Majestic 3 Limited

Blenheim House Specialist Care Centre

Inspection report

27 Shurnhold
Bath Road
Melksham
Wiltshire
SN12 8DD

Tel: 01225709271
Website: www.majesticare.co.uk

Date of inspection visit:
11 September 2018
12 September 2018

Date of publication:
26 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Blenheim House Specialist Care Centre is a care home and can accommodate up to 85 people across four separate units, each with separate shared space. One of the units specialises in providing care to people living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This inspection took place on the 11 and 12 September 2018 and was unannounced on the 11 September 2018.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager will be applying to register as manager with CQC.

There were a range of quality audits undertaken and the manager told us there was an action plan on driving improvements. We found that audits were not in place for all areas of service delivery. For example, care planning. A comprehensive action plan was not in place from outcomes of all the audits. While patterns of accidents were analysed, action plans were not in place to prevent the same type of accident from reoccurring. This meant the monitoring of service delivery was made more difficult because action plans were not in place for all shortfalls identified or on how they were to be met.

There was an online care planning system which relatives and staff told us they preferred from the old paper system. Relatives said the previous system took time from their relative for report writing. However, there were inconsistencies within the system. This meant information about an area of need was not consistently recorded in the same section of the online care plan. The manager told us some icons were unlinked to reduce the sections where information could be repeated.

Care plans were not always person centred or reviewed monthly when people's needs changed. Where there was input from health care professional their guidance was not used to develop care plans. For people that at times became anxious and frustrated care plans were not in place on how situations were to be managed by staff.

Risk management systems were used to assess people's individual level of risk. Action plans were devised were risks were identified. While risk assessments gave staff guidance on how to minimise the risk, for some people the information was not up to date. Monitoring charts were used to ensure the risk level was minimised. For example, repositioning, food and fluid intake. However, monitoring checks were not consistently completed. This meant staff could not be certain the level of risk was minimised and if people's health was deteriorating.

The training matrix showed that staff had completed multiple courses on the same day which may not be effective to embed good practice. Staff gave positive feedback about the training offered.. One to one meetings known as mentorship meetings took place with a line manager to discuss shortfalls in training. For example, moving and handling.

The home was clean well decorated and free from unpleasant smells. We saw housekeeping staff on duty within the home. While there were some areas of the environment that were adapted for people living with dementia, signage was needed to improve people's orientation. For example names on doors and signs for toilets. For some people personal items were not included in the memory boxes on their bedroom doors. Without names on doors and memory boxes people living with dementia were not helped to find their bedrooms independently.

Medicine systems were managed safely. There was an electronic system for medicine administration and audits of medicine systems showed outcomes were met.

The staff we spoke with knew the types of abuse and how to report their concerns. They said they had attended safeguarding adults training to help them recognise the signs of abuse and about reporting concerns. People said they felt safe living at the home.

We saw adequate number of staff available to support people. People told us the staff responded to their request for support and assistance.

Where possible people made decisions about their day to day care and relatives said they were consulted. Deprivation of Liberty Safeguards (DoLS) were appropriately applied for. Staff were knowledgeable about the principles of Mental Capacity Act (2005) and there was guidance available to staff for reference.

People dietary requirements were catered for. However, people told us the menus were not varied.

People had access to healthcare services as required. Relatives told us they were kept informed about GP visits and about important events.

People we spoke with and relatives praised the staff for their caring manner. We saw some good interactions between people and staff.

Structured activities from two activities coordinators were spread across all units. Activities for people in the dementia unit were not as regular.

The complaints procedure was on display. Complaints policy in place with timescales on when to respond. There was a detailed response, investigated and action taken.

We found breaches of Regulation 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.

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 safe

People had been assessed for all areas of risk. Care plans were not always up to date on how to support people safely. Where people became anxious and frustrated care plans were not in place on how to support people.

Staff knew the procedures for safeguarding people from abuse. People told us they felt safe at the home.

Medicines were managed safely.

There were sufficient staff on duty during the inspection.

Is the service effective?

Requires Improvement

The service was not effective.

Staff attended multiple training courses on the same day. This meant there was little opportunities for reflection and on how to embed training.

Staff had one to one supervision known as mentorship meetings to discuss training shortfalls. .

Consent to care was sought in line with legislation.

Is the service caring?

