Leyton Healthcare (No. 12) Limited

Delves Court Care Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 4 and 5 November 2015. At our last inspection in January 2015 we asked the provider to take action to make improvements to ensure there were sufficient staffing levels within the home, people's dignity was respected, medicines were managed, administered and stored safely and the home had good governance systems in place. We found that some actions had been completed however further improvement were still required in areas.

Delves Court Care Home provides accommodation, nursing and personal care for up to 64 older people who may have dementia. At the time of our inspection 43 people were living at the home. The home has three floors with the first and second floor providing nursing care. The home does not currently have a registered manager in place. The manager had commenced the process to become registered. 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

People's care needs were not being met in a timely manner as staff were not deployed effectively throughout the home. People's medicines were not managed safely. People told us that they felt safe from the risk of harm or abuse. Staff understood their responsibilities to report concerns or issues to keep people safe from harm or abuse. Risks to people had been assessed and appropriate equipment was available for staff to use.

The provider ensured staff were safely recruited and received the necessary training and support to meet people's needs.

Staff sought people's consent to their care and treatment and principles of the Mental Capacity Act were known and understood. People were able to choose what they wanted to eat and drink but drinks were only available at specified times. People received the support they required to eat their meals, but not always in a timely manner. People were supported to access other healthcare professionals.

Some people told us staff were kind and caring but our observations showed people's dignity was not always respected by staff. People and relatives told us that they were involved in planning their care. Staff understood people's needs but people's care records were not always accurately maintained.

People were supported to maintain relationships and relatives we spoke with said that they were made to feel welcome when they visited the home. People and relatives told us that they felt able to share their views about the home with staff or the managers. The provider had a system in place to respond to people's complaints or concerns.

There was a clear management structure in place, staff felt well supported and were able to approach the manager for advice or guidance. The provider had established quality assurance systems which could be used to identify issues or trends. However, these were not always effective as issues we identified had not been recognised by the system. The manager recognised the need for further improvements to be made.

In this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People living at the home were put at risk because their medicines were not handled or managed safely. Staffing numbers were increased however staff were not always deployed effectively to meet the needs of people in a timely manner. People felt safe at the home and staff understood their responsibilities to protect people from the risk of harm or abuse.

Requires improvement

Is the service effective?
The service was not consistently effective.

People had a choice of food and drinks but staff limited this choice by only offering drinks at specified times. People received their care from staff that received regular training and had the skills to meet people's needs. People were asked for their consent before care was delivered and the provider had taken steps to ensure people's rights were protected. People had access to health care professionals to meet their individual care needs.

Requires improvement

Is the service caring?
The service was not consistently caring.

Opportunities for positive interactions were sometimes missed by staff as staff were focused on tasks. Staff did not always respect people's dignity.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

Staff did not always respond to people's requests in a timely manner. People and their relatives were involved in planning how they were supported and cared for. People were supported to make a choice about day to day activities. People and their relatives had the information they needed to raise concerns or complaints should they need to.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

People, their relatives and staff were complimentary about the manager and felt they were approachable. The manager had developed new quality assurance systems and there was some improvement to the quality of service provided to people, however some areas we identified had not been picked up from audits.

Requires improvement

Delves Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 took place on 4 and 5 November 2015 and was unannounced. The inspection team consisted of three inspectors, two pharmacy inspectors 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.

We looked at information we held about the home. This included statutory notifications which are notifications the provider must sent to inform us about certain events. We also contacted the local authority and clinical commissioning group for information they held about the home.

We spoke with ten people who lived at the home, nine visitors and three visiting healthcare professionals. We spoke with six members of staff, the manager and deputy manager. We looked at five people's care records, records relating to medicines, four staff files and records relating to the management of the home. We also carried out observations across the home regarding the quality of care people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

At the last inspection in January 2015 we found that the provider was not meeting the regulations regarding safe care and treatment and the risks associated with the unsafe use and management of medicines. The provider sent us an action plan outlining how they would make improvements. We found at this inspection the provider was still in breach of this regulation.

