Country Court Care Homes 4 Limited

Heartlands

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 10 and 11 November 2016. The provider for this service has changed since the last inspection and a new provider is now in place. Therefore, this will be the service's first ratings inspection under the new provider.

Heartlands is a care home which provides accommodation and nursing care for up to 36 older people. At the time of our inspection 35 people were resident at the home.

Heartlands is currently undergoing a major modernisation project. Half the home has been demolished and was is the process of being rebuilt. When the first part of the project has been completed, people living at the home will be relocated into the new build and the remaining section of the home will also be demolished and rebuilt.

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

We found mental capacity assessments completed for people who lacked the mental capacity to consent to their care and welfare, were not decision based. There were issues with consent being sought solely from family members who were not authorised to do so. Best interests meetings were not consistently recording the decisions required to be made, how the decision was agreed and who was involved in best interest discussions. Staff told us if a person could not consent, they would ask a family member to consent for the person. This does not follow the principles of the Mental Capacity Act 2005 and required improvement.

The provider had taken suitable action when they had identified people who did not have capacity to consent to their care or treatment. Applications had been made to authorise restrictions on people's liberty in their best interests. However, staff members were not always clear on what could constitute a restriction on somebody's liberty and required improvement.

Staff felt the change over from the previous provider to the new provider had been smooth. We were told by staff, people living at the home and visitors that the registered manager was approachable and everyone was complimentary about the way they were managing the home through the rebuilding project. There were audit systems in place to monitor the quality of the care people received, however they were not always effective at identifying some of the issues we had raised with the registered manager and required some improvement.

People and relatives told us they felt the home was a safe environment for people to live in. Staff spoken with could confidently identify the different types of abuse and explained how they would report abuse. People were protected from the risk of harm and abuse because staff knew what to do and were effectively

supported by the provider's policies and processes. Risks to people were being managed although there was some inconsistency with risk assessments being completed. However, staff identified risks people faced and explained how those risks should be managed. Staff had a good understanding of the risks and the action that was required. The plans and risk assessments were reviewed and updated on a monthly basis and/or when people's needs changed.

Staffing levels had been reviewed because the size of the home had been significantly reduced due to the modernisation project. Everyone spoken with felt there was a requirement to increase care and domestic staffing levels and maintain current nursing staff levels. We saw all staff were busy but were available to provide support to people when needed. This included support for people to eat, drink and move around the home safely. Requests for assistance from people were responded to promptly. The provider's recruitment processes ensured suitable staff were recruited.

People received appropriate support to take their prescribed medicines and nursing staff maintained accurate records of the medicine they administered to people. Medicines were stored securely and consistently at the recommended temperature given by the manufacturer and were safely disposed of when no longer required.

People were supported by suitably trained staff that told us they received training and support which provided them with the knowledge and skills they needed to do their job effectively. People and relatives felt staff were knowledgeable on how to support people effectively and that staff possessed the necessary skills.

People were able to choose what they ate and drank and were supported to maintain a healthy diet with input from dietary specialists. People were supported to receive care and support from a variety of healthcare professionals and received appropriate treatment if they were unwell.

People's records contained care records relating to their specific needs and there was evidence that the plans were updated when people's needs changed. People and relatives told us they were involved in developing and reviewing care records. People were supported by caring and kind staff who demonstrated a positive regard for the people they were supporting. Staff understood how to seek consent from people and how to involve people in their care. We saw staff interacting with people in a friendly and respectful way and that staff respected people's choices and privacy.

People were supported to lead active lives and, where appropriate, to access the local community. In addition, people were supported by staff that provided activities on a daily basis. People and relatives told us they had no complaints but were confident it they did, that the registered manager would deal with it effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People told us they felt safe. People were safeguarded from the risk of harm because staff was able to recognise abuse and knew the appropriate action to take.

Risks to people's health and safety had been identified and were known to the staff. This ensured people received safe care and support.

