Gracewell Healthcare Limited

Gracewell of Edgbaston

Inspection report

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Date of inspection visit:
12 April 2016
13 April 2016

Date of publication:
08 June 2016

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**

Summary of findings

Overall summary

We inspected this home on the 12 and 13 April 2016. This was an unannounced inspection and was the first inspection of the service since they were registered with the Commission in April 2015. The home is registered to provide accommodation with personal and nursing care for up to 70 people. A number of people living at the home were living with dementia. At the time of our inspection there were 30 people living at the home. Of those living at the home, eight people were staying at the home for a short period of time for assessment of their needs or for a period of respite before returning to their former home.

The current registered manager of the service had been registered with the Commission a month prior to the inspection and was present throughout the inspection. 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 also currently receiving support from an interim manager who was responsible for the day to day management of the service. The registered manager had advised that they were going to be leaving the home to work at another location owned by the same provider. We were advised that a new manager had been recruited who would be applying to become the registered manager. Both the interim and current registered manager advised that they would be continuing to offer support to the new manager.

People told us they felt safe and well cared for. Family members that we spoke with told us they thought their relative was safe at the home. Staff had a good knowledge of safeguarding procedures and we saw that training around safeguarding had been provided.

The provider had carried out assessments to identify risks to people. Where a risk had been identified appropriate action had not always been taken to reduce or monitor the risk for the person. You can see what action we told the provider to take at the back of the full version of the report.

Whilst most people received their medicines safely, the provider did not have robust systems in place to ensure that people had sufficient supplies of medication in a timely manner. Staff did not always have the information they needed to administer as required medications. You can see what action we told the provider to take at the back of the full version of the report.

Whilst some people and staff told us there were generally enough staff available to meet their needs, at times there was a need for higher levels of staff or improved staff deployment. We saw that there weren't always enough staff available to meet people's requests for support and people who chose to spend time in their bedrooms received little staff interaction.

We found examples of the service meeting people's healthcare needs. However, there were some instances where people's healthcare was not monitored appropriately or safely. You can see what action we told the provider to take at the back of the full version of the report.

Staff were supported to maintain their skills and knowledge through regular training. However, this knowledge was not always put into practice to support some people living at the home.

People told us that they were involved in developing their care plans. We saw that there care plans had not been completed in a timely manner or updated with changes in peoples care needs. Care plans contained little detail of how a person wished to be supported. People could not be assured of receiving consistent care that met their needs. You can see what action we told the provider to take at the back of the full version of the report.

People were happy with the care they were receiving. We saw that some staff knew people well and we saw examples of caring interactions between people and staff.

People told us that staff offered them choices and sought consent before supporting them. Staff had knowledge of the Mental Capacity Act (2005) and put this into practice in their daily work.

During the inspection we saw that activities were offered to people who spent time in communal areas. People enjoyed a singing session and some people had activities offered based on past interests. However, there were limited opportunities for activities for people who chose to spend time in their bedrooms.

There had been a lack of consistent management and leadership since the home had opened which people, their relatives and staff said had been unsettling. The provider's processes for monitoring and improving the quality and safety of the service were not robust and had failed to identify some of the findings of this inspection. You can see what action we told the provider to take at the back of the full report.

Immediately following the inspection we received assurance from the provider that the issues identified would be addressed and that improvement would be on going and be sustained.

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.

Known risks to people were not always managed well.

People could not be assured of receiving the medication they needed in a timely manner.

There were not always enough staff available to support people.

Appropriate recruitment checks had been carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff had received training on some people's healthcare conditions, this knowledge was not always put into practice.

People were not always supported in a timely manner with their healthcare needs.

People were supported in line with the MCA.

Is the service caring?

Requires Improvement

The service was not always consistently caring.

Care plans did not contain people's preferences or the things that were important to the person.

People told us that they felt cared for and some staff we spoke with knew people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have their care reviewed to make sure it was meeting their needs.

Whilst we observed activities taking place during the inspection,

activities did not occur regularly and people who chose to spend time in their bedrooms did not have the same opportunities for stimulation.

More recently complaints had been handled appropriately.

Is the service well-led?

