Countrywide Care Homes Limited

Manor Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 23 and 31 August 2016 and was unannounced on the first day. The service provides accommodation and nursing care for up to 75 people, some of whom may be living with dementia. There were 59 people living at the home at the time of the inspection.

There was no registered manager in post, as the previous manager had left and a peripatetic manager was temporarily in place. The peripatetic manager had applied to be the registered manager until a new manager could be appointed. 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.

Manor Park Care Home was previously inspected in March 2016 and there were five breaches in the regulations. We found improvements had been made, although we identified continued breaches in two of the five beaches highlighted at the last inspection and a further breach of regulation. Our concerns were in relation to the general nursing unit.

Staff had an understanding of the safeguarding and whistleblowing procedures to follow to ensure people were protected from harm.

Risk assessments had improved although were still lacking in detail in some people's care records.

Staffing levels on the nursing unit were at times insufficient to meet people's needs, which was an ongoing concern from previous inspections. Continuity of nursing staff was poor, as was communication between shifts.

Systems for managing medicines had improved since the last inspection; medicines were stored correctly and there were more thorough audits. However, not all nursing staff were confident in the recording of medicines on electronic records, which meant there was potential for errors to be made.

Improvements had been made to ensure the temperature in some parts of the home was comfortable for people, although there was a communal area in the dementia unit that was too warm. There were plans in place to address this.

Training had improved to ensure staff felt supported to gain relevant skills and competencies. Staff had a basic understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards which affected people's care. However, not all authorisations were in place or renewed for people.

Staff had regular staff meetings and there were improving supervision meetings to discuss their role. However, handover documentation lacked detail and there was a lack of clear direction for staff on the

nursing unit, particularly where agency staff were deployed, for them to understand the requirements of their role each shift.

Attention to nutrition and hydration had been given priority to ensure people's good health, especially on the nursing unit. People mostly enjoyed the food and they had many opportunities to drink.
Staff consistently displayed a kind and caring attitude and they were patient and friendly in their approach to assisting people. Staff showed respect for people's dignity and there was evidence this was continually monitored and reinforced by managers.

Care documentation had improved since the last inspection, although this still lacked detail and accuracy. Where people were nursed in bed, there was a clear reason and this was regularly reviewed and monitored.

Quality assurance systems were more robust to address key aspects of people's care and support, and address concerns identified at the previous inspection, although there were still weaknesses in the leadership on the general nursing unit.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that although some improvements had been made, there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing was not consistent to meet people's needs on the nursing unit.

Information in some people's risk assessments was conflicting.

Premises were well maintained, but too warm in one communal area on the dementia unit.

Medicines were managed safely, but not all staff were confident in how to record these on the computer system.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was in place to enable staff to carry out their roles effectively, but handover documentation was sparse and lacked detail for staff to know the risks on each shift, particularly on the nursing unit.

Not all DoLS authorisations were in place or followed up.

People's nutrition and hydration needs were met and monitored appropriately.

Is the service caring?

Good

The service was caring.

Staff demonstrated an inclusive, sensitive, kind and patient approach to their caring role.

People's dignity and privacy was respected throughout and staff recognised the importance of this.

Staff promoted people's independence and gave appropriate, enabling support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans held inconsistent information about people's care, although improvements had been made and further work was being done to develop these.

Resources for people to engage with were more readily available and staff enabled people to be purposefully involved in activity.

There was a system for recording and responding to complaints and people felt confident to approach the staff and managers with any concerns.

Is the service well-led?

Inadequate

The service was not well led.

The service had no registered manager in place, although the peripatetic manager was visible in the service and staff reported improved confidence in the running of the home.

Systems and processes for monitoring the quality of the provision were improving, but there was no clear direction, ownership or clinical oversight of practise on the nursing unit.

Some breaches in the regulations identified at the previous inspection had been addressed, but some breaches remained at this inspection, with continuing concerns about the nursing unit.

Manor Park Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 31 August 2016 and was unannounced on the first day.