We reviewed how medicines were managed within the home including looking at the Medicine Administration Record (MAR) charts for 26 people. We found concerns about the arrangements in place for handwritten MAR charts. Information that was recorded was not always accurate. One person had a handwritten MAR chart for an antibiotic which had been checked by two staff. The person had not been prescribed this antibiotic but nursing staff had signed the MAR chart for the administration of the antibiotic for two days. Another person on the same floor had been prescribed this same antibiotic and two of their tablets were unaccounted for. We immediately informed nursing staff that we had identified a serious medicine error. They could not explain how this had happened or explain why two tablets of another person's antibiotic were missing.

We found some people's medicines were not recorded accurately. In particular we looked at two people prescribed a medicine that needed careful monitoring to ensure a safe dose was given to the person. We were not able to check that the medicine had been given as prescribed because the total amount of medicine available did not match the records of receipt or administration. When people were prescribed a variable dose of a medicine such as 'one or two tablets to be taken' we found that the quantity given was not always recorded. This is particularly important for pain relief medicines to determine if people had been given the maximum prescribed dose or could be given a further tablet for pain relief.

Medicines with a short expiry were not always dated when they were opened or disposed of when their expiry date was reached. There was an increased risk of medicines being used longer than the expiry date and the preparation may no longer be effective. Two people had run out of their prescribed medicines. One person had not been given their pain relief medicine for four days. A nurse told us that the prescriptions were ordered and the medicines "would be delivered today".

Controlled drugs are medicines that require special storage and recording to ensure they meet the required standards. We found that controlled drugs were stored securely and recorded correctly. Although medicines were stored securely we found that prescribed nutritional feeds were not. We found two unlocked cupboards containing peoples prescribed nutritional feeds that were not safe or secure. Medicines were not always stored according to the manufacturer's instructions or according to the attached pharmacy label. We found one medicine that should be stored in a fridge was stored in the medicine trolley. We also found a medicine stored in the fridge that did not require cool storage.

We found that medicines stored to be given as 'homely remedies' were actually people's prescribed medicines. 'Homely remedies' are a supply of medicines purchased and agreed with the GP to give to people for minor ailments. We found medicines that had people's pharmacy labels removed. Medicines prescribed for a person are their property and should not be shared with other people. We also found a strip of a prescription only medicine stored with the 'homely remedies'. This is unsafe practice with the potential risk of a medicine error.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014, Safe care and treatment.

At our previous inspection in January 2015 we found that the provider was not meeting the regulation regarding staffing. The provider sent us an action plan outlining how they would make improvements. Although we found at the inspection the provider had made some improvements to staffing levels, they were still not meeting the requirements for this regulation.

People who lived at the home had mixed views about whether there were enough staff to meet their needs but most people felt there had been some improvement since the new manager started working at the home in January. One person said, "Sometimes staff are busy at night but I've never had to wait that long." While another person said, "They are really short staffed and they say don't get buzzing us" and, "Sometimes they can't come for ages…its 30 to 45

Is the service safe?

minutes before they come." Other people we spoke with told us staff were busy, and they had to wait but, "Staff do eventually come." They said they probably had to wait because, "Other people had more urgent needs."

We spoke to some people who chose to be cared for in their rooms. One person said, "We are supposed to have the door open so they can see if we are alright." A relative told us, "Staff prefer the doors to be open because they can keep an eye on people as they go past they have not got the time to keep coming in to check on people." Staff we spoke with did not think that the staffing levels were unsafe and confirmed that staffing levels had improved. One staff member said, "The work can be demanding but the ratio is excellent in terms of staffing." Another staff member said, "Staffing levels have improved since new management." Some staff said they were very busy and could not respond as quickly as they would like to people's needs or requests but they would respond as soon as they were able.

We saw people asking for assistance and heard staff say, "I'll be with you soon." We saw that staff did not always respond promptly to requests made by people when they required support and observed on both nursing floors people were left waiting for their care needs to be met. For example, we saw one person who requested to go to the toilet not being taken and another person shouting out to staff for assistance. This person became upset which disturbed other people in the communal room. We observed another person who required support with their meal being left for a period of ten minutes before someone assisted them with their food. Their food had become cold whilst they waited for staff to finish supporting other people. Staff completed some tasks at specific times of the day, for example, providing people with hot drinks or taking people to the toilet. During these times there were reduced staff available to assist people with their care needs. We saw there were times where no staff were visible in the communal areas of the home for periods of time up to fifteen minutes because they were providing support to people elsewhere During these times people were unable to attract the attention of staff if they needed care or support.