People were supported by suitably recruited staff.

People were supported by staff to take their medicines as prescribed by their GP.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were arrangements in place to ensure that decisions were made in people's best interest. However, the process for assessing a person's capacity to make a decision required improvement. Staff sought people's consent before they provided care and support.

People were supported by suitably trained staff.

People enjoyed the meals provided and were given snacks and drinks at regular intervals, or when requested. People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration.

People received support from healthcare professionals to maintain their health and wellbeing when it was required.

Is the service caring?

Good

The service was caring.

People were supported by staff that was kind and respectful.

People's independence was promoted as much as possible and staff supported people to make choices about the care they received.

People were supported to maintain relationships with their friends and relatives.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People received care and support that was individualised to their needs, because staff was aware of people's individual needs.

People were engaged in group or individual social activities to prevent isolation.

People knew how to raise concerns and were confident the provider would address the concerns in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to assess and monitor the quality and safety of the service, although they were not consistently effective and required some improvement.

People, relatives and staff felt the registered manager was approachable.

People were happy with the care and support they received.

Heartlands

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 unannounced inspection took place on 10 November 2016 with a return announced visit on the 11 November. The inspection team consisted of one inspector, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health difficulties.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us and any other information we had about the service to plan the areas we wanted to focus our inspection on. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

During our inspection we spoke with 10 people, 12 relatives, the registered manager and seven staff that included care, nursing, kitchen and domestic staff. Because some people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to six people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included; three staff recruitment and

training files. This was to check suitable staff were recruited, trained and supported, to deliver care to meet each person's individual needs. We also looked at records relating to the management of the service and a selection of the provider's policies and procedures, to ensure people received a quality service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us the home provided a safe environment for people to live in. One person said, "I certainly feel safe, there are always carers around." Another person told us, "I feel very safe living here." A relative said, "I've never seen any practice that would give me a cause to be concerned." There were a number of people living at the home who were not able to tell us about their experience. We saw that people looked relaxed and comfortable in the presence of staff and that staff acted in an appropriate manner to keep people safe. For example, safely using equipment to move and transfer people from a lounge chair to their wheelchair. Staff were able to explain to us in detail what could constitute abuse and how they would recognise the signs of distress in people. For example, one staff member told us, "We'd know by their actions, if the person pulled away and this was unusual for them." The Provider Information Return (PIR) stated staff had received safeguarding training and how staff should report a suspected safeguarding. We found that 35 of the 46 staff had received safeguarding training, with training sessions planned for those who were yet to receive the training. Staff we spoke with knew how to escalate concerns about people's safety to the provider and other external agencies for example, the local authority and Care Quality Commission. A staff member we spoke with told us, "Without hesitation, I'd tell the local authority or CQC if I needed to."

Risk assessments had been completed for people. We saw equipment such as pressure relieving mattresses and cushions were in use to support people who were at risk of developing skin damage. We found some identified risks to people were not consistently recorded. For example, we found there was no risk assessment in place for one person who was at risk of harm due to their behaviours. We saw the latest records had noted the person's behaviours as 'increasing over the last few months' but there were no earlier recordings in the previous months notes to indicate what the behaviours were or what impact this had on the person or those around them. We did speak with staff that supported the person and they were able to give us examples of how they kept the person safe and how they recognised when the person was becoming upset. We discussed this with the registered manager who told us they would review the person's care plan with a view to ensuring a risk assessment would be in place.

Other risks to people's welfare were managed effectively. For example, we saw that some people had been assessed as being at risk of weight loss. The provider had sought specialist advice and a range of preventive measures had been put in place which were understood and followed by staff. As a result, people's weight had stabilised.