There were three adult social care inspectors. We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed posters to inform people and visitors that we were inspecting the service and inviting them to share their views.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with 15 people, four care staff, the cook, the peripatetic manager, the quality manager and the regional manager as well as five visitors.

We looked at care documentation for six people, four recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said: "Oh aye, I'm safe here. They look after me these two (indicating towards staff members)". Another person said: "Well put it like this, if I lived on my own who would I have looking out for me? So I'm safer in here by far". Another person said: "Yes I do feel safe, why wouldn't I? They [the staff] keep asking me if I'm alright". One person said: "I do feel safe-ish but I don't suppose it's safe if there aren't enough of them [staff]". "They could certainly do with more staff, there are never enough of them and it's not fair. Don't get me wrong, the staff are lovely, but they can't be in two places at once". Another person said: "I do like this place, but what would make it better is if there were more staff so I didn't have to wait as long".

Relatives we spoke with said they thought their family members were safe, although some relatives said they did not think there were enough staff. One relative on the nursing unit said: "Sometimes we come and there's no staff in the lounge and people might need the toilet or something. Once when we came, we couldn't find any staff for ages". Another relative said: "There's not always enough staff, it's the same in all nursing homes, but there should be more. There's a lot of needy people here". Another relative said: "We have been in the lounge sometimes for 30 to 45 minutes and seen no staff".

Staffing levels on the first day of our inspection, were not sufficient to meet people's needs in a timely way on the nursing unit. One member of staff had called in sick and the peripatetic manager had been unable to cover their place on the shift at short notice. We saw the dependency tool which assessed people's needs in relation the numbers of staff required and the management team said staffing levels were sufficient. However, we saw on some occasions people had to wait for staff attention because staff were attending to others. For example, staff response times to people's call bells were delayed for up to 10 minutes. One person waited 25 minutes to be assisted from their chair to their wheelchair to go out with their family. We saw during the lunch service one person had not been served their meal. The inspector brought this to staff's attention and staff were unsure whether the person had been given a meal, then when they checked with a colleague they told us "They [person] have been missed" and located the meal in the food trolley. Staff we spoke with told us there were eight people who needed one to one support at mealtime on the nursing unit and we saw some people had to wait to be assisted. On the second day of the inspection, which was announced, staffing levels were improved and one member of staff was supernumerary.

Staff we spoke with on the nursing unit said there were not always enough staff to meet people's needs in a timely way. One member of staff said that when the nurse was giving medication and care staff were assisting people to get up or taking their breaks, communal areas, such as the lounge were not staffed. Staff told us all but two people needed two staff at a time to assist with their care, which meant other people had to wait.

Staff recruitment procedures were robust and all necessary checks made to ensure staff were thoroughly vetted before working with people. The peripatetic manager told us there had been high levels of staff sickness and the service had difficulty recruiting qualified nurses. We found agency staff had been employed frequently, particularly to provide nursing care and this resulted in weaknesses in oversight of clinical

practice, with no clear or consistent lines of responsibility for people's health care.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 18.

Staff confidently described the signs of possible abuse and told us they knew what to do to report any concerns about people's well-being to managers and relevant safeguarding authorities. Staff understood the whistleblowing procedure. One member of staff said: "I have always known I can report any poor practice and I would go straight to the manager. If they didn't do anything about it I'd go higher". Staff knew where to locate contact numbers for reporting safeguarding concerns.
However, there had been a safeguarding concern regarding lack of monitoring of one person's care on the nursing unit. This was not initially notified to us by the home, although the peripatetic manager had begun to establish what had given rise to the concerns and taken steps to improve recording and reporting of people's care moving forward.

Staff were observant of people's safety. For example, one person on the dementia unit was walking into a table and staff encouraged them to move on, reminding them to take care not to fall. We spoke with staff on the nursing unit and they knew who was at risk of choking and described the person's mealtime regime. Risk assessments we saw for individual people were in place but lacked detail. For example, there was no explanation of what risk rating scores meant or how they had been worked out.
We found not all staff had read people's individual risks on their care records. For example, prior to the inspection there had been an injury to a person as a result of poor moving and handling where staff were unaware of the risks to the individual. This had been followed up by the peripatetic manager and training needs had been identified.

