Angel Care (Orchid Care Homes) Ltd

Orchid 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 16 October 2018 and was unannounced.

Orchid Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Orchid Care Home provides care to people who may require nursing care and for people living with dementia. Orchid Care Home accommodates up to 84 people in three separate units, each of which have separate purpose-adapted facilities. There were 81 people using the service at the time of the inspection. One of the units specialises in providing care to people living with dementia.

At our last inspection on 17 and 18 August 2017 we had rated the service 'Requires Improvement' and identified breaches relating to management of medicines, failure to follow the Mental Capacity Act 2005 (MCA), and records being out-of-date.

Following the last inspection, we asked the provider to complete an action plan. We needed the provider to inform us how they intended to improve.

There was no 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. The application to register the manager with the Care Quality Commission (CQC) was submitted precisely on the first day of the inspection.

Recruitment checks of new staff were not sufficiently robust to ensure candidates were safe to work with people using the service.

Records contained in the emergency folder and the fire risk assessment were out -of -date. We raised these issues with the manager and saw evidence they updated the information on the second day of the inspection.

Where it was questionable whether a person had capacity to make care and support related decisions, the service did not always follow the principles of the Mental Capacity Act 2005. The Act helps to ensure actions are taken in people's best interests.

People gave mixed feedback about the quality of meals served to them.

There were gaps in the care records. Quality assurance systems were in place but not always effective and had failed to identify the issues which we found at the inspection.

Staff told us they were not always supported to obtain nationally recognised qualifications and were not always actively involved in developing the service. They told us they were not able to participate in discussing and considering new ways of enhancing the service, including changes in the management structure, which affected their work.

People told us they felt safe. Systems were in place to ensure people were safeguarded from abuse. Staff knew how to protect people from avoidable harm or abuse and were confident in raising concerns if they needed to.

Staff received support through one-to-one or group supervision, regular meetings and performance appraisals.

Effective general healthcare support was provided and external healthcare practitioners were consulted when required.

People were supported by staff who knew them well. Staff we spoke with were enthusiastic about their jobs, and showed care and understanding both for the people they supported and their colleagues.

People's privacy and dignity were respected and promoted. Staff understood how to support people in a sensitive way, while promoting their independence. People told us they were treated with dignity and respect.

There was a range of activities available to people both within the home and in the local community that were adjusted to suit people's preferences.

People had access to a complaints procedure and people knew how to make a complaint if they needed to.

People, their relatives and staff praised the manger. Although the manager had been newly appointed and it was too early to see significant improvements, the manager was perceived as very accessible and listened to the views of others and acted on them.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Documentation relating to fire evacuation and fire risk assessment was incomplete and out-of-date.

The service assessed and managed risks to people's individual safety and welfare. The premises and the equipment were regularly checked to ensure the environment was safe.

Appropriate arrangements were in place in relation to safe management and administration of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Records showed that consent was not always gained and recorded in line with the principles of the Mental Capacity Act.

People were supported by suitably trained staff.

People provided us with mixed feedback about the quality of meals served to them.

People had access to healthcare services and received on-going healthcare support.

The adaptation, design and decoration of premises facilitated meeting people's individual.

Is the service caring?

Good

The service was caring.

People told us the current staff were caring and treated them kindly. People and their relatives felt involved in making decisions about people's care.

Staff interacted regularly with people and knew them and their needs well.

Relatives visited people during both days of the inspection and told us they were always made to feel welcome.

People were supported to express their views and make their own decisions about their care and support. Their independence was promoted.

Is the service responsive?

Good

The service was responsive.

The service provided people with a broad range of mental and physical stimulation.

Documentation was mostly personalised and included specific information about people's backgrounds, events and persons important to people.

People had access to a complaints procedure and they knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

Whilst there were many governance processes and audits in use at the service, these were not consistently effective and they had not identified the shortfalls that we found.

Staff told us they were not always actively involved in developing the service.

