Guinness Care and Support Limited

# Margaret Allen House Residential Home

## Inspection report

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## Ratings

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|---|---|
| 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

Margaret Allen House is a residential care home for 15 people, including people living with dementia. There are two floors accessed by a passenger lift and the lounge and dining room are based on the ground floor. An unannounced inspection took place on 24 and 30 August 2017. At the time of the inspection, 15 people were living at the home.

When we visited there was 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 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. However, during our inspection the registered manager was unavailable. The service was being overseen by a senior manager who was assisted by a team leader from another service. Since the inspection, the team leader has been promoted to manager.

After our inspection, we received information from the provider about a safeguarding alert, which was being investigated.

People living at the home were positive about living at the home and said they would recommend it to others. However, some people said they would like more to do to fill their time. People had good relationships with staff and they said staff were usually kind and caring. There had been some changes in the staff team but people mainly described the staff team as stable. Agency staff were being used to supplement the care team until newly recruited staff had completed their induction. People had not been provided with an opportunity to formally provide feedback on the service in the form of a survey. However, they felt informed about changes relating to the service.

The provider had created a Learning and Development Team that had set up an academy induction which starts staff on the Care Certificate. This ensured all newly recruited staff had received mandatory training before arriving on their first shift. This training took 6.5 days. The whole induction process takes six months once the staff member has completed further training on site in the care home. However, staff did not benefit from regular on-going support such as supervision, team meetings and observation of their practice. Staff morale was described by some team members as low, which they said negatively impacted on how the staff group worked as a team.

People were offered a choice of meals. They were supported with their health needs and had access to health professionals, when necessary. They told us staff respected their privacy and dignity. However, there were occasions when some staff practice undermined people's privacy.

Staff knew how to recognise and respond to allegations of abuse. During the inspection, we shared feedback with the senior manager about concerns regarding staff practice, which a staff member said had not been managed appropriately.  Subsequently the senior manager completed an investigation. Staff confirmed they

had been spoken to about their practice but records were not found to corroborate this action. After our inspection, the senior manager completed an unannounced spot check visit to the home to monitor staff practice.

Staffing levels were based on a tool to assess the level of people's care needs. Changes had been made to increase staffing availability at night in recognition of people's increased needs. Following feedback during the inspection, the senior manager said the way the afternoon and evening shift was run would be reviewed. It had been identified that the staff rota had been poorly managed resulting in a risk of staff working excessive hours; this rota was now being overseen by senior staff to ensure there was an appropriate mix of staff skills and experience.

Quality assurance reports had highlighted improvements were needed in the running of the service. Care records and staff practice were not reviewed regularly to ensure they were meeting the needs of people. Risks to people were being reviewed and action was now taking place to ensure they were managed appropriately There had been delays in addressing the areas of concern highlighted by the quality assurance reports, including the security arrangements of the building. In response to these delays, a senior staff member from another service and a senior manager were now reviewing staff practice, care records and making environmental changes. They had begun work to deliver training to care staff in the completion of care records and risk assessments to make them effective and meaningful. As part of this review, improvements had been made to medicine practice at the home.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection two applications had been made to the local authority in relation to people who lived at the service. CQC had been notified about the outcome of one of these applications as it had been authorised, which they are legally required to do.

At the last inspection, the service was rated as Good. However, at this inspection the overall rating was Required Improvement. We judged there was one breach of regulation.  You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

Some aspects of the service were not safe.

There were sufficient numbers of staff on duty to meet people's needs but roles in the afternoon were due to be reviewed.

Improvements had been made to how people's medicines were managed but the practices needed to be embedded.

Risks to people were being reviewed and action was now taking place to ensure they were managed appropriately.

Staff knew how to recognise and report allegations of abuse.

Staff who worked at the service had undergone a robust recruitment process.

### Is the service effective?

**Requires Improvement**

Some aspects of the service were not effective.

A good range of training was available to staff. However, support and feedback to staff had not occurred on a regular basis and this meant some staff felt unsupported.

Work was taking place to ensure people's legal rights were being protected by staff who knew their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to access healthcare services to meet their needs.

People were supported to maintain a healthy diet.

### Is the service caring?

**Requires Improvement**

Some aspects of the service were not caring.