We saw staff supported people in moving and handling them and this was done patiently and safely. Staff we spoke with told us they had completed moving and handling training and been shown how to use equipment. We saw certificates for moving and handling in staff files.

Accidents and incidents were recorded and analysed, but the recording still lacked detail and some parts of accident forms were not always filled in. We discussed this with the peripatetic manager who said they were aware this was not being done correctly. As a result they had produced a protocol to be kept in the accident book and to be followed after accidents. We saw the protocol included detailed instructions for staff about how to complete accident forms and follow up investigations. In addition, a post falls pathway checklist had been introduced.

We saw some action had been taken to address the variable temperature in the home and in the medication storage rooms there was air conditioning. Cooling fans were in use and staff made sure there were windows opened wherever possible. The weather was warm during the inspection and we saw staff frequently checked whether people felt comfortable. We found a particularly warm corridor in the dementia unit and the peripatetic manager told us there were plans in place to address this. People had plenty of regular drinks to keep them hydrated and we saw staff offered cold and hot drinks at regular intervals. In addition, drinks and glasses were available to and on view for people to access or indicate if they needed to.

For those people who were immobile and remained in bed, we saw evidence of frequent support and position changes, which were recorded. Staff told us there were currently no people with pressure related skin damage in the home. The peripatetic manager told us she discussed critical areas of people's care, such as reasons for them being in bed, and pressure care, at regular meetings with senior staff from each unit.

We observed people being assisted with medicines. Staff administering medicines wore red tabards to demonstrate they should not be disturbed during this process. We saw staff gave support patiently and explained what each medicine was for, and checked whether people required any pain relief.

At the last inspection we had concerns about the storage of medicines as the treatment rooms were too hot to store medicines safely which may alter their effectiveness. This matter had been addressed at this inspection with the addition of air conditioning. We saw there were appropriate systems and recording for the disposal of medicines.

The medication administration records (MARs) we saw were held on the computer system. The peripatetic manager told us staff all received training in how to record medicines in this way. However we spoke with two members of staff who said not all of them were confident to use this system and it was difficult to identify when some medicines that did not need to be given daily, were last given. Not all agency nurses had received the training needed to navigate the system safely. This meant there was potential for medicines errors to be made.

We saw staff wore personal protective equipment (PPE) such as gloves and disposable aprons as required and we saw these were in good supply throughout the home. The home was visibly clean, although some chairs were stained and dirty in communal areas. Staff followed safe infection control practices and we found no significant malodours in the home, although in some areas odours lingered where there were fittings such as carpets in need of replacement. The peripatetic manager told us there was some refurbishment taking place to replace worn items and we saw a skip outside, demonstrating some old furnishings and fittings had been thrown away.

Requires Improvement

Is the service effective?

Our findings

Some people and some relatives we spoke with told us staff were capable in their roles. One person said: "Oh they know what they're doing". Another person said: "They are good you know, good at what they do, some of them deserve a medal". One relative said: "I have no problem with the way the staff care for [my family member], they know how to meet their needs and they're always in doing some training or another". Another relative said: "They know [my family member] really well and that's what helps; it's the little things they know that make the biggest difference".

All staff we spoke with said opportunities for training had improved and whilst some was done via e-learning, some training was face to face. Staff spoke about a "dementia bus" that had provided training in which staff experienced simulated experiences to help them understand the experiences of people who are living with a diagnosis of dementia. Staff told us their shifts were worked around training opportunities so all staff had the chance to complete the training relevant to their role. One member of staff we spoke with said: "Can speak with them [managers] and ask for training if you want". Another member of staff said: "Oh, training is so much better than before, I feel I get the support I need".

