CareQuality
Commission

Avidcrave Limited

Braintree Nursing 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?	**Requires Improvement**	●
Is the service well-led?	**Requires Improvement**	●

Overall summary

The inspection took place on 12 and 15 May 2015 and was unannounced.

Braintree Nursing Home provides nursing and personal care for up to 51 people. The service incorporates the separate building formerly known as The White House. At the time of our visit there were 41 people living in the service.

The service had a 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.

People at the service were not always safe as the registered manager did not ensure that the care and treatment of people was appropriate and met their needs. The service did not effectively manage risks. Whilst systems were in place to carry out individual risks assessments these were not carried out to a consistent standard. Where incidents and accidents occurred, the manager did not have adequate systems in place to analyse the cause and patterns, with a view to questioning or improving practice and minimising risk. Recruitment processes were in place prior to people being appointed. Medications were stored safely and most medicines were administered safely however staff did not always correctly record administration of prescribed creams as required.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and are required to report on what we find. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The DoLS are a code of practice to supplement the main MCA code of practice. The registered manager had some understanding of MCA and DoLS but had not ensured the necessary DoLS applications had been made. Mental capacity assessments had been carried out where people were not able to make decisions for themselves, however these assessments were not always reviewed.

People were supported to have a balanced diet and to make choices about the food and drink on offer; however, there were not effective monitoring measures in place where people were at risk of malnutrition. People were supported to maintain good physical health. They had access to a range of healthcare providers such as their GP, dentists, chiropodists and opticians. However, people were not always supported to maintain mental health and wellbeing, as there was a lack of care planning in this area.

Staff provided care in a kind, caring and sensitive manner. Staff knew the people they cared for and spoke to them with respect and in a way which they understood. People were supported to make decisions about their care.

People had their needs assessed but care planning was not always developed in a person-centred way. It was not always possible to establish whether people had received the care they needed in line with their needs as required documentation was not consistently completed. Whilst individual complaints were responded to and action was taken, there was not an effective log of complaints with a view to learning from concerns raised and improving practice.

Staff were motivated and felt supported. The manager was committed to supporting people, their families and professionals to contribute their views but did not always respond in a positive way and feedback was not always used to improve the service. The manager had not put in place effective measures to assure themselves that safe and person-centred care was being provided.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service was not always safe. Risks to people's welfare were not always managed effectively. Staff recruitment processes were in place to check that staff were suitable to work in the service. There were sufficient numbers of suitable staff to keep people safe and meet their needs but staffing was not always deployed effectively across the service. Staff did not always record prescribed medication safely.	**Requires Improvement** ●
Is the service effective? The service was not always effective Staff received flexible and tailored training but systems did not effectively support them to put their learning into practice. The manager had not applied for the necessary assessments under the Deprivation of Liberty Safeguards (DoLS). People were supported to have a balanced diet and to make choices about the food and drink on offer. There were not effective systems in place to monitor and minimise risk of malnutrition.	**Requires Improvement** ●
Is the service caring? The service was caring. Staff knew people well and treated them with compassion. People were communicated in a way which they understood and spoken to with respect.	**Good** ●
Is the service responsive? The service was not always responsive. People's needs were assessed and had individual care plans but these were not always person centred and were not consistently reviewed. People were supported to maintain relationships with families but people were not always supported to follow their interests. People had access to a complaints process and individual complaints were responded to, however complaints were not logged and analysed in an effective way.	**Requires Improvement** ●
Is the service well-led? The service was not always well led	**Requires Improvement** ●

Summary of findings

The manager was visible and promoted innovation; however changes were not always well implemented.

Staff enjoyed working at the service and felt supported by the manager.

Quality Assurance measures did not consistently minimise risk and ensure effective development and improvement of the service

Braintree Nursing 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 12 and 15 May 2015 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us within the last year. A notification is information about important events which the service is required to send us by law. We used the information in statutory notifications to make a detailed inspection plan and identified the areas we were going to focus on.

