Adiemus Care Limited

Sherford Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Sherford Manor is registered to provide accommodation for up to 105 people. The home is currently divided into three self-contained units and the home is due to open a fourth unit. Rose is for people requiring residential care and is the base for the activities in the home. Redwood is on the first floor and provides nursing care. The Sutherland Suite was recently refurbished to care for people either living with dementia or had behaviours that could be challenging. It is on the ground floor and offers access to large, secure gardens. This inspection was unannounced.

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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

The service was not meeting the requirements of the Mental Capacity Act (2005). Staff could not consistently demonstrate an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and how they applied it to their practice. Given the complex needs of people living in the home, this meant people without capacity may be at risk of having their freedom restricted unlawfully.

Staffing was not always maintained at safe levels. Staff could not confirm that people's needs were met promptly and felt there were not sufficient staffing numbers. Staff were not receiving the relevant training and support to meet people's needs.

Care files were not personalised to reflect people's likes, dislikes and preferences on Rose nor Redwood. However, in contrast, we saw evidence on the Sutherland Suite which demonstrated that people's likes and dislikes were documented and they were receiving personalised care and support specific to their needs and preferences. Care plans did not show people were in agreement with the care and treatment being delivered.

Despite audits identifying issues the registered manager or provider had not taken action to ensure they were addressed in a timely way. For example, people's likes, dislikes and preferences not being documented.

People confirmed they felt safe and supported by staff and relatives did not voice any concerns. Their individual risks were identified and the necessary risk assessments were carried out to keep them safe. People saw appropriate health and social care professionals when needed to meet their healthcare needs. People spoke positively about the care they received and were encouraged to remain as independent as possible. They spoke positively about how the registered manager was accessible, approachable and worked well with them.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.

Staffing was not always maintained at safe levels. Staff could not confirm that people's needs were met promptly and felt there were not sufficient staffing numbers.

People we spoke with confirmed that they felt safe and supported by staff and relatives did not voice any concerns.

People's individual risks were identified and the necessary risk assessments were carried out to keep people safe.

Is the service effective?

Requires Improvement

The service was not effective. Staff were not receiving the relevant training and support to meet people's needs. However, staff knew how to respond to specific health and social care needs and were observed to be competent. For example, recognising changes in a person's physical health.

People were supported to eat and drink and maintain a balanced diet.

People were able to see appropriate health and social care professionals when they needed to meet their healthcare needs.

Is the service caring?

Requires Improvement

The service was not caring. Although we found some good interactions, we saw occasions where it was not as caring and respectful as it should have been.

People spoke positively about the care they received.

People were encouraged to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not responsive. Care files were not personalised to reflect people's likes, dislikes and preferences on Rose nor Redwood. However, in contrast, we saw evidence on the Sutherland Suite which demonstrated that people's likes and dislikes were documented and they were receiving personalised care and support specific to their needs and preferences.

Care plans did not show that people were in agreement with the care and treatment being delivered.

There were opportunities for people and people that matter to them to raise issues, concerns and compliments.

Summary of findings

Is the service well-led?

The service was not well-led. Despite audits identifying issues the registered manager or provider had not taken action to ensure they were addressed in a timely way. For example, people's likes, dislikes and preferences not being documented.

People using the service, relatives and staff spoke positively about how the registered manager was accessible, approachable and worked well with them.

The organisation took account of people's views and suggestions.

Requires Improvement

Sherford Manor Care Home

Detailed findings

Background to this inspection

We visited the service on 24 and 25 July 2014.

The inspection team consisted of two inspectors and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 who could not talk with us.

At the time of our visit there were 62 people receiving a service from Sherford Manor. We spoke with 14 people receiving a service, nine relatives, 15 members of staff and the registered manager. We reviewed 10 people's care files, four staff files, staff training records, a selection of policies and procedures and records relating to the management of the service. Following our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from two professionals, a GP and Independent Mental Capacity Assessor (IMCA).

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern and to identify areas of good practice. We also reviewed the information we held about the home and notifications we had received. At our inspection in July 2013 we found issues with record keeping. This was followed up in November 2013 and improvements had been made.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

Staff could not consistently demonstrate an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and how they applied it to their practice. For example, staff gave various answers about what actions they would take if they felt people were being deprived of their freedom to keep them safe. The Deprivation of Liberty Safeguards provide legal protection for those people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Training records showed that only 44% of staff had received training on the Mental Capacity Act (2005) and only 24% had received training on Deprivation of Liberty Safeguards. Given the complex needs of people living in the home, this meant people without capacity may be at risk of having their freedom restricted unlawfully.