Some staff practice undermined people's privacy. People were supported by staff who were usually kind and caring. People were involved in decisions linked to their care and daily life. Staff

knew people well and there was a friendly atmosphere.

## Is the service responsive?

**Requires Improvement**

Some aspects of the service were not responsive.

People living at the home identified how arrangements to meet their social needs needed to be improved.

Assessments and care plans were not completed in a consistent manner and were not regularly reviewed.

People were confident their complaints would be listened and acted upon.

## Is the service well-led?

**Requires Improvement**

Some aspects of the service were not well led.

Quality assurance staff regularly visited the home and were committed to improving the service. However, identified shortfalls in the running of the home, which included security improvements and how staff were supported, had not been addressed in a timely way.

People living and working at the home told us there was a friendly atmosphere.

# Margaret Allen House Residential 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 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. This was a comprehensive inspection which was unannounced on the first day and took place on 24 and 30 August 2017. We announced the second day so that key staff members were available to assist with the inspection. The inspection was completed by one adult social care inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received. By law, CQC must be notified of events in the home, such as accidents and issues that may affect the service. We received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people about their experiences living at Margaret Allen House. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia.

We reviewed three people's care files, two staff recruitment files, staff training records and a selection of records relating to the management of the service. We also spoke with four staff members about their roles and training, and a senior manager and a senior care staff member from another home.

Requires Improvement

# Is the service safe?

## Our findings

Prior to the inspection, a concern was sent to CQC in March 2017 regarding the security of the building and the safety of people living with dementia. We asked the provider to respond to this concern; they confirmed this was being addressed. A quality assurance visit report recorded in April 2017 staff practice had also potentially put people's security at risk when staff left the front door propped open. A quality assurance visit report recorded in May 2017 that action to improve the front door security in response to the concern raised in March 2017 had not taken place.

When we arrived unannounced for the first day of our inspection, staff confirmed they monitored the security of the front door. However, the senior manager acknowledged the contractual work to increase security in the home had been delayed and had letters to show they were following this up with the contractors. We have now received written confirmation that the work has been completed. Safety checks were organised centrally, such as checking the safety of portable electrical appliances. Moving and handling equipment was serviced and there were individual evacuation plans for each person living at the home.

The provider's quality assurance team had identified actions were needed to address risks to people's health. Action had been taken to update risk assessments. For example, in relation to monitoring people's weight loss and referring to health professionals. An additional experienced staff member from another home owned by the provider was working alongside care staff to ensure people's risk assessments were accurate and timely action was taken. Following a review of risk assessments, their actions had included referrals to GPs and regularly weighing people to help assess the risks to their health.

People's risk of pressure sores had been assessed using a risk assessment tool. We highlighted to the senior manager that one had been incorrectly completed, indicating an exceptionally high risk. Despite this, no action had been taken to review the risk or reduce the indicated risk. However, action was being taken to update other records. For example, a newly completed care plan held good quality information about the risks relating to diabetes. Staff were provided with guidance to help them support the person with skin care, their diet and foot care.

People told us they felt safe. They said this was because the staff team was generally stable and staff knew them and how they liked to be cared for. People who chose to stay in their room showed us their call bells which were accessible. People using communal areas showed us their pendants which enabled them to call for staff if they needed assistance. Agency staff were being used to supplement the staff team until newly recruited staff had completed their induction. They received comprehensive handover sheets to help them support people living at the service, to meet their individual care and emotional needs.

A list was being introduced to try and ensure consistency with the agency staff that worked at the home. People said they preferred to be supported by staff who worked permanently at the home; several people commented about the changes in the staff team. For example, one said "There is a higher turnover of staff than I'd like".

The provider used a dependency tool to help them make a judgement regarding staffing levels. People told us they usually did not have to wait long for staff to respond to their call bell. However, they said staff sometimes took longer in the evening to respond to call bells; the rotas showed care staff levels reduced in the afternoon to two care staff and a kitchen assistant. A staff member told us it was hard to monitor people's well-being in communal areas later in the day as some people using their bedrooms needed the assistance of two care staff. During a quality assurance visit in May 2017 completed by a representative from the provider, staff fed back concerns of how the staffing arrangements were not working. The report stated the rota was not being managed appropriately and according to the report staff were 'at risk of working excessive hours.'