We discussed the staffing levels with the manager and they told us that they had completed a dependency needs analysis in order to determine the number of staff required to support people safely. The manager said that since they had been in post they had recruited permanent staff to posts and staff numbers were higher than they had determined they required to meet people's needs. However, staff were not always deployed effectively within the service as people were sometimes left waiting for the support they required. We discussed how staff were deployed around the home to ensure that people's needs were responded to in a timely manner. The manager assured us that they would review this particularly during busy times to ensure that there was always enough staff available to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014, Staffing.

Staff told us and four staff records we looked at demonstrated that the provider had undertaken the appropriate pre-employment checks before staff started to work at the home. One staff member said, "Had an interview, looked around the home and they took references and made checks; it took a while before I started at the home as I had to wait for the checks to come through." These checks included assessment of staff's suitability for the role and disclosure and barring checks (DBS) completed. DBS checks help employers reduce the risk of employing unsuitable staff.

People who lived at the home told us that they felt safe and that they would speak with staff or the manager if they had any concerns about their safety. Comments from people included, "They're all very good actually I feel safe here" and "I am safe here they look after you well." Relatives we spoke with had no concerns about the safety of people living in the home and one relative said, "Not seen anything to think its unsafe here." Another relative told us, "I feel it's safe here I feel staff give me the reassurance that they are looking after my relative." Staff we spoke with understood how to keep people safe and protect people from harm. They were able to give examples of how they would identify signs of potential abuse. Staff told us the actions they would take if they needed to report any concerns. All the staff we spoke with said they would speak with the manager. One staff member said, "I would speak with the managers; I am aware that I could escalate if I had any concerns." Staff we spoke with were confident any concerns would be taken seriously by the provider and appropriate action would be taken. We looked at records and saw that

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Is the service safe?

where incidents had occurred concerning people's safety, the manager completed notifications and we saw that staff followed the provider's procedure to protect people from abuse.

Staff we spoke with understood how to support and protect people where risks had been identified. We saw staff supporting people with their mobility with the use of equipment such as walking frames and hoisting equipment. We saw one person being guided to use their walking frame by a member of staff. We saw staff offer encouragement and explain to the person where they should hold the frame to remain safe. We looked at this person's care records and saw that it contained guidance for staff about how to reduce this person's risk of falls and promote their safety. Our observations confirmed staff were providing care as directed in the risk assessment.

All incidents, accidents and falls were recorded and reported appropriately, information was analysed by the manager to identify any recurring themes. We saw one person was receiving one to one support from staff. The manager told us this person had had a number of falls. The manager had contacted the falls team and additional support was agreed to ensure they remained safe.

Requires improvement

Is the service effective?

Our findings

We observed breakfast and lunch and saw that those people who chose to have their meals in their rooms or required assistance from staff did so, but this was not always completed in a timely manner. Staff we spoke with knew which people were nutritionally at risk and those people who required their fluid intake to be monitored. People received drinks at set times but not always outside these times. We observed staff telling people to wait for the drinks trolley if people requested a drink. One person we spoke with told us they wanted a drink as they were very 'dry', we found a member of staff and requested they give this person a drink. The member of staff got the person a drink. People might be at risk of not receiving enough fluids to remain healthy.

People and their relatives were complimentary about the food. One person said, "Get to order food the day before, there is plenty of choice." Another person told us, "They give us this [menu with pictures] and we choose what we want" and "The meals are quite good here, they are always red hot." People told us if they did not like the food options available then an alternative choice was offered. We spoke with staff and they were able to tell us about people's nutritional needs. They understood people's individual likes and dislikes and had knowledge of people's dietary needs such as, people who needed a soft diet. One relative told us, "[Person's name] has pureed food. Carrots and peas look like carrots and peas; they have obviously been pureed separately and they have a thickener."

People we spoke with told us that staff sought their consent before offering care and support. One person said, "They always check first before providing care." We observed staff gained agreement from people before supporting them with their care needs. One person told us, "When they come in [staff] say we are coming to change you and I say I'm free." Staff we spoke with told us some people living at the home had different ways to indicate their consent such as through gestures or smiling. One staff member said, "If a person does not consent to care I tend to leave them and come back a bit later."

