The Orders Of St. John Care Trust

Avonbourne Care Centre

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

Avonbourne Care Centre 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. Avonbourne Care Centre provides accommodation and personal care for up to 120 older people. At the time of our inspection 53 people were living at the service and one side of the building had not been in use since the service opened. This was the second inspection since the service was registered in April 2016.

This inspection took place on 10 April 2018 and was unannounced. We returned on 11 and 12 April 2018 to complete the inspection.

The current manager joined the service in December 2017 and was awaiting registration with CQC at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Staff told us they felt confident in the way the manager and newly appointed deputy manager were managing the service. They told us they had started to see positive changes and felt this was due to the change in management. Their comments included, "There was a lack of stability, things were always changing, up then down, then up again. The new manager has made some better changes. There are new staff coming on board. I feel there is much better support."

People, relatives, staff and professionals told us that staffing had been the main issue impacting the quality of care people received. The manager had successfully recruited into a large proportion of the vacant hours. There were new staff joining the service who were in the process of completing their training.

There were times when people's calls for assistance were not heard. People were looking for staff and their needs were not always met in a timely manner. Care staff wanted to do their best for the people living at the service. However, staff resources were stretched due to the layout of the units and needing to complete tasks, such as mass bed linen changes.

There were insufficient recording processes in place regarding the support people received for their personal care. This meant some people went for long periods of time without receiving support to bathe or shower and staff had no overview of this.

There were no protocols in place for the administration of medicines used to reduce anxiety. The care plans for supporting people with their anxiety lacked detail. Medicine trained staff were unable to explain when they would administer medicines to reduce anxiety. Medicine protocols for pain relief were not person centred and lacked sufficient detail for staff to know if the person required their medicine. Where people

could not communicate to let staff know if they were in pain, there were insufficient guidelines in place for staff to provide consistent treatment.

Where people required their food or fluid intake to be monitored to prevent the risks of illness and infection, these were not completed consistently, or with enough information. For example, fluid intake goals were not recorded, so it was not possible to know if a person was achieving their required intake. The intake recorded fluctuated greatly. There was no evidence of people being offered more to drink later in the day, where their fluid intake was low in the morning or afternoon.

Care plans and accompanying risk assessments were out of date. The information documented did not always reflect the person's present needs. During the inspection staff were being given time to work on updating the care plan documentation.

There was an activities programme in place and people spent time with their relatives. Some people told us there was not enough for them to do and comments included, "You just sit around and no-one talks to you." There were plans in place to develop the programme to include day trips and a new activities coordinator had been appointed to expand the team.

People said they felt safe living at Avonbourne Care Centre. The feedback from people included, "Yes I think I do feel safe here. If I ring the bell, someone will always come." Staff understood their responsibilities for reporting concerns to people's safety. The manager reported concerns and incidents in a timely manner to the local authority where appropriate.

People were complimentary about the food on offer. Comments included, "The food is always nice here, we get different choices." There were snacks such as fruit, chocolates and crisps available in each unit, as well as juice and hot drinks machines. Where people chose to spend time in their bedrooms, they were provided with jugs of juice or water.

The manager was aware of most of the issues and concerns that were raised during the inspection and had already made positive steps towards responding to these shortfalls. There have been positive changes in the recruitment at the service, as well as in training the new and existing team members.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicine protocols were not always in place or completed with enough information.

People's requests for assistance were not always answered promptly.

There were safe recruitment processes in place.

Staff understood their responsibilities with regards to identifying and reporting safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Recording of fluid intake and repositioning was not completed to a standard that ensured the person remained safe from risk.

People did not receive personal care in accordance with their needs or wishes.

The staff had a good understanding of the principles of the Mental Capacity Act (2005).

Is the service caring?

Requires Improvement

The service was not always caring.

Staff wanted to do their best for people living at the service.

There were constraints on how much quality time staff could spend with people, due to the volume of other responsibilities.

Staff interacted with people in a friendly and caring way.

People and relatives were complimentary about the staff and their approach to providing care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people told us they didn't feel they had enough to do.

There were activities offered, but these were not always well attended.

There were occasions where staff used outdated or inappropriate language.

Daily records lacked detail and were task focussed

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a manager in post, on a temporary basis awaiting recruitment of a permanent manager.

While there had been positive changes, these were only implemented over a short period of time and were not yet proven as sustainable.

Staff felt the change in leadership had meant there were improvements at the service.

Audits and analysis took place to review progress and understand where improvements were required.

