Whiston Hall Limited

Whiston Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Whiston Hall provides accommodation for up to 44 older people, including people living with dementia in one adapted building. At the time of our visit there were 26 people using the service.

People's experience of using this service:
After the last inspection of September 2018, the provider had sent us an action plan to tell us how they would address the areas we raised on inspection. At this inspection we found concerns regarding safe care and treatment, infection, prevention and control and staffing. Whilst the action plan had addressed some of our immediate concerns, it had not been fully effective in improving the service.

The service did not have a registered manager, their last day had been Monday 8 April 2019. The deputy manager was working nights due to staff shortages so there was no management. The nominated individual was at the service during our inspection. The nominated individual told us they had put in place management arrangements that the quality lead and themselves would be overseeing the service until a new manager was recruited. Since our inspection the provider has confirmed in writing the management arrangements to ensure improvements are sustained.

We completed a tour of the home with the nominated individual and found some areas, equipment and furniture were not clean, although audits had been completed they had not identified all the issues we found at inspection.

Risks associated with people's care, including moving and handling had been identified. However, we found the care plans and risk assessments in respect of moving and handling people to meet their needs were not followed. We also found they had not always been reviewed when there were changes to people's needs. This put people at risk of harm.

We found people did not always receive care that was responsive to their needs. Care plans we looked at did not always contain the most up to date information or contained information that was contradictory. People were not always provided with opportunity for meaningful activity.

People we spoke with told us they felt there were not always enough staff, as they were not always available to provide care and support in a timely way. The nominated individual explained to us that they had a dependency tool and the hours required were maintained. However, the layout of the building was over three floors and the tool did not fully take this into consideration and the deployment of staff was not always effective.

People told us they generally felt safe. The provider had a system in place to safeguard people from the risk of abuse. Staff told us they received training in safeguarding and confirmed that they would take appropriate action if they suspected abuse. However, the unsafe moving and handling that we observed

during the inspection was reported to the local authority safeguarding. This was because staff did not follow risk assessments or care plans to ensure peoples safety.

Recruitment procedures followed safe practices. Medicines were managed safely. Incidents and accidents had been recorded and analysed. However, the analysis was not always effective to ensure safe management of these to reduce occurrences. The provider improved these systems following our inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider was adhering to the principles of the Mental Capacity Act (MCA). People who lacked capacity had decisions made in their best interests.

Peoples nutritional needs were met. People who required support with their diet had their needs met by staff that understood their dietary requirements. We observed the lunch time meal the food served was well presented, appetising and special dietary needs were met. However, we found the experience for people could be improved, people sat waiting for a long time for their meal to arrive. Staff did not always offer assistance in a timely manner.

Staff told us they had received the training and support they needed to carry out their roles well. They said they had been supported by the registered manager who had finished in post the week of the inspection. People had confidence in the staff and told us, although at times the service was short staffed they were happy with the care they received form the care workers. All people we spoke with spoke highly of the care workers. Staff were respectful of people's privacy and dignity. However, although we found staff interactions to be caring and kind, due to lack of direction and effective deployment, staff became task orientated. Therefore, care was not always person-centred or individualised.

There was a complaints procedure available which enabled people to raise concerns or complaints about the care or support they received. The registered manager had kept detailed records of concerns that evidenced any issues were actioned promptly and satisfactorily. However, one concern was raised with us during our inspection and the person felt it had not been dealt with appropriately. We asked the nominated individual to look into this again.

The registered manager, when in post, had implemented an audit system, which we looked at, this had identified many issues and had an action plan in place. However, the audits had not identified all of the issues we found at inspection. The nominated individual had also compiled a quality monitoring system and this was being implemented to drive improvements. The nominated individual explained they had identified progress with improvements was slow, so had employed a quality lead to ensure improvements were implemented and embedded into practice.

We found three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 12; safe care and treatment, regulation 17; good governance and Regulation 18; staffing.