During the inspection, we shared feedback with the senior manager for the service from staff about staffing levels. We also shared how one person living at the home said they sometimes felt a responsibility for another person who could become unsettled in the lounge in the late afternoon. The person said they used the call bell to call staff for assistance who would come when they were available; they said "They do what they can". The senior manager said they would review the roles of staff in the late afternoon to ensure staff were available in the lounge or dining room. They provided an example of how this had worked well following the first day of the inspection.

One person commented on one occasion staffing levels in the evening had recently impacted on the timing of their medicines. With their agreement, we shared this with the senior manager who planned to review the tasks for staff in the evening. They also said they would request assistance to review the response to call bells to measure if there was a delay in staff response times in the evenings. Minutes from a staff meeting recorded that equipment for staff to contact each other in the building was being reviewed to help reduce waiting times.

Staff members with different roles in the home were clear about their responsibilities to report poor practice or abuse and were knowledgeable about the different types of abuse. For example, a staff member working in the kitchen said part of their responsibilities was to ensure people were well cared for. Staff said they would report concerns immediately to a staff member who was in a role senior to them and if they were not happy the response to keep people safe would report the matter to the manager or providers or an external agency, such as CQC.

People told us the timing of their medication was usually consistent and on time. During the inspection, we saw staff explaining to people what their medication was for. They stayed with people to ensure they took their medication. People's prescribed medicine was stored in locked cabinets in their bedroom. One person administered their own medicines. They were clear about their responsibility to keep the medicine secure. Medication records showed staff understood how to use codes correctly, although further work was needed to ensure records were completed consistently. An audit of medicines had highlighted areas for improvements and staff were working hard to ensure that the positive changes were embedded.

Requires Improvement

# Is the service effective?

## Our findings

A service improvement plan recognised action was needed to improve support to staff. We saw action was taking place to address this issue, including providing training to senior staff to provide them with the skills to ensure effective supervision. Staff gave us mixed feedback on how the care team worked together. In April 2017, a quality assurance visit report recorded that the staff may be losing focus and direction during a period of change for the service. It was suggested staff may need time for discussion and questions with the registered manager and senior manager. Staff said they had not received regular supervision, which records confirmed; we were shown a new supervision rota had been drawn up to address this issue.

Since the quality assurance report in April 2017, some staff had begun to feedback concerns to the provider about how they were not feeling supported to carry out their roles. Quality assurance reports for May 2017 identified further breakdowns in how staff were working with each other. The senior manager said this was being addressed through staff meetings, both on a one to one basis and in groups to help staff feel more supported. Based on discussions with some staff and their feedback, this was still work in progress for some team members, which some staff said could jeopardise effective team work.

People said the staff team knew how to support them and the approach of staff made them feel confident. Staff told us they benefited from an intensive period of training over seven days as part of their induction. Records showed their induction included mandatory training, such as safeguarding and moving and handling. Other topics included fluid and nutrition, medicines, equality and diversity and working in a person centred way. Some topics were updated annually, such as medication and others over three days of training every three years. This meant staff had the opportunity to update their skills to ensure they provide effective support and care to people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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. Where people have been assessed as not having capacity, there were processes in place to make best interests decisions on their behalf. For example, whether they could consent to the use of bedrails. One person had been judged by staff to have the capacity to consent for the use of bedrails but this was not recorded.

A staff member was also reviewing records to ensure that treatment escalation plans completed by GPs (TEP) were up to date. A TEP form is a way of a doctor recording an individual treatment plan, focusing on which treatments may or may not be most helpful for individuals. A variety of treatments can be considered, such as antibiotics, artificial feeding or ventilation of a person's lungs. The same staff member was also requesting copies of documents if people had a lasting power of attorney (LPA) as these were not routinely requested when people moved to the home. A LPA is a legal document that lets people (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. It is important for the service to have this information to ensure people have the legal power to make

decisions on other people's behalf. This helps to protect people's rights.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had identified people who they believed were being deprived of their liberty. At the time of the inspection two applications had been made to the local authority in relation to people who lived at the service. CQC had been notified about the outcome of one of these applications as it had been authorised, which they are legally required to do.