The training matrix showed where training was undertaken and where staff were booked on to courses. We saw recent training certificates in the four staff files we looked at. The peripatetic manager told us they had a clear overview of people's training needs and strongly encouraged staff to undertake opportunities provided.

One member of staff told us they were new in post since the last inspection. They told us they had undertaken a thorough induction and felt prepared for their role. The peripatetic manager told us they monitored staff practice through being present and visible in the home and they carried out spot checks including night visits. Where poor practice had been identified we saw appropriate action had been taken, either through improved training or disciplinary action.

The peripatetic manager told us they had identified supervision meetings and appraisals for staff had not been as regular or consistent as they should have been. However, a plan was in place and a line management supervision structure was being implemented so meetings took place every other month in line with company policy. Staff we spoke with said they felt much more supported to do their job than at the last inspection. We saw some supervision notes which showed meetings with staff had not taken place for some months, but more recent ones we reviewed showed notes associated with staff's job description, that acknowledged any issues with specific duties, looked at any training needs and discussed the culture in the home. The peripatetic manager and the quality manager told us they were working hard with the staff team to develop a more positive culture and recognised this underpinned the way in which staff worked together.

Staff told us they worked well together as a team and decided between them how to share the tasks each shift. However, we saw the handover documentation between shifts lacked detail, particularly on the nursing unit and nursing we spoke with said there was not enough information about key risks for them to know the priorities for people's care. For example, the handover document contained a list of people's

names and room numbers, but very little else to highlight key areas, such as individual risks and pertinent health information.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had increased their awareness of the legislation that affected people in relation to their mental capacity. Staff told us training for this had improved and we saw recent training evidence and future training scheduled.

We discussed with the peripatetic manager the people who were subject to DoLS. We looked at the file of DoLS applications for people whose mental capacity was considered and we saw not all authorisations were in place. The peripatetic manager told us DoLS applications were still to be made and some had expired and had to be renewed for some people in the home and this was work in progress. However, although there was some progress, this was more systematic than on the basis of need for individuals and there was no clear evidence of any follow ups.

In some people's care records we saw evidence of mental capacity assessments and best interest discussions having taken place, where it was agreed a person may lack capacity to make a specific decision about their care. However, these were not consistently in place where required.

This illustrated the provider was in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 13.

Staff consulted with people within their daily activities and encouraged them to make their own choices. We saw staff asked people about any support they might need or want before assisting them with care tasks. When people were supported with moving and handling, staff asked their permission and then gave clear explanations and reassurance. Care records highlighted people's preferences and how they should be supported to make choices for themselves.

The dining experience for people was well organised, calm and relaxed overall, with the exception of the nursing unit on the first day of the inspection, where low staffing levels resulted in staff being under pressure. People were asked about meal content, portion size and where they preferred to eat. Condiments were available and people had a choice of drinks with their meals.

People told us they enjoyed the meals on the whole, although not everyone we spoke with was complimentary. One person said: "Oh the food here is lovely, that's what I enjoy the most". Another person said: "We get plenty to eat, that's for sure". Another person said: "The food here, well it's not bad" and another person said: "The meals are nowt special". We heard staff gave people choices of what they might like and explained what was on the menu.

We observed where people who were living with dementia and needed support to eat and drink, staff gave

gentle reminders and encouragement. Plate guards and aprons were offered to people to support their dignity and independence at mealtimes. Where some people were confused about the cutlery they needed or which meal was theirs, staff supported them. Choices and alternative meals were offered to people patiently and staff gave people chance to make their choices in their own time. On the nursing unit we saw one person was assisted to eat a pureed diet and the member of staff sat and patiently explained what food was on the fork each time.
Relatives we spoke with told us they sometimes visited at meal times and they thought the food was of a good enough standard. One relative said their family member had put on weight since they came to the home and there was 'always plenty of drinks, meals and snacks'. Another relative said staff made the effort to encourage their family member to drink regularly. We saw staff brought drinks to people and sat with them to encourage them to drink. During a game of bingo, staff came round with jugs of juice and poured drinks for people to have as they played.