More information is in the detailed report.

Rating at last inspection:
At the last inspection the service was rated Inadequate (report published November 2018).

Why we inspected:
This was a scheduled inspection based on the previous ratings.

Follow up:
We will continue to monitor the service through the information we receive. We have also requested some further information from the provider to reassure us people are safe. The provider has also provided an action plan.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Whiston Hall

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
This inspection was carried out by 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.

Notice of inspection:
This inspection was unannounced in line with our current guidance.

Service and service type:
Whiston Hall is a 'care home.' 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. The service provides accommodation for up to 44 older people, including people living with dementia in one adapted building. At the time of our visit there were 26 people using the service.

The service did have a manager registered with Care Quality Commission. However, they were not at the service at the time of our inspection and we were informed by the provider they had left on 8 April 2019. The provider had appointed a quality lead who, with the nominated individual would be overseeing the service until a new manager was appointed.

What we did:
Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the CQC by the registered provider. We contacted commissioners, health care professionals and the local authority safeguarding team to obtain their views on the service.

We used a range of different methods to help us understand people's experiences. We spoke with eleven people who lived at the home about the support they received. We observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We completed a Short Observational Framework for Inspection (SOFI) to gain an understanding of this interaction. We also spoke with seven people's relatives to gain their feedback on the quality of care received.

We spoke with ten staff; the nominated individual, the quality lead, four care staff, a senior care worker, a domestic, the cook and the maintenance person. We also spoke with two visiting health and social care professionals to gain their feedback. We reviewed care plans for five people to check they were accurate and up to date.

We discussed medication procedures with the senior care worker and checked medication records for two people. Checked recruitment records and training and supervision records. Looked at accidents and incidents analysis, complaints management. We also looked at quality assurance checks systems to check if they were identifying areas of improvement and acting to address them.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires improvement - Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At our inspection of September 2018 this key question was rated inadequate. This was because risks associated with people's care were not always identified or managed safely and insufficient staff and ineffective deployment of staff meant people's needs were not always met in a timely way. At this inspection we found the provider had made some improvements. However, these were not sufficient to fully address the improvements required. The rating for this key question was requires improvement.

Assessing risk, safety monitoring and management

- At our inspection of September 2018, we found the provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment. This was a breach of regulations. At this inspection we found although there were some improvements there was continued shortfalls in this area.
- Risks associated with people's care and treatment had been identified and most were managed. However, the risks associated with people's mobility were not managed safely. This put people at continued risk of harm. For example, people who require the use of moving and handling equipment for care and support had been assessed but we found staff were not following the risk assessment and were using inappropriate slings. Staff were not following correct procedures.
- We observed a number of people being supported to use either a hoist or stand aid and staff did not follow safe procedures. We discussed this with the nominated individual who assured us this would be addressed as a matter of urgency. We received confirmation following our inspection this was being addressed and embedded into practice.
- Staff could tell us about risks associated with people's care. They knew where to find information in the care plans regarding risks. However, staff were not always following the risk assessments.
- Staff told us they had received manual handling training as part of their induction, with refresher training provided periodically. Staff were not always following correct practice so training was not effective.

The above is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Preventing and controlling infection

- People were not protected from the risk of infection. We found areas of the home were not kept clean and some furniture and equipment was found to be dirty. We discussed this with the nominated individual who addressed issues with staff. They also told us they were trying to clean the furniture but the dirt was so engrained it was not possible to remove. The nominated individual told us they were being replaced as part of a phased replacement programme.

