Riverside House Propco Limited

Riverside House

Inspection report

Low Stanners
Morpeth
Northumberland
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01 May 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 and 27 April and 1 May 2018. The first day of the inspection was unannounced. This meant the provider did not know we would be visiting.

This was the first inspection since the location registered with a new provider in March 2017. Riverside House 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. There were 46 beds and 44 people living in the home at the time of the inspection.

A registered manager was in post who as on extended leave at the time of the inspection. Their post was being covered by an interim manager who supported us during the inspection. They are referred to as 'the manager" in the remainder of the report.

We checked the management of medicines and found records did not always provide clear instructions about how people's medicines should be administered. Homely medicines were not always recorded.

There were ample staff present during the inspection but we found deployment was not always effective. People and staff told us things could be chaotic, and staff said they would like more direction. We have made a recommendation that the provider monitors the deployment of staff.

Safeguarding procedures were available and staff were aware of these. We found they were not always followed and the manager told us staff would be reminded of the correct procedure should they have any concerns of a safeguarding nature.

Accidents and incidents to people were recorded and monitored. Risks to people were assessed and measures put in place to mitigate these. We found that some records were not up to date or there was conflicting information about the risks posed to some people.

A falls analysis had resulted in action being taken to support one person and the number of falls recorded had reduced as the result of this intervention.
Safe recruitment processes were followed to help ensure people were cared for by staff that had been correctly vetted.

Maintenance records were well organised and up to date. We saw checks to the safety of the premises were carried out regularly and procedures to control the spread of infection were followed by staff. A number of improvements had been made to the building.

People were nicely supported at mealtimes by staff who gently encouraged people to eat. Most people told us they enjoyed the food. Records relating to food and fluid intake and dietary needs had gaps and

omissions. People's weights were monitored and where they were found to be losing weight advice was sought form their GP or dietician.

The service was not always operating within the principles of the Mental Capacity Act [MCA] and the regional manager had identified gaps in staff knowledge and issues with care records which they were addressing. We have made a recommendation to monitor the consistency of the quality of care planning and application of the MCA.

Staff received regular training. There were some training gaps but plans were in place to address these. Some new staff told us they felt the induction could have prepared them better for working in the home. We passed this back to the manager to enable them to review this with staff.

The health needs of people were met. They had access to a number of health professionals.

There had been a number of improvements to the environment which had been redecorated and new flooring laid.

We observed numerous kind and caring interactions between staff and people. People and relatives gave us positive feedback about the staff.

At times the privacy and dignity of people was compromised through the language staff used which was not always person centred. Some information about people including personal care needs was publicly displayed which also compromised their dignity.

Care plans were in place but these varied in quality and detail. There were gaps and conflicting information in some care records. Communication between staff teams was not always effective. Handover information was vague and lacking in detail.

People's routines and preferences were recorded but these were not always supported in practice and care was not always provided in an individualised and person centred way.

We observed some activities which people were enjoying during the inspection. There were long periods however, where people sat in lounges with limited interaction. The manager told us they were aware of the need to increase the availability of meaningful activities and we have made a recommendation about this.

People were aware of how to make complaints and a log was maintained of complaints made and action taken.

Staff told us there had been an unsettled period in the home while the registered manager was on leave. There had been two replacement managers in quick succession which they said had unavoidably impacted upon the management of the service.

We received mixed views about the management of the service. Some people said things had improved under the current manager, others felt the opposite. Staff said they felt they needed more direction from senior care staff and would like the manager to be more visible in the home.

We found gaps in records relating to people and medicines. We also found information of a safeguarding nature had not always been acted upon robustly. There were issues with organisation and direction of staff in the home.

Feedback mechanisms were in place to obtain the views of people, relatives, staff and visiting professionals. Audits were carried out and visits by the provider were carried out on a regular basis.

We found two breaches of the Health and Social Care Act 2008. These related to person-centred care and good governance. You can see the action we told the provider to take at the back 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

Not all aspects of the service were safe

Medicines records contained gaps and omissions which meant instructions to staff were not always clear.

Staff were not always effectively deployed in the home.