In July 2017, a quality assurance report completed by the provider identified improvements were needed to improve the environment to promote the independence of people living with dementia. Some work had taken place to make improvements but another report in August 2017 stated 'The service needs a lot more signage for general orientation around the building.' A person told us that another person in the room next door still regularly came into their room uninvited because they became disorientated.

People said they were supported to have regular appointments with their GP, optician, chiropodist and other specialists. For example, community nurses, audiology and chiropodist. Records showed these appointments took place but a lack of consistency in how these visits were recorded sometimes made it difficult to track the outcomes. Staff said there was not a dentist who regularly visited the service to provide a planned check-up and they would look into this provision for people who were not registered with their own dentist. However, they said people would be assisted to visit the dentist if needed. One person's oral risk assessment showed they had been assessed as 'unhealthy' but no action had been recorded. They had lived at the home for approximately 12 weeks. Staff said they would review what action was needed.

People were supported to maintain a healthy balanced diet. Staff involved in preparing food were aware of the potential risks to people's health, such as weight loss or being diabetic. They said there was no one currently needing their food prepared in a specialist manner because of a risk of choking. They explained how they met with people when they moved in to find out their likes and dislikes. They were knowledgeable about people's individual tastes and preferences. They gave an example of how they double checked with individuals if they knew their menu choice went against their listed dislikes. Records were kept to show what choices had been made by people, including a cooked breakfast for some people at weekends.

Staff checked with people what they would like to eat and offered alternative suggestions if people did not like the choices on offer. Records confirmed people had a choice. People were positive about the quality of the food and the choice, for example saying it was "very good" and "first class". One person said the general menu did not meet their taste so they liaised with the cooks to discuss an alternative menu which they said worked well. There was a choice of drinks and staff ensured drinks were available throughout the day and encouraged people to drink.

Requires Improvement

# Is the service caring?

## Our findings

Quality assurance visits by the provider's representative in May 2017 had highlighted areas for improvement in providing a consistently caring approach. There were several occasions during our inspection, when staff shared information in communal areas that compromised people's dignity. On other occasions, some staff members spoke about people, such as how well they had eaten their meal, without including the person in the conversation. A care plan containing personal information was left outside a person's room in the corridor. We shared the examples with the operations manager during the inspection and they said they would address these issues with staff.

However, the majority of interactions between staff and people living at the home were positive. For example, on the second day of our inspection, one person became anxious. A staff member handled their concerns in a sensitive and reassuring manner, which helped the person become more settled and able to return to their room with a cup of tea made by the staff member. At the same time, another person was quite abrupt with the staff member; the staff member was diplomatic in their response and remained professional in their manner.

People looked at ease with staff and people commented favourably on their relationships with staff saying they felt at ease with them and relaxed in their company. One person said "They work so hard on our behalf". We heard regular laughter between people and staff. There was a good rapport between some of the people living at the home as they shared communal areas of the home. They chatted with one another and assisted each other if they had forgotten information. Staff recognised their friendships, for example supporting them to sit with each other at mealtimes.

People shared their views on how they were supported by staff. One person said the staff were "good" and "excellent". Eight other people said they were happy with the standard of care at the home. For example, one person said "I feel relaxed and safe...so much better here." Another person described the atmosphere as "friendly". During a lunchtime meal, the atmosphere was relaxed. Staff were attentive whilst also giving people time to try to be independent before assistance was offered. When support was provided it was discreet, such as providing alternative equipment to help with people's independence. These actions helped maintain people's dignity and independence. One written compliment had been made in relation to a social event held at the home and the work of staff to make it a success.

During our inspection, people told us they would recommend the home to others based on their experience of living at Margaret Allen House. People said they could make choices about their routines, such as when they got up or went to bed. One person had made a decision about where they would sleep at night and the bed in their room had been removed to make more room for a specialist chair which they chose to sleep in. They had recently moved rooms and told us how they had been involved in the discussion regarding the move. They said they missed being near the front door where they could see people coming and going but preferred the size of the room. The room was personalised and they were happy with how they had been assisted to make it homely. Other people's rooms were personalised with pictures and photos.