Improvements had been noted since the current manager had taken their post. People and staff felt the manager was approachable and was already addressing issues.

Orchid 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.

This inspection took place on 9 and 16 October 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and two experts 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.

Concerns about poor standard of care and people's safety had been raised with us prior to the inspection. We took these into consideration while planning the inspection. Before the inspection, we reviewed information we held about the service. This included any information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (those who fund the care for some people) of the service and asked them for their views.

During the inspection we used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who were not able to talk to us. We spoke with 13 people living at the service and six visitors. We spoke with the manager, three nurses, one senior care worker, two care workers, and the activities co-ordinator.

We looked at records including nine care and support plans for people using the service, six staff recruitment files, training and supervision records. We looked at records relating to maintaining and improving the quality and safety of the service, which included a range of audits and other checks.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection in August 2017 we had identified a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines had not always been managed in a safe way.

At this inspection we found that the service had taken appropriate action to address these issues.

People had their medicines administered safely. The nurses administering medicines operated in a planned, organised and consistent way, following best practice. Each of them was wearing a tabard with the words 'Do Not Disturb' printed on them in order to ensure minimum distraction during the medicine round which allowed the nurses to focus on administering medicines safely. The nurses demonstrated an awareness of the needs and preferences of the people they administered the medicines to. The records seen confirmed that nurses had received medicine management training, and that competency checks were undertaken annually.

A selection of medicine administration records (MAR) were reviewed for each unit. Any medicine allergies were recorded and a photo of the person was attached. Other details recorded included the person's name, date of birth, their preferred method of taking their medicine and a list of any medical conditions. Appropriate codes had been entered onto the MAR sheets when medicines had not been administered.

Where people had been prescribed transdermal patches, a record sheet including a body map was kept in order to record where on the person's body the patch had been applied. Controlled Drugs (CD's) were stored securely and recorded appropriately. Records indicated that stock levels were checked daily by two staff members. We checked the stock levels of four individual CD's in two units and found them to be accurate. Appropriate fridges for storing medicines were available in all the units and the temperature was recorded daily. The temperature records seen indicated that medicines were stored appropriately.

However, we found that more improvements in other areas were needed in order to keep people safe.

People were at risk of not being supported appropriately in the event of an emergency, such as a fire. The emergency plan contained incorrect and out-dated information, including one of the previous managers' names and their contact details as the person to contact in the event of an emergency.

The emergency plan and the fire risk assessment were out-of-date. We checked people's Fire Evacuation Assessments, which detail the support that people need to evacuate the premises in the event of a fire. There were 32 assessments that contained incorrect information, for example, three assessments were for people who no longer lived at the service; people's assessments did not always match the correct room number; and assessments were not present for all people. We raised these issues with the manager on the first day of the inspection. On the second day of the inspection we saw the above mentioned shortfalls had been addressed by the service manager.

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

Risk assessments had been completed for identified individual risks and specified the action staff needed to take to reduce the risks. The assessments included risks involved in moving and handling, the risk of falls and the risk of choking. Staff were able to tell us how they would support a person who may be at a particular risk. For example, one person's care plan identified that the person was at high risk of falling. Their risk assessment described appropriate methods to support the person with moving and handling transfers.

People at risk of developing pressure sores had pressure relief equipment in place. However, the equipment was not always used correctly. Some air mattresses settings did match people's weight. Although the correct weight was noted in the care plans, the weight specified in the air mattress monitoring form differed from the one recorded in the person's care plan. For example, the air mattress monitoring form instructed staff to set the mattress for the weight of 60 kilograms even though the person weighed 41 kilograms. This meant people were not always protected from the risk of developing pressure sores. We raised these issues with the manager on the first day of the inspection. On the second day of the inspection we saw that all the pressure relief equipment was checked and all the air mattresses had been set correctly.

People and their relatives told us they felt people were safe in the home. One person said, "Everyone is very kind here". One person's relative told us, "For me, the most important thing is knowing that he is safe and can't be found wandering the streets, as he was before moving here".