On the day of our inspection to the service we focused on speaking with people who lived at the service, speaking with staff and observing how people were cared for. Some people had complex needs and were not able, or chose not to talk to us. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with eight people who used the service, four visiting relatives, one visiting friend, the registered manager and eight members of the care staff. Outside of the visit we spoke to a further two family members. We also spoke to three health and social care professionals.

As part of the inspection we reviewed eight people's care records. This included their care plans and risk assessments. We looked at the files of two staff members which included their recruitment, induction and training records.

We also looked at records relating to the management of the service, including staff recruitment and training records, medication charts, staffing rotas, quality monitoring audits and records of complaints.

Requires Improvement ●

Is the service safe?

Our findings

Whilst there were systems in place to monitor risks to individuals, risks across the service were not looked at in a proactive way and there was not always an approach to prevention and mitigation. People had a range of risk assessments in place, however some risk assessments were not dated and some had not been reviewed. We also found that some people had not had assessments carried out in a timely way which left them at risk. For example, one person, found to be at very high risk of pressure sores, was assessed four days after admission to the service and had no prevention techniques applied for those four days.

We found that where people were at risk of developing pressure ulcers. Adequate systems were not in place to minimise this risk and people had developed pressure areas as a result. The manager and staff did not monitor the cause and trends in relation to pressure sores, with a view to questioning or improving practice and reducing risk. Staff spoke of the importance of supporting people with pressure ulcers but did not follow systems in place to support staff in meeting people's needs. People being cared for in bed, had charts in place to record their care. Staff had not consistently completed these and therefore they did not give a full account of people being turned and their skin being checked. For example, we examined the records for a person who needed to be turned every two hours and saw that whilst some staff members had recorded when they had turned the person, on some days there were no records of turning being done at all. Staff also completed body maps identifying concerns over skin integrity but often these were not dated, so it was not possible to get an accurate picture of the person's needs. People were being cared for on pressure relieving beds and cushions but there were discrepancies between what the bed settings were on and the required settings.

People were at risk due to limited assessments. For example, bedrails were widely in use for people living in the service and some risk assessments were in place. However, records were not sufficient to show that a full assessment had been completed and did not provide enough detail to ensure the rails were used safely. Some people who had bed rails in place did not have any risk assessment in place.

Risks to health and safety of people at the service were not consistently assessed and measures were not fully in place to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our visit concerns were raised from relatives who did not feel their family members were safe at Braintree Nursing Home and did not feel their needs were being met. However, during our visit people said that they felt safe living at the service. One relative told us, "He [relative] is safe and secure. I know he's ok." Another family member told us, "The carers are very good. I've never seen anyone ill-treated. Never."

People said that there were members of staff that they could talk to if they had concerns and one relative said, "There are people here you can discuss things with." Staff told us that they had an understanding of the issues around safeguarding individuals from abuse and neglect. We saw that they had received training around safeguarding. Staff knew who to raise concerns with if they felt that the individuals they cared for were not safe.

There was an area within the garden which was designed to be safe and accessible however, measures to minimise risks around the building were not effective. Though appropriate plans were in place to deal with emergencies in the building such as a fire, these were not regularly reviewed and fire drills were not logged effectively. Where people were using oxygen, safety notices were not displayed. Storage of equipment was poor, and as result some bathrooms and corridors were cluttered. A set of lockers and a trolley were stored near the bottom of a flight of stairs, which posed a risk. One of the dining rooms also housed old and unused equipment which made it less attractive and welcoming. We were told by the manager that they were aware of this problem and that the issues with storage would be resolved with the planned extension of the building.

There were sufficient numbers of suitable staff during our visit to keep people safe and meet their needs. The manager made baseline calculations using the residential forum staffing tool in order to calculate the staff needed. However we observed that staff were not always deployed effectively across the units. People told us there were usually enough staff but that sometimes weekends and night times were less well staffed, in particular in the smaller unit at the service. Staff roles varied and were

Is the service safe?

allocated each day which enabled the service to respond flexibly. All staff, including domestic staff, provided hands on care, if required, so staff rotas and roles were not always easy to analyse.

The service completed a thorough recruitment and selection process before employing staff to make sure that they had the necessary skills and experience. We looked at two recruitment files and found that all appropriate checks had taken place before staff were employed. Staff confirmed that they had attended an interview and that all the relevant checks had been obtained, to make sure they were suitable to work with people who use the service.