Safe recruitment procedures were followed which helped to keep people safe.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People were nicely supported with eating and drinking but records relating to their food and fluid intake and special dietary requirements were not always up to date or accurate. Most people told us they enjoyed the meals.

The service did not always work within the principles of the Mental Capacity Act [MCA] and best interests decisions were not always correctly recorded. Gaps in records and staff knowledge had already been identified by the provider.

Staff received regular training. Gaps in training had been identified and plans put in place to address these.

Improvements had been made to the physical environment. A number of areas had been redecorated and new flooring was in place. The design took into account best practice principles of dementia friendly design.

Is the service caring?

Good

Not all aspects of the service were caring.

We observed numerous kind and caring interactions between staff and people.

The privacy and dignity of people was compromised at times by staff using language which wasn't always person-centred and

through displaying of personal information publicly.

Staff explained to people what was happening to help to prevent them becoming anxious, and offering assistance when necessary while promoting independence.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Care plans were in place which varied in quality and detail. There were gaps in care records and conflicting information.

Care was not always provided in a person centred way. At times, the routines in the home dictated the time and frequency of support provided to people.

Activities were available and we saw people enjoying some of these. The manager was aware of a need to improve access to meaningful activities.

Complaints were recorded and monitored. People and relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

The registered manager was on leave and an interim manager was in post.

There were gaps and omissions in records relating to people and medicines. Communication was not always effective.

Audits were carried out and feedback mechanisms were in place to obtain the views of people, relatives staff and visiting professionals.

New staff rewards initiatives were in place and the regional manager told us they felt well supported by the new provider who visited the home regularly.

Riverside House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection we were aware of concerns about the quality of care provided to some people which had been referred to the local authority safeguarding team. This helped to inform our inspection planning.

This inspection was carried out on 18 and 27 April and 1 May 2018. The first day of the inspection was unannounced. This meant the provider did not know we would be visiting.

The inspection was carried out by two adult social care inspectors.

We did not request a Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we reviewed information we held about the service including notifications. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted the local authority contracts and safeguarding teams and used the information they provided when planning our inspection.

We spoke with nine people and eight relatives. We also spoke with the regional manager, interim manager, three senior care workers and six care workers [days] and two senior care workers and four care workers [nights], a laundry assistant, cook, activities coordinator and maintenance staff member. We also spoke with a medicines optimisation pharmacist and two infection control nurses from the local NHS Trust.

We looked at seven care plans and three staff recruitment files. We also checked a variety of records relating to the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Riverside House. One person told us, "I feel absolutely safe here." A relative said, "I feel they are safe. I can go away on holiday without worrying."

Safeguarding procedures were in place and staff told us they were aware of the procedures to follow. One staff member said, "There is whistleblowing information in the lift and posters displayed around the place about it." A relative told us they had reported a safeguarding concern and said this had been managed very well by the regional manager.

We found that on one occasion procedures had not been followed correctly by staff. One member of staff told us that another staff member had raised concerns with them about the conduct of a care worker. The staff member had advised them to report these concerns to the manager.

We found that neither staff had reported the concerns which meant the manager was unaware of the issues. We passed this information to the manager and regional manager on the first day of our inspection. On our second visit we found action taken regarding this concern was not sufficiently robust. We spoke with the manager and regional manager about this who told us these concerns would be addressed, and staff reminded of the procedures to follow.

We looked at medicines management. There was an ongoing safeguarding issue regarding medicines management which the provider was investigating.
We identified some medicines recording issues. One person whose medicines administration records we viewed was prescribed Warfarin which is a blood thinning medicine. Some of the recording on the MAR was confusing and we noted that a member of staff had written information about the person's Warfarin dosage on a post-it-note.

Another person was prescribed rescue medicines. These are medicines which are prescribed in case the person's medical condition worsened. Written information about when and how these should be administered was not clear. Charts used to record the administration of a medicine via a transdermal patch did not always evidence that these had been applied as per the manufacturer's guidance. We looked at the most recent audit dated 6 March 2018. This was scored at 86% and the manager had recorded "Fail."