Requires Improvement

The service was not always consistently well-led.

There had been a lack of consistent management and leadership since the home opened a year ago.

Quality monitoring of the service had not been undertaken until more recently. The provider had failed to undertake robust record management.

Some people knew who the manager was.

Gracewell of Edgbaston

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 unannounced inspection took place on the 12 and 13 April 2016. On the first day of the inspection the inspection team consisted of one inspector 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 service. On the second day of the inspection the inspection team consisted of one inspector and a specialist advisor who had clinical knowledge of the needs of the people who used this type of service.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us and any other information we had about the service to plan the areas we wanted to focus our inspection on. We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We used this information to help us plan the inspection.

As part of the inspection we received feedback from a person from the local clinical commissioning group who monitor the quality of the service and from the local authority who commissions care for people living at the service.

We visited the home and met with twelve people who were living at the home and nine relatives of people. Some of the people who lived at the home were unable to communicate verbally due to their health conditions. We spent time observing how people were supported in the communal areas of the home and 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 to us.

We spoke with the registered manager, interim manager, deputy manager, a home manager of one of the providers other services and six members of staff. We spoke with two visiting healthcare professionals. We looked at records including five people's care plans and three medication administration records to see if people were receiving care which kept them safe. We looked at three staff files including a review of the provider's recruitment process. We sampled records from training plans, staff meetings, incident and accident reports and quality assurance records to see how the provider assessed and monitored the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at how the service managed risks to people living at the home. The service carried out assessments of people's needs prior to them moving into the home on either a short term or residential basis, although we saw that some of these assessments were not fully completed. The interim manager gave examples of when they had refused admission of a person into the home due to the service not being able to meet their needs. Whilst risks to people had been identified action had not always been taken to minimise the risk for the person. For example, we found that one person who had been assessed as a high risk of falls, and had experienced a number of unwitnessed falls in the months prior to the inspection, did not have detail recorded in their care records of how to reduce the risk of the person falling. During the inspection we saw this person was left unattended by staff for over an hour and no other steps had been taken to reduce the risk for the person. Although a referral had been made to the falls prevention team no immediate action had been taken. Records for another person who had a risk associated with their healthcare condition had no plan in place to monitor or reduce the risk for the person. The lack of action taken to reduce risks and record strategies about support people required placed people at risk of not receiving appropriate support.

We looked at how medicines were managed at the service. People were generally happy with how their medicines were managed and one person told us, "They bring me pain killers if I am in pain." Prior to the inspection we had been notified of a number of medication errors that had occurred, including people who had not received the medication they needed for a long period of time. The registered manager had informed us of action they were taking to reduce the risk of a reoccurrence. The home had initiated changes in medicine management before the inspection and we saw that medicines were stored safely. We looked at current medication administration records (MAR) for four people. We saw that each person had any allergies noted on their MAR chart. Some people had been prescribed medication to be taken 'as required'. There was no information available about when a person may need their 'as required' medications in two different instances. We found that the totals for one person's 'as required medication' did not correspond with the amount that had been administered and that the correct dosage had not been given. The daily audits carried out each shift had not noted this concern or identified that the medication that had been supplied to the home differed from the description of what had been provided. This presented a risk that the person could have received incorrect medication. On the second day of the inspection the registered manager had reviewed all people's medicines to ensure staff had the information they needed to administer medicines safely. The failure to have robust medication administration procedures and systems in place presented a high risk to people. There were a number of agency nurses covering shifts at the time who did not have prior knowledge of the person or awareness of signs and symptoms that people presented which indicated that they needed their medication.

In three peoples care records we saw that there had been occasions when there had been insufficient stocks of medicines available for people to receive their prescribed medication or there had been a delay in obtaining the medicines from the pharmacy. In one instance a person had been prescribed a medicine for a temporary healthcare condition. The medicine they needed had not been obtained for four days after it was prescribed, presenting a delay in the treatment commencing. In another instance a person was not given

their prescribed medication for two days as it was recorded that the medicine was out of stock. The provider had not put systems in place to ensure that people had sufficient quantities of medicine or received the medication they needed in a timely and safe manner.