We saw concerns around diet and nutrition at the last inspection had been addressed and there was improved communication about people's dietary needs. Drinks and snacks were regularly offered and where people stayed in their rooms, drinks were available and replenished regularly. During the warm weather of the inspection we saw ice creams were offered to residents and staff. We spoke with the cook who told us the meals provision had 'much improved' and we saw individual requirements for each unit were written on a board in the kitchen. The peripatetic manager told us they were in the process of developing a new menu, with people's choices and dietary needs considered. Specific information about individual diets was displayed in food serving areas. People's weight was monitored and where there were concerned referrals were made to dieticians. Where dieticians had been consulted, information was well recorded in people's files.

There was evidence in people's care records where other professionals involved in people's care and health. People and their relatives told us staff sought medical help when this was needed.

We noted improvements were in progress to the environment for people who were living with dementia. The décor was being upgraded and there was improved signage to help people to orientate. The peripatetic manager told us work was continuing to this effect and we saw there was work in progress.

Good

Is the service caring?

Our findings

People said they felt well cared for. One person said: "The staff are lovely, they take time to make sure I am alright". Another person said: "I don't feel like I'm a nuisance and I know they care". Another person said: "I'm a prankster, I like a laugh and a joke with them [the staff] and they're lovely, I don't have any worries". One person told us staff attitude was caring and said: "They're all different, the staff, I like some more than others, but that's life. They do care I can tell, even when they're rushing round". Relatives we spoke with said they had no concerns about staff attitude. One relative said: "They're [the staff are] all lovely, well-meaning and kind. They have the right approach to care". Another relative said: "Anything they do is done in a lovely way for people".

Staff we spoke with told us they cared about their role. One member of staff said the best part of their job was 'the residents'. Some care staff had worked at the home for a number of years and said they thought people received good care.

We saw staff spoke with people in caring, respectful ways and there was evidence of good relationships between people and staff. For example, we saw one person affectionately told staff: "I do love you" and staff responded warmly with friendly gestures and facial expression. We saw another member of staff stroked a person's hand in reassurance. Staff danced when people spontaneously wanted to and responded appropriately to hugs.

Staff took time to notice people and ask how they were feeling, then actively listened to what people had to say. Staff actively acknowledged people with smiles and eye contact as they went about their tasks. We saw staff spoke directly with people, rather than about them in their presence. Where one person looked uncomfortable we saw a member of staff asked if they wanted a change of chair, or to rest in their room. The person asked for a cup of tea and we saw staff brought this and sat with them whilst they drank it.

Staff promoted people's independence in the daily routine. Where people remained in bed, staff understood the reasons why. Where people were able to get out of bed, but chose not to, staff offered opportunities for them to be included in what was taking place, although respected their choice not to.

Care records detailed a section for recording people's social, cultural and spiritual needs, although there was more emphasis on people's social information. We saw people's dignity and privacy was respected and there was a clear emphasis on this throughout all aspects of care and support. We saw there had been plenty of communication within the home about dignity and how to ensure people's care was appropriate, sensitive and respectful. There were two designated dignity champions within the staff team whose role was to promote dignity and challenge others where this could be improved. Staff knocked on people's doors before entering and ensured assistance for personal care was discreet. Where people's personal appearance was compromised through spillages, staff discreetly and sensitively offered support to change their clothing. Staff used respectful terminology when verbally discussing people, although entries in care records were not always as professional. For example an entry on one person's notes stated "[Person] is getting terrible with [their] temper". The peripatetic manager told us work was ongoing with individual staff to improve the

standard of recording and terminology in care records.

Confidentiality was respected and we found staff confirmed with the peripatetic manager before allowing inspectors to see care records. People's wishes for their end of life care were noted on some of the care records we looked at.

Requires Improvement

Is the service responsive?