We read 10 care files for people. Where there were suggestions that people did not have the capacity to make particular decisions about their care and support, due to conditions such as dementia, there was no evidence of mental capacity or best interests' assessments. For example, we saw people had bed rails in place for their safety. The need for these had been risk assessed by a member of staff. There was no supporting evidence of how people's capacity to consent to bed rails had been assessed and whether any best interest discussions or meetings had taken place. This meant decisions to use bedrails may not have been made appropriately. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Staffing was not always maintained at safe levels. Staff informed us at times people's needs were not adequately met. For example, personal care was rushed or not done properly. People and their relatives commented that staff were under pressure, with their ability to provide the level of service they would have wished being limited. Staff comments included: "The lounge is not always supervised because staff are busy"; "For people who are being cared for in bed, we have no time to sit and spend time with them" and "There is never enough staff and this reduces our ability to do extra for people and complete paperwork." We observed that staff were stretched at times. For example, at lunchtime it took a long time for people to get their meal and food and fluid charts were not being completed at the time. Due to many people needing support to eat their meal, we saw main courses were still being taken to people's bedrooms at 1.50pm. This meant that some people had been waiting over an hour to have their meal brought to them.

People confirmed they felt safe and supported by staff and relatives did not voice any concerns. Comments included: "I feel safe and well looked after" and "This home is much better than the previous home (relative) had been in and we have peace of mind that they are being cared for."

We spoke with staff about their understanding of what constituted abuse and how to raise concerns. They confirmed they knew about the home's safeguarding policy and procedure and where to locate it if needed. They demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they may have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission (CQC). Staff told us that they had received safeguarding training. We confirmed 57% of staff had received up to date safeguarding training by looking at training records. Although we found 57% of staff had received this training it left 43% who had not, which could pose a risk they would not know when to report concerns.

The provider responded appropriately to any allegation of abuse. They had a policy which set out the measures to safeguard adults, such as working in partnership with the local authority. The provider contacted the local authority safeguarding team to discuss any allegation or event which had taken place and affected people in their care.

Following our visit we spoke with an Independent Mental Capacity Assessor (IMCA). The IMCA is a safeguard for those people who lack capacity, who have no one else other than paid staff who it would be appropriate to consult. The safeguard is intended to apply to those people who

have no network of support, such as close family or friends, who take an interest in their welfare. They told us: "The

Requires Improvement

Is the service safe?

home is proactive in contacting the IMCA service. I have been involved in people's reviews. The home manages people's complex needs really well and everyone always looks well cared for."

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incident records and actions had been taken in line with the organisations policies and procedures. For example, involvement of health care professionals to review people's care and treatment plans. The home had a member of staff who had the responsibility of being clinical lead for the home. They reviewed incident reports as part of their role. However, a record of these were not kept in an order or central place to make it easier for any themes and trends to be identified quickly. This meant there was an over reliance on the clinical leads knowledge to address incidents and accidents. We raised this with the registered manager, who acknowledged they had to look at different pieces of paper to review incidents and accidents. This meant there was a risk that learning from incidents would not take place and improvements in people's care could be compromised.

People's individual risks were identified and the necessary risk assessments were carried out to keep people safe. For example, risk assessments for skin care, bed rails and managing people's anxiety. The risk management process considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible, such as the use of distraction techniques when a person was becoming distressed. We observed staff providing people with soft toys which they found reassured them to help reduce their distress.

We spoke with the registered manager about how they ensured they had enough staff on duty across the home. They explained they used the organisation's staffing level calculator to help them prepare a suitable staffing rota to ensure people's needs were met. This guidance was based on the numbers of people living at the home. It stated the calculator was not a substitute for the judgement of the home's manager and the enhanced care needs of people. We asked the registered manager what they would do if a person's needs increased. They said in the past they had increased staffing numbers and had liaised with health and social care professionals to review people's needs. They added that on the whole staff were on 33 hour contracts which allowed them room to pick up an extra shift if needed and they used bank staff and students to help cover shortfalls. As a last resort they used agency staff. The home operated an on-call system which meant a member of the management team was always available for staff to contact if concerns were identified. Despite the registered manager having a system to calculate staffing levels and ensuring staffing numbers reached this level, we found these did not always meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

There were effective recruitment and selection processes in place. We read four staff files and saw completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and Criminal Record Bureau (CRB) checks completed. CRB has been replaced by 'Disclosure and Barring' checks which apply the same principles. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures. This was to help ensure staff were safe to work with people living in the home.