A third person had 'homely medicines' in an unlocked drawer in their room. These were not listed in their care plan or documented on the 'homely medicines' list which the GP had authorised. A homely medicine is a non-prescription medicine. They can be used for the short-term management of minor, self-limiting conditions such as a cold or occasional pain.

Several people self-administered their own medicines. We visited one person in their room. They told us that they did not have a key to lock their drawers where their medicines were stored. A key was provided by the end of our inspection.

We spoke with the manager and regional manager about these issues. The regional manager also contacted the medicines optimisation team for support. We emailed the medicines optimisation pharmacist following our inspection who told us that they had spoken with the manager and regional manager about the medicines issues and had arranged to revisit the home in a month to carry out a more in-depth review of their systems and records. Individual risks to people had been assessed, but care records were not all up to date or evaluated regularly and we found conflicting information relating to risks.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

A record of accidents and incidents was maintained, and a falls analysis was carried out. This had identified a peak in falls due to one person's health condition. Action was taken and additional support was provided. This resulted in a reduction in falls and injuries to this person.

We observed there were staff members visible and available around the home during the inspection, but we received mixed views about staffing. Some people told us they thought there were suitable number of staff. A relative told us, "Things have turned around. There never used to be much reaction [to call bells] but now three or four staff turn up." Two people told us however, "They're always late," "It depends on whether the staff have time to [help me] have a shower," "They woke [name of relative] up at midnight to give her her tablets because a member of staff has been doing upstairs and downstairs" and "I would like to get up earlier – today, I didn't get out of bed until 11…They keep on telling me there is other people."

Some staff also told us that staffing levels and deployment could be improved. They said that more direction from senior staff would be appreciated. We contacted night staff by phone. We spoke with one staff member who asked us to phone back at 11:45pm because they were still administering medicines. They explained that sometimes there was only one member of staff who was able to administer medicines. We discussed this issue with the manager who told us that this had been addressed and there were now always two senior care staff on duty.

Most staff on night duty had commenced employment within the past three months. Some staff told us that this could be difficult because new staff did not always know the routines. Some night staff informed us that staff deployment could be improved and they did not always have time to give people drinks in the morning after they had assisted people to get up. In addition, several staff told us that they considered that there was an expectation by day staff to get people up in the morning.
We passed this information to the manager for their information. The manager advised us that staffing was in line with the dependency tool they completed on a regular basis. This is a tool which takes into account the level of care people need and staffing can be provided accordingly. From our observations and discussions with staff the issue appeared more to do with organisation and deployment than numbers of staff available.

We recommend the provider keeps staff deployment and skill mix under review due to the mixed feedback we received.

We checked staff recruitment records and found safe recruitment procedures had been followed including checks of identity, and references. Checks were also carried out by the Disclosure and Barring Service [DBS]. The DBS checks the suitability of staff to work with people who may be vulnerable, helping employers to make safer recruitment decisions.

We spent time looking around the premises. There were some malodours around the home especially on

the first floor. These had reduced by our third visit. Staff had access to and used personal protective equipment such as gloves and aprons. There was a sluice room for the disposal of bodily waste and the cleaning of continence equipment. This was clean and well maintained. There had been a recent diarrhoea and vomiting outbreak. We spoke with two infection control practitioners from the local NHS Trust. They said that the correct actions had been taken during the outbreak. They also told us that the home's infection control champion had attended one of the four 'link' meetings organised by the local NHS Trust during the previous 12 months. This helped staff to remain up to date with current best practice.

We checked maintenance records and found checks took place on a regular basis and records were well maintained. Checks carried out included electrical and gas safety, window restrictors and pull cords and fire safety equipment including alarms and equipment. A Legionella risk assessment was in place. Training had been provided for staff relating to the safe use and storage of oxygen.

Requires Improvement

Is the service effective?

Our findings

We joined people at lunch time and observed most people enjoying their meal. We asked people about the meals, comments included, "The food is fine" and "The food, we better not discuss the food, it's not very good." Another person said, "I am perfectly happy with the food," and a relative told us, "The food is good, they [name of relative] never leave anything."