Safety checks of the premises and equipment had been completed and were up to date although we found fire extinguishers had not been checked since February 2015. On reviewing the provider's Fire Risk assessment, we saw this had been identified and recorded the appropriate action to be taken. Staff explained what they would do in the event of an emergency. For example, what action to take in the event of a person choking. The provider safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

All the relatives and staff we spoke with told us they felt there was a need to recruit additional care and

domestic staff. People spoken with told us they received support when they needed it. One person said, "They [staff] respond promptly if I call for help." A relative told us, "The staff are so busy, they don't get a chance to just sit and talk to [person's name], they [staff] do their best but sometimes when we ask for assistance, we do have to wait because there might be an emergency they [staff] need to attend to first, I guess it can't be helped sometimes." Another relative said, "Sometimes they could do with extra staff because they [staff] are busy with other residents and tend to go in twos." A staff member said, "No, I don't think there is enough staff, there are lots of people here that require two to one support and that can leave just one person on the floor which means if someone in their room needs assistance, there could be a delay because you're not supposed to leave people unattended in the lounge areas." Another staff member told us, "It was better when there was four care staff that meant there was always at least one carer in the lounge at all times." We did bring the concerns relatives and staff had discussed with us about staffing levels to the attention of the registered manager. They explained to us how they deployed staff and how this was reviewed. At the time of the inspection, there was one nurse and three care staff on each floor available to attend to people's support needs. Although we found staff were constantly busy with limited time to sit and talk with people, we saw that alarm activations and requests for support were responded to by staff in a timely manner.

The provider's PIR stated, 'recruitment is based on our detailed policy and procedure which incorporates checking references, professional registers and the DBS checking process.' We saw the provider had a recruitment process in place to make sure they recruited staff with the correct skills and values. This included criminal checks through the Disclosure and Barring Service (DBS) and the checking of employment and character references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people.

People we spoke with told us they had no concerns about their medicines and confirmed they received their medicines on time and as prescribed by the doctor. One person told us, "I take lots of medicine; the nurse gives them to me." Another person said, "Nurse helps with my medicines, they give them to me and watch that I take them." We saw medicines at the home were stored in medicine trolleys and when the trolleys were not in use they were locked and kept securely in separate, air conditioned areas. The nurses were responsible for administering medicines and for auditing and completing the Medical Administration Records (MAR) sheets. The provider's PIR stated 'a weekly medication audit is completed which included observations, cross-referencing to care records, storage and audit trails.' We reviewed four people's MAR sheets and found there were people who required medicine to be given 'as and when'. We found protocols that provided guidance for staff when people required pain relief were in place. One person we spoke with told us, "They [staff] give me my tablets when I'm in pain." We also conducted an audit of some medicines and found the medicine stocks balanced with the medicines that had been administered to people.

Requires Improvement

Is the service effective?

Our findings

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
At this inspection 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. Five of the seven staff we spoke with demonstrated limited knowledge of DoLS, nonetheless they identified people who they felt could be put at risk if they were not restricted, for example, from leaving the home unsupervised. We saw that some people were closely supervised and had been subjected to a restricted practice, in their best interest, to prevent injury to themselves or others. The Provider Information Return (PIR) showed 11 people had their liberty, rights and choices restricted in some way with further applications submitted to the supervisory body for their consideration.

The provider's PIR stated 'if people lack mental capacity we apply for DoLS.' However, discussions with the registered manager and staff demonstrated to us there was some misunderstanding about how the MCA and DoLS legislation should be applied to some of the people living at the home. For example, we found two DoLS applications had been made for people who had the mental capacity to consent to their care. We asked why applications had been submitted to the supervisory body. The registered manager explained the DoLS applications were submitted because both people were unable to leave the building unaccompanied. We found this was due to their physical frailty and not their lack of mental capacity to consent. The registered manager informed us, post inspection, that one of the persons, who had been assessed by the supervisory body, was found to have the capacity to determine where they lived and the authorisation was not granted. This showed the registered manager's understanding of when a DoLS application should be considered and the provider's assessment processes for DoLS applications, required improvement.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "I talk to people and reassure them, you can tell if they understand by the reaction on their face." One person told us, "They [staff] do ask me first before helping me if it is okay." A relative said, "They [staff] do ask [person's name] permission."