The interim manager explained that in these instances and some past medication errors the pharmacy hadn't been responsive in supplying stock to them as was needed. Although the provider had identified that there were issues with the pharmacy they had taken little action to rectify this problem. Following the inspection the provider informed us they were going to look into this concern to ensure that appropriate stocks of medication could be obtained in a timely manner.

These issues related to management of risk and management of medication represent a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us they felt safe living at the home. One person told us, "I am safe and well looked after here." Another person commented, "Of course I feel safe here there are no issues." Relatives of people living at the home told us that they felt their family member was safe and one relative commented, "The residents are very safe here I have never noticed anything of concern when I am around."

Staff we spoke with were able to recognise the signs of abuse people were at risk from and told us action they would take should they have any concerns. Whilst staff were confident that the manager would take appropriate action to safeguard people they also knew the appropriate agencies to contact should they feel that appropriate action had not been taken. Staff told us they had received training in safeguarding people. Records confirmed that safeguarding training had taken place although half the staff had not completed the refresher course within the time frame specified by the provider. We spoke to the interim manager about this who told us they were aware that some training was out of date and they were taking steps to rectify this.

Over the months prior to the inspection the service had experienced a high turnover of staff and were using known agency staff and nurses each day to cover staff absence. The interim manager informed us that staffing levels were altered depending on the number of people at the home and their needs. People living at the service told us that generally there were enough staff on shift to support them although one person commented, "I get looked after well but when they are short staffed it makes a difference." Another person commented, "Sometimes they are busy and they say they are coming and turn up after a long time or forget." One person we spoke with felt a lack of staff contributed to her reduced opportunity to spend time out of her bedroom. Staff told us that generally there were enough staff on shift but some staff commented that they would like more staff on shift to be able to talk with people. One staff member told us, "People may use their buzzer just to have a chat with you and I haven't got time." During the inspection we saw that staff were not always available to meet people's requests for support. On four different occasions the inspection team were required to intervene to respond to people's requests for support. During handover times between shifts and meal times we saw that there were not always enough staff to meet people's support needs. We found an example of insufficient staffing levels had led to one person having to attend hospital on their own after a healthcare emergency. We observed that some people who chose to spend time in their bedrooms only received interaction from staff when a care task needed to be carried out. One relative commented, "Perhaps carers could visit her room more." A visiting healthcare professionals told us that there were often times that there weren't enough staff at the home to accompany them visiting the person and that they often found it hard to find a member of staff to pass on important information. This meant that people's needs may not be met promptly or safely due to insufficient staff being available.

The registered manager informed us that they were currently recruiting staff to maintain designated staffing levels. We reviewed the processes in place for staff recruitment and found that safe practices were carried

out. We found that the service checked that nurses had the required qualifications to practice and we saw that the service obtained Disclosure and Barring Service (DBS) checks to ensure staff employed were safe to be working with people. Further checks such as obtaining references were in place to ensure staff employed were suitable to support people who used the service.

Requires Improvement

Is the service effective?

Our findings

We looked at how people received support with their healthcare needs. We saw that in some instances the service had been responsive in making appropriate referrals to healthcare professionals when a person's needs changed. We saw that some people's healthcare conditions were not been monitored as stated in their care plans. For example one person's care plan stated that weekly monitoring checks should be carried out but we found that this had not happened consistently and there had been large periods of time where these checks had not happened. We found instances where identified needs had not been actioned. For example one person was assessed as experiencing pain. There was no care plan in place to support the person with their pain management and the person told us, "Pain is my biggest concern."

The service was providing short term support to eight people with a view to enable each person to move back to their own home or to support them whilst they sought longer term residential care. We saw that healthcare professionals were involved in these people's care. We found that advice given by these healthcare professionals was not always carried out consistently. We were informed that weekly meetings were held with healthcare professionals involved in these peoples care to monitor progress made. One healthcare professional informed us that staff didn't always have the information they needed about the person to aid them with their visit.