Staff we spoke with knew how to report safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the manager who they were confident would deal with any issues promptly and appropriately. Staff were also aware they could report concerns to other relevant agencies. A member of staff told us, "I would report this straight away to the manager. If the manager is not here, I would report this to the safeguarding team".

There were enough staff to keep people safe. Staff, people and their relatives provided us with mixed but mostly positive feedback on the staffing levels. A member of staff told us, "It is alright, but we could do with one more staff in the morning. We work quite hard so that we get it done". Another member of staff said, "It is OK, but we could do with one extra staff member. Currently we are reviewing the dependency tool and we are to provide feedback to the manager tomorrow".

The manager audited accidents and incidents reports. These were analysed for trends and appropriate actions were taken to minimise the risk of re-occurrence so the lesson learned could be shared within the service.

Systems were in place to ensure infection control practices were followed. We observed staff wore personal protective equipment such as gloves and aprons appropriately. Facilities were available to ensure good hand hygiene, including a hand sanitiser. One person's relative commented, "It is of a high standard, particularly the hygiene".

Regular checks and tests, such as weekly fire alarm tests and external checks of firefighting equipment, were completed to promote and maintain safety in the home. As a result, people were protected from potential risks caused by faulty equipment.

The service took appropriate action to reduce potential risks relating to Legionella disease. When staff reported any maintenance requirements and issues, these were resolved in a timely manner.

There were robust contingency plans in place in case of an untoward event. The contingency plan assessed the risk of such events as fire or bad weather conditions and how the service would continue in the event of these occurring.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection in August 2017 we had identified a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not always been assessed in line with the Mental Capacity Act 2005 as required.

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. We checked whether the service was working within the principles of the MCA.

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).

At this inspection we found that very little improvement had been made and further improvements were needed. Not all people had specific capacity assessments undertaken with regard to specific decisions. Some decisions were made on behalf of people by relatives who did not have Lasting Power of Attorney (LPA) to give them the legal authority to do this.

We found a safety belt and bed rails were in use for a person who was deemed not to have capacity. Although we acknowledge this had been implemented to mitigate risks to the person, no best interest meeting had been convened to determine that the use of that restraint measure was in the person's best interest. There was no specific mental capacity assessment or DoLS application in place regarding the use of the safety belt or the bed rails. Instead, the permission form for using these precaution measures was signed by a relative who did not hold legal rights to make such a decision. Safety belts and bed rails are used as a safety measure to prevent falls, but are restrictive and restrict people's freedom of movement. That is why a best interest process should be followed in line with the Mental Capacity Act 2005.

Information on people's mental capacity kept in the care plans was contradictory. One person's care plan stated that the person had full mental capacity. However, a relative of the person had signed consent forms on behalf of the person without having LPA. The consent form signed by the relative related to the use of bed rails, administration of medicines, treatment and information sharing.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were looked after by staff who were well-trained. One person told us, "They know my needs. I suffer from seizures caused by dairy intolerance, so they make sure I have a lactose free diet". One person's relative said, "From what I've observed, I'd say yes, they are well-trained".

People were cared for by suitably trained staff.We looked at the training matrix of the service and found that staff had recently undertaken refresher training in moving and handling, administration of medicines, safeguarding and infection control. This meant that staff had the training and knowledge that they needed to support people effectively.

All new staff expected to undertake induction training which included the completion of mandatory training in relevant areas and completion of a probationary period. Newly employed staff shadowed more experienced staff and had their competencies assessed.

We saw that people's health care and support needs were assessed before they moved into the home and this assessment continued whilst the person lived at the home. These assessments covered areas of health and well-being, support needs, mobility, nutrition, communication, medicines and personal care. One person's relative told us, "We came and had a look around to start with and then the manager came and saw mum in their own environment. Together with us they talked through exactly what it was that she needed and how her condition was progressing. Once we had funding agreed, she was able to move in and we've been very pleased with how well she's looked after ever since".