Our findings

People told us care was responsive to their needs. One person said: "They [the staff] are good to me. I like it here, yeah". The person pointed out the names of individual staff. One person on the nursing unit said: "Well, they are good on the whole, but I should have had my bath today and they've been busy with someone else". One relative told us they visited often and had no concerns about the care. Another relative said care was not always individualised. For example, they told us their family member's fingernails were not attended to and this was something they [relatives] did when they came to visit.

On the nursing unit we noticed some people did not appear to be comfortably seated as their legs were sticking out with no footrest or support. We could not see any assessment for seating on people's individual care records and we asked the peripatetic manager to review people's seating needs and ensure their posture was comfortable and supportive.

We saw care was more person-centred than we had observed at the last inspection. For example, staff consulted with people individually about what they wanted, and how they would like to be supported. We heard staff ask people what they would like to do. For example, one member of staff asked a person if they would like a game of dominoes and we saw the maintenance staff made sure people had been given their newspapers. Staff conversations with people indicated they knew them well as they asked about their families and social histories.

We saw orientation boards were up to date with the correct date and weather and on one unit this sparked some conversation between people and their relatives. There were some rummage boxes, containing items of interest for people to look through and we saw people took an interest in these. Rummage boxes can help people to remember things from the past and may be useful as a distraction technique, an activity or to stimulate conversation.

We looked at care records and found the detail in these had improved since the last inspection, although there was still information that conflicted and staff did not always update these accurately. For example, one person's care record stated they had no falls and were at 'no risk' of falls, yet we knew from accident records the person had recently fallen. In some records there were half finished sentences with missing information. Care records contained little or no reference to people's cultural or spiritual needs. There were some generic statements within people's care plans that lacked specific personal detail for staff to understand how to support a person in an individual meaningful way. The peripatetic manager told us they were reviewing these records individually, in detail and highlighting where improvements in the quality of information were needed. This was then being discussed with the staff involved in each person's care. We saw evidence the process of reviewing care records had begun.

The peripatetic manager told us staff were expected to record events on the computer notebooks as they happened, such as with what people had to eat or drink. We found that whilst details were added to people's care records, these were not always accurate. For example, we saw one person had only eaten half their meal, yet staff recorded this as 'ate full meal'. This meant people may not have received the necessary

support.

Staff we spoke with said they were increasing in confidence with inputting and locating information electronically, although there were varying levels of staff confidence and competence in using the system. The peripatetic manager told us training was available and scheduled for the staff who needed to improve their skills with computer care records. We found where nursing agency staff were used, those staff did not all have the necessary skills to use the system.

Care records contained details of people's personal preferences, likes, dislikes and hobbies. The peripatetic manager told us there was work in progress to develop a one-page profile with key information for staff to see at a glance. The peripatetic manager had created one about themselves to illustrate the information this could contain and it was displayed on the office door for staff to use as an example.

We found care records could be printed and shared with people and their relatives where appropriate, if required and we saw this happened in practice. One person's relatives told us they had been involved in their family member's' review of care and had a printed copy of the care record to look at. Relatives told us they felt involved in the running of the home and were kept up to date through relatives' and residents' meetings.

We saw a member of staff who was new to the activities role, organising group activities of baking and bingo. The baking activity sparked conversation about what people used to bake and what they wanted to bake that day. One person said "I always used to bake at weekends and it would be all gone in no time". Other people joined in the conversation and we saw staff tried to include as many people as possible. One person said they did not want to join in with the baking, but would happily eat what was made. During the bingo, staff gave appropriate support and set a pace that enabled all people joining in to keep up with the game. For other people not participating in a group activity we saw they spent long periods of time in their chairs and occasionally, although not consistently, staff attempted to interest them such as with a magazine.