Requires Improvement

Is the service effective?

Our findings

The service was not effective because staff were not receiving the relevant training and support to meet people's needs.

Staff were able to speak confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. However, care staff told us they had not read people's care plans and risk assessments, relying on verbal handover meetings at the start of each shift to understand people's needs. They added they had no involvement in people's care plan development and so did not know their content. Care staff said these records were for nursing and senior staff to refer to. Staff commented: "If a staff member returned from leave we could not establish how the staff member knew what the up to date care was to be provided safely" and "I would make sure I was updated by asking a nurse or senior carer. However, this would depend on me having time to do this". Other staff said they would read old handover sheets. This meant there was a risk that key information may not be communicated to certain members of staff which could lead to inappropriate care being given to people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Staff told us they received training in subjects such as moving and handling, safeguarding adults, first aid, fire safety and infection control. However, staff told us training in respect to people's specific needs had been less important recently, such as mental health, dementia care and managing behaviours which challenged. When we asked a newer member of staff how they would diffuse a situation that could escalate out of control, they were unable to tell us. They told us they would watch other experienced staff. A staff member commented: "The training is sporadic and if you are on shift you can barely be spared to attend training. I think the training is not good enough to meet people's complex needs." We found gaps in staff training records in subjects relating to people's complex needs. For example, the training statistic record as of 25 July 2014 showed that 58% of staff had received dementia care training; 38% had received pressure care training; 49% had received training in managing challenging behaviour and 0% of staff had received training specific to nutrition. The gaps in training on specific subjects and staff members concerns about the level of training provided to them to carry out their roles competently and confidently posed a risk that people were not receiving effective care specific to their needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Staff did not always receive on-going supervision and no members of staff had received an appraisal of their work in order for them to feel supported in their roles and to identify any future professional development opportunities. We looked at staff and supervision files and found supervisions were carried out sporadically. We asked the registered manager how they knew staff felt supported. They replied: "I probably don't." This meant staff were not being regularly supported to carry out their roles or discuss development opportunities. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Staff had completed induction training when they started work at the home. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles. The induction formed part of a three month probationary period, so that the registered manager could assess staff competency and suitability to work for the service.

People were supported to eat and drink and maintain a balanced diet. Staff were good at assisting individuals with eating and encouraging others to eat. There was a desert of stewed apples and custard which was very hot, and staff were careful to inform people of this and make sure it was cool enough before eating. However, we observed there was no recording of food and fluids charts being completed at the time of the meal due to the number of people requiring assistance and different people clearing plates. This meant there was a risk these may not be completed accurately, as they were being filled in at a later time.

People were assessed for the risk of malnutrition, had relevant risk assessments and care plans to ensure staff were provided with appropriate information. However, we found that on occasions the monthly monitoring of people's weights were not documented in line with their

Requires Improvement

Is the service effective?

care plans. This meant there was a risk that people whose weight had changed may not be monitored and action taken appropriately, for example involvement of other health professionals.

People had been assessed by the speech and language therapist team in the past. As a result, people were prescribed specific diets, such as food being pureed or thickened. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties. We spoke with the chef who, though aware of people's dietary needs, was not being provided with regular updates in respect of people's changing needs, likes and dislikes. The registered manager agreed to review the communication system with the kitchen and ensure they had up to date information about people's specific and changing needs.

People were able to see appropriate health and social care professionals when needed to meet their healthcare needs. We saw evidence of health and social care professional involvement in people's care on an on-going and timely basis. For example, GP, speech and language therapist and mental health practitioner.

Requires Improvement

Is the service caring?

Our findings

We spent time talking with people and observing the interactions between them and staff. Although we found some good interactions, we saw occasions where staff were was not as caring and respectful as they should have been. We observed eight people in one of the lounges in Rose and found there was virtually no interaction between them and staff over a 20 minute period. When one person became distressed and a member of staff was seeking to comfort her, the senior staff member was rather dismissive as she passed by distributing medicines, with the comment "if she wants to get up - she'll get up." In contrast to this, we observed staff at other times spending time on an individual basis, reassuring people and seeking to comfort them.

People told us: "It's very good here, it's a good crowd. The staff that is. I don't want to move ever" and "I am fine. The staff are lovely. I am happy. No problems, no problems at all." Relatives and people's friends comments included: "The staff have a real empathy with what we are going through" and "there are good interactions with people and the staff are very pleasant when talking to and treating people."