The care records we reviewed showed the MCA principles had been considered, however the mental capacity assessments were not always person centred and were not decision based. An assessment of a person's capacity must be based on their ability to make a specific decision at the time it is needed to be made and not the person's ability to make decisions in general. A person may lack capacity to make a decision about one issue but not about others. We found there was some misunderstanding by staff about who could give consent for people that did lack the mental capacity to consent to their treatment. For example, three of the staff we spoke with told us they would ask relatives' to consent for people. We found

relatives did not have the legal right to make decisions for people and records did not consistently show how decisions for care and support were made in the person's best interest. For example, we saw a note from a GP had 'agreed' to administer medicine covertly for one person. On reviewing the person's care records we found there had been no best interest discussions recorded or whether less restrictive ways had been considered. We also found on another person's folder a 'sticker' that noted they were not to have a flu injection. The person did not have the mental capacity to consent to their treatment and there was no evidence to demonstrate how this decision had been reached and who was involved in making the decision. Staff asking family members, because they were next of kin, to consent for people living at the home demonstrated there was a lack of understanding around MCA and how it should be applied. The provider's current processes did not consistently follow the principles of the MCA and required improvement.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "The nurse is really good, she takes care of my health." Another person told us, "The staff know me well." A third person explained, "I think the staff are well trained." The staff we spoke with said they were supported by the management team and received the necessary training to support them in carrying out their roles. One staff member told us, "The training has much improved, we get more in-house training." Another staff member told us, "The training is great, the tutors are great, and it's all good." Staff members spoken with told us they felt supported by the registered manager and were happy with the training they received from the provider. We saw that staff received training and refresher training for staff were reviewed. Staff new to the service explained how they completed their training induction and spent time shadowing another staff member before being permitted to work unsupervised. One staff member said, "I spent time with [staff name] she was lovely, really informative."

Staff we spoke with had told us that during the changeover [to the new provider] supervisions had not consistently taken place but this had improved. One staff member said, "Supervision was hit and miss but we have started to have supervision more often." We saw from the staff records we looked at that supervision had taken place. The registered manager and nursing staff explained how they held daily 'handovers' to discuss people's support needs and were confident to approach the management team if there were any concerns.

People we spoke with told us they were offered choices at every meal and had access to drinks. One person said, "I always have a drink if I need one." Another person told us, "Oh yes, there is a choice on the menu." We saw the day's menu was displayed on a board and people were reminded what was for lunch. We saw one person that did not want the choice of lunch and was given an alternative. The staff were organised while lunch was served to people. Staff provided one to one support where people required it. We saw staff encouraged people to eat, offered more food to those who had finished and meals looked well presented. We saw that people who chose to eat in their own rooms received their meals without delay and that meals were plated and covered to keep the food hot. We saw that staff supported people to access snacks and drinks throughout the day.

Staff we spoke with said people were assessed to meet their individual dietary needs and ensured people received a healthy and balanced diet. Two staff we spoke with explained to us how they would use food supplements to thicken drinks to aid swallowing. We saw that people's dietary needs and preferences were recorded in their care records and the registered manager demonstrated how peoples' weight was accurately recorded to identify those at risk of losing weight. Where appropriate, we saw referrals had been made to dieticians and Speech and Language Therapist for support (SALT). A SALT is a healthcare professional that provides support and care for people who have difficulties with communication, or with

eating, drinking and swallowing.

