross transmission to others and prevent thorough hand washing to be effective.

We found no evidence that people had been harmed. However, the management and administration of people's medicines did not always follow best practice to ensure people received their medicines as prescribed. Risks management plans in place to ensure people's safety were in place for some areas of identified risk and not consistently followed by staff. Some areas of Infection Prevention and Control procedures needed to be strengthened to ensure people were safe from the spread of infection. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing COVID -19 testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

- Although the staff rotas showed there were sufficient staff on duty as determined by the providers dependency tool, we received feedback that staffing was not adequate. We observed that people had to wait for their needs to be met in a timely manner and people were unobserved for long periods.
- People we spoke with felt there were not always enough staff on duty to meet their needs swiftly and they often had to wait for support. One person said, "You wait a long, long time for anything." Another commented, "It's rubbish (here) you have to wait, wait, wait, wait. They don't have staff. Why do they take people on? If I don't get to the toilet on time, I spoil my clothes and that's more work for them [meaning staff]."
- Staff told us that staffing numbers were not always sufficient. One said, "We are short staffed today. It's very difficult when we don't have all the staff on duty." Another told us, "Some days it's a struggle. We don't have time to sit with people for a chat. It's always rushed and chaotic."
- We observed one person who needed to go to the toilet but there were no staff around. We found a staff member who told us they were, "doing breakfasts." The person waited 15 minutes in total to be supported

to visit the bathroom.

- During the day of our inspection there were periods ranging from five to 24 minutes when there were no staff present in communal area. For example, whilst we were in the dining room, we observed six people left unobserved for approximately 24 minutes. Another person came into the dining room and started eating another person's food.
- The provider had improved their recruitment practices. When they recruited new staff, they completed two interviews with applicants. One of these was carried out by an external person who asked specific questions in relation to their role. All necessary employment checks were carried out before new staff started the probationary period.

We recommend the provider conducts a thorough review of the deployment of staff and staff workload, and the capacity to meet people's safety-related needs in a timely manner.

Systems and processes to safeguard people from the risk of abuse

- People and relatives felt Rushey Mead Manor Care and Nursing Home was a safe place to live. One relative told us, "I know [family member] is safe because they are not complaining. They are smiling and singing."
- We had mixed comments from staff about safeguarding training. One told us, "I've not had any safeguarding training and nothing around whistleblowing." Another staff member commented, "I have had safeguarding training and I think the staff have the knowledge to ensure the safety of all residents."
- Records showed there were 11 new staff who were still working their probation period. They had not yet received safeguarding training; however, the provider had put in plans to ensure they completed the training in the near future.
- Eleven long term staff had completed safeguarding training. This included domestic and kitchen staff. Staff understood about the procedures in place regarding safeguarding people from potential harm and were aware of the whistle blowing policy.
- The provider had policies and procedures to keep people safe. They were aware of their responsibility for making safeguarding referrals and reporting concerns to the Care Quality Commission (CQC). Records showed that these were completed.

Learning lessons when things go wrong

- Accident and incidents were logged in month order onto an electronic system which was able to produce an analysis. The registered manager informed us these would be discussed during senior staff meetings so they could be used as a 'lessons learnt' approach.
- The registered manager informed us concerns and complaints were discussed with staff during staff meetings. They gave us an example of how they ensured lessons were learned when things went wrong. The provider had received a complaint regarding some missing clothing. As a 'lessons learned' approach the registered manager had implemented a stronger inventory system for all new people being admitted into the home. This had been fed back to the family and was also discussed during a recent staff meeting.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- There was a lack of choice of meals for people. For example, we looked at the pre-planned menus for the month of July. Option 1 was a more English menu and Option 2 was a more traditional Indian menu. There was, however, no choices within each of the 'options' meaning that people's preferences or their religious or cultural needs were not always met.
- Meals were not always appetising and presented in an appealing way and alternative meals were not offered if a person did not like the meal on offer. We saw that one person refused their meal and were offered a small dish of ice cream which they ate with great relish, however they were not offered an alternative meal of the same nutritional value.
- We observed a staff member pushing a trolley with two meals that had been returned untouched. The member of staff said the people concerned had refused their meals because it was too hot to eat. We asked what they could offer instead, and they replied they would offer them some orange squash. This lack of understanding about people's nutritional needs put people at risk of weight loss.
- One care file showed the person had diabetes. There was no specific plan in place to manage the persons diabetes which could put them at risk of health complications related to their diabetes.
- Meals were not appropriately spaced and flexible to meet people's dietary needs. We looked at one person's food and fluid intake record that showed they had gone 14 hours without food (they had refused breakfast and a snack offered at 11.46am) and had consumed 600mls of fluid. We did not see any supplements, or fortified drinks being offered to ensure their nutritional needs were met.