We observed the activities coordinator passing through the corridor in one area of the home, encouraging a person to keep their legs up on a stool in order to aid the swelling going down and spending time to help her do this. Staff were seen to interact appropriately with people and provide reassurance when people were becoming distressed. For example, we saw a person being given their soft toy to help relieve their distress. This helped them to calm and showed that staff knew this person well and what helped them in times of upset.

We spoke with the hairdresser who had been coming to the home for 17 years. They said there was a great atmosphere within the home and they tried to make people's experience as close to what they would have done before they entered the home. They felt it was important to the families that their loved ones hair looked the same as they would have done before they came into the home.

Staff told us how they maintained people's privacy and dignity when assisting with personal care, for example by knocking on doors before entering and gaining consent before providing care. For example, we observed a person in their bedroom who was appropriately covered and their dignity had been respected. Another example was we observed a person being supported to the office to receive a telephone call. The staff member asked if they would like to take the call and could they help them into the office to take the call. We saw staff adopted a positive approach in the way they involved people and respected their independence. We heard and saw staff working with people and they demonstrated empathy through their actions, in their conversations with people they cared for and in their discussions with us.

We saw staff spending time with people talking about a range of subjects of interest. Interactions between the staff and people were good humoured and caring. People were treated with kindness and compassion. For example, we heard one member of staff supporting a person with a level of dementia that meant they were forgetting what was happening and how to help themselves. The member of staff supported them by calmly reminding them of what they were doing and going back over this time and again until the task was completed. The staff member checked they were settled and there was nothing else they wanted or needed before moving on. However we witnessed one event where a member of staff interacted with a person in an aggressive manner that concerned us. This was reported to the registered manager and dealt with straight away. The registered manager told us this was not the usual pattern for this member of staff with other people. Later on during our inspection, they were seen working with people in a caring manner and in a way that supported people in their own time.

There were couples living in the home with varying needs in respect of a diagnosis of dementia and therefore lived in separate parts of the home. We saw that their needs were being met whilst supporting them to maintain their relationships. The staffing in the home had been reorganised to meet these needs. We spoke with a family member who told us a plan had been worked out with their full involvement and there had been a beneficial outcome for both parents and the family. They told us: "The staff make it good; they are very flexible. They can come and go; they are never contained. My mum can stay over with dad. They take mum back when she becomes agitated. It works for them." This showed that the home valued the importance of people maintaining contact with those people close to them.

Requires Improvement

Is the service caring?

One person whose religion was important to them told us their faith was respected and they were supported to attend their place of worship and could come and go as they required.

People told us they were encouraged to remain as independent as possible. However, where they required staff support this was always carried out carefully to maintain their dignity. For example, to have a bath. People told us staff would always remind them to have the curtains closed and supported them to dress.

We heard staff referring to people who required their food prepared in a manner that supported them to not choke being referred to as 'softs' and 'pureed' as if this was their surname or name. This was not respectful. We raised our observations with the registered manager. They told us they would raise this at the next staff handovers and monitor the situation to ensure other unacceptable language had not become the norm.

Requires Improvement

Is the service responsive?

Our findings

Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. However, care files were not personalised to reflect people's likes, dislikes and preferences.

We read 10 people's care files. Care files included personal information and identified the relevant people involved in people's care, such as their social worker and GP. The care files were presented in an orderly and easy to follow format. However they did not include a history of people's pasts which would have provided a timeline of significant events which had impacted on them. There was little evidence of people's likes and dislikes being taken into account on Rose and Redwood. One person's care file had been audited in May 2014, where it was identified the person did not have a life history completed and this was to be addressed. The audit also identified that the person's likes and dislikes needed to be included in the care needs summary. Both of these actions had not been completed. Therefore over two months had passed without this person having their personalised information documented. This meant when staff were assisting this person they may not know what kinds of things they liked and disliked in order to provide appropriate care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

We raised our findings with the registered manager, who acknowledged that care files did not contain enough information about people's likes and dislikes. They added that new paper work had been implemented throughout the home and historical information had been archived. They explained that the archived information contained people's likes and dislikes. They agreed this information should have been incorporated into the new paperwork. They said they would address this.

However, in contrast, we saw evidence on the Sutherland Suite which demonstrated that people's likes and dislikes were documented and they were receiving personalised care and support specific to their needs and preferences. For example, one person liked particular foods and another person had a 'my story in pictures'. This showed that when staff were assisting people on Sutherland they would know about them and know what kinds of things they liked and disliked in order to provide appropriate care and support.