Good

The service was caring.

People gave positive feedback about staff. People told us the staff knew how to care for them in their preferred manner. We saw examples of good interaction between people and staff.

People said staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always person centred.

Documentation was not kept up to date.

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not well led.

Audits were not in place for all areas of service delivery. Actions plans arising from audits were not part of the quality assurance system.

There was no registered manager in post.

People and staff said there had been many changes of managers.

Blenheim House Specialist Care Centre

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 11 and 12 September 2018 and was unannounced on the first day.

The inspection was undertaken by two adult social care inspectors. Before the inspection we reviewed other information, we held about the service including notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people and six relatives. We spoke with six staff, a registered nurse, nursing assistant, activities coordinator and chef. The deputy manager, manager, acting regional manager and nominated individual were involved in the inspection. We reviewed five people's care plans in detail. We looked at specific areas of a further five care plans. We reviewed the staff matrix provided, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

Systems were in place to assess people's individual risk such as mobility needs t risk of falls, malnutrition, choking and pressure ulcers. Screening tools were used to assess the risk of people developing pressure ulcers and for malnutrition. Risk assessments Action plans were then developed giving staff guidance on how to minimise the risk. For example, regular repositioning and monitoring of people's food and fluid intake. The records of two hourly repositioning and food and fluid intake were not consistently completed. This meant staff were we could not be confident that action plans were being followed or gained an that staff had accurate information about the person's health.

Moving handling risk assessments were in place for people with mobility needs but the information on how to support some people were not up to date. The relatives of this one person told us there was an incident of poor moving and handling where their family member had sustained bruising. They told us a safeguarding referral was made and since then the staff had received training. This person's risk assessment was reviewed on 05/08/2018 and stated that two staff were to use the small toileting sling and hoist for transfers. The staff were also able to use the hoist to support the person to be raised in the bed for continence needs. However, the summary of needs states "do not hoist ". Although the manager told us this person was cared for in bed and the therefore equipment for transfers was not needed it was not clear how personal care was delivered to this person without using a hoist.

There were people that at times expressed their frustration and anxiety using behaviours staff found difficult to manage. While care plans made references to people resisting personal care, agitation and repetitive behaviours there was little guidance on how staff were to manage these episodes. Staff recorded incidents when people became anxious or agitated. These reports were often incomplete with little explanation on how these behaviours were presented, how they were resolved and following incidents there was no analysis of the event. This meant reports could not be appropriately analysed because information was missing to identify potential triggers. The manager told us care plans on managing difficult behaviours were to be developed. We discussed that without appropriate care planning staff were not able to respond appropriately to difficult behaviours. This meant reports could not be appropriately analysed because information was missing to identify potential triggers.

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

Safeguarding systems and processes were in place. The safeguarding adult's procedures on display within the home told staff how to raise concerns to the local authority and managers. However, when safeguarding concerns were raised by a family member the manager did not follow safeguarding procedures which delayed action from the lead local authority. For example, instigating an investigation to reach outcomes on the findings.

The staff we spoke with had attended safeguarding training on how to identify the signs of abuse and on reporting their concerns. Staff were knowledgeable about their responsibility to raise concerns relating to

poor practice witnessed from others. A member of staff told us "I have had to use it [whistleblowing procedures] when I came into this job and a few practices were changed. It was a positive experience and enriched that person's life."

People we spoke with told us they felt safe living at the home. One person told us "I'm quite happy being looked after". Other comments included "yes, I'm safe with the staff and I have a bell" and "I'm very comfortable". Two relatives we spoke with during the inspection said their family members were safe with the staff that cared for their family members.

Individual personal emergency evacuation plans (PEEP) were in place. The PEEP's gave staff guidance on the assistance and equipment needed for the safe evacuation of the property in the event of an emergency.

People told us there were sufficient staff on duty to meet their needs. Comments from staff about the staffing levels included "sometimes people are off and we are short, but it is getting better, we set out to cover all shifts from the team," "I think it is important that we all work over the whole home, it stops the floor becoming stagnant," "Just because we have always done it like that does not make it right, we have to move with the times. Everyone needs to be treated equally." "There is lots of overtime which is good, I would rather work overtime than have agency staff as we know people better." During the inspection we saw staff present and available to assist people. The manager told us there had been an increase in staffing levels since the last inspection.