People and their relatives provided us with mixed feedback about the quality of meals served to them. One person said that the food was, "lovely', tasted "beautiful" and that it looked "out of this world". One person's relative told us, "Mum needs her food to be pureed these days. I have been impressed by the fact that they will take the normal meal that they have made for all the other residents and then they will puree this down for her rather than buying some ready-made purée that you don't know what's in it. This way I know she's getting a good balanced diet". However, another person's relative told us, "The one thing that we have noticed is that there is never any fruit put out in any of the communal rooms or even put out with lunch and supper for them to have. We usually end up bringing anything in that we think he will like to eat, and to be quite honest, for the amount of money that they charge each week, you would think they would provide some fruit for all the residents as a matter, of course". We checked that people at risk of malnutrition had their weight regularly checked and we saw evidence that this was the case and that people were consistently gaining weight as appropriate. People had access to the appropriate equipment to enable them to eat and drink as independently as possible such as adapted cutlery or beaker cups for their individual needs.

People had access to healthcare services and received on-going healthcare support. For example, people were referred to a speech and language therapist, an occupational therapist, a mental health team, a respiratory specialist, GPs and district nurses. One person told us, "They do everything here, I don't have to worry about a thing. The GP usually visits twice a week and the dentist and optician and also somebody to look at my feet usually comes quite regularly. If I need anything else, one of the nurses will usually organise this for me". Another person said, "It's been so much easier since I've been living here, because I don't have to worry about trying to get through to make appointments to see someone and then struggling to find somebody to take me to wherever the appointment is because that's all organised for us here and they will come to us here rather than us having to go to see them".

People had 'This is me' folders in place detailing their likes, dislikes, health related issues and support they needed in place to assist them in hospitals. The aim of these folders was to provide hospital staff with the necessary information about people. We saw that the 'This is me' folders were person-centred, however, some of them lacked information relating to people's health. For example, one person had been identified at being at risk of choking. This was not reflected in their 'This is me' folder. Another person suffered from anaemia due to iron deficiency. This information was not included in their 'This is me folder'. We brought this to attention of the manager who told us they would update the 'This is me folders' immediately.

The interior of the service premises was dementia-friendly. For example, carpets were free of any patterns that might cause confusion. Each floor of the building had been designed with regard to people's conditions and needs. There were also different decoration patterns to suit people's tastes. For example, one place in the building depicted a cinema. In another part of the building there was a post office, a toy shop and a laundry room. It provided people with sensory stimulation but also helped them relax and evoke their memories. One person's relative told us,
"The premises are lovely and well-maintained. This summer, the residents were able to sit outside, do activities, have barbecues and help with the raised beds, all in glorious weather".

All the rooms we visited were of decent size and residents had a combination of their own furniture and that which is provided by the home. Each room had an ensuite facility which was a wet room equipped with a shower, a sink and a toilet. Everyone had a lockable drawer to be able to put their valuables in for safe keeping.

Good

Is the service caring?

Our findings

People using the service and relatives spoke very positively about staff and the care they received. One person told us, "They do always want to make sure that I'm comfortable and that I have everything that I need". One person's relative told us, "Mum is always dressed nicely, in clean clothing, her hair is always tidy and she always smells clean".

We observed that staff respected people's dignity and privacy. Staff knocked on people's doors before entering their rooms. They also ensured that curtains were pulled and doors were closed while they provided people with personal care. We saw that care staff took time to talk to people to make them feel supported and comfortable at the service. For example, we observed care staff talk to one person and then give them assistance with a drink and a snack. One person told us, "They have certainly never attempted to start providing any care to me whilst either the door or the curtains were open, so they are mindful of the fact that I like not to be on show when they are in my room and helping me".

People's personal history and preferences were listed and their preferred names were noted at the front of each plan. Care workers used people's preferred names in a respectful manner.