Some aspects of medication management are dealt with well, whist others required improvement.

People had their own medication cupboards in their bedrooms, which promoted individual care and administration of medicines. Daily medication records were completed well with administration being signed for. However, staff were not consistently recording how many tablets are given when medication was prescribed to be given 'as needed'. This meant that it was not possible to get an accurate picture of how many tablets were given each day or over time. Staff were not always recording the administration of prescribed creams so there was therefore not a full picture of the use and effectiveness of the creams. Some people were receiving medication covertly and staff had consulted their GP to gain agreement, however it was not straightforward to see in a person's records how the final decision had been reached and the exact approach to be used to give this medication safely. Staff had received training on medication and regular audits and competency checks had taken place, however, these were not carried out consistently and audits did not always address any concerns found.

Requires Improvement ●

Is the service effective?

Our findings

The manager and staff had some understanding of the Mental Capacity Act (MCA) 2005 and of the Deprivation of Liberty Safeguards (DoLS); however, they had not always applied the Act effectively within the service. Care records contained MCA forms which detailed day to day best interest decisions that had been made, where people were not able to make these decisions independently, however these assessments were not consistently kept under review. The manager had communicated with the supervisory body responsible for authorising applications under the DoLS and showed us one record of where they had applied for a DoLS assessment. We observed that there were people at the service who did not appear to have capacity and who were having their freedom restricted, for example they were prevented from leaving the service unaccompanied due to the keypads in place. There was no application for a DoLS assessment for these people.

DoLS assessments had not been applied for in accordance with the Mental Capacity Act (MCA) 2005 and of the Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff who had been there some time had sufficient skills and experience to care for them, however two people told us that newer staff did not know what their needs were. A family member told us, "Nursing staff were excellent and personable. Within a week I didn't mind who was on duty… whoever I went to, knew what was going on." Another visitor said, "You can't fault the staff."

Staff received personalised and tailored training but were not always supported to put their learning into practice. We saw the training matrix which outlined the courses staff had been on and plans for on-going development across the service. The manager had introduced a new role of facilitator to identify and coordinate training flexibly based on the needs of people and individual staff. Staff confirmed that they attended training and received ongoing support and supervision. New staff completed an induction process and received ongoing training. Whilst training was in place, systems did not support staff in implementing their learning and staff did not know always know how to find out about people's assessed needs and risks were not well managed. For example, some of the staff we spoke with did not demonstrate that they understood the importance of written documentation, such as care plans, and depended instead on verbal communication.

People were supported to have sufficient to eat, drink and maintain a balanced diet. Whilst staff were observed to support people who required additional assistance in this area, systems in place to manage areas of risk were not always effective. Staff monitored people's weight but records showed this was not done consistently. People who were seen to have lost weight recently, did not always have up to date risk assessments in place and care plans did not outline any action taken by staff. One person had lost six kg in two months; however we were unable to locate records to show that this was part of their care regime. Some people had nutritional risk assessments in place; however these were not all up to date. This, combined with inconsistent weighing, meant staff and visiting health care professionals were not able to fully evaluate people's status and risk accurately.

There was a nutrition & hydration officer who coordinated and monitored the food and drink people received and supported communication with the kitchen. Whilst communication was ongoing, and this worker completed fluid and nutrition monitoring charts, it was unclear whether staff revised individual care plans as a result of this information.

Some people who had difficulties or risk around eating had been referred to speech and language therapy (SALT) and had plans in place, for example whether a person needed pureed food. Staff worked closely with SALT and reviewed these people's needs with the professionals involved. Other people, however had not been referred to dietary and nutrition specialists and did not have the necessary plans in place to support staff to meet their needs. For example, one person had been admitted with a history of recent weight loss and dehydration. They had been weighed on admission but the guidance in their nutritional care plan was generic and lacked detail. It was unclear what triggers staff used to refer to dietary and nutrition specialists.