Avonbourne Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was prompted in part by a notification of complaints regarding staffing levels and safety concerns. This inspection examined those risks.

Before the inspection we contacted the local authority commissioning team and requested their feedback on the service. We also reviewed information from notifications received from the service regarding accidents and incidents.

The inspection took place on 10, 11 and 12 April 2018 and was unannounced. The inspection was conducted by one inspector and two experts-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.

During the inspection we spoke with twenty-six people who used the service and seven relatives. We interviewed five members of staff and the manager. We also spoke with three visiting healthcare professionals. To gather evidence, we reviewed records about the management of the service, including staff recruitment and training files. We reviewed care plans and daily records for nine people. We also looked at the medicine records for eighteen people, and reviewed the fluid and food, personal care, and repositioning records for each person with these records in place. We spent time observing the way staff interacted with people who use the service and recorded this using a Short Observational Framework Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether people had positive experiences.

Requires Improvement

Is the service safe?

Our findings

The medicines were not administered safely. The Medicine Administration Record for topical prescriptions (TMAR), such as creams and lotions, for each person and on each unit of the home were completed inconsistently. Some staff signed the TMAR with a tick and their initials, others signed using the code 'N' and then their initials, despite there being no key to explain what 'N' referred to. There were also gaps in the TMAR, with nothing recorded. This meant it was not possible to know if the person was receiving the prescribed cream or lotion. Some people had topical prescriptions where one lotion was used to cleanse and another used to protect the skin after it has been cleansed. There were discrepancies between recordings which showed that these instructions were not being followed. The instructions on the TMAR lacked detail and specific guidance for staff to follow. For example, one person was prescribed a soap substitute and moisturiser. The guidance for staff stated 'Use as a moisturiser and soap substitute'. There was no information to guide staff as to how often the prescription is required and at what quantity. This was a consistent issue amongst all TMAR guidance reviewed and meant that people were not always receiving the appropriate treatment in accordance with their prescription.

Staff who were trained to administer prescribed medicines, were not confident in the protocols they would follow for administering medicines on a PRN basis. Protocols for medicines that were required on a PRN, 'as and when' basis, were insufficient in ensuring that people received their medicines when needed. We found that there were no PRN protocols in place for three people who were prescribed Lorazepam for anxiety or agitation. We asked two members of staff responsible for administering medicines, how they would know when the person required their Lorazepam medicine. One staff member said, "I would have to ask the medicines lead, or if they weren't in then I would ask the deputy manager, but I wouldn't know without having to ask." Another member of staff said regarding one person prescribed PRN Lorazepam for anxiety, "Well for that person, she is the sort of person that always asks for her medicines, she just keeps asking." This meant that people were at risk of receiving medicines when they were not needed, or in place of alternative care and support. This issue was raised during the inspection and protocols were put then in place for the Lorazepam.

The remaining PRN protocols lacked detail in the administration guidance for staff to follow. For example, each person prescribed PRN paracetamol had a protocol in place. The protocol document prompted staff to provide information about the 'Purpose of administration (when it should be given, signs and symptoms)'. Each person had the same information recorded, 'To relieve pain'. This included people who could not communicate verbally if they were experiencing pain. We cross-referenced the PRN protocol guidance with the care plans and found that the care plans for some people referred to identifying if a person was in pain based on their body language or facial expressions. However, the plans did not go on to then explain what type of facial expressions or body language would indicate the person was in pain. This meant that medicines may not be administered in a consistent or person-centred manner.

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

Concerns with medicines management were identified at the previous inspection. We found there to be improvements in the quality of Medicine Administration Records (MAR) and could see that staff were completing regular checks of the records and stock to ensure that the margin for error was reduced. Medicines were stored safely and there were no gaps in the MAR.

The manager explained that there was an updated medicines policy coming into place from the start of the week following the inspection. As a result, the PRN protocol format would be changing, to encourage more detail to be recorded.

The service supported people who required pressure care to protect their skin integrity. We reviewed records that showed repositioning charts were inconsistent and lacked necessary guidance for staff to promote skin integrity. Staff recorded when people were repositioned, however the records had no guidance as to how often this should happen. People's repositioning records also did not contain information about what setting their pressure relieving mattress should be set to. These concerns relate to poor record keeping and processes, as there were no people requiring support for pressure ulcers or skin damage.

Risk assessments were in place in the care plans; however, the care plans and risk assessments were not up to date. The manager acknowledged this and explained that plans were already in place for a peripatetic manager who had been supporting the service two days per week, to spend one month at the service re-writing the care plans and associated risk assessments.