Medicine systems were safe. An electronic medicine system was recently been introduced to promote safe management of medicines. During the inspection we observed medicines being administered. People were not rushed and staff sat with people to ensure they were taking their medicines.

Medicine care plans gave staff clear guidance on how people preferred to take their medicines and any known allergies. Medicine care plans were reviewed regularly and changes added, for example when the consultant or GP had changed a medicine or a dose. Where people refused medicines the action plans gave staff guidance on offering medicines before administering medicines covertly.

The property was well maintained. We observed the home to be clean well decorated and free from unpleasant odours.

Requires Improvement

Is the service effective?

Our findings

Some staff attended training set by the provider. This training may not be effective because staff attended multiple training courses on the same day. For example, on the 06/08/2018 a member of staff completed 18 courses including dementia awareness, basic Life Support, Deprivation of Liberty. Another member of staff completed 23 courses on the 05/08/2018 including Adults Safeguarding, Mental Capacity Act, medicines and dementia awareness. The number of courses in one day is not effective for reflection and to embed learning into practice. In addition when we compared the names on training matrix and the staff rota we found the names of six staff were not included in the training matrix. We could not therefore confirm the training that these staff had received. At the end of the inspection the nominated individual told us our findings will be discussed with the organisations training department.

Staff told us the online training was "good" but that they would also prefer face to face and practical training courses as "you learn better through face to face". A member of staff told us "Last year I stepped down from a senior role as I didn't feel I had the skills, I have just finished my level three diploma, it is getting better, there is a gap and they have been proactive with more training in last three months. I would like more face to face, interactive training. Face to face is always good."

Before the inspection the manager provided us with information about one to one supervision known as mentorship. The information stated that staff had regular supervision and annual supervision. The information also stated was that "All staff are now receiving mentorship in Mental Capacity/DoLS to ensure our residents are fully supported in making their own decisions and are cared for in the least restrictive way". Records showed mentorship had taken place to discuss staff's training needs such as moving and handling.

Relatives we spoke to gave their opinion about the staff skills. Two relatives said the staff had the skills needed to care for their family member who was living with dementia.

People's individual needs were mostly met by the adaptation, design and decoration of premises. The property was well decorated and maintained to a high standard. Two relatives we spoke with said the unit where their family member was living had been adapted for people living with dementia. On the first day of the inspection we saw people in Clover St (the area that supported people living with dementia) had little access to all parts of the building. There were keypads on entry and exit doors and the door into the covered veranda was locked. The manager told us staff had been instructed not to use keypads during the day. Relatives confirmed that recently doors were not locked during the day.

The environment in Clover Street unit were brightly coloured, there were points of interest and boxes with items for people to "rummage". While there was some signage we noted people's, names were not on their doors, not all toilets were labelled and memory boxes on bedroom doors for some people were empty. This meant that people were not supported to find their way around the home.

People's dietary requirements were met. However, some people we spoke with said the menus lacked variety. One person told us "I made suggestions about improving the meals at a meeting. More variety [was

needed] for the lunch and evening meal." The minutes of the "residents and relatives" meeting dated 04/09/2018 showed that people had raised concerns about the lack of variety with the meals. The manager told us there had been discussions with the chef about changing the menus to include more variety.

The chef told us they prepared menus from the information people gave about their likes, dislikes and special diets. The chef said the menus were on a three-week rolling cycle which meant people were served the same meal three times in a 12-week cycle. The chef said, "all meals are fortified and 96 % of meals are prepared fresh at the home." The chef received feedback from people during visits to the unit and hostess staff received direct feedback at meal times.

The weeks menus were on tables in all units except for the Clover St, the dementia unit. The registered manager told us menu were removed because people were shown the options at mealtimes. At lunchtime we observed hostess staff ask people to make a choice from the options available. There were two choices of meals available which included a vegetarian option and light bites. We observed some people at risk of choking were served pureed meals.

People were supported with their ongoing healthcare. People had access to community NHS facilities such as opticians and dentists and were referred for specialist support. For example, Speech and Language therapist and Care Liaison (visits services to offer advice on how to deliver care to people). A social and healthcare professional told us they visited the dementia unit each week. They told us there had been "a lot of management changes". They said the staff "try to follow advice and they see the benefit of the guidance but staff are not always available for activities. Activities are rare in the dementia [unit]."