Lunch was no longer cooked on site and was ordered in from an outside company. The manager told us the change was introduced in consultation with people and the food was specifically developed for care homes, had more available nutrients, was more calorie dense and easier to chew. One person said, "The food is excellent," however another said, “We all liked the dinners when they were cooked here.” We observed that people were offered choice at meal times. People had told the manager they didn’t like the fish and chips on offer so this was now brought in from a local takeaway. The service had put in place measures to support people to have sufficient to eat and drink throughout the day, and provided snacks outside of meal times. One person said that he was given buttered toast and tea before bed.

Lunch in the smaller unit was a social and enjoyable occasion with staff chatting to people and interacting with them whilst providing support. In the larger unit, very few people used the dining room, sitting instead in the lounge area with a small table in front of them. We did not observe staff offering people a choice of where they ate and a staff member later told us that they knew already where people wanted to have lunch. We spoke with one resident who said she would have liked to go in the lounge but was not given the choice that day.

People had good access to external health and social care professionals. Records showed people saw their GP proactively and staff referred to them if they were concerned about their health, for example for pain relief. One person told us when they had been unwell staff had immediately contacted a doctor. People also had access to other health professionals such as dentists, opticians and chiropodists and one person told us staff had accompanied them to the opticians. However it was not always possible to review and monitor other professionals’ involvement over time as staff did not consistently document the input of outside professionals.

Good ●

Is the service caring?

Our findings

People told us staff were, “Very kind and patient,” and that, “There’s a nice family atmosphere.” One family told us the service had been supportive and caring when their relative had passed away, “The staff were supportive and lovely, they were upbeat and offered refreshments throughout.”

We observed staff talking to people in a courteous way. Staff knew people and chatted to them about their interests whilst providing support. Staff knew people’s relatives by name and talked to them positively about recent family visitors to the service.

People were involved in making choices about their care. Staff told people what was happening before providing support. People told us that carers asked permission before providing support. One relative said, “They ask him if they can move him.” Staff used supportive non-verbal communication such as gently putting a hand on a person’s arm whilst talking to them. One member of staff was very caring towards a person who felt nauseous, and gave them a bowl in case they were sick. The member of staff talked to them reassuringly whilst providing support.

Staff offered choice and listened to people’s views. People were offered a choice of meals at lunch time and were asked if they wanted pain relief. One person told us, “You can say no to anything, they won’t force you.” People could choose when to get up. One person said, “If you want to lie in, you can.” People were able to specify whether they wanted a male or female member of staff to support them. One person told us a male member of staff had asked if she minded him washing her back, and that when she had said she preferred a female member of staff this was arranged.

Staff communicated with people in a way which they understood. Some care records outlined how people should receive information, for example staff were advised that, “Where possible, language should be kept simple, keeping questions and commentary straightforward.” We observed that staff took time to communicate to people to make sure they understood, sitting or kneeling near them so that they were at eye level. Staff showed us pictures used to communicate with a person who had experienced a stroke and told us, “We know [what she wants] by her facial expressions…Her family have told us what her likes and dislikes are and how to communicate with her.”

People were mostly treated with dignity and respect. People told us staff knocked on their door before entering. A relative said, “Even if your door’s wide open, they still knock.” Another relative told us, “If they’re in there washing him the door’s always shut.” Written guidance advised staff providing personal care to use a towel to cover legs, involve the minimum number of carers and close the bathroom door. We observed that when someone was receiving personal care there was a sign on the door which said, ‘Privacy and Dignity - personal care in progress.’ We observed a screen in use in a double room and a member of staff said that screens were always used in double rooms to maintain dignity and privacy.

We found that people using continence pads were wearing communal net underwear that, although laundered, were shared amongst people in the service. We also observed a box of continence pads left in the entrance hall of the service. This did not respect people’s dignity.

Requires Improvement ●

Is the service responsive?

Our findings

People were not always supported to maintain good health because systems were not in place for nursing staff to monitor people's health and implement treatment options in a timely way. For example, appropriate systems were not in place for nurses to evaluate the effectiveness of their wound management. Records were variable, with some staff recording the state of the wound or dressing whilst others did not.