There were insufficient staffing levels in relation to the layout of the service, to protect people from risk. People, relatives, health and social care professionals, and staff raised concerns around the staffing levels. One person said, "You can't expect a lot from them because there are a lot of us to see to. Luckily, I'm still able but a lot are elderly." We observed one person close to falling from their chair and we had to alert a member of staff who was busy in the adjacent corridor. Also, people were asking for help and looking for staff, but were unable to find anyone to support them at times. One staff member raised concerns about staffing levels at night due to the layout of the service and if people are being supported in their bedrooms, there can be periods of time with no staff available.

The manager told us the biggest challenge at the service was recruitment. They said the provider had employed two recruitment leads and that the recent recruitment drives since the leads had been in place was proving to be successful. We saw documentation evidencing that the service had recruited for over one thousand vacant hours of care staff since the recruitment drive began earlier in the year. The service used a dependency tool to identify people's needs and assign a staffing ratio. This tool was insufficient due to the layout of the building not being considered as part of the calculation process. The manager explained that because of issues identified with regards to staffing levels, the service was recruiting staff to a higher ratio than dictated by their dependency tool.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intent to work with children and adults. This helps employers make safer recruiting decisions and reduce the risk of unsuitable people from working with vulnerable adults and children.

The home was clean throughout and where there were odours these were only present for short periods of time. Personal Protective Equipment (PPE) was available. There were stores for PPE in the main corridors, including gloves, hand sanitiser and aprons. Staff did their best to maintain the clean and tidy environment, with care staff loading the dishwasher and ensuring the dining rooms remained clean, as well as changing

the bedding for people. Completing these tasks meant that staff had reduced time to spend with people, and that they were not always available or visible when people needed support.

There had been an increase in the number of safeguarding incidents reported. The manager explained that this was due to an increase in recordings, rather than an increase in incidents, and previously had been a lack of recording. Staff we spoke with had an understanding of the types of abuse and told us they felt confident in speaking with the manager to report any concerns. Staff knew who they could contact within the organisation and also knew how to contact the safeguarding team at the local authority.

Requires Improvement

Is the service effective?

Our findings

Fluid intake was not monitored in a way that supported people to live healthier lives. There were people at the service who had food and fluid charts in place, however these were not being used consistently or effectively. People did not have their daily fluid goal recorded, but staff still recorded their intake. The fluid intake was not totalled each day, or always counted throughout the day. This meant that there was no clear overview of the total fluid intake for that person in relation to their level of need. Also, some fluid intake records recorded 'Sips', instead of the amount of fluid consumed. This terminology made it difficult to understand how much fluid the person has had. We reviewed records for two people where no fluid intake was recorded for one day in the week prior to the inspection. Although drinks were available in the kitchens, not everyone would be able to access these. For example, there were people on each unit that required assistance to mobilise, or who were cared for in bed. The service had people who had dehydration, urinary tract infections and people with low fluid intake. The records to guide staff in how much a person needed and how much fluid they had received were insufficient in ensuring people's hydration needs were being met.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive personal care in accordance with their needs or wishes. There were charts documenting when people had received a bath or shower. The charts were broken down into weeks, with room for one signature per week to document that a person had been supported to have a bath or shower. We spoke with staff and found they were unable to identify for people who had no signatures against their name for the week prior to the inspection and the week of the inspection, as to when those people last received this level of personal care. We found records documenting that most people had not received a bath or shower in the two weeks prior to the inspection. We reviewed records for two people who had not received support for a bath or shower for six weeks. The relative for one person expressed their concern that their family member had not received a bath for ten days. The records for one person evidenced that they had wanted a bath yet they did not have the strength to use the bath chair. The member of staff had recorded that staff could consider using a hoist next time. The records were reviewed two weeks later, yet the person had not been offered the opportunity for a bath in that time. The recording system in place on a weekly basis when a person had received a bath or shower was not fit for purpose and did not address the issue of people not being supported to have a bath or shower.

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

Most people told us they enjoyed the food provided by the home and were offered meals that they liked. We saw people choosing snacks throughout the day. People were supported to choose their preferred option at lunchtime, with staff offering two plated options of food. Feedback from people included, "They always ask me what I would like to eat." And, "We do get a choice, usually about four options, the food is good here." Relatives had mixed feedback about the food. One relative said, "The food is bland. I have tasted the rice

pudding. It has no taste and is stodgy." During the inspection we observed staff providing assistance with meals for people who needed it. We saw that people were supported to use adapted cutlery and crockery, such as "lipped plates" and large handled cutlery.