The Mental Capacity Act (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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Care records we looked at showed that mental capacity assessments had been completed for those people who lacked capacity and decisions to provide care in a person's best interest had been completed in line with the MCA. The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so. We found the manager had an understanding of the correct procedures to follow to ensure people's rights were protected. One person had an authorisation in place to deprive them of their liberty. The person's representatives had discussed and agreed a decision in the person's best interest. We saw that staff were complying with the conditions applied to the authorisation to ensure the person remained safe. All staff we spoke with confirmed they had received training in MCA and DoLS and were able to explain how they supported people's choices and rights.

We looked at one 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) record which had been agreed by the doctor in consultation with a family member However, we saw that the person had the capacity to make decisions; but had not been involved in any consultation about this decision. The manager said they would review these records and raise any issues with the doctor.

We observed an incident where healthcare advice was not sought in a timely manner which resulted in us raising a safeguarding alert with the local authority. This is currently being investigated by the local authority.

People we spoke with told us that they had access to healthcare professionals when they needed them. One relative told us, "They keep me informed; they called me to say that they had called an ambulance and that the carers had gone to the hospital with [relative]." Another relative said, "Staff keep me informed about [person's name] health." Staff we spoke with were able to tell us about

Requires improvement

Is the service effective?

people's individual needs as well as any health issues that affected their care. We looked at five people's health care records and saw that referrals to other healthcare professionals had been made where concerns had been identified. For example, we were told by staff that a doctor and nurse visited the home each week to support people with their health needs and provide guidance to staff where required such as with fragile skin. Healthcare professionals told us that guidance they gave to staff was followed and they had not had any problems with advice not being followed.

People who lived at the home and their relatives thought that staff were knowledgeable and skilled. One person said, "They seem to know what they are doing." One relative said, "I have noticed a tremendous improvement in [person's name] since they have been here I think the staff know what they are doing" and "Everyone seems well trained." All the staff we spoke with said that they had received the necessary training and support to do their job such as supporting people to receive a nutritious diet using a PEG tube. A PEG tube is passed into a patient's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate. One staff member said, "There's training going on every week. There's also other training like care planning, dignity and pressure sore training." Two healthcare professionals we spoke with told us in regard to training and staff development; the manager encouraged staff to develop their skills to ensure they had the expertise to deliver safe care to people. Staff we spoke with told us that they had completed an induction which included shadowing experienced staff to get to know the people they cared for. One staff member said, "Induction was good and training is always being updated." Staff told us one to one meetings and appraisals took place regularly with the manager. One staff member said, "Clinical supervisions are every six to eight weeks" and "Staff meetings every Wednesday and minutes are displayed in the staff room." We looked at records and saw that staff received supervisions and that training requirements were tracked and planned.

Requires improvement

Is the service caring?

Our findings

At our previous inspection in January 2015 we found that the provider was not meeting the regulation to ensure people's dignity, privacy and independence was respected. The provider sent us an action plan outlining how they would make improvements. We found at the inspection the provider was still in breach of this regulation.

Some people we spoke with told us staff respected their dignity. One person said, "They close the door and the curtains" when providing personal care. However, other people told us their dignity had not always been promoted by the staff team. One person told us, "Certain staff will leave me wet at night-time." Another person told us that they were told they would have to wait to be changed because staff were busy and told to, "Just do it and we'll clean you up."

Our observations showed that people's dignity was not always respected. For example, we observed staff shout across the lounge areas on several occasions, "You need to use the toilet." We saw one staff member inform people sitting in the lounge area that another person was going to the toilet. We observed one person ask staff if they could be taken to the toilet. Two staff ignored their request and carried on distributing drinks. We did not see this person being taken to the toilet during our observations. We saw three people sitting in wheelchairs who were left in the middle of the lounge area for a period of half an hour waiting for a hoist to become available so staff could support their transfer to a chair. At no point during this period of time did any member of staff approach or speak with these people to explain why they were left waiting. We saw one person being supported by two staff members to transfer to a chair using a hoist on the nursing floor. The staff members continued with their conversation and did not speak with the person they were supporting until the task was completed. We observed medicines being administered to people and saw one staff member unable to wake a person fully, administer their medicine whilst they were asleep, without any communication. We also found that people's privacy was not always maintained. We heard two members of staff discussing a person's health matter in front of other people in a communal area.