People were not always supported to maintain mental health and wellbeing, as there was a lack of care planning in this area. For example, a person admitted to the service with a history of depression had no care plan in place to guide staff on how to care for and support them.

The care and treatment of people was not always appropriate and did not always meet their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that that staff supported them well, for example one person said when they told staff they had a headache, they were offered pain relief. One relative told us, "Mum loved her cat and they let us bring it in to her." One person felt that staff didn't have time to sit and chat with them and said, "It's very difficult. They're very busy."

Some people had been involved in making decisions about the support they received. For example, we observed that a couple had been were offered independent choices about their care. We saw detailed plans for some people with dementia which gave staff information on a person's background and needs, however these were not always in place.

Assessments and care plans were not consistently personalised and did not always provide enough detail around individual needs. People were assessed before they came to the service and whilst the assessments were comprehensive, they were not always person-centred. People had care plans in place that outlined their needs. Whilst some people's plans detailed their individual needs other plans were generic, for example a care record said "[Person] is encouraged to eat a healthy amount", but lacked details about how this would be measured and how the person would be supported to achieve this aim. Records contained limited information on people's strengths or abilities and their personal preferences.

People had care plans in place for their communication needs, however some of these were basic, primarily highlighting the needs, rather than giving staff information on how the person communicated or the best way to communicate. Where people were cared for in bed there was limited information about their social needs.

There were two systems in place to record people's care needs, one was computerised and the other paper based and we noted information was frequently different in each system. As a result, it was difficult to find information about the care a person needed and it was not always clear whether specific support needs had been carried out. We were told by the manager that some care staff were not computer literate, this meant they did not find it easy to access full details about a person's care needs. We observed that information about people's needs was often transferred verbally, with inconsistent daily records for staff to refer to. Documentation was provided for each person to record what support had been provided, however staff did not always use this form. For example, they had not consistently recorded whether a cream had been applied or whether someone requiring care in bed had been turned so people were at risk of receiving inconsistent care and of their skin deteriorating.

The review of people's care was variable, with some people's assessments and records being reviewed regularly and kept up to date whilst other records were out of date and not reviewed as required. Staff did not always involve families in reviewing the support provided. One relative said that they had access to the daily record of their relative's care and had been told that they could look at other records which were kept on computer. Other family members told us however that they had not been invited to any meetings to discuss the support their family member was receiving or been involved in planning for their care.

Whilst staff did support some people to follow their interests, for example, taking people to the local park, people were not always supported to take part in stimulating activities of their choice. This was particularly the case for people with more complex needs. We observed most people sat watching television in the two lounges and a relative told us, "They're a bit static. They could do with something to keep them occupied." Other people told us that the smaller unit had less activities then in the past, as these had mainly transferred across to the larger unit. We were shown a timetable of activities and

Is the service responsive?

one person told us they did gentle exercise to music once or twice a week and that there had been visits to the coast and a local pantomime. Relatives told us activities such as bingo and karaoke took place and that people had a choice about what activities were arranged. Staff told us people were supported to take part in gardening activities and to access the local community.

Before our visit, concerns were raised with us that people who were cared for in bed did not receive sufficient attention and stimulation. We observed limited interaction with people who were cared for in bed and those who had more complex needs, such as dementia, did not always have a specialist plan in relation to their social care needs. A relative told us their family member was cared for in bed and liked to listen to the radio, but did not have one in his room. Where there were radios in people's bedrooms and in the corridors, radio channels appeared to have been selected by staff. A social care professional we spoke to said they had observed limited specialist dementia provision within the service.

Family members and friends were welcomed to visit people at any time. The service was committed to supporting people to maintain links with family members and had introduced a diary for people to support them in recording and remembering who had visited them.

Prior to our visit we were contacted by family members who told us staff had not interacted well with their relative and that issues they had raised with the manager and other staff, such as poor personal care, had not been dealt with adequately. The manager had set up a new role of family liaison officer to improve communication with family members. At our visit a relative said that staff listened to them and acted on what they said and told us, “Everything I've mentioned has been dealt with straight away.” People knew who to speak to if they had a complaint and told us that when they had raised a concern it had been sorted out. We saw records of complaints and of the response provided and action taken. There was a notice that named members of staff to speak to if people wanted to raise anything, however there was limited information displayed for people throughout the service advising them of how to complain formally. Whilst individual issues were resolved there was little evidence that the manager analysed themes and patterns over time with a view to learning from complaints.