The environment and layout of the service was not dementia friendly. Each unit had two identical corridors parallel to one another, neutrally decorated. People did not always recognise whether they were in the corridor or where their bedroom was located. Staff could not respond effectively to people's calls for assistance where people were unable to use the call bell, because of the layout of the building. We observed people frequently looking for their bedrooms and searching for staff.

Staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA.
Mental capacity assessments had been carried out to determine whether people had the capacity to make certain decisions. For example, there were assessments in relation to people's capacity to consent to live at Avonbourne Care Centre and to receive care and treatment. Where people did not have the capacity to make decisions, best interest decisions had been made following involvement of the person and others involved in their care, including their family, staff at the service, social workers and health professionals.

People can only be deprived on their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The management team had submitted DoLS applications for people where appropriate. There was a record of all DoLS applications that had been made and these were reviewed regularly .

People were supported by staff who were trained to meet their needs. Where staff were not achieving the expected outcomes for their role and responsibilities, the manager had performance monitoring processes in place. Staff who administered medicines were trained to do so. Staff told us they had received different types of training in areas such as the Mental Capacity Act, Health and Safety, and Safeguarding. The manager had a training matrix in place, with an overview of the training completed and training due. The matrix reflected that the staff team had received up to date training in all areas. Where training needs had been identified, which did not form part of the mandatory training programme, the manager arranged for training to be sourced and delivered by trained professionals. This included the diabetes and stoma care nurses who delivered specific needs training. Also, the district nurse provided regular drop-in pressure care support sessions for staff who had any questions, or situations where they required feedback or guidance from the nurse.

People were able to see healthcare professionals when necessary. The senior staff team understood the health needs of those requiring input from a professional. This meant that care leaders could liaise with visiting practitioners and explain the person's current situation. We saw this when one care lead was advising the visiting nurse practitioner of people's healthcare support needs throughout the service. There was guidance in the care offices to inform staff of the signs of health conditions such as dehydration. This guidance included reminders of the support staff should provide, points to consider, as well as professionals to contact for advice regarding their situation.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring. We observed some people's requests for assistance at times going unanswered and people waiting for long periods of time without any interactions. This was partly because staff resources were stretched to ensure they completed the tasks involved in their daily duties, or staff were located in a different part of the unit. The service was at risk of not providing a caring service at times, because staff time was occupied with tasks, rather than with supporting people. The manager explained that this issue had been recognised and that it was being addressed through recruiting to increased staffing levels.

People told us that they felt staff worked hard and were caring. One person told us, "I think they are always trying to do their best." Another person said, "They do good things here." And, "They are keen to help." Feedback from relatives included, "The care workers are very personable, we can approach them at any time. Mum is happy here." Another relative said, "We had a birthday party here for mum, it was good, they were very accommodating." One relative said, "She's clean, warm and comfortable but I do come every day to make sure it stays that way."

At times, some staff spoke to people in a way that was not dignified or appropriate. For example, we heard one member of staff ask people, "Would you like a bib?" when offering clothes protectors to people before their meal. Another member of staff spoke in a communal area and described supporting someone with their personal care as, "Just dealt with [person's name] and their dirty protest." A different member of staff referred to supporting people as being "on the shop floor." One person was talking about their concerns while waiting for a podiatrist due to foot pain and the member of staff said, "I'm handy with a chainsaw." The comment was not appropriate as it was not understood or received in the intended manner, because the person continued to ask about seeing the podiatrist. We also saw staff asking in communal areas, asking out-loud and not in close proximity to the person, "would you like the toilet?" rather than asking this in a private and dignified manner.

We observed most care staff interacting with people in a friendly and caring manner. People were offered choices and their decisions were respected. Where staff were available, people were helped to understand where they were in the building and staff walked with people who were asking to be shown where their bedroom was located. During the lunchtime service, we observed the kitchen assistants and care staff working well together and meeting people's needs in a caring and efficient way. For example, one person was becoming agitated during their meal and the kitchen assistant explained to a new member of the care team how they could support the person. Once in the company of the member of staff, the person relaxed.

Some people had up to date care plan information, including their personal life history, their plans for the future, important relationships. Most people did not have a life history record which would enable staff to understand more about the person and their past interests. Although staff demonstrated and could explain what was important to the person, this information was not always up to date in the care plans and records.