• Health care professionals told us infection, prevision and control procedures were not always followed by staff. For example, during a recent incident precautions were not taken to ensure the incident was resolved quickly and prevented any further cross infection. Therefore, people may have been affected because of lack of precautions causing cross infection.
• Staff told us they had completed infection control training and there was ample PPE available. However, from observations this was not effective. For example, staff used the same slings to toilet people which posed a risk of cross infection.
• When we spoke with staff there was variation regarding the use of slings. Some staff told us people had their own slings that were for their use only, while other said some slings, especially toileting slings were used communally.
• The domestic we spoke with told us there was a team of six domestics, which included the housekeeper. They said they worked to a planned schedule and recorded what tasks had been completed. They also described the deep clean schedule in place. However, from issues we saw during a tour of the home this was not effective. An audit had been completed and identified some issues and there was an action plan. However, not all the issues we saw had been picked up by the audit so this was not effective.

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

Staffing and recruitment
• From our observations and speaking with people who used the service and staff it was not clear if there were adequate staff available on each shift who were effectively deployed to meet people's needs.
• People we spoke with said that the staff were very busy, and they said they were reluctant to ask staff for anything as staff often said they were busy and would need to wait.
• Most staff said they felt at least one extra member of staff was needed during the day due to the layout of the building and the number of people who needed two staff to provide care and support.
• Staff told us there was usually a senior care worker and four care workers on duty during the day. On the day of our inspection there were two additional staff on duty, the nominated individual was not able to provide an explanation why this was.
• Staff told us the senior care worker focussed on medication and records and rarely helped with providing personal care, which left one care worker on the top and bottom floor and two on the middle floor. One care worker told us on bottom floor there were three people who needed two staff to support them and on the top floor four people needed two care workers. The middle floor was satisfactory as two care workers were based there. Where there was only one care worker they had to help each other out, which meant floors were sometimes left with no staff.
• Staff also stated a care worker was used in the afternoon to organise the teatime meal. This meant a prolonged time with no staff member on a floor and no-one to help the staff member on the other floor.
• Staff said occasionally when someone rang in sick and no replacement could be sourced they had worked with just three care workers, but this was not often.
• At lunchtime, even with the two extra care staff on duty, some people had to wait over 45 minutes before their meal was served. There were also many people who required assistance and support with eating their meals and they waited a long time to be served.
• Staff comments include, "We need more staff, at least five care workers." "There are layout problems [with the premises] which makes it difficult to monitor people [over the three floors] and so many people needing hoists."
• Following our inspection, the nominated individual provided us with a dependency tool and calculations for staffing. However, it was still not clear from the tool and information provided if there were adequate staff and if they were effectively deployed to meet people's needs.
• New staff had been recruited robustly. One recently recruited care worker told us they had provided two

referees and had completed a DBS check prior to starting work at the home. They also said they received an induction to the home and was completing the Care Certificate. The records we sampled confirmed a robust process had been followed.

The above is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Using medicines safely
- People's medicines were managed in a safe way.
- Systems were in place for ordering, administering and disposing of medicines safely.
- Staff were trained to handle medicines safely and had completed competency assessments to ensure their knowledge remained up to date.

Systems and processes to safeguard people from the risk of abuse
- All people we spoke with told us the staff made them feel safe. Comments included, "The staff always make me feel safe." Relatives also felt people were safe, one relative said, "She wouldn't be here if I didn't think she was safe." Although people and relatives commented, that lack of staff sometimes impacted on people.
- The provider had a safeguarding policy in place. The staff knew the process to follow to report any concerns. All safeguarding concerns had been reported appropriately following procedures to safeguard people.
- Staff we spoke with understood the importance of safeguarding adults from abuse. Staff knew how to recognise and report abuse. They explained the correct procedures to follow if they needed to report a safeguarding concern including whistleblowing. This is one way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice. However, the incorrect moving and handling we observed put people at risk of harm and we referred this to the local authority safeguarding team. The nominated individual addressed the issues to ensure peoples safety during our inspection.