Is the service well-led?

Our findings

There was a lack of management oversight of how effectively the different elements of the service were working, therefore whilst staff were aware of their role within the service they were often focused on individual tasks. For example staff did not appear to understand the importance of completing turning charts and updating care records when people's needs changed and there was limited evidence that this was being successfully addressed.

Feedback was not always welcomed and readily accepted with a view to improving the quality of the service. For example, the service had received feedback from a health professional that staff were not trained sufficiently to deal with people with dementia. It was not clear that the discussion had been used as an opportunity to reflect on practice or training needs.

There was not a consistent approach to quality assurance to support effective development and improvement of the service. We saw a number of audits in place to monitor the quality of care such as care plan and drugs audits. However these systems were not effective. The audits did not appear to identify the gaps we had found in recording, such as turning charts and weight records. The manager told us that new systems to address this had been introduced but they had not been fully implemented yet. Where issues had been identified it was not always clear what actions had been taken and whether longer term improvements had been made as a result of the audits. For example, we saw an audit of care plans which did not result in any recommended areas of improvement, despite team meeting notes highlighting the need for improvement in care planning across the staff team. There were also limited systems in place to analyse and minimise risk across the service. For example, when people fell, staff recorded the action taken to reduce risk to the person but there was limited further analysis to identify patterns or themes to prevent this happening again to another person.

Systems were not in place to effectively assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an informal and relaxed culture. People said that they knew who the manager was. One relative said, "[Manager] is out and about and says 'hello'." However, whilst the manager aimed to promote an open culture, some people told us they did not always feel comfortable raising issues with the manager. We also saw documentation describing how a relative had found it difficult to raise a concern with the manager.

The manager was visible and accessible to people and knew all the people at the service. We observed them communicating with people in an open and relaxed manner. People were encouraged to give their views informally, for example someone told us they were asked about what activities the service should offer. There were limited opportunities however, for people in the service to meet with the manager and share their views as a group. We were told that resident meetings had taken place in the past, but that these no longer occurred. People in the smaller unit, known as the 'White House', told us that they used to find these meetings useful.

Relatives meetings did not take place and the manager told us that the service had not found surveys and questionnaires to be very successful. To improve relationships and communication with relatives, the post of Family Liaison Officer had been created, who was responsible for linking with families and gathering their views. We saw records of individual meetings with families and the actions taken by staff and the manager to address concerns raised. Whilst we were told by the manager that they met with families and the staff team to discuss and address the concerns raised by families, there was no system to capture themes over time and allow for effective analysis of the issues raised.

The manager promoted good links with the local community and developed networks with other services and resources in the region. The manager was an active member of the local 'My Home Life' association, which is an organisation committed to improving the quality of life in care homes and improvements had been introduced in the service as a result of this involvement. For example, the service had joined the Friends and Neighbours (FaNS) scheme and was using this resource to support links between the service and the local community.

Staff were positive about working at the service and told us the manager was approachable and supportive. Staff said

Is the service well-led?

that they felt able to question poor practice. A staff member told us, “I couldn’t ask for better support from a manager I can talk to her whenever I need to and raise any concerns.”

The manager provided a visible presence and had a clear vision for the direction of the service; however this vision was not always implemented well. Where changes had been introduced, such as team leader roles and the more specialist roles around nutrition and training, these were not working effectively. The manager told us that the service would continue to improve with the planned refurbishment (which will join the two buildings) and with the introduction of a new computerised care recording system. There was limited evidence that the manager measured the impact of any changes before new innovations and changes were introduced.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of people was not always appropriate and did not always meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent DoLS assessments had not been applied for in accordance with the Mental Capacity Act (MCA) 2005 and of the Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to health and safety of people at the service were not consistently assessed and measures were not fully in place to mitigate any risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did not ensure that systems were in place to assess, monitor and improve the quality and safety of the services provided.