Staff told us they enjoyed working at the service and that they enjoyed caring for the people who lived there.

One member of staff told us, "We all do really care. We just needed the right manager to help us get everything else up together." Another staff member said, "We all pull together and are like a big family." And, "I always think, how would I want my mum or dad to be cared for and that is what I try to deliver for other people." One new member of the staff team said, "The care staff I cannot fault. There are some here that just work so hard for the people."

The service employed volunteers. We met one of the volunteers and they told us, "I try to see as many people as I can, have a chat with them and see how they are. I've not been here for a while, but I have really missed coming." We observed the volunteer interacting with people in a kind, considerate and friendly manner, which was well received by people who welcomed the company.

People were supported to contribute to decisions about their care and were involved where possible. Relatives were invited to attend care plan reviews. One member of staff told us, "I have just re-written the care plan for [person's name]. Their relatives were visiting, so I have spent some time with them going through the plans to make sure they reflect [person's name] needs." The members of staff responsible for updating the care plans understood that where the person was unable to explain their choices and preferences, it was important to speak with family members for this information.

People spent time outside of the service with their relatives. We also saw relatives visiting and spending time in the communal areas with their family members. There were plans in place for day trips during the upcoming summer months. The manager told us that they were organising trips to the seaside and were keen to encourage every person that wanted to spend time outdoors to do so. For those who cannot travel as far, the manager said they were looking into options for trips that were closer to the service.

The service had received several compliments from relatives in recent months. The comments included those from the relatives of one person who had moved to a different location and said. The feedback said, "We are very sad that she has to move from Avonbourne, as she really has been happy to be part of your care family." Staff were also praised by relatives for ensuring continuity of care staff during periods of adverse weather.

Requires Improvement

Is the service responsive?

Our findings

People's social needs were not consistently met. One person said, "You just have a room. I was just told you might like it here. I did like it, but they don't like you going outside. It is hard to adjust. I used to go out walking, they've done that with me once or twice, but I think they've lost interest." Another person said, "Since I've been here, it's been all television. But I like knitting. I used to do a lot of knitting at home." One other person told us, "I haven't been here long, but I haven't done anything. Just had a rest." Staff frequently asked different people "alright [person's name]?" as they went about their duties, but did not always wait for the response. This did not allow the person the opportunity to interact.

We observed small group activities taking place, including a quiz and nail painting. There was an activities programme in place, including entertainers and animals visiting the home. There were events advertised such as watching the Grand National in the home's coffee shop, with tea, coffee and cakes. Relatives were invited to attend as well. One relative said, "Normally they have activities every day. They're good. This Saturday the Grand National is all sorted."

The service had a well-equipped hairdressing salon and a visiting hairdresser each Wednesday and Thursday that people could be booked in with. We were also advised that people could have a hairdresser of their preference visit and use the premises as well.

There were some positive one to one interactions taking place. We observed one lady sat in the dining room enjoying a cup of tea and singing songs with the activities coordinator. They were chatting as though they were good friends.

People were not always living in the area of the service that was best suited to their needs. There was a mix of people receiving residential and dementia care throughout all three units in the home. People's views varied about this and feedback from one person included, "When I was coming here, I read the brochures, but they stick me in the lounge with [people with a high level of need]. I would much prefer to sit in the other lounge, at least I could read a book in there. A lot of things want altering." And, "We're better off sitting in our room all day to avoid [people with more complex needs]." People were not introduced to others who had similar experiences or interests. One person said, "I know I've got a neighbour living next door to me, but I've never met him." Another person told us, "I have only been here for a week, some of it I like, some of it I don't. You just sit around and no-one talks to you."

People's care plans were not up to date. Not all care plans contained information about people's future and end of life care wishes, such as where they would wish to receive treatment. Staff and the manager told us that the care plans were in the process of being re-written because this had been identified prior to the inspection.

The daily records, at times, were written using undignified terminology. The daily records for one person said, "[Person's name] has been very vocal this evening. When asked, said she was looking for her dog. Now starting to settle." Another entry said, "[Person's name has been vocal all evening. She has been shouting for

staff members and also been following another resident around all evening." The entries did not demonstrate that person centred care had been provided. Staff identified that when the person was seeking their assistance, but do not explain how staff had supported that person. There was no evidence that the person's actions and responses were being analysed as to what worked well and what did not work well in improving the quality of care for the person.