People told us they were satisfied with the cleanliness of the home and how their rooms were maintained. They told us their visitors were welcomed and one person had the facilities to make their own hot drinks, which helped support their independence and their dignity. A staff member working at the home to help make improvements to the home told us they had arranged for areas of the home to be deep cleaned and for some bedrooms to have new flooring to ensure there were no on-going odour issues.

Requires Improvement

# Is the service responsive?

## Our findings

Care records were not consistently completed and therefore did not always provide key information about people's care needs. For example, there was no record of an assessment being completed for a person who had recently moved to the home to ensure the service could meet their care and social needs. Another person's pre-admission assessment held only basic information and did not show who had been involved in the assessment and who had provided the information. A staff member expressed frustration at the poor quality of written information that staff were given when a new person moved to the home. However, people confirmed to us they had visited the service prior to moving in and had felt welcomed by staff, which had helped them make the decision to move to the home.

In May 2017, quality assurance records for the service had highlighted that care plans were not being completed in line with the company's timescale policy of five days after admission. We saw care plans had not been regularly reviewed, which was also identified as an area for improvement in the quality assurance report. For example, one person was assessed as at high risk of pressure damage but this area of care had not been reviewed since 2015. This meant up until recent management changes, the recommendations from quality audits had not been fully actioned to improve the service.

There was a whiteboard in the staff room which contained the names of people living at the home. It had sections to identify their key care needs and identified health risks. However, the information recorded on the whiteboard was out of date by at least two months. For example, people's weights were not accurate and risks to their health and safety had not been updated, such as the outcome of a referral to the speech and language team. The handover sheet given to staff was also missing key information such as information from people's treatment escalation plans and whether a deprivation of liberties application had been approved.

Permanent staff working at the home demonstrated up to date knowledge through their practice and conversations during our inspection. However, the lack of accurate or up to date written information potentially put people at risk. This risk was increased by the use of agency staff who may not have the same level of knowledge as staff who worked permanently at the home.

Quality assurance records for the service had highlighted action was needed to provide a wider range of social events. Several people told us they would like more to do to fill their time. People said staff did not often have time to sit and chat with them. People praised the staff member who provided activities at the home but some people said the staff member had limited hours and a limited budget. The staff member was contracted to work for ten hours a week. People described the staff member as a "nice lady". One person enjoyed going for a walk with the staff member and another designed posters to publicise social events at the home. There had been three trips out to local attractions, such as a garden centre and the canal. There was a small group of people who attended these trips. Records did not always show how the needs of people who preferred one to one support were met. Quality assurance records completed by a representative from the provider highlighted that some contacts with local organisations had decreased, such as visits from school children to the home. They had made recommendations for improvement.

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

Since the inspection, the senior manager has sent CQC an update on the work being undertaken to review people's individual social needs and how they could be met.

A member of staff from another service was working at the home to assist with updating the care plans. They had worked with staff and the operations manager to identify the care plans which needed to be prioritised. For example, they showed us a care plan they had worked on for a person who was the most recent person to move to the home. This contained up to date information and identified potential risks to the person's safety. For example, their use of an electric wheelchair. It provided good information to staff about how to support the person's well-being. The person had signed their own care plan and told us how they needed to feel safe and secure to maintain their well-being. In response to people's changing needs and feedback, there had been changes to staffing arrangements at night so there was now two waking staff on at night. People were positive about this change. One person said they did not sleep well at night and appreciated the time staff spent with them.

People told us they had not made any recent complaints and would feel able to talk to staff if they had a problem. Complaints information was available in the home's hallway and information was available in people's rooms. Staff knew where this information was displayed so they could refer people to it if necessary. We reviewed two complaints that had been received about the service since our last inspection. These had been investigated and responded to by the provider. On the last day of inspection, a visitor asked to meet with senior staff to raise a concern. We were sent the outcome of this meeting. Records showed action had been taken promptly to reassure them about how agency staff were provided with information about the people they were supporting at the home. Prompt action showed the matter had been resolved and the complainant did not wish to pursue the issue further.

Requires Improvement

# Is the service well-led?

## Our findings

Since the inspection we have been formally notified by the provider that alternative arrangements were in place to manage the service. The notification confirmed that the management arrangements in place during the inspection were continuing. These arrangements were a senior manager overseeing the running of the service. A senior care worker from another home run by the provider had been appointed as the new manager. They already knew the staff group and the people living at the home as they had been working with staff to make improvements to the service.