We found no evidence that people had been harmed. However, systems in place to meet people's nutritional and hydration needs were not adequate to ensure their dietary needs were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting nutritional and hydration

- Following the inspection, the registered manager informed us that Dining for Dignity training had taken place recently and they had been working with staff and people who used the service to improve the food choices available to people'

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

- We found that systems in place to ensure people's oral healthcare needs were met needed to be strengthened. We saw there were detailed oral health care assessments in place. However, where they

identified gaps there were no actions in place to address these.

- For example, in the oral healthcare assessment for two people it identified they did not see a dentist regularly, it was unknown when they last received dental treatment and it was ticked as unknown if their medication may cause a dry mouth. In addition, it identified their lips and tongue were dry and coated. However, there were no actions in place to ensure improvements were made to the person's oral healthcare needs.
- Throughout the day we observed numerous people with dirty teeth and some people had debris from their last meal stuck in their teeth.

We recommend the provider consider current guidance on improving oral health care for adults in care homes and take action to update their practice.

- Following the inspection the registered manager informed us that although despite working with local health professionals they had experienced significant difficulties finding a community dentist.
- Records showed people had access to a GP service, dietitian, Speech and Language Therapy (SALT) and other professionals as required. However, referrals were not always made in a timely manner.
- On the day of our inspection we saw new toothbrushes were being distributed to all people using the service and some staff were attending training in oral care.
- The registered manager had implemented a clinical risk register to improve the timely referrals to healthcare professional's when needed. This was reviewed monthly. This gave an overview of potential risks to people's physical and mental health needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- We found that people did not always receive person centred care that was in line with their preferences. We observed some staff interactions were task focused and lacked an individualised approach.
- One care file showed the person had diabetes. There was no evidence that regular foot checks or eye screening was taking place. Their care plan also showed that the person liked to pray five times a day, but there was no evidence in their care plan about how this was to be managed/offered or if there was a specific space in the home where they could pray.
- During the Covid-19 Pandemic, the provider was not visiting people in their homes or at hospital to undertake an assessment of needs. The provider confirmed they were using a local authority assessment and/or hospital information to develop care plans for people who were newly admitted to the service.

- Following the inspection the registered manager informed us that, where needed, all the people living at the service had recently been seen by an Optician and a Chiropodist/Podiatrist.

Staff support: induction, training, skills and experience

- Staff completed an induction before they provided personal care. One staff told us, "My induction consisted of 2 x12 hr shifts shadowing (more experienced staff) plus 1-day in-house training on moving and handling."
- We spoke with a visiting health professional who was providing training to staff to provide better mobility support for people. They told us that staff knowledge was 'variable'. They told us they had had to tell a staff member staff who was providing personal care to an individual that two staff were required to ensure their safety. They commented, "Staff should know how to support people's mobility."
- We requested a copy of the staff training matrix following the inspection. We saw some gaps in staff training and saw that training had not been completed by staff that was relevant to their roles. For example, the staff rota showed there were two 'nutritional assistants' employed but the training matrix showed they had not completed training in relation to nutrition and hydration.

- The registered manager informed us that they had already identified gaps in staff training as an area for further development. They informed us the provider had signed up with the Care Skills Academy, which is accredited by Skills for Care. Staff had been registered with the system so they could complete online training. We were also informed that the newly recruited manager had experience as a trainer and would be facilitating face to face training for all staff.
- Staff told us they did not receive regular supervision to discuss their practice and training needs. The registered manager informed us they had recognised this as an area for development and had devised a supervision and appraisal matrix. Records provided showed that this would ensure a more structured system would be in place to ensure staff received the support they needed through the supervision process.

Following the inspection, the registered manager informed us that both nutritional assistants had completed the Care Certificate that provided them with training in relation to fluids and nutrition.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We observed throughout the day that people's consent was not always sought before staff carried out tasks and there was a lack of choice in relation to meals and activities.
- Records showed that DoLS applications and authorisations from the local authority were closely monitored and regularly reviewed. This ensured any restrictions were appropriate for the person, and always followed the principles of being the least restrictive.
- Decisions to deprive a person of their liberty followed the best interests' approach. Related assessments and decisions had been properly taken, using a multidisciplinary approach, involving relatives, and relevant health and social care professionals.
- Not all staff had completed training in relation to the MCA and DoLS. Some staff demonstrated a lack of understanding about the importance of gaining people's consent before providing them with care and support, in order to comply with the MCA. Plans were in place for staff to complete this training.