The outcome of clinical visits and guidance was difficult to access within the computerised recording system. We found reports of GP visits difficult to find within the electronic care planning system. Guidance from social and healthcare professional's visits was not documented or used to develop care plans. Professionals told us input was sought but their guidance was not documented on how to manage behaviours that had become difficult to manage. This meant staff did not have up to date guidance on how to improve the delivery of care.

People's needs were assessed before their admission to the home. One person told us before their admission for respite care there was a visit from a member of staff to discuss their needs. The deputy manager showed us a copy of the pre-admission assessment. Feedback was gathered from the person about their needs, preferences and routines. For example, for one person their daily preferences was to be cared for in bed and to have a box of tissues and refreshments within close proximity and we noted them in place during our visit. On the day of admission, a "residents" questionnaire was completed which expanded on the pre- admission assessments. The deputy manager told us "there is more in-depth information. For example, for this person specific television programmes about the Ukraine and nightly routines [was important]". The admission checklist ensures all areas of needs were assessed. The deputy manager said, "Nothing is missed, the GP is contacted for a summary and registration with GP."

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.

Two people we spoke with told us they made all their decisions. The staff we spoke with were knowledgeable about the MCA (2005) and how their principles were applied. Comments from staff included

"always assume that the person has capacity", "people are able to have the freedom of the floor", "If they want a glass of wine, as long as there are no medical implications they can have one. It's about the person, enabling them to have things they want. Encourage their independence and likes and dislikes as much as possible, it gives them a sense of empowerment. The social model of care not medical model." Copies of MCA principles and guidance for staff in lounges. The unit manager said that the guides were available in the lounges for seniors to regularly check out the knowledge of the support workers.

People's capacity to make decisions was assessed for accommodation, continuous supervision and for specific decisions. For example, the mental capacity assessment for one person states they lacked capacity to make decisions about their accommodation. There were key entry and exit systems in place and were to be accompanied to leave the building. Where the person lacked capacity best interest decisions were made in consultation with relatives and professionals. For example, GP for covert medicines. Best interest decisions were taken when people's freedom was restricted and DoLS applications were made. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?

Our findings

The people we spoke with said the staff cared for them in their preferred manner. One person told us the staff were "splendid. You get to know about them". Another person told us "there were frequent checks from staff at night. Sometimes I don't sleep and they are always attentive and pleasant. It's very comfortable and we are well looked after."

The manager told us how they ensured the staff were caring towards people. The manager told us there were "regular observations of on the floor practice from staff towards people and mentorship was to be rolled out. Talking to staff about ensuring people were to be cared for like their mum or dad. The philosophy is to put people first, [we] operate a zero tolerance policy for abuse."

At lunchtime we observed staff chatting with people in the dining room about their likes and dislikes. Staff comments to people about the meal options included "you're a sweet person aren't you?" "any gentlemen having soup today?". We saw for one person the portion size was too big and the staff member said, "is that too big would you like a smaller one?". When one person was struggling with their meal a member of staff said, "would you like me to help you?" and the staff gently assisted the person while checking "is that cooler?"

The relatives told us the staff were caring. They said the staff were kind towards their family member living with dementia in Clover Street They said whenevier they visited they saw that there was a consistent approach towards people from the staff. These relatives said the "care staff are brilliant and rise to the challenge" as there had been changes of managers. Through discussion with these relatives they told us suggestions on improving the service were taken seriously and acted upon.

Copies of resident's meetings showed people's views were gathered. One person told us they had attended these meetings and made suggestions about improving the meals and housekeeping such as laundry. They registered manager told us a meeting was held with the chef and asked to review the variety of menus.

People's rights were respected. The training matrix showed that staff had attended "Privacy and Dignity" training. Care plans directed staff to ensure people's privacy and dignity was respected. During the inspection we observed staff seeking permission before entering people's bedrooms. For example, we saw housekeeping staff stop and greet one person. We saw them chat briefly and once permission was gained entered the bedroom to undertake cleaning regimes.

Staff comments regarding dignity and respect included "It is common courtesy to introduce yourself." "I treat people as I would want to be treated." "It's a beautiful place to work, but I wish we could have more interactive time. I would like more time to sit and chat. Take time to get to know people." "Care plans are sterile, it's about getting to know people."