We saw visiting professionals attended to people to assess and review the person's care and support needs. For example, a GP, opticians and social workers. People told us they were regularly seen by the GP and health care professionals. One person said, "I have seen the doctor and the optician." Another person told us, "The office arrange my hospital appointments for me." Staff spoken with were knowledgeable about peoples' care needs and how people preferred to be supported. A relative said, "They [staff] call the doctor when it is necessary." Another relative told us, "When the doctor was called we were asked if we wanted to attend as well." We saw from the care records we looked at that people were effectively supported to maintain their health and wellbeing with additional input from health and social care professionals.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring and kind. One person said, "I think some of the carers spoil us a little." Another person told us, "The staff are interested in me as a person." A relative told us, "I have found the staff to be very caring." A staff member told us, "I know there is a lot going on at the moment with the rebuilding work but it's a lovely home, it'll be even better when it's finished."

The provider information return (PIR) stated that all staff had undertaken equality and diversity training. People we spoke with told us staff listened to them. One person said, "The staff take time to treat you as an individual, they listen." Staff explained how they supported people who could not express their wishes, for example, once they got to know people, they could tell by facial expressions and body language whether the person was happy with their care. Staff spoken with explained they would make sure they would deliver care in a way the person was happy with. If the person was not happy, staff told us they would leave the person for a while, then return later to check if the person had changed their mind. People we spoke with told us staff treated them with kindness and empathy. We saw staff understood people's communication needs and gave people the time to express their views.

We saw people exercised choices with regard to their daily routines; such as the time they got up, went to bed, and what leisure activities they enjoyed. For example, one person told us, "I can choose when I get up, I am a morning person." Another person said, "I am encouraged to pursue my interests." We asked staff how they encouraged people to maintain their independence. One staff member said, "We try to encourage people to do as much as they can. It might be combing their hair or washing their face." Another staff member told us, "I hold up different clothes for [person's name] to choose, they point to the one they want to wear or shake their head if they don't like what I have offered." Staff demonstrated patience and understanding when people needed encouragement and reassurance. For example, one person became upset and shouted at staff when they tried to support the person. We saw staff responded to the person's distress and confusion in a caring and compassionate way.

We saw that staff protected people's dignity and privacy when providing personal care. We heard staff discreetly prompt people so that their personal care needs were met in a sensitive and private manner. One person told us, "As far as respect, privacy and dignity are concerned, they [staff] make sure they use towels to cover me so I do not feel exposed." People's personal appearance had been supported. One person told us "I see my hairdresser every week." A relative told us, "They [staff] encourage mum all the time, I've never seen them [staff] stop or discourage anyone from doing something." Staff ensured confidentiality was maintained; nurses were discrete when talking to professionals on the telephone. However, we did find some records were stored in the downstairs lounge area in an unlocked filing cabinet. We were told this was temporary and the cabinet was to be moved to a more secure area by the maintenance person.

People told us that their family members were made welcome. We saw there was a constant arrival of visitors. One person said, "My family come to visit." A relative told us "Lunch time is protected which is understandable but any other time you can visit and always made to feel welcome." Another relative said, "I come every day and the staff make me a cup of tea." Due to the rebuilding there was limited private space

for relatives to meet their family members in private. However, we saw there were opportunities for relatives to meet in the person's bedroom, giving people the opportunity to meet with their relatives in private. We were invited into some people's bedrooms and found them to be maintained by the provider and individualised with pictures and belongings that were important to the person.

Good

Is the service responsive?

Our findings

The provider's information return (PIR) stated 'Our ethos is one of involving, information and supporting people.' People we spoke with told us they had been involved in discussions about their care. One person said, "Yes, I know what's going on with my care", another person said, "My family is involved." Relatives we spoke with confirmed they were involved in their family member's care and support. One relative told us, "Oh yes, we are consulted all the time." Another relative said, "I am involved because mum does not always know what to choose."

We saw individual care records were in place which reflected people's support needs. Staff demonstrated in their answers how they supported people. For example, we saw nursing staff put processes in place that had successfully eliminated one person's sore skin and maintained the person's skin integrity. Although this could not be demonstrated in the person's care records, discussions we had with staff and the person's family confirmed the action taken by nursing staff. Staff we spoke with were knowledgeable about people's life history and their support needs. Staff demonstrated that they understood how to engage with people who may have memory loss or difficulties expressing themselves. We found that care records detailed people's medical conditions. Staff told us that they had the guidance and instructions they needed to meet people's specific needs. This showed that people's preferences were known by staff which enabled people to have their care delivered in a way that met their individual needs.

