Seahorses Nursing Home

Seahorses Nursing Home

Inspection report

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Date of inspection visit:
25 April 2017

Date of publication:
23 June 2017

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 25 April 2017 and was unannounced.

Seahorses Nursing Home is a service that provides accommodation, nursing care and support for up to eight people living with Huntington's disease. Huntington's disease is an inherited condition that can affect movement, cognition and behaviour.

At the time of the inspection, there were seven people living at the service.

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.

During this inspection, we found that the registered provider was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have robust oversight of the service's operations. The registered provider did not take an active role in the governance of the service and the registered manager did not have sufficient time to undertake all responsibilities required of the role. This resulted in a lack of regular and robust auditing to ensure the service was effective and of a good quality. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). Where people were unable to give consent to specific aspects of their care, there was no record to show that these decisions had been made in the person's best interests. Some people were subject to restraint, however, the service had not considered if there was a deprivation of people's liberty and if appropriate authorisation was required. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement was needed in the way the service recruited staff. Some documentation relating to employment checks were not available so we could see that staff were suitable for the role. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provision of periodic supervision and performance management for staff was not adequate. Staff had not received formal supervision for 12 months. Not all staff had received necessary training updates and assessment of their competence. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People received their medicines in a timely manner. However, improvements were needed to ensure

medicines were stored at the correct temperature and dated when opened to ensure they did not expire. Staff had not received recent medicines training or had annual competency checks in line with national guidance.

Risk assessments were completed to ensure that people were kept safe. However, we found that the level of information needed to be more detailed to ensure that staff had up-to date and clear guidance to help them support people safely. The use of bed rails and associated risks needed to be assessed more comprehensively, and we have made a recommendation about this.

Information recorded in people's care plans was not consistent across the service. Some held detailed information on people's social care needs, others only gave brief information. Where reviews had taken place, no changes were made to the main pages of the care plan to demonstrate that the review was comprehensive.

Activity provision was provided by care staff when time allowed. More detailed information on people's social care needs will help to inform individual needs and preferences for social activity, and we have made a recommendation about this.

Staff respected people's privacy and dignity and interacted with people in a caring, respectful and professional manner. Systems were in place which safeguarded people from the potential risk of abuse. Staff understood their roles and responsibilities in keeping people safe.

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to. The views of people, relatives and staff were sought via an annual survey. This was mainly positive, and action had been taken in certain areas as a result of feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Documentation relating to recruitment checks were not available in some staff files to ensure appropriate checks on new staff were carried out.

The registered manager was reviewing staffing levels to ensure they met the changing needs of people using the service.

Staff recognised types of abuse which they could come across in their work, and their responsibility to protect people from abuse.

People received their medicines in a safe and timely manner. However, improvements were needed to ensure medicines were dated when opened and that regular temperature checks were carried out.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent to care and treatment had not been obtained in line with the principles of the Mental Capacity Act 2005.

Not all staff were up to date with their training and professional development to ensure good practice. Where staff had received training, no checks had been carried out to ensure staff were competent to apply the learning gained.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity by staff who knew them well.

The atmosphere in the service was relaxed and people were listened to.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Information recorded in people's care plans was not consistent across the service; some care plans provided a good level of detail about people's social care needs, whilst others held only brief information.

More detail was required within people's care plans to demonstrate that all areas of people's care had been periodically reviewed.

Activity provision was provided by care staff when time allowed. More detailed information was required to ensure staff were aware of individual preferences.

There was a complaints procedure in place for people and relatives to access.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not ensure that the registered manager had sufficient time dedicated to carry out the required responsibilities of managing the service.

Quality assurance systems were in place, but not sufficiently organised or analysed to identify where improvement was needed.

There were systems in place to ensure regular feedback from people, relatives and staff.

Seahorses Nursing 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.

The inspection took place on 25 April 2017, was unannounced and undertaken by one inspector.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with local quality assurance and safeguarding teams.

During the inspection we spoke with two people living at the service. Some people had complex needs, which meant they could not always readily tell us about their experiences. They communicated with us in different ways, such as facial expressions, signs and gestures. We observed the way people interacted with staff and received feedback from three people's relatives. We spoke with the registered manager, and three members of care staff. Following the inspection we spoke with a Huntington's disease advisor, and four health professionals.

To help us assess how people's care needs were being met we reviewed three people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We checked the procedures for the recruitment of staff. Records we reviewed, confirmed Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) had been undertaken before new staff started work. However, we found that one DBS contained information of two previous offences. In these cases the provider should consider if the applicant is suitable despite them having information recorded. If they consider them suitable, the reasons should be recorded for future reference. This had not been completed. We also found that one file held no references, and another had no details of their previous employment history. The registered manager assured us that no staff were employed without two references and a DBS check, however, the records we reviewed did not hold the necessary information. Providers need to operate robust recruitment procedures to ensure the suitability of staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us that there was usually enough staff on shift to meet people's needs. However, sometimes this was not the case if people were on leave, or sick. One staff member said, "Sometimes there is not enough staff, and occasionally people have to wait. This is not often, and usually when we have been unable to find cover". Another said, "There are not enough staff at times, its ok when there are three staff on, but occasionally there is only two, and then people have to wait". A person using the service said, "It used to take a while for staff to answer if I rang my bell, but this is much better now".