A feedback book was kept in the dining room to record people's comments about the meals. We read that most of the feedback was positive. Comments included, "Beef and dumplings was very nice – beef was so soft," "Lovely Yorkies [Yorkshire puddings]" and "Enjoyed the cake and custard afterwards." This helped the catering staff to monitor the satisfaction with meals provided.

Staff supported people with eating and drinking. They gently encouraged people who were reluctant to eat. One staff member said, "I know you said you weren't hungry, but would you like a sandwich?" They brought the person two choices and they said, "Oh yes, I think I could manage that." The staff member asked before placing the sandwich in the person's hand which they then ate unaided. People were regularly offered top up drinks through the meal and we saw a selection of drinks and snacks including fresh fruit being offered regularly throughout the day to people.

There were gaps in food and fluids records. Target fluid intake had been calculated to ensure people had enough to drink each day. There were gaps in records and also days when people appeared to have failed to achieve their target fluid intake. There was no record of action taken. We spoke with the manager and regional manager about this and we saw these records had improved by the third day of our inspection.

We read one person's care plan and noted that they required a special diet. There was no information however, about the food or drinks which should be limited or avoided. We spoke with the chef about this issue. She immediately downloaded a list of food and drink that were suitable for the person to have to add to the person's care plan so everyone was aware. Information relating to one person's dietary needs was conflicting. We noted that one document stated that their food needed to be pureed. Another document stated that they required a Category E fork mashable diet.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

People's weights were monitored and there was evidence of specialist advice being sought where people had lost weight. The frequency of weights checks were increased to weekly where there were concerns about weight loss.

The Mental Capacity Act 2005 (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 in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Decisions taken in people's best interests where they lack capacity, should be recorded and decision specific. We viewed one person's mental capacity assessment and noted that this was not decision specific and multiple decisions were included on the same assessment. This stated, "The decisions to be made are for care planning which includes taking photographs, sharing information, handling mail and money."

One person had a sensor mat in their room. The person said, "They come and check on it, but I didn't know what it was [until you told me]. I try and avoid it and step around it." There was no evidence that the person had consented to the use of the sensor mat. We spoke with the manager about this issue and she told us that it had now been removed.

We heard staff ask people before providing care. One person told us however, "They ask me about what I want in a roundabout way – but they are very vague." We spoke with the regional manager who told us they had identified that records relating to MCA could be unclear and staff understanding of issues relating to capacity and consent was inconsistent. They showed us an email they had written highlighting these concerns following their own audit, and advised us they were reviewing care records and had plans in place to address this training need.

We recommend the provider closely monitors consistency of practice in the application of the MCA.

Staff told us there was sufficient ongoing training to enable them to carry out their role. However, several staff said that the home's induction training could have been improved and more support would have been appreciated. We saw that one staff member's induction record had not been fully completed. We gave the manager and regional manager this feedback to enable them to review the support in place for new staff.

Staff explained that there were two moving and handling coordinators who were involved in supporting staff with moving and handling issues and providing training. One member of staff said, "I have had moving and handling with [name of moving and handling coordinator]." We observed staff using appropriate techniques to support people to move or change position during our inspection.

There were gaps in the training matrix which was provided to us but we were sent a 'home development plan' contained details of training booked and the record demonstrated the provider was aware of where gaps were and had a plan in place to address these. We found records of staff supervision and appraisal and staff told us they mainly felt well supported.

People were supported with health needs. Care records showed people had access to a variety of health professionals including GP, nurses, dietician and chiropody. The Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] forms were in place and reviewed regularly.

There had been recent improvements to the environment which had been redecorated and new carpets fitted. The décor considered the principles of dementia friendly design such as visible signage to help people find their way around the home and using visual clues as to the purpose of a room, for example pictures of

food in the dining room. Handrails in corridors and bathrooms, and toilet seats were contrasting in colour to assist people to see them more easily.