These practices did not ensure people were treated with respect and their dignity was promoted. We discussed our observations with the manager who was open with us about where improvements needed to be made. They accepted that they needed to improve staff understanding and attitudes to ensure people received their care in a dignified manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on whether they were able to make day to day choices and decisions. One person told us that they preferred to stay in their room and said that staff respected this. Other people told us they were given the flexibility of when to get up or go to bed and were offered a choice of a bath or shower. However one person said that they were not given a choice where they would like to spend their time and were told they had to sit in the lounge area. We found some staff were focused on tasks and this impacted on people being able to make their own decision such as when they could have a hot drink or go to their bedrooms. One person said, "[Staff] are very kind to me" and another person told us, "[Staff are friendly and caring they ask if I am alright they can't do too much for you." Although some people and their relatives told us staff were caring and kind, our observations showed this was not always consistent. We saw where people were not able to verbalise, staff interactions were limited in there frequency and not personalised. We observed that on occasions staff spent time talking with each other rather than interacting with people.

Requires improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us about their different experiences of their needs being responded to by staff. One person said, "They're always busy, haven't got time to talk" and "They will come and check on you but don't stay long." We saw at specific times during the day staff performed particular tasks such as serving hot drinks or taking people to the toilet following lunch. During these times people often had to wait for their individual care and support needs to be met. We discussed this with the manager who confirmed that they had observed staff during our visit and noticed people were kept waiting for periods of time. The manager assured us that they would address these concerns and provide support and training where required to staff.

Staff we spoke with were able to explain people's individual care and health needs and tell us how they responded to those needs. For example, staff told us how they supported a person who required one to one support and how they responded to people who had fragile skin. People and their relatives told us that they were involved in developing their care plans. One relative told us, "We were involved in developing the care plan with [person's name] we were asked questions about [person's name] getting up and dressing preferences." We looked at care plans and saw that care needs were reviewed and people or their representatives had signed some care records to show their agreement with them. We saw that care plans provided guidance for staff to follow. However, there were some gaps in the information recorded such as when there was a change in a person's needs information had not always been updated. We spoke with staff and asked how they shared information. Staff said there were daily shift handovers and these provided staff with the "most up to date information" about a person needs. However, some staff said there were occasions when communication was not as effective as it should be such as when staff had been off for a period of time. They said there was a communication book but not all staff used it. Staff may not always have accurate information to care for people.

We asked people what interested them and what they enjoyed doing during the day. People told us that different activities were planned every day. Several people showed us an activity sheet which gave details of various events for people to choose from. One relative we spoke with told us about a 'virtual cruise' which was taking place at the home. They told us about a Caribbean activity which people enjoyed outside in the garden. We saw that various events were advertised across the home which included shopping trips, a 'children in need' event and various entertainers performing at the home. People and their relatives told us that they enjoyed the activities and events they took part in. People said that the activities workers spoke with people to find out what they were interested in. One relative told us, "[Person's name] goes to the activities there is bingo and coffee mornings you can't fault the activities they are very good." Care staff we spoke with said that they enjoyed supporting the activities but were often busy and did not have the time to sit and talk with people or help with interests.

Visitors told us they were always welcomed at the home. One relative said, "I come in anytime of the day… it's always the same I am welcomed." Another relative told us, "I visit anytime, I am welcome. If I come at mealtimes I do have to wait until it's finished but I respect that."

Everyone we spoke with told us that they felt able to raise concerns with the staff or the manager. One person told us, "I have never had to make a complaint but if I did I would complain to the carers." Another person said, "If I wasn't happy or had a complaint I would speak to the carers or the manager." One relative we spoke with said, "There is a book downstairs you can write any concerns in it I have no concerns and have no reason to make any complaint." Staff we spoke with were able to explain how they would handle complaints and were confident the manager would investigate and resolve any issues quickly. We looked at the complaints book and saw that there was a process in place to investigate and respond to complaints. We looked at the complaints raised and saw that these were investigated and responded to appropriately.