Learning lessons when things go wrong
- We found some risks had not been addressed despite being identified at the previous inspection.
- The quality monitoring systems were not always effective. However, the nominated individual had identified through the quality monitoring that issues were not being addressed in a timely way. They were taking action to ensure improvements were embedded into practice.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our inspection of September 2018 this key question was rated requires improvement. This was because people did not receive effective care that met their needs and staff did not receive appropriate support, training and professional development. At this inspection, the rating for this for this key question had remained as requires improvement. We found the staff training was not always effective, people's meal time experience could be improved, and the environment did not always meet the needs of people living with dementia.

Supporting people to eat and drink enough to maintain a balanced diet
• Our observations showed people received a healthy balanced diet which met their needs and took in to consideration their preferences and any special dietary needs.
• The menu was clearly displayed as people entered the dining room, but the menu holders on the tables were empty. This meant the menu was not available to all people.
• Most people praised the food and told us it was very good. One person said, "The food is brilliant, it will be today because it's fish fingers, mash and spring cabbage." However, some relatives said the food did not look very nice. One relative said, "I was here last Saturday when the dinner came. It was a small portion of omelette, mashed potatoes, salad and gravy. I took it back to the kitchen and the cook said there was nothing else to cook. I don't know why, but the care staff were really good. One of them cooked [relative] poached egg on toast."
• People's dining experience could have been improved. There was lack of organisation and effective deployment of staff. The meal service was very slow and people did not receive appropriate support. For example, there were two more staff on duty than the planned numbers, however, we saw some people were sat for over 45 minutes before their meal was served, with a few people falling asleep while waiting. People were not always prompted and encouraged to eat their meals when it was clear from our observations and talking with staff they needed support.
• Although most staff interacted with people when they gave them their meal, others just put the plate down in front of them and left, not asking if there was anything else they needed or required.
• People were given drinks throughout the meal, but choice was limited to a jug of juice on the table. For instance, one table had blackcurrant and another orange, this restricted people's choice.
• The nominated individual acknowledged the deployment of staff could be improved to ensure an improved meal time experience for people.

Staff support: induction, training, skills and experience
• All the staff we spoke with felt they were well trained. One care worker told us, "There's lots of training, I feel well trained."

• Staff had completed an induction when they started working at the home. They said they had shadowed an experienced care worker for two to three days before being allowed to work on their own. Newly appointed staff told us they were undertaking the Care Certificate, which included essential training. Staff who already had a recognised national care award said they had received a basic induction to the home, as well as specific training, such as manual handling. Although the moving and handling we observed did not follow best practice or meet peoples identified care needs. This meant the training was not always effective. Following our inspection, the nominated individual addressed this with staff.
• Staff told us they had completed periodic refresher training.
• Staff felt well supported. They said they had received periodic one to one support sessions and took part in staff meetings, where they were updated on new systems and changes at the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before any service was provided, this was to ensure their needs could be met by the home. However, we saw people's assessed needs were not always followed by staff. The nominated individual was addressing this during our inspection.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People told us staff supported them to access healthcare professionals such as their GP when necessary. Information we found in care files showed health care professionals were accessed. However, when people's mobility needs changed health care advice was not always obtained.
• Staff were aware of procedures to follow if they identified a person was unwell or had deteriorated. We found If someone needed to go to hospital a system was in place to ensure all the relevant information would be sent with them.

Adapting service, design, decoration to meet people's needs
• Some refurbishment had been carried out. However, we found areas that were not well maintained and required attention. This was discussed with the nominated individual. For example, some chairs were engrained with dirt and could not be cleaned the nominated individual told us there was a plan to gradually replace these.
• The environment was not dementia friendly. At our last inspection we found people's needs were not always met by the adaptation, design and decoration of the home. The provider had not always considered the needs of people living with dementia. The corridors were bare and signage could be improved. We were informed at our inspection of September 2018 the activity coordinator was looking to make improvements and had been allocated a budget to be able to facilitate this. We found no improvements at this inspection.
• Many signs on the walls were out of date and not relevant. The clock in the lounge was one hour wrong, so could cause confusion for people living with dementia. The home lacked colour and signage to aid orientation and coupled with the out of date information displayed, could cause confusion and disorientation.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found the staff were aware of their responsibilities in respect of consent and involving people as much as possible in day-to-day decisions. Staff were also aware that where people lacked capacity to make a specific decision then best interests would be considered. We saw best interest decisions had been made where required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been breached.