Staff often stripped back beds to wash and then let them air for a period. We noted that the time beds were left unmade could be quite long including in one case up until 5pm. Some people told us they would prefer their bed to be made sooner, particularly if they had visitors or in case they wished to lie on their bed later in the day. We spoke with the manager and regional manager about this who said they would speak with staff about ensuring beds were made promptly once aired.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. Comments included, "They are very caring," "On the whole I'm treated like a Queen," "They are perfectly amicable," "The staff are nice here, they're not abusive or anything" "The staff are excellent, they have been tremendous" "The staff here are friendly," "The staff are lovely." We spoke with the hairdresser who told us that the care was "fantastic."

A relative told us they knew that staff loved their relation. They said, "That has made the process of moving into care so much easier for us as a family." We observed numerous kind and caring interactions between staff and people. One care worker said, "I'm trying to get him out of his shell and making conversation with him. He has just moved into the home."

We observed staff promoting the independence of people by offering assistance where necessary and asking if they would like help. Staff explained what they were doing including before transferring people from chair to a wheelchair. We observed one staff member gently stroking one person's arm and explaining each step to avoid startling them.

Another staff member told one person who had just come back from the hairdresser, "Don't you look glamorous?" they smiled broadly and said, "You've boosted my ego!"

People told us they were treated with respect. One person told us, "They are the most polite people I have ever met. They are the most considerate people I have ever met."
We observed a small number of staff using terminology that did not promote people's privacy and dignity. While it was recognised that staff did not mean to cause harm, referring to people as tasks or using negative terms to describe behaviour or distress is poor practice. We spoke with the manager and regional manager about this who told us they would address this through staff supervision.

One person told us that they did not like the positional chart and the information about them which was displayed on their bedroom wall and wardrobe door. They said, "I do not like that and that one there with the photograph of me – I think it should be inside the wardrobe." We also saw information displayed which was designed to remind staff of people's care needs but drew attention to private matters. We spoke with the manager about this who told us they would ensure information was located discreetly. We were contacted by the provider following the inspection and advised that staff had received training in promoting dignity and respect.

There was no one using an advocate at the time of our inspection but staff knew how to access this service if required. Advocates provide objective support to people to help them to make and communicate decisions.

Requires Improvement

Is the service responsive?

Our findings

Care plans were in place which recorded people's needs and preferences, likes and dislikes. They varied in detail and quality and a number of care plan evaluations were seen to be out of date. Information we read in staff handover books had not always been added to care records in a timely manner meaning information contained in them was sometimes out of date or inaccurate. The involvement of people and relatives in care planning was inconsistent. We spoke with one relative who told us they had been heavily involved in care planning and said, "Their [person's] records are incredible. It's all there and I can see it." Other people told us they had not been involved in or seen their care plans.

Preadmission assessments were carried out before people came to live at the home to ensure that staff could meet their needs. We viewed one person's preadmission assessment and noted that not all areas of the preadmission assessment were completed. These omissions meant that staff had to obtain the necessary information following the person's admission to the home. This could cause delays in receiving important information about the person's care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

People's routines and preferences were recorded in care plans, but we found numerous examples of these not being supported in practice. A relative told us, "They don't give the patients tea [in the morning…She [relative] has been up since 6.30am." We heard one person asking for some breakfast and they were told they would need to wait until 9.30am which was breakfast time and they would, "get it at the same time as everyone else."

We spoke with the person and they told us they slept badly and often woke early. They had been awake since 5.30 am and said they had not had anything to eat or drink. They told us, "I only want some tea and toast, not a Sunday dinner. I can't understand why they can't provide that." We asked the staff member whether people had a choice about when they had breakfast. They told us, "It depends how busy the kitchen staff are."

We also found people were not able to access a bath or shower when they wanted to. One person had been told when they moved into the home they could have a daily shower as per their routine at home. This had not been the case so they spoke with staff about this. They were told they would need to have a shower at 6am which they accepted as they were worried they may otherwise be unable to have a shower daily although they found this too early. We spoke with the manager about this who arranged for the time to be changed and explained there was no reason why this couldn't have been arranged to suit the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Person-centred care.

Two activities coordinators employed. We saw that people were supported to access the local community.