Adapting service, design, decoration to meet people's needs

- The current provider took over the service in March 2020 and had addressed immediate health and safety concerns. For example, the provider had installed a new call bell system, a new fire safety system, replaced fire exit doors and emergency lighting.
- There were many areas of the service that required attention and we saw the provider had begun their refurbishment plans. The upper third floor was unoccupied and was in the process of being refurbished. The registered provider described their plans to give it a London theme. They explained that each floor would have a different theme, and they wanted to introduce a hairdresser and a prayer room.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- On the day of our visit the provider confirmed a new manager had been recruited and was due to commence employment on 02 August 2021.
- There was a wide range of quality monitoring checks in place. These included quality assurance checks such as routine auditing and analysis. However, these had not always been effective at identifying areas where improvement was needed.
- For example, medicines audits and infection control audits had not been effective at identifying concerns we found during our inspection. We found gaps in monitoring charts and care plans, but care plan audits had not identified these areas so that swift actions could be taken.
- We found there was a lack of oversight in relation to assessing and providing adequate staffing numbers so that people received the care and support they needed, in a timely manner.
- There was a lack of managerial oversight in relation to ensuring people received sufficient nutrition and hydration and ensuring swift actions were taken in relation to people's health care needs.
- The provider was aware of their legal obligations to notify the Care Quality Commission of serious incidents involving people living at the home. However, at this inspection we saw one person with a large black eye and asked how this had happened. We were told it was due to a fall. However, CQC had not been informed of the incident and a safeguarding alert had not been sent to the local authority. The duty of candour had not been followed.

Systems in place to assess, monitor and improve the service were not always effective at identifying areas that needed to be improved so swift action could be taken. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the registered manager informed us they had been given advice about what to report and what not to report in relation to this person and falls and they were following this advice.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider was aware of and had systems in place to ensure compliance with duty of candour responsibilities. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:

- There was a lack of managerial oversight in relation to working alongside staff and observing practice so poor practice could be identified straight away. For example, we observed some staff who supported people with minimal or no conversation or involvement, they did not provide reassurance and comfort when people were upset and distressed.
- There had been a lot of changes at the service, including management and staffing changes that had caused anxiety and uncertainty among people using the service, relatives and staff. However, the provider was able to demonstrate their commitment to improving the quality and culture of the service.
- Staff told us they felt supported by the registered manager and the provider and felt hopeful that changes would be positive. One staff member told us, "[Name of registered manager] is kind and helpful." Another commented, "[Name of registered manager] has been supportive since she arrived."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff told us they had regular staff meetings but not all staff said they felt listened to. One staff member told us how they had raised several concerns and new ideas at the staff meeting but nothing had changed. They commented, "No-one listens to us."
- We were informed by the registered manager that resident's meetings had not taken place so far in 2021 and satisfaction surveys had not been used to gain feedback from people. However, the provider had recognised this as an area that needed improvement. They had devised some satisfaction forms to be used to gain feedback from people living at the service, relatives, staff and visiting healthcare professionals. The registered manager informed us that the satisfaction surveys could be provided in people's first language.
- The providers had been open and honest about the areas that needed to be addressed and were working closely with the local authority to make the necessary improvements. The local authority confirmed that continuous improvements were being made.
- The service was working with other health professionals involved in people's care. For example, the doctor undertook a weekly visit. The Medicines Optimisation Team were also working with the provider to improve the safe administration of medicines. The local authority was conducting regular infection prevention and control visits to the service to ensure they were following best IPC practices.

Continuous learning and improving care

- The provider had recently introduced a clinical risk register which focused on key aspects of people's care. For example, catheter care, end of life, wound management and weight monitoring. This was reviewed monthly by the registered manager and would provide good oversight of the risks to people so that swift actions could be taken to improve outcomes for people.
- There was a newly implemented accident and incident log. This gave the senior management team oversight of all accidents and incidents. This included the ability to create tables showing how many falls or unwitnessed falls, at what times of the day, how many deaths in a month, pressure injuries etc. The information would then be analysed and discussed with the Senior / Management team each month so they could discuss any trends.
- The registered manager told us they were in the process improving the concerns and complaints system. They had implemented a new form that contained the relevant areas of complaints management and lessons learned. For example, action taken, outcome, what action had been taken to prevent reoccurrence, what had been learnt from the concern/complaint and can anything be done to prevent the concern/complaint happening again. The registered manager informed us that these would be discussed during staff and/or resident's meetings.
- The providers, in conjunction with the registered manager had recognised that further development was

needed and had implemented numerous improvements already. The demonstrated a commitment to the ongoing improvements at the service.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The management and administration of people's medicine's did not always follow best practice to ensure people received their medicines as prescribed. Risks management plans in place to ensure people's safety were not consistently followed by staff.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs</p> <p>Systems in place to meet people's nutritional and hydration needs were not adequate to ensure their dietary needs were met.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems in place to assess, monitor and improve the service were not always effective at identifying areas that needed to be improved so swift action could be taken.</p>