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not fully person centred, reflective of their needs or reviewed regularly. The manager was aware the care planning system needed to improve. This manager told us that in the residential unit the staff had been supported to develop person centred care plan. While we acknowledge that care plans in the residential unit were person centred in all other unit's care planning systems needed improving.

An online PCS (person centred system) care planning system was recently introduced. Members of staff used handheld devises to document information using icons and emojis directly into the care plans. Most staff were positive about the PCS and mobile system as it felt quick and didn't take them away from the people. Staff comments included "On the phone you are doing it as you go along, you are still with them but are able to update, it saves time, spending more time with the residents." However, they also commented that there were too many icons to choose from which made it un-necessarily complicated. For example, there was a fluid watch icon as well as tea, coffee, water icons for monitoring fluid intake. When staff then used the tea or coffee icon the fluid watch was not populated automatically. This meant an accurate recording was not available on how much fluid a person had. The staff said it would be better to have one icon for fluid. When we spoke to the manager it was agreed that just using the 'fluid watch' icon would be more practical and accurate. The manager told us following the inspection some icons had been unlinked and changed for "drink" and all refreshments would be recorded under the same icon.

Care plans lacked detail and all areas of peoples' physical, emotional and mental health needs were not always person centred. Where people had mental health care needs there was no guidance to staff on how to deliver care when there was a deterioration of mental health needs. The medical care plan for one person stated, "can become confused, becomes unable to walk, refuse meals and has a fixated stare." The personal care plans stated that when they experienced low mood they neglected their health and needs. Staff were given guidance to "intervene and further encourage [name] and support her to ensure she does not become neglected". Other documentation also showed this person had previous admissions to hospital for their mental health disorder. The emotional care plan for this person gave guidance for staff to contact the GP in the event they became confused or not orientated. However, a detailed emotional care plans that detailed the signs of mental health deterioration and how staff were to support the person during these periods were not in place.

While people we spoke with said the staff cared for them in their preferred manner some care plans were not always person centred. For example, the personal care for one person stated "Two members of staff to assist [name] with all of her personal care needs. Staff to explain all procedures to ensure that she doesn't become anxious as her eyesight and hearing are poor. Staff to offer [name] a bed bath daily and at least once a week a bath. Staff to check her skin integrity throughout care delivery and report any concerns to the person in charge." This meant the person's preferences on how their personal care was to be provided.

Care plans were not always reviewed or up to date. The manager told us since the introduction of the resident of the day some care plan reviews had "fallen behind".

Care plans were not always reviewed or up to date. The manager told us since the introduction of the resident of the day some care plan reviews had "fallen behind". The medicine prescribed for one person inferred end of life was anticipated. However, the care plans were not up to date on the priorities of care for this person.

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

The end of life care plan for one person was reviewed on 10 September but was out of date due to the person's deterioration in health. This person was receiving end of life palliative care, but this was not obvious from the care plans.

Clinical care plans were detailed and up to date. For example, the care plans for one people with epilepsy detailed the signs of a seizure such as jerking of the arms and legs. Guidance for seizures longer than five minutes was for staff to contact medical assistance urgently. All seizures were to be recorded and reported to the nurse in charge immediately and to the GP who will ensure the care plan was reviewed as necessary.

There were opportunities for people to join group activities. The activities coordinator told us there were twice daily activities and the aim was to provide three outings per week. There were resident's meetings to discuss the activities programme and people were provided with a copy of the programme. On both days of the inspection we saw activities taking place. However, the activities were not planned for people living with dementia. The activities coordinator told us there were only two staff to deliver activities for the whole home. This activities coordinator told us it was their intention to celebrate the world Alzheimer's day

There were opportunities for people to have one to one time from the Majesticare Companion. This companion told us "I feel it is a privilege to work here, I sit and talk and listen and offer my time and companionship." "I sometimes go to appointments with people as we don't like them to attend on their own. I also help out when activities are on and join in. 'I love it, it is a real pleasure."

Structured activities were provided. One person told us I watch TV a lot I don't mix so much in group activities. I go on the pub lunches. During the day I sit at reception and watch people arriving". Another person told us they joined in activities and were able to pursue their hobbies of painting in their bedroom.