During our observation we saw staff assisting people with their meals. People were offered food options by staff who talked to them or used gestures and other prompts to ensure people understood them and could make their choices. We observed staff assisting people with eating and drinking in a calm and caring manner. Staff worked well as a team; there was frequent communication among staff members who shared all information needed to ensure people's needs were met. Staff showed a caring approach by asking people where they would like to sit, if they would like an apron, if they needed support in putting it on and if they would like their food to be cut up. People were offered more food when they had finished and could go at their own pace. People used appropriate equipment like adapted cutlery or beaker cups for their individual needs.

People and their relatives were involved in preparing and, if necessary, amending people's care plans. One person told us, "I've very much been involved in developing the care offering he receives from the home". One person's relative said, "I have always found them to be very open and honest with me about what they can and can't provide for my husband and I am always involved in any decision relating to his care".

People's care plans described the ways in which people should be supported to promote their independence. During the inspection we observed staff providing prompt assistance but also encouraging and prompting people to build and retain their independence. One person told us, "When I am having a wash, I do the top half and the staff help with the bottom half".

People were able to have visitors at any time and they could talk to their guests in the privacy of their own rooms. There was also a visitors' room ready for people and their families if they required more space.

Staff were discreet and respected people's confidentiality. We saw that records containing people's personal

information were kept in the main office which was locked so that only authorised persons could enter the room. People knew where their information was and they were able to access it with the assistance of staff. Some personal information was stored within a password protected computer.

Good

Is the service responsive?

Our findings

People were mostly supported by detailed care plans. Care plans were in place to give staff guidance on how to support people with their identified needs in such areas as personal care, medicines management, communication, nutrition and mobility. Staff were provided with information which detailed what was important to each person, described their life history, daily routine and the activities they enjoyed. We saw people's input in care planning. For example, a person had indicated that they would 'like lights on in bathroom left on, with the door slightly open'.

People and they relatives told us that the service was responsive to people's changing needs. One person said, "I think because they see me all the time, they probably notice changes in my health and care needs before I do". One person's relative told us, "They know the residents well and notice even slight changes remarkably quickly".

People and their relatives told us they were involved in regular reviews. One person said, "The reviews take place quite often and I've always been present at them and I've always been made very welcome and felt that my views have been valued". One person's relative told us, "We are always invited to and I am fully involved in these meetings. If at any time in between the planned ones we feel as the nearest relative that a further review is necessary, then we can just speak with the manager and it's arranged."

There was a wide choice of activities offered to people. These activities included trips out to a garden centre, games, quizzes, listening to music and gardening. There was a full-time hairdresser employed by the service and people valued the fact that they did not have to go out to get their hair attended to. Activities were reviewed and feedback was sought from people to see what they preferred most. We saw people sat in the communal areas listening to music and reading newspapers. Others stayed in their bedrooms, watching television, reading or being visited by their relatives. People's spiritual needs were met by church services offered to people on Monday afternoons. One person told us, "I enjoy company. I like the singalongs, my daughter visiting, the cinema and watching the soaps". Another person said, "I watch TV, enjoy trips out, pub lunches, cinema, and music. The ukulele was very good and I have a list of activities in my room".

People said they knew how to complain if they were not satisfied with the quality of care. One person told us, "I don't like to complain but I would if I needed to". Another person said, "I would talk to the manager". One person's relative told us, "We certainly know how to make complaint and would probably speak to the manager first, to see if the problem could be resolved without having to-make a formal written complaint. Having said that, in the last 2 1/2 years there's really not been anything to complain about".

An equality and diversity policy was in place at the service. There were procedures for people's cultural and religious backgrounds as well as people's gender and sexual orientation to be recognised at the initial assessment stage and respected within the service. Staff received training in equality and diversity.