We heard from people and their relatives that staff were responsive to people's requests. Relatives we spoke with told us they were kept informed about any changes if people became unwell. A relative told us, "Anything to do with mum we are consulted." Another relative said, "We have reviews about twice a year but if anything changes, they [staff] will call me." Staff told us that they had daily handovers to keep them up to date with people's changing needs and updated on any significant risks so that they could respond to people's care needs. A new initiative, 'resident of the day' had been introduced by the registered manager. Staff told us how useful they found these discussions to be. The resident of the day would have their care plan reviewed; this was in addition to the routine monitoring of records completed by the provider. The resident's room would be deep cleaned and any maintenance issues would also be addressed. The registered manager explained the resident of the day was an additional way of ensuring people received more personalised support from the provider.

There were dedicated activity coordinators that planned and delivered a programme of activities for people. We saw there was one to one and group activities. One activity with one person was interesting to watch and we could see the person enjoyed what they were doing. We spoke with the person they were smiling and happy to show us what they had done. Another person told us that they enjoyed their visit to the local pub and that they would be supported to go to the library. Feedback from people and their relatives about how people's leisure and social needs were responded to was positive. One relative said, "[Person's name] doesn't really like to be involved with other people in the home but he loves [staff name] when she comes to see him, they do their best to encourage [person's name] to take part in things." One staff member told us about a future trip to a garden centre that had been planned for people. Our observations of the activity staff showed them to be very interactive with people; lively, encouraging and inclusive.

People we spoke with told us they had no complaints. One person said, "I have never complained but if I did, I'd speak with the manager." Another person told us, "There is nothing here for me to worry about." Relatives we spoke with explained that if they were worried about anything the registered manager and staff were approachable and they would not hesitate in raising issues with them. One relative told us, "I have no concerns and if I did I'd speak with [registered manager's name]." The provider's PIR stated that there had been four complaints made about the service. We saw that a record of the complaints was maintained which showed the provider had investigated, resolved and responded to the complainants.

Requires Improvement

Is the service well-led?

Our findings

The new provider took ownership of the service in January 2016 and had recently started a major redevelopment programme that involved the demolition of parts of the home. A range of audit checks were carried out to monitor the quality and safety of the home. This included audits on the arrangements for people's medicines, risk assessments, care records and health and safety. However, the audit checks were not always effective and required some improvement. For example, we found the sluice room on the ground floor was unlocked. The door did not fully close on its recess when leaving the room and had to be forcibly closed. It is important to ensure this room is kept locked at all times because some people, living at the home, could walk into the room unaware of the chemical and biological hazards and be at risk of harm. This was pointed out to the maintenance person who attended to the door immediately to adjust the retainer to ensure the door closed fully. It was also noted that some of the pressure relieving cushions were worn. We raised this with the registered manager who told us they would conduct an audit of all pressure relieving cushions and replace those that required replacing.

We found the affected areas of the building had been partitioned off with secure boarding. However, it was noted that some areas and the general upkeep of the remaining building was in some need of repair. For example, some of the flooring on the ground floor was uneven between the dining area and corridor which was a potential trip hazard for people using walking aids. The downstairs toilet area used by people living at the home was in a poor state of repair and there was a damaged toilet seat. We discussed our concerns with the registered manager. We acknowledged areas that required maintenance would eventually be addressed with the rebuild. However, we reminded the registered manager that whilst the building work was on-going, they had a duty to maintain standards for people living at the home in order to reduce any risk of harm. The following day the toilet seat had been replaced and the registered manager gave us their assurances that the maintenance person would attend to other areas of the home that required attention. We saw that people who used the downstairs toilet were always accompanied by at least one staff member. People who walked with a walking aid was closely monitored by staff, therefore the risk of people being harmed was reduced. People and relatives we spoke with did not express any concern about the environment. One relative told us, "It will be lovely when it's finished."