Daily records were task focussed and did not record how the person was feeling or how they had chosen to spend their day. The entries reflected concerns that staff are unable to spend quality time with people, enhancing their experience of living at the service. For example, the daily records contained generic and sweeping statements, such as, "Personal care given", and "Diet and fluids taken." This is insufficient in explaining what support the person has received.

One healthcare professional felt that there had been improvements in record keeping regarding people's health issues. They said, "We introduced ward round sheets for staff to write down who they wanted us to see and why. There have been improvements and they are getting better. I used to have concerns and now I can see that things are changing."

People did not always feel they had the opportunity to give feedback about the service. One person told us, "I've nobody to ask for advice." During the inspection the manager circulated a survey for people living at the service to gain their feedback and had started to receive people's comments. The survey had not been utilised since November 2016 as a way of gathering people's feedback. The manager has also held relatives meetings, where relatives were invited to discuss concerns and receive updates. At the most recent relatives meeting, the manager informed relatives that people would be moving to new units in the home and provided a deadline for this. The manager told us, "It didn't go ahead as planned. But this is because the unit needs to be made more dementia friendly first." The manager discussed that it is in the best interests of people that the unit is prepared to the appropriate standard first.

Complaints were responded to promptly. At the previous inspection the service had been in breach of regulation for failing to respond appropriately to complaints. Since the manager has been in post, we found that where complaints had been received, these had been acknowledged, investigated and followed up efficiently.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post, awaiting completion of the registration process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service had a manager in post, on a temporary secondment basis from another service within the organisation. The manager had been working at the service for four months before the inspection, but had worked for the organisation for many years. The manager was the fourth manager at the service since it had opened in 2016. A new deputy manager had been working at the service for two months. The manager had submitted their application for registration to CQC and this was in the process of being assessed .

Staff told us they had seen positive changes since the manager and deputy manager had joined the service. Staff said they were happy with the way the management team were managing the service, but explained that they had concerns due to the frequent changes in management they had previously experienced. Staff told us that morale had been low due to the changes in management and that it had been difficult to retain members of the team. The manager told us that although they were managing the service on a secondment basis, they would be in post until a new manager had been appointed and fully inducted. To recognise achievements within the staff team and improve morale, the manager had a recognition system in place where staff received thank you cards.

Staff described the manager's management style as, "Firm but fair." This was echoed by the manager who explained, "If someone isn't achieving, then we support them with clear objectives and provide all the training and tools they need. The objectives are about the staff working within what we expect from them, but also in accordance with the law." Staff said, "The manager is fair, they explain everything they want us to do in detail." And, "[The manager] has an open door policy, which really helps as you know you can go to them if you have any problems." One staff member said the deputy manager was, "very approachable. [The deputy manager] wouldn't ask you to do anything that [the deputy manager] wouldn't do herself."

The manager had a strategy in place for developing the service. They told us that in order to learn from the mistakes previously made at the service, they had needed to implement a stronger senior staff team. The manager had ensured training refreshers had taken place and that the care leaders had clear objectives. Also, there were regular supervision meetings and reflective practice when things went wrong. For example, learning from any errors in medicine administration. There were plans in development to liaise with the local college and to promote work experience placements at the service.

The management office was located in the main foyer, away from the units where people lived and received care. The manager explained that there were plans submitted to the organisation to move the management office to a more accessible location in the home. The manager told us that they regularly visited and worked within the units to ensure that they knew what is happening within the service.

Audits of the building and infection prevention control took place regularly and were completed by the regional and operational managers, as well as the organisations internal quality assurance team. In addition, more frequent audits and checks were carried out by the manager, deputy manager and the care leaders. Where possible, action was taken promptly to address issues identified in the audits. Data from audits of areas such as safeguarding notifications, as well as the number and location of falls was analysed annually.

The manager maintained an overview of the audits of the service to ensure they understood where areas needed improvements. Each aspect of the feedback provided to the manager during the inspection was around concerns that had already been identified by the service and there were action plans in place for these .

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 Systems in place did not ensure that people received personal care and treatment in accordance with their needs and wishes. Regulation 9 (1) (a) (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine protocols were not in place for medicines to treat anxiety. Protocols for medicines to treat pain were insufficient and did not promote safe administration of medicines. Regulation 12 (2) (c) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's fluid intake was not consistently recorded where required. Recordings were not totalled and fluid goals were not recorded. There were discrepancies in how fluid was recorded for people who were diagnosed with dehydration. Regulation 17 (2).