One staff member played the piano for one person which the individual enjoyed. One of the activities coordinators took round an ice cream trolley on the second day of our inspection. We saw that people enjoyed their ice creams. However, we did observe that some people spent long periods sitting in the lounge area with little staff interaction. We spoke with the regional manager about the provision of more meaningful activities. She told us that she was aware of this and they were looking into this.

We recommend that the provider reviews activities provision at the home to ensure that the activities provided meet people's needs.

A record of complaints was kept, which showed complaints had been addressed within the timescales outlined in the provider's policy. A relative told us, "I have made complaints and they have been resolved. Staff are consistent in their responses and are usually good at communicating about complaints."

There was no one receiving end of life care during the inspection. Support was available from district nurses to support people to end their lives in the home if they wished to do so. End of life wishes were discussed with people and recorded in their records where they were happy to share this information.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was on planned leave of several months and there had been an unsettled period due to a new manager coming into post to cover then leaving and another one being appointed in quick succession. We spoke with the regional manager about this who explained this had unsettled the service for a short period of time but they had been keen to provide a replacement in the absence of the registered manager. People and staff also reported this had been unsettling although some felt things were improving.

We received mixed feedback about the management of the service from people, relatives and staff. Comments included, "[Name of manager] is absolutely great," "They are better since [name of manager] came" and "It's as good as anywhere – I can't fault it." However, other people and staff commented, "Nothing gets done with [name of manager]," "I think they try, but don't always succeed," "I would rate it as requires improvement" and "I think it's badly organised" and "I would rate it as requires improvement, but it has a lot to be said for it."

Staff told us they did not feel the service was always well organised and said they lacked direction. Comments included, "The seniors sit in the office – all they do is care plans…We have to run the floor," "Seniors don't lead the floor" and "Seniors just sit in the office together…They just think their job is care plans and medicines." Two people also commented that more organisation was required. Comments included, "This is absolute chaos" and "It has been pretty chaotic here – it's not the same." Staff also told us they thought the manager should be more visible in the home.

Communication systems at the home were not always effective. Staff used a number of communication records to pass on important information. These included a diary, senior communication book, carers' communication book and handover records. These multiple communication records were sometimes confusing since certain information differed in each of the records. In addition, it was not always clear whether certain actions had been completed.

Some staff told us that the handover period was not always effective. There was a 15 minute crossover period for staff coming onto duty. Several staff told us that certain staff turned up late and therefore missed the handover. Comments included, "We didn't know [name] needed one to one" and "We thought that [name] was on a pureed diet, but actually they are on a category E diet. We wouldn't have known this until I went through their care plan."

We viewed handover sheets which were used during staff handovers. Comments were often vague such as 'settled day' or 'no concerns.' There were no details of people's needs, resuscitation status, monitoring requirements, or DoLS. This information would be useful for new staff or agency and help ensure staff knew people's needs such as their dietary requirements. We spoke with the manager about this who agreed it would be useful to add standard information.

We found shortfalls in the maintenance of records relating to people including medicines, nutritional needs and risks, and care plans.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

Audits were carried out including medicines, infection control and hand hygiene. There were feedback mechanisms in place for people, relatives, staff and visiting professionals to give their views on the quality of the service.

Visits by the owners of the service took place on a regular basis, including at week-ends. The regional manager told us they felt well supported by the new provider who had made a number of changes and improvements to the environment.

One relative told us there were some very good staff and hoped they would stay. They said, "Are they being rewarded and praised? We don't want to lose them, we want a culture of praise." Some staff told us they felt valued and that they liked some of the initiatives which had been introduced, "We get free meals" and "They do an employee of the month scheme and we get a £50 Asda voucher."

Most staff told us they enjoyed working at the home. Comments included, "I love it," "Everything us great – I have settled in fine. If I need any help," and "Morale is alright."

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 Regulation 9 HSCA RA Regulations 2014: Person-centred care Care and treatment was not always designed and delivered in a way which met people's individual needs and preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014: Good governance An effective system to monitor and mitigate risks relating to the health, safety and welfare of people was not in place. Records relating to the care and treatment of each person using the service were not always accurate or up to date. Regulation 17 (2) (b) (c)