People were not always supported appropriately with their healthcare needs. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people received adequate nutrition and hydration. People who we spoke with were happy with the food they received and told us that the service met their dietary preferences and dietary requirements. People told us, "They feed me well. The food is excellent," and another person commented, "The food is good. It really does meet my needs." We saw that relatives were offered the opportunity to have a meal with their family member. We spoke to the chef who informed us that people's individual preferences had been catered for within menu planning. The chef was able to tell us people's dietary requirements and had devised a system where each person had their preferences, food allergies and dietary requirements recorded in a visual format to allow people to receive food in a safe way. If someone had not enjoyed a particular meal this information was fed back to the chef to ensure adjustments could be made to future menus. We saw that there was a written menu available for people outside the dining room informing them of what was for dinner that day. There were no other communication aids available to support people in decision making around meal times although we were informed that this was to be introduced in the future. When we asked people at meal times what was for dinner they told us they didn't know. We saw that there was times when staff were not effectively deployed to support people with their meals. We were told that there were seven people who needed assistance but there was only four staff on shift. People had not been supported and served meals when staff were available. We saw that people sat with their meals in front of them but staff were not available to prompt or support the person. This did not make a pleasurable dining experience for some people living at the home and placed people at risk of not receiving adequate amounts of food and drink to maintain good health.

People living at the home told us they believed staff met their needs and that staff were suitably qualified. One person told us, "Personally, I think the staff have the appropriate skills." Another person commented, "They are trained and knowledgeable in my view."

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 people lack mental capacity to take particular decisions, any decision 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 told us that they were offered choices in most aspects of their care. Staff we spoke with told us they had received training in the MCA and described how they supported people following the principles of this legislation. Staff that we spoke with explained how they sought consent from people before supporting them and how they offered people choices in their care. We found that assessments of people's capacity had been carried out for most people but one person had not had an assessment carried out. Assessments were reviewed monthly.

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 are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS had been made for five people living at the home as it was determined that they did not have the capacity to decide to live in the home and would not be safe if they left the home on their own. These applications had been sent to the appropriate authority to gain authorisation to support people in this way. Each floor of the home had keypads on the doors which required entry of a code had to be to gain entry or exit. The interim manager explained that people who had capacity and who wanted the code were able to have this to allow them to leave the building if they wished. We saw that people were able to freely move around the floor of the home that they lived on.

We found that the provider was carrying out overt surveillance of the car park, entrance to the home and external exits of the building. There was no signage to let people know they were being filmed. Although some people at the service told us that surveillance was carried out there was no evidence that people had been consulted about the surveillance carried out at the home. We brought this to the attention of the registered manager who had displayed signage by the second day of the inspection.

Staff told us that they received sufficient training to carry out their role. The service had recently identified that a number of training sessions needed to be carried out again to refresh staff's knowledge. The service was putting plans in place to rectify this to ensure staff had current knowledge and skills. Staff working at the service were being supported to complete the care certificate. This is a nationally recognised course for new staff and provides care staff with knowledge of good care practice. The provider had access to a training officer who was available to support staff with their training.

We saw that a number of people at the home were living with dementia. We saw that training had occurred but this had not been extensively applied for people in the home as there was limited support available for people living with dementia. There were no communication aids available to specifically support people living with dementia in decision making and there were limited visual cues around the home to support people to know where they were in the building such as signs indicating where the lounge or bathrooms were. Some people had memory boxes outside of their bedroom door which contained personal items, displayed behind glass, which people could look at as a way of identifying their own bedrooms. However we saw people trying different bedroom doors in an attempt to find their own bedroom. People living at the home told us that they had reported people entering their bedrooms as a past concern although they advised that they thought this issue had seemed to have been resolved. During the inspection we met with a