Quality assurance reports completed by staff visiting the home identified improvements were needed to support staff and ensure the service met the social and care needs of the people living at Margaret Allen House. The first quality assurance report to highlight the need for improvement was in April 2017 and a number of actions were recorded to improve the service. By July 2017, the quality assurance report identified on-going problems with the standard of care plans and how risks were monitored and had highlighted further areas for improvement. In August 2017, during our inspection audits of care plans showed work was still needed to update people's care plans and this was now taking place. This meant up until recent management changes, the recommendations from quality audits had not been fully actioned to improve the service.

Other audits showed there were now no significant concerns with how medicines were being managed in the home. Safety checks were organised centrally, such as testing portable electrical appliances and the lift being serviced. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire.

There was mixed feedback from staff working at the home regarding how the staff team worked together. The majority said there was poor morale amongst the staff team, including the management of staff rotas, which impacted on how they worked together. Staff had not benefited from regular supervisions or observations of their practice to help ensure they were working in a safe and caring way. Some said staffing levels in the afternoon impacted on their ability to have time to check the records of other staff members. Staff sickness levels and poor timekeeping was now being addressed. Staff had been given different opportunities to feedback if they had concerns which included meeting with the Human Resources department.

Some staff said that improvements were not being made quick enough. Steps to improve the service included a staff meeting in June 2017 with the aim of addressing staff concerns and raising morale. It was recognised that poor teamwork could impact on the people living at the home and a letter was sent out to staff members who could not attend with the key findings and actions. Another team meeting was planned for 13 July 2017 to focus on team work and roles but was delayed until 3 August 2017 to enable more staff to attend.

Not all staff felt supported when they had raised concerns in the past; a staff member told us several people had reported concerns to them linked to the poor attitude of some staff. The staff member said they had

shared this information with the management team but had not felt the concerns had been addressed appropriately. With their agreement, we shared this concern with the senior manager; a record could not be found of the concerns or the actions taken when they were first reported. Since the inspection, the senior manager has investigated the concerns and an unannounced spot check has taken place with the findings sent to CQC. Plans were in place to improve staff practice through supervision, further training and robust management of the rota.

The senior manager said many of the staff were eager and willing to make things better at the service. A team leader from another service was working with the senior manager and staff at the home to make improvements to recording, such as in daily records. Recent training sessions had been implemented to help staff members understand the purpose of completing records, such as food and fluid charts. A senior guidance file had been introduced to help build staff members' confidence and skills. A senior staff reported they were seeing improvements in record keeping so they were less task focussed. Staff meetings were being scheduled in advance to give more notice to staff and minutes were to be sent out to all staff members to ensure everyone kept informed of the discussions that took place. However, these steps were work in progress and still being rolled out across the staff group. Therefore these practices were not yet embedded.

Despite the above, people were positive during the inspection about the standard of care provided by staff and said they would not change how the service was run. People said they would recommend the service to others looking to move into a care home. One person said "I'm all right here, they treat me OK". Another person described the staff as generally cheerful and told us "This is my home...they are my family". People gave us different examples of good practice by individual members of staff which they said showed thoughtfulness and care. For example, stopping to have a cup of tea and a chat when a person could not sleep at night.

People told us there were meetings during which they were informed about any planned changes to the service and they gave us examples, such as updating the fire doors. People told us they knew who the registered manager was, although one person said they would like to see them more often. The senior manager said further written information was due to go out to update people on future plans for the home.

A decision had been taken by the provider not to send out a survey for people living at the home about their experiences so this feedback was not available. Several people shared some comments/suggestions for improvement with us about recent experiences. They agreed we could share these with the senior manager to address. We shared this information and the senior manager said they would follow up on these comments. For example, one suggested improvement was actioned before our second day of inspection. Other feedback related to how people could identify staff more easily as they did not always wear name badges; the senior manager said they recognised people would find it difficult to make a complaint or provide a compliment if they did not know the name of the staff member. They said this would be addressed.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care records were not consistently completed and therefore did not always provide key information about people's care needs. The lack of accurate or up to date written information potentially put people at risk. Improvement was needed to provide a wider range of social events to meet everyone's emotional and social needs. |