At our inspection of September 2018 this key question was rated requires improvement. This was because people did not receive care that met their needs in a person-centred way. At this inspection the rating for this key question had remained as requires improvement. Although staff were kind and caring, they were at times task focused due to lack of effective deployment and leadership.

Respecting and promoting people's privacy, dignity and independence
• People we spoke with felt their independence was not promoted. They told us staff did not have the time to walk with them. One person told us they used a wheelchair as it was quicker. Relatives we spoke with also raised concerns about lack of promoting independence and said staff were always in a rush so didn't have time to let people do things at their pace.
• Staff understood the importance of maintaining people's privacy and dignity. One care worker described how they always knocked on people's doors before entering, covered people up with a towel when washing them, closed doors and curtains when providing care and spoke to people discreetly when asking them if they wanted to use the toilet. They added, "We have a [person using service] who has a catheter, I always take them to the bathroom to empty the bag and give people privacy when using the toilet."

Ensuring people are well treated and supported; equality and diversity
• We observed staff who were friendly, caring and mostly responsive to people's needs and preferences. Although at times people had to wait for assistance due to lack of staff available to meet their needs in a timely way.
• People told us there had been a change of staff and many had left. However, people told us the new staff were very good. One person said, "There's lots of new staff and they're much better, they're very kind."
• Through talking to staff and reviewing people's care records, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality. Although people living with dementia did not always have their needs met. For example, the environment was not dementia friendly and there was lack of appropriate stimulation.

Supporting people to express their views and be involved in making decisions about their care
• Staff encouraged people to make choices in the way they received their care and their choices were respected. However, we observed on occasions people had to wait for support so there was lack of choice. This was due to lack of staff on duty and ineffective staff deployment. People we spoke with told us at times they had to wait for support and could not go to bed or to their room at a time they would like.

• People told us the staff were very caring, but that they did not have the time to give to on an individual basis. There was no time for a chat or to pass the time of day. Due to lack of staff and ineffective deployment staff were at times task orientated and not person-centred.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

At our inspection of September 2018 this key question was rated requires improvement. This was because people's care plans did not always reflect their current needs. At this inspection the rating for this key question had remained as requires improvement. We found although some care plans had been updated some were out of date and had not been reviewed since December 2018. We also identified contradictory information in plans of care and staff did not always follow people's care plans.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff told us there had been a marked improvement in the care plans and other information highlighting people's needs and how they liked to be supported. This included a summary of people's needs which was kept in the person's room, so staff had easy access to information. Although only a few people had these at the time of the inspection we were told they were being rolled out for everyone. A care worker said these were really useful as, "You don't have to read the whole care plan to know them [people using service]." However, from our observations we saw staff did not always follow people's care plans putting them at risk of harm.
• Some care plans we looked at had not been updated or reviewed. For example, one person's care plan had not been reviewed since December 2018, yet the person's mobility needs had completely changed. The care plan stated they did not get out of bed, we saw them up in the lounge and using moving and handling equipment. Care plans also contained contradictory information which could lead to confusion and people's needs not met safely. For example, one person had been referred to a health care professional and was the review stated place on a fortified diet, but the care plan had not been updated since February 2019. Although information was available in the review documentation, the care plan did not document the need for a fortified diet.
• Staff said usually there was a good activity programme, but the activity person was currently off work. It was unclear what activities took place during their absence as staff said they were very busy. We did not observe any activities taking place on the day of our inspection.
• People told us the activity person was new so were not sure what would be arranged. However, people told us there was not much stimulation or activities. One person said, "They've got a new activities person, so we'll have to wait and see."
• The activities calendar had not been updated since the 11th March 2019. There was a poster on the notice board advertising an event 'Rattle in Retirement on Wednesday afternoons' the nominated individual told us they had not known it take place, it was dated 2018. The activities board and calendar were in a prominent position on the main corridor near the lounges, yet staff had no identified they were out of date and not relevant.
•People's communication needs were known and understood by staff. People's care plans included details about their communication needs. The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating

to a disability, impairment or sensory loss. We observed most staff communicating effectively with people they supported.