People told us they felt able to complain if they needed to. One person said: "They sit up and take notice and I'm not afraid to speak my mind". Relatives said they knew there had been management changes and felt able to raise any concerns with staff or the manager. They told us their opinions mattered and they felt able to share these. However, one relative said they had raised concerns about staffing levels with the manager, 'but it made no difference'. We saw evidence in minutes of relatives' and residents' meetings that the complaints procedure had been discussed. Records showed complaints had been recorded and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

There had been changes to management since the last inspection; the previous manager was no longer in post and a peripatetic manager had been in place for five weeks prior to this inspection. They had applied to be the registered manager until a new manager could be appointed. Recruitment for a new manager was ongoing at the time of the inspection and the peripatetic manager told us they would continue as support once a new person had been appointed. Support for the running of the home was provided by the quality manager.

People told us they were aware of the new manager at the home and felt they were approachable to raise any concerns or discuss any aspect of their care. One person said: "There's a new boss, we see [them] around from time to time". Relatives told us they had been informed of the changes to the management of the home and they had been involved in relatives' and residents' meetings in which such changes had been discussed. Relatives we spoke with were aware of the previous inspection findings and the actions being taken to address any areas of concern. One relative told us: "Things are getting better, we have noticed". Another relative said: "There's a new manager from head office who seems to know what they're doing so we feel reassured things will keep on improving".

Staff we spoke with said they felt the running of the home had improved and things 'felt much better'. One member of staff said they felt the new manager had 'got to grips' with the issues affecting the home and the home was much better than at the time of the previous inspection with regard to staff morale and support. One member of staff who had been appointed since the last inspection said they had read the previous report and considered there had been many improvements since that time. Another member of staff who had been in post since before the last inspection said: "It's got better; training has improved, there are some really good new starters [staff]". Another member of staff said "[manager] is fab, feel supported".

We saw maintenance records were maintained in relation to premises and equipment, such as fire equipment, lifting equipment, gas, electricity, and water supply. We saw these were kept up to date by the maintenance staff to ensure people's safety. We saw the maintenance staff actively engaged in checking the premises were safe and suitable. Records relating to the care and treatment of people were not always completed accurately and there were gaps in some documentation. For example, although we had seen people given drinks, these were not always recorded.

The peripatetic manager and quality manager showed us the latest action plan in response to the last CQC inspection and to the recommendations made by a recent Clinical Commissioning Group (CCG) visit. This plan highlighted the issues, the action required, the staff responsible for completing the actions, the timescale and details of progress made. It was evident from our inspection findings some issues had been dealt with and others were in progress. The peripatetic manager said they were confident in the staff's willingness to help make the necessary improvements and they had an open door wherever possible for staff to speak with them. The peripatetic manager told us any improvements needed were highlighted to staff as expectations, not criticism. We saw the peripatetic manager and the quality manager were visible in the service and staff approached them with ease.

Audits had become more consistent and detailed and these identified strengths in the service and areas to improve. There was acknowledgement from the peripatetic manager and the quality manager that documentation throughout the home needed to be improved and this was accepted as a matter to be addressed, particularly care documentation which was being given priority. We saw evidence of manager walk rounds, night visits and meetings held in numerous ways and with staff, people and relatives. Where meetings were held, we saw these led to documented actions. We saw improved audits in relation to premises, equipment, medication, staff support and practise. Where concerns had been identified we saw action had been taken or was in progress and the peripatetic manager highlighted these as opportunities for lessons learned, to share with staff.

We found, however, continued concerns about the oversight of practise on the nursing unit, particularly regarding clinical risks to people and how these were being monitored and managed. Nursing staff were not consistent and the handover from shift to shift lacked detail for nurses to understand the level of risk and prioritise their work accordingly. Weaknesses in communication as a result of frequent agency nurses and no consistent designated person in charge, meant there was no sense of ownership or responsibility for the unit. As a result, monitoring of people's care was not sufficiently robust and meant there was potential for issues to be overlooked, such as with the recent safeguarding concern. We found there was insufficient clarity in respect of staff roles and responsibilities on this unit and this impacted upon the quality of service delivery in this area.

This illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 17.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all valid DoLS authorisations were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was no clinical leadership or oversight of practise on the nursing unit.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were insufficient to meet people's needs on the nursing unit.