dementia care manager who worked for the provider. This person was working with the home to improve the service provision for people living with dementia which included providing staff with further training and supplying aids to support people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People told us that they had been involved in completing their care plans to enable their likes and dislikes to be recorded. Some people living at the home were able to tell staff how they wished to receive their care on a daily basis. There were some people living at the home who would not be able to do this. We found that care plans in some instances lacked detail about how people preferred to be supported which meant people may receive inconsistent support that does not meet their individual needs. Care plans were not centred around the uniqueness of the person and instead detailed care tasks to be competed. We found that some care plans were not fully completed with key information about the person's care needs, including one person who had moved into the home almost a month prior to the inspection. Another person's care plan had differing information of how to support a person and care notes showed that one person had been supported in three different ways with their mobility. Care plans were not updated when a person's needs changed. It was important for staff to have access to up to date information of how a person wished to be supported as many of the staff working at the home were agency staff who did not know the person well. People could not be assured of receiving personalised, consistent care that met their individual needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy living at the home. Most people we spoke with said that the regular staff team were caring and had got to know them well. Comments from people included, "Staff are nice. They always say hello as they pass my bedroom." Comments from some people indicated they felt some carers were better than others. One relative told us, "She has built a rapport with the carers," and another relative said, "I think they're very kind, nothing is too much trouble." We observed staff responding to people in a kind, supportive way and offering comfort when people appeared upset.

The service was using agency staff to maintain designated staffing levels until permanent staff could be recruited. People, relatives and staff said this had caused unsettlement in the home and many relatives we spoke with were concerned about the turnover of staff. We saw that the permanent staff team had got to know some people well and could tell us what was important for the person. We were aware that the provider was in the process of addressing the need to recruit more permanent care staff.

We saw that people on the most part were treated with dignity and respect. People had been supported to maintain their appearance and we observed staff respecting people's privacy by shutting bedroom doors when assisting them with personal care. We observed an instance where information about people's support needs were talked about in front of other people living at the home. During the inspection we noted that one person was called three different derivatives of his name. We brought this to the attention of the registered manager who told us they would address this issue promptly to ensure it did not reoccur.

Some people told us that staff encouraged them to retain their independence. One person told us, "I do some things myself those I can't, they support me." Staff informed us of how they encouraged people with their independence in meeting their personal care needs and staff said that they saw the importance of people being as independent as possible. However, we saw missed opportunities where people's

independence could have been promoted further.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff usually responded appropriately to requests for support. One person told us, "I have a buzzer they don't take too long to come." Another person told us, "They respond to the bell as quickly as they can depending on how busy they are." Staff gave an example of how they had encouraged one person with their mobility after having an operation and staff were happy this person could mobilise again.

During the inspection we noticed that people in communal areas took part in activities. On one of the days a singing session was taking place which encouraged participation. People who took part in this activity were enjoying singing along to the music and were happy and smiling. We observed that people who chose to spend time in their bedrooms did not have activities available to them and staff only spent time with the person when competing tasks such as personal care or assisting with food and drinks. Some people living at the home explained that they preferred time in their bedrooms rather than joining in group activities. One staff member told us, "I'd like to spend more time with the residents. There's not enough time to do activities." We saw that newspapers were available on the first day of the inspection although one relative commented that it was the first time they had seen a newspaper at the home in the past seven months. People were confused as to whether they were allowed to look at the newspapers or who the newspaper belonged to. We saw that on one occasion an activity was planned based on the persons past interest. The service had recognised that this was an area that needed improvement and were in the process of recruiting an activities co-ordinator at the time of the inspection.

We saw that relatives were welcomed into the home and were able to visit without restrictions. One relative explained to us, "You can visit any time you want." Some relatives were happy with the way the service involved them and kept them up to date of any concerns regarding their family member. One relative told us, "They keep in touch with the family all the time and let me know what's going on with mum."

We saw that there was a dedicated handover period for staff where information was shared about people between shifts. This gave opportunity for current needs to be shared to enhance the chance of continuity of care for the person.

There was some evidence in people's care plans about their life histories. Staff we spoke to knew parts of people's life histories but nothing had been done with this knowledge to provide more personalised care. The service was aware of this and was taking steps to find out more information about people's life histories.

Some people and their relatives told us that their care was reviewed with them. One relative said it would be helpful to have a meeting about their family members care as they had lived at the home for a number of months. We saw that there was little evidence that care reviews had taken place with people. We spoke to the interim manager who told us that the service was putting plans in place to address this and that people's care would routinely be reviewed with the person and their family three monthly. The service hadn't considered how it would review care with people. This meant that people did not have the opportunity to review how their care was been provided and whether it was meeting their needs.