We spoke with the registered manager about how they calculated staffing levels. They told us that the current levels were determined by the Health authority many years ago, and they had continued to provide this level of staff. They also told us they adapted staffing levels if a person had increased support needs.

Our observations were that staff responded to people's needs in a timely manner (this included responding to call bells, assisting people with eating, and attending to personal care tasks). However, given the feedback from staff, we could not be assured that this was always the case. Staffing levels and skill mix should be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service. Providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. We asked the registered manager to review this and ensure people's changing needs, and staff duties, were considered when determining staffing numbers.

The service's risk assessment procedures assessed risks to people's safety and wellbeing. This included mobilising, choking, malnutrition universal screening tool (MUST) and Waterlow (gives an estimated risk for the development of a pressure ulcer). Where appropriate, actions to mitigate risks were put in place. For example, the provision of pressure relieving equipment. Outcomes of risk monitoring informed the care planning arrangements, for example we saw that weight loss had prompted onward referrals to dietetic services. However, some risk assessments needed to be clearer and provide more detail about how risks were minimised. For example, in the case where people were at risk of choking, more detail was needed

such as how people were supported to eat or drink, their positioning, and how they showed that they were in discomfort. Moving and handling assessments also needed more detail; where hoists and slide sheets (equipment used to move people safely) were being used, there needed to be clearer instruction for staff such as how to position the sling, which would ensure that people were moved safely and comfortably.

Though the use of bed rails were referred to within people's records, these needed to describe more clearly the risks associated with the use of these. For example, taking into account the bed occupant, the bed, mattresses, and all associated equipment which may alter the effective and safe use of these.

We recommend that the service explores current guidance from a reputable source (Such as the Health and Safety Executive) in relation to ensuring the safe use of bed rails, and the associated risks which should be considered when assessments are completed.

People's records did not include Personal Emergency Evacuation Plans (PEEPs). These show the support people require to evacuate the building in an emergency situation. The lack of this information meant that staff may not know how to support people to evacuate the building in the event of an emergency. We brought this to the attention of the registered manager to review.

Manual handling equipment, such as hoists, had been recently serviced, and there were systems in place to monitor the safety of water systems and the prevention of legionella bacteria.

People told us they felt safe living in the service, and we also observed relaxed body language from people who were interacting with staff. One person said, "The staff are great, every one of them".

Staff were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member told us, "I know the signs to look out for. We know people well here, so we could spot if something was not right". Another said, "If I thought someone was being abused I would report it to the manager immediately, or the [provider]".

People told us they received their medicines when required. One person said, "They bring me my tablets regularly, I haven't got any worries with those". We also observed people receiving their medicines which were dispensed correctly and in line with their care needs. For example, on a spoon with thickened fluids.

Systems were in place for managing medicines and people received their medicines in a timely manner. Medicines which needed to be taken on a particular day of the week were highlighted within medicine administration records (MAR) to ensure all staff were aware.

Some medicines were in liquid form and were held in a locked trolley. However, we found that these had been opened and staff had not written on the bottle the date of opening, which is necessary to ensure the medicine does not expire. We also found that daily temperatures had not been taken in the medicines room since 6 April 2017. This was necessary to ensure that medicines were stored at a safe temperature.

Some people had creams for external application, and staff documented when this had been applied. However, the body maps in place did not indicate where the cream was to be applied, to ensure it could be monitored effectively.

For people receiving medicines 'as required' there were detailed protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling. One person was prescribed medicines for agitation. There was clear guidance on

interventions which may work to reduce the agitation before the medicines were considered. It also stated that medicines were not to be given unless all other interventions had failed. Having this in place reduced the risk of medicines being given when they may not be needed.

Requires Improvement

Is the service effective?

Our findings

Staff had received training relevant to their role, such as first aid, infection control, moving and handling, mental capacity, neurological conditions and Huntington's disease. This training gave staff a better understanding of how the condition affected people living in the service. However, other relevant staff training was not routinely undertaken. For example, only five of the eight registered nurses had recently received training in PEG feeds (percutaneous endoscopic gastrostomy; a tube to provide a means of feeding when oral intake is not adequate). The registered manager who told us they were the lead nurse for PEG feeds had not received recent PEG training. Only two registered nurses had received recent wound management training, and we were concerned that clinical training for registered nurses was not routinely undertaken to maintain the necessary skills to meet the needs of the people they cared for. This meant that there were occasions where shifts were running with staff who had not recently received training updates in certain subjects, such as PEG feeds. Additionally, not all staff were up to date in their mandatory training, such as safeguarding (11 out of 20 staff received training in 2014) and mental capacity (seven out of 20 staff received training in 2016).