The chef told us people people's birthdays were celebrated with cakes and there were opportunities for families to join the celebrations. The chef also told us festivals were celebrated for example, Harvest. They said meals from other parts of the word would be provided if staff made them aware of these festivals.

The complaints policy in place detailed the procedure which included written acknowledged of concerns within three days. Since the appointment of the manager the register of complaints were managed appropriately. The nature of the complaints, the names of the people involved and the agencies made aware of the complaint were detailed. We spoke to the manager about the complaints and we were the relatives were satisfied with the outcome of the most recent complaint. Two relatives told us in the past they had made complaints and "we would say something" if concerns arose again.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post. The manager was appointed recently and told us they were applying for registration with CQC as registered manager.

The quality assurance system in place lacked a comprehensive action plan from the outcome of audits. Audits were not in place for all areas of service delivery. Some audits did not address the effectives of the action in place. For example, for one person the Waterlow audit gave the actions to prevent pressure ulcers but not if the action plan was effective. The action plan stated two hourly repositioning with end of life care. However, we found the staff were not consistently recording when repositioning had taken place and end of life plans were not detailed. There was an analysis of incidents and accidents and it was identified that most accidents had occurred in bedroom. A plan on how these accidents were to be minimised was not part of the quality assurance action plan.

The head of Memory and Lifestyle Care carried out an audit of services for people living with dementia. The assessment showed improvements were needed. For example, "the staff need to understand the reasons for doing what they are asked to do. Appropriate training, both face to face, and 'on the job' coaching is urgently required." The nominated individual and area manager told us the head of Memory and Lifestyle Care will be working two days per week at the service to improve the care for people living with dementia. Medicine systems and infection control audits were detailed and showed all standards assessed were met.

Staff received some feedback from staff meetings to enable them to know what action to take. There was mentorship from their line manager to cascade training and 10 minute meetings at 10 am for heads of department and senior staff. However, staff meeting were not regular and staff did not benefit from structured one to one meetings where performance and personal development was discussed because recent mentorship meetings were used for training The staff meeting on 23 April 2018 was with the previous home management team. The manager, deputy, nursing assistant and senior manager were new and had been in post for six weeks. A staff meeting was held in 19 June to discuss issues relevant to Clover Street only. This meant team meetings and one to one mentorship which gave staff feedback on the actions to take were not regular or from the current manager.

The manager told us "I am a motivational leader and only autocratic when necessary. I Support and nurture the staff team, praising staff which motivates them. Happy workforce crucial for the openness and transparency of the home". Regarding the leadership of the home the manager said they "sailed between coaching and auditing. Can't coach staff unless they are empowered the links in the chain must go well for all outcomes to be met. We will never turn staff away when they need our advice and support. Hard job long hours and can be physical and emotionally tiring." During the inspection we noted staff seek the manager and deputy managers input and guidance.

The manager told us the challenges included changing staff culture but was "confident that the culture will change as some staff want to join the journey that ensures people receive the best care." They said time was needed to drive improvements and the timescale anticipated was 12 to 18 months.

There were incentives to develop team working. The staff told us there was three monthly team building across the organisation. The staff we spoke with were very positive about this andsiad, "we go away and stay overnight with other Majesticare care homes staff and network. We went to one in February and won £1000". The money was used to take people to the seaside for fish and chips.

The manager said the vision and values of the home were the same as "family values that reflect what people want, love and are able to feel that it's their home". People were supported to be "part of an extended family where they felt loved, safe and well cared for. It's an open honest and transparent culture where staff feel able to put their hands up and apologise when errors are made". For example, when the manager made errors the staff would be told "Hey guys look at what I have done and I will apologise we don't always get it right. Staff are coming on board and staff are now reporting. We have to be honest with all parties, there is the duty of candour and building trust. I take time to gain people's trust."

The manager told us "as reputation builds then occupancy will increase and the home will be more sustainable. Once it becomes known in the community." The manager said the intention was to build relationships with external providers and commissioners of care and also to raise the profile of the home with local support groups and charities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always person centred. Care plans were not in place for all needs identified and for some people lacked guidance on how to meet the needs identified . Care plans were not up to date for all people accommodated

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always clear on how staff were to minimise the risk. Charts to monitor people at risk from pressure ulcers and malnutrition were not always completed. Where people expressed their frustrations and anxiety with difficult behaviours care plans were not developed.