We looked at how the service managed concerns and complaints. Prior to a person moving into the home they received a copy of the complaints procedure which detailed how to make a complaint. The service had received three complaints in the last year. We saw that complaints had been handled appropriately and responded to. There were systems in place to review complaints received to analyse concerns in order to prevent similar incidences occurring. In addition to the active management of complaints, the interim manager had recently started to record and respond to minor concerns to monitor the quality of the service provided. The systems in place indicated that the provider was open to investigating concerns to provide a quality service for people living at the home.

Prior to the inspection we had received concerns and complaints about the service from members of the public. Where issues of safety were disclosed we raised these concerns with the local safeguarding authority.

Requires Improvement

Is the service well-led?

Our findings

On the day of the inspection there was a registered manager in post, who was being supported by an interim manager who was carrying out the day to day management of the service and a deputy manager who had recently started working at the service. The home was registered with the commission in April 2015. Since becoming registered the service has had three different registered managers and three interim managers. The current registered manager had been at the home for four months and had become the registered manager a month prior to our inspection. The lack of consistent leadership and management has led to some of the people, staff and relatives feeling concerned about the future of the home. One person told us, "There's been so much change in management it takes a bit of getting used to. Ideally we should have the same staff." A relative we spoke with told us, "It's a bit concerning regarding the direction of the home with so many managers," and another relative commented, "I have no clue of the hierarchy here." The permanent staff team described the effect of inconsistent management to us and one staff member said, "It's been very confusing for staff having different managers but we've tried not to let it affect the care." Another staff member told us, "I would like a permanent manager that's going to stay." The service had recognised the unsettlement that the change in managers had caused to the service and were open in their conversations with us about this. We were informed at the inspection that another new manager was due to start working at the home in a few weeks after undergoing induction training into the company and would also be applying to become the registered manager. We were advised that support was to be provided to the new manager by the current registered manager and the interim manager before they left to work at other locations owned by the provider.

The interim manager had started working at the service a number of weeks before the inspection visit. The interim manager had introduced changes to improve the service and to provide staff with more support in their roles. This included having more frequent staff meetings and giving staff the opportunity to air their concerns. The interim manager was also developing awards for staff to recognise and celebrate staff achievements. Staff that we spoke with informed us that they were happy with the recent changes and told us they thought improvements had been made to the service. One staff member told us, "Things seem to have settled in the last couple of months," and another staff member commented, "The new management team are the best we've had so far. They listen to us."

We found that the quality of the service had not been consistently monitored since the home had opened. Issues we identified in the systems around medication management had not been reviewed or actioned leading to a number of medication errors occurring. The monitoring systems had not identified that care plans did not contain sufficient or up to date information to provide people with safe consistent care that was focussed on meeting their individual needs. The provider had failed to ensure records were completed in a timely manner or keep records up to date to ensure people received safe care. The lack of an effective system to manage risks and improve quality is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider was aware of most of the issues found on the inspection prior to our visit and in a monitoring visit in January had raised concerns within the home. We saw that development plans had been

put in place to address these issues and we saw that improvements had been made in some areas. The provider was monitoring the service more frequently to ensure that action was taken to improve the quality of the service provided. This included daily conference calls with key people within the service to discuss progression. Monthly audits had recently been carried out which monitored key areas of service provision such as the number of accidents in a month, the number of medicines errors and notifications sent to the commission. These audits were sent to the provider's own staff leading on quality who highlighted and acted on any concerns raised.

The registered manager was aware about requirements to inform the Care Quality Commission of specific events that had occurred in the home. The registered manager had a good knowledge of what the change in regulations meant for the service and demonstrated duty of candour throughout the inspection visit.

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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not make sure that people received personalised care that met their individual care and support needs. Regulation 9(1).

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 The provider had not taken appropriate action to reduce known risks to people. Regulation 12(2)(a). The provider had not ensured that consistent robust arrangements were in place to monitor and manage people's known healthcare conditions. Regulation 12(2)(b). The provider had not ensured that people had sufficient quantities of medication and had not carried out safe management of medicines. Regulation 12(2)(g).

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 The provider did not have effective systems in place to fully monitor the quality and safety of the service. Regulation 17(1).