People's care plans included information relating to their physical and mental health, mobility, skin care, personal care, communication and eating and drinking. They were written with clear instructions. However, although they were written as if the person had written them, they lacked the evidence they had been completed with the person. For example, there was no evidence of people or their families to show their agreement or involvement in the planning of care. However, relatives told us they had read the care plans and were involved closely in reviews of people's care. They added they were kept up to date with any changes in their relatives care.

Activities took place and the home employed an activities coordinator. Activities included singing, playing games, listening to music, arts and crafts and attending events in the local community. People were encouraged to maintain relationships with their friends and family. For example, care plans documented the importance of people seeing their family to aid their general wellbeing. We saw that people's religious beliefs were respected. For example, one person whose religion was important to them told us that their faith was respected and they were supported to attend their place of worship.There were opportunities for people and people that matter to them to raise issues, concerns and compliments. The complaint's policy set out the procedure to be followed by the provider and included details of the provider and the Care Quality Commission. Where complaints had been made, these had been appropriately followed up and actions taken to resolve the issues. For example, increased cleaning checks on people's bedrooms due to a complaint about their cleanliness. However, the complaints procedure was not visible throughout the home for people to refer to if needed. The registered manager agreed to address this.

Requires Improvement

Is the service well-led?

Our findings

We saw that a range of audits were carried out. These were conducted on an on-going basis to monitor the quality and safety of the service provided. Areas covered included care plans, skin tears and pressure sores, incidents and accidents, bed rails, infection monitoring and medicines management. Where changes were needed some had been followed up by the registered manager. For example, issues raised at staff meetings. However, despite these audits identifying issues the registered manager or provider had not taken action to ensure they were all addressed in a timely way. For example, people's likes, dislikes and preferences not being documented.

People, relatives and staff spoke positively about how the registered manager was accessible, approachable and worked well with them. Comments included: "Her door is always open and has supported us as we learn to cope with (relative) being in a care home"; "She is very nice and walks the floor every day, checking both people and staff are OK"; "The manager is amazing and very approachable" and "The manager is very supportive of training and very helpful in arranging for staff to complete their training."

The organisation took account of people's views and suggestions. People and their relatives were encouraged to complete satisfaction surveys. Subjects included: cleanliness of the home, food and menu and generally about the care provided. Where suggestions had been made, these had been followed up by the registered manager. For example, increased monitoring of the cleanliness of the home and changes to menus.

Staff confirmed they attended staff meetings and felt their views were taken into account. We saw meeting minutes which showed that meetings took place and were an opportunity for staff to air any concerns as well as keep up to date with working practices and organisational issues. For example, we saw that on 1 April 2014 staff were reminded that documentation needed to be completed in full and people using the service or their relatives needed to sign care plans to show agreement. Our inspection identified that these areas were still in need of being addressing and showed staff had not adhered to management requests.

Health and social care professionals worked together in line with people's specific needs. The home notified the local authority and Care Quality Commission of various issues. Staff felt communication between providers was good and enabled people's needs to be met. Care records showed evidence of professionals working together. For example, the GP and nursing staff.

Monthly visits were conducted by the organisation's compliance officer. We saw a visit on 24 June 2014 took place. Areas they looked at included, health and safety, staff training, care plans and risk assessments, medicines management, safeguarding and the Mental Capacity Act (2005) and environment issues. The issues that were identified during our inspection were also raised during this visit. For example, care plans needing to be more in depth and personalised. Where improvements were needed in some areas these had been attended to by the registered manager. For example, a daily infection control checklist was now being completed by the registered manager and housekeeper walking around the home to ensure cleanliness and good infection control practices.

We spoke with the registered manager about the concerns we had identified throughout our inspection and what their plans were for the future. They said they had recognised a need for each unit to have a head of department to help ensure staff were managed at a local level. This had recently been agreed with the organisational management team and the registered manager was currently in the process of recruiting to these roles. They felt the issues we had identified would be addressed effectively if they had a more robust management structure within the home. This showed that the registered manager recognised the need for more resources to ensure people received a quality and safe service, personalised to their individual needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them.** **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There was not enough suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people.** **Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People did not experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights.** **Regulation 9 (1) (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Staff were not appropriately trained and supported to enable them to deliver care and treatment to people safely and to an appropriate standard. Regulation 23 (1) (a)
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People, or those acting on their behalf were not encouraged to express their views as to what was important to them in relation to the care or treatment. Regulation 17 (2) (c) (ii)