One relative we spoke with said that the manager was, "Very proactive in obtaining feedback." They said the provider had regular meetings with relatives and people who lived at the home to share and provide information. Relatives said they had received questionnaires from the provider requesting feedback about the home. We looked at records and found there were monthly meetings with people and their relatives. Minutes were taken and displayed on the notice boards of the home. We saw that feedback was sought from people and their relatives and used to improve services such as food and mealtimes.

Requires improvement

Is the service well-led?

Our findings

At the inspection completed in January 2015 we found that the provider was not meeting the regulation regarding auditing and quality assurance systems. The provider sent us an action plan outlining how they would make improvements. We found at this inspection the provider was compliant with the regulations although further improvement was required.

At our last inspection we found that the provider did not have systems or processes in place to assess and monitor the quality of service provided to people. During this inspection we saw that the provider had implemented a quality assurance system within the home which consisted of regular checks to improve the quality of the service provided. However, these were not always effective. For example, we found that the management of medicines had been audited by the provider but the unsafe medicines practice we identified during our inspection had not been recognised by the provider's own audits. Other issues we identified during our inspection in relation to the deployment of staff and practices around promoting people's dignity had also not been recognised by the quality assurance system. However, the manager recognised the need for improvements.

We looked at the other governance systems within the home and found that since our last inspection new systems and processes had been developed. These were used to improve the quality of service provided to people living in the home. For example, we found appropriate systems in place to record allegations of abuse, incidents, accidents and falls. We also found that infection control and food hygiene audits had been completed. Information was used to identify any trends or areas of improvement. We found that compliments, complaints and feedback were recorded and monitored by the manager in order to identify issues or trends to improve the quality of service provided and manage risks to people. We found that where the provider had been required to submit a notification about a significant event to us by law, this had been completed. We found that the manager had made improvements since our last inspection however further work was required to ensure that the improvements were sustained, understood and implemented by all staff.

At our last inspection the manager was new to the post. The manager told us they had commenced the process to become registered with CQC Since their appointment they had appointed a deputy manager to assist them with the day to day running of the home and implemented a number of changes within the home such as developing audit processes and recruiting permanent staff. We discussed the support the manager received from the provider. We found that the manager had implemented changes to improve the culture and running of the home with little input from the provider. We saw that the manager had contacted the provider on numerous occasions regarding different issues such as technology concerns and staff supervision meetings. However these remained unaddressed by the provider.

People, relatives and staff told us they felt the home was well managed and everyone we spoke with knew who the manager of the home was. One person said, "The manager is very nice they are approachable." The manager told us that since they had started to work at the home they had worked hard to improve the quality of care people received. The manager acknowledged improvements were still required and said they would look to address the concerns we raised during the inspection. The manager encouraged everyone to make suggestions and provide feedback about any improvements they would like to see. For example, we saw that there were monthly 'Residents and Relative' meetings and staff meetings within the home. Some people we spoke with chose not to attend these meeting but said they felt informed and that any information was displayed on the notice boards within the home. People said they would speak with staff or the manager if they had any concerns and said they felt the manager would respond appropriately.

Staff we spoke with told us that they had regular supervision meetings with the manager and attended team meetings. Staff told us they were able to voice their views during these meetings and through staff questionnaires. Staff said they felt their views were listened to and any issues raised were addressed by the management team. The provider had a clear record of the training staff had completed and we saw training certificates were present in staff files. We saw evidence of regular supervisions and staff meetings taking place which were recorded and signed by both parties. Staff we spoke with said that they felt supported in their roles by the management team and said the managers were "very approachable." One staff member said, "Staff morale has greatly improved since [manager's name] and [deputy manager's name] have arrived, the

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Is the service well-led?

team approach is good there is continuity of care and we only use agency staff as a last resort." Another staff member said, "The managers are open and transparent and staff support is great." Staff said that they would have no concerns about whistle-blowing and felt confident to approach the manager. They said if it was necessary they would contact CQC or the local authority if they felt people were at risk of receiving unsafe care. Whistle-blowing means raising a concern about a wrong-doing within an organisation.

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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People's dignity was not respected at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not deployed effectively to meet people's needs

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe use and management of medicines, by means of making appropriate arrangements for recording , handling, using, safe-keeping, dispensing and safe administration of medicines.

The enforcement action we took:
We have served a Warning Notice on the Provider for breaches of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.