There were records of people's concerns and evidence showed the service had responded to these concerns in line with procedures. There had been seven complaints recorded in 2018. People's concerns and

complaints were monitored and appropriately investigated. Furthermore, this information was used as a basis for actions aimed to enhance the service. We also saw letters of appreciation. Relatives wrote in their comments that they were grateful and thankful as people at the service were well looked after and safe, and could rely on staff's constant support.

The home was not currently providing end-of-life care to anyone. However, the provider had systems and procedures in place to enable staff to identity people's end-of-life wishes and had developed associated plans. These included information about people's religious requirements, wishes for medical aid to assist recovery and funeral arrangements.

Requires Improvement

Is the service well-led?

Our findings

There was no 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. The service was run by a manager who was to become registered with the Care Quality Commission (CQC).

At our previous comprehensive inspection in August 2017 we had identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care records had not always been complete, contemporaneous, or an accurate reflection of decisions made regarding their care. Systems and processes had not been sufficiently robust to assess, monitor and improve the quality and safety of the service.

At this inspection we found there was limited evidence of service improvement.

There were gaps in the records such as care plans and topical medicine records. Some information contained in care plans such as information relating to people's consent was contradictory and confusing. The systems in place to assess, monitor and improve the quality and safety of the service were not always effective. For example, the issues identified during the inspection had not been identified through their internal monitoring systems.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recent change in the management structure meant that the post of deputy manager was cancelled and the duties of the deputy manager were split between nurses who were promoted to unit leaders. However, feedback from the nursing staff indicated they were not consulted about the changes within the management structure. The unit leaders said that they were allotted eight hours a week to complete their duties, such as auditing medicine management, care plans and compiling duty rotas. However, they felt that this was not enough time and described how they had to complete some work at home to keep up. They felt doing away with the deputy was not a good decision as they felt the deputy role provided a good link between the units, providing continuity in clinical practice and duty rostering. A unit leader told us, "Eight hours is not enough to do rotas, medicines audits, care plan audits and mental capacity assessments". A registered nurse told us, "It was important to have a deputy manager dealing with problems relating to management of medicines. My unit leader works only three or four days per week. Eight hours is not enough for them to do that job".

Staff told us they were not involved in discussing and considering new ways of running the service, including changes in the management structure which affected their work. A member of staff told us, "We didn't get asked if the deputy manager should stay. It was easier when she was here. For example, rotas came out quicker. This situation puts more stress on the nurses". Another member of staff told us, "We've got the unit

leaders but they have so much pressure on them. Now the nurses have to do an extra job in such a short time. They are stressed out which makes us stressed out. No one asked about our opinion but this is affecting our job. If a unit leader is on holiday, where do I go with a problem? There is no link between the nurses and the manager". A unit leader told us, "We were not asked. This was rather an abrupt announcement. There was no mention of it beforehand".

Staff told us that although the manager had taken up their post a few days before, their presence was visible and had already made a positive impact on team morale. A member of staff told us, "She is the best manager we could ask for". Another member of staff told us, "[The manager] is very approachable. If you have any concerns about what is happening on the floor, she will address them".

People told us they were aware of the new manager being in post, however, it was too early for them to provide us with their opinion on them. One person told us, "We've got a new manager and she's advertised a resident's meeting tomorrow afternoon". One person's relative told us, "[The manager] is new, but my sister and I have met her and she's putting on a cheese and wine evening for all the relatives on Thursday". Another person's relative told us, "Still early days, but a meeting is a good starting point".

Staff said that since the new manager started there was an open culture within the service as they knew their views and opinions were always taken into consideration. A member of staff told us, "She is very supportive in our opinion". Staff told us and records confirmed staff had asked for a pay rise and this was accommodated by the service on the second day of our inspection.

Staff meetings were held on a regular basis. We saw that during these meetings staff discussed such matters as infection control, responding to call bells, timekeeping and record keeping.

Staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures. The provider complied with the condition of their registration to have a manager in post to manage the service. The manager was aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services and others were not protected against the risks associated with giving their consent to care, support and where required treatment. This was because the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not robust or effective.