On checking some of the provider's policies in the upstairs nurses' office, we found there was a fire risk assessment with the contact details of a different provider and was clearly a number of years out of date. We saw there was an up to date fire risk assessment available to staff but this was not in place in the nurses' office on the first floor. We explained to the registered manager that keeping out of date information could lead to confusion particularly for new or agency staff unfamiliar where polices may be stored and that all previous and out of date information should be discarded. The registered manager explained the provider was in the process of updating all policies and processes. We also noted that people's care records were still in the process of been updated and transferred to the new provider's format. We could see care records included people's preferences and routines so that people received personalised care however, the audits had not consistently identified some of the issues we had found for example, within the risk and mental capacity assessments.

Everyone we spoke with was complimentary about the service. One person told us, "This is a happy place to be, we all get on well and can celebrate important events like Christmas and birthdays." We were told the registered manager was approachable. Another person said, "Yes I know the manager, he's approachable, so is the staff." A relative told us, "The manager is good, he manages the home well." Another relative said, "He [registered manager] is very approachable, always see him around talking to people." One staff member told us, "It has been difficult at times with the changeover of owners but I have to say they [management team] handled it well." Another staff member said, "I feel valued by the management, they are fair and approachable and things are much more organised since the new owners have come in." People and relatives told us that they could speak with members of the management team and confirmed there was an 'open door' culture to the office. We saw that people and relatives approached the registered manager and other staff freely during our visit.

Staff we spoke with told us they were able to raise concerns at staff meetings which were held regularly. Staff were supportive of the registered manager and for the development of the service, one staff member said, "I love working here." Another staff member told us, "You do get support from the managers they come out onto the floor." We saw team meetings were held. One staff member told us, "The team meetings are much better now, we talk about the best way to do things."

People and relatives told us they had been asked for their views on how the service could be improved. One person said, "I've attended a couple of meetings." A relative told us, "To be honest, the staff are always asking is everything ok, so I can't really remember if I've filled in a survey." We saw there was a suggestion box in the main reception area if visitors wanted to leave anonymous feedback. We saw evidence to support the provider had issued feedback surveys where an analysis of the information received had been reviewed and where appropriate action taken. Relatives we spoke with told us they felt the provider had kept them informed during the change of ownership and that the transition had been effectively managed.

The provider's PIR stated 'there was daily contact with the manager and team by the Operations Manager to offer guidance and expert knowledge.' We found there was a leadership structure that staff understood. There was a registered manager in post who was visible on each of the floors. We could see from the reactions from people that lived at the home, they thought highly of the registered manager. One person told us (smiling) "There he is, the MD, he says hi to everyone." Staff we spoke with told us they could approach the registered and operations managers at any time, staff continued to tell us the management team were always available to ask for guidance and support. One staff member said, "I like him [registered manager] he is a good manager, talks calmly and always supportive." Another staff member told us, "[Registered manager's name] is good, understanding and considerate; he will always get back to you. He's always on the floor and makes sure he says hello to everyone." Staff told us they would have no concerns about whistleblowing and felt confident to approach the management team, and if it became necessary to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. Whistleblowing is the term used when an employee passes on information concerning poor practice.

It is a legal requirement to notify the Care Quality Commission of any significant incidents or accidents that happen as this helps us to monitor and identify trends and, if required, to take appropriate action. We had been notified about significant events by the provider and saw that where appropriate, investigations had been conducted in partnership with the local authorities to reach a satisfactory outcome.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always being provided with the consent of the relevant person. Staff were unaware of how to implement the Mental Capacity Act 2005 and how to record decisions made on people's behalf who could not make informed decisions for themselves.