Improving care quality in response to complaints or concerns
• A complaints procedure was in place. We saw complaints were documented and outcomes shown. However, a relative raised a concern and told us they felt they were not listened to by the previous manager. We discussed this with the nominated individual who agreed to investigate the concern to ensure it was resolved.
• The provider had systems in place to communicate with people who used the service, staff and health care professionals. They were committed to listening to people to ensure continuous improvement of the quality of the service.

End of life care and support
• People were supported to make decisions about their preferences for end of life care if they wished. Care records we saw showed discussions had taken place with the people and their relatives. Their wishes had been recorded.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

At our inspection of September 2018 this key question was rated inadequate. This was because there was lack of governance and oversight as the service had not been effectively managed. At this inspection the rating for this for this key question is requires improvement. We found although some improvements had been made they had not always been sustained or embedded into practice. Although the nominated individual had identified this and was taking action to address the issues.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- At our inspection of September 2018, we found that audit systems were not effective and there was lack of oversight and governance by the provider. This was a breach of regulations. At this inspection we found this was a continuous breach. Although systems had been implemented these were not always effective and required embedding into practice.
- From our observations during our inspection we saw there was lack of leadership and direction to inform staff and ensure people's needs were met. Although the senior care worker was new in post and the registered manager has only left the same week. The nominated individual assured us they would put management arrangements in place.
- The nominated individual had identified that the action plan in place was not being followed effectively and progress was slow. They had implemented a new quality monitoring system that the quality lead was implementing. This was being closely monitored to ensure consistent, continuous progress.
- We saw the quality lead had commenced the audit process which was identifying issues. This needed to be fully implemented and embedded to ensure improvements. The provider gave us assurances these would be actioned and there would be continuous oversight to drive improvements.

The above is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was not a registered manager they had left the service the week of our inspection. Most staff spoke positively about the improvements the registered manager had made before they left. This included communication, the laundry arrangements, care plans and monitoring tools.
- Most staff said they felt well supported and felt they could take concerns to the former manager.
- The senior care worker said in the past the operations manager had 'popped in regularly' but had been

based at the home since the registered manager left.
• The nominated individual told us the quality lead and themselves would be overseeing the service until a new manager was successfully recruited.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Overall, staff told us they also felt listened to and supported by the management team.
• Staff were aware of the new management arrangements and were committed to ensure improvements took place.
• Not all the people or relatives we spoke with were aware the registered manger had left. However, it was only a few days and the nominated individual told us they would communicate with people to ensure they were aware.

Continuous learning and improving care
• Staff told us they had attended regular staff meetings and periodic one to one support sessions. These kept them informed about how the home was operating, gave them the opportunity to share their views and assessed their work performance.
• Minutes of meetings showed the manager had shared ideas and new processes with staff and people using the service, such as changes in the care plans, and gained their opinion.
• They only area staff highlighted to us they felt needed improving was having an extra member of staff on duty.

Working in partnership with others
• The previous registered manager had formed links with others to work in partnership to improve the service. This included commissioners, health care professionals and relatives. The nominated individual assured us this would continue.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks were managed to ensure peoples safety. Infection, prevention and control procedures were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had identified issues through the quality monitoring system, but this had not always been effective and required embedding into practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure a consistent staffing tool was used taking into consideration the layout of the building. To ensure adequate staff who were effectively deployed were available to meet people's needs.