Only registered nurses were permitted to administer medicines in the service. However a review of the training records identified that staff did not have up-to-date medicines training in place (4 nurses had last received training in 2014) and had not received an annual update and assessment for competency, in line with NICE (National Institute for Health and Care Excellence) guidelines. This meant that the registered manager could not be assured that nursing staff were fully trained and competent to carry out the safe administration of medication.

The registered manager acknowledged that training had fallen behind and was an area to prioritise, but they were confident that the quality of people's care had not been compromised as a result. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.

Staff working in the service were not supervised adequately to ensure that their competency and application of their learning was effective. Staff working in the service had not received supervision for the past 12 months. Supervision provides staff with a forum to discuss the way they work, identify training needs, and receive feedback on their practice. One staff member said, "I haven't had actual supervision, but [registered manager] asks to work with me, so she can observe what I am doing". Another said, "I've not had supervision recently but we chat informally all the time". Informal discussions do not provide an appropriate setting to discuss individual needs. Additionally the registered nurses working in the service were not receiving clinical supervision to ensure their knowledge was current, or identify where further training was needed. The registered manager acknowledged that this, and staff training, was an area to improve upon, but had not had the time to do so. Staff should receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

All of the above constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) 2014.

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 decision 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

People living in the service required support with aspects of their care, and some people were considered to lack mental capacity. However, it was not clear how consent to assist with care tasks had been determined as there were no formal MCA assessments or best interests decisions in place. No assessment of capacity had been carried out where doubt existed about a person's ability to make particular decisions. Some people had mechanical restraints in place for their own safety, such as bed rails, lap belts, and chairs which were reclined. Though these had been assessed as appropriate by health professionals, they were forms of restraint and there was no evidence that consideration had been given to whether the actions the service were taking to keep people safe were depriving people of their liberty. The process had not been followed to establish whether the decisions staff had made in people's best interests were the least restrictive and whether or not the restrictions would deprive a person of their liberty.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We observed staff asking people for consent prior to assisting them with tasks such as personal care, and eating and drinking. One staff member said, "I talk people through the tasks I am going to do so they know what is happening. I watch their body language, and if they [people] refuse I leave them, then I come back later and try again".

People were supported to eat and drink and maintain a balanced diet. This included keeping records of their food and fluid intake when there were risks, preparing and providing food and drinks and encouragement of drinks. We saw a chart in the kitchen where drinks and food were prepared. This clearly outlined each person's requirements for the consistency of their food. For example, some people needed their food to be liquidised or prepared as a soft mashable consistency to reduce the risk of choking. There was also guidance on how to prepare thickened fluids for each person, and we saw that professional guidance from dieticians had been followed. A dietician routinely visited the service every three to four months to review people's nutritional needs, including feeding regimes for the PEG feeds.

People were supported to maintain good health and have access to healthcare services. Records reviewed showed that people had been assessed or seen by GP's, physiotherapists, dieticians, continence nurses and occupational therapists. There was also a Huntington's Disease advisor who visited the service every three months. They told us, "We have general discussions. They [staff] do act on my advice if I give any, but staff also have a good knowledge of the condition. People tend to do well there [at seahorses]". The registered manager also told us the advisor informed them of any relevant training sessions which they could attend, and that the advisor attended support meetings in the service every three months to help advise and support people living with Huntington's Disease.

Good

Is the service caring?

Our findings

People told us and indicated that care staff were caring. One person said, "The staff are very good. They look after me well, I'm happy with the care here". Another said, "Good staff, no complaints". A relative told us, "The staff here couldn't do more. Not just for [relative] but for me as well".

We saw that staff were caring and respectful in their interactions with people. For example, they made eye contact, gave people time to respond and explored what people had communicated to ensure they had understood them. Staff spoke with people in a caring manner which people responded positively to, such as smiling. Many of the people had lived in the service for several years. When staff spoke with us it was clear that they knew people well; demonstrating an understanding of people's preferred routines, and their likes and dislikes. People's rooms had been personalised to reflect their preferences, and contained items which were meaningful to the person, such as photographs, ornaments and cards from relatives. A health professional told us, "They [staff] seem to have a good rapport with people, they know people well".

Staff described how they provided a sensitive and personalised approach to their role and were respectful of people's needs. One staff member said, "I love my job, I've worked here for years. We keep a good routine with people and relatives. We aren't institutionalised here, people get up when they want; they can eat lunch when they want". Another said, "I enjoy my work, we know people well here, so we know when they might get upset and what action to take".

People and their relatives (where appropriate) had been involved in planning their care and support. Staff told us they used different communication methods for people who could no longer verbally communicate. One staff member said, "We use picture cards which people can use to point at, and hand gestures such as 'thumbs up'. However, we did not see that people or their representatives had signed the care plans to consent to the care and treatment they were receiving.

We saw that meetings had been held with relevant people, such as family members, nurses, and GP's to discuss people's end of life care arrangements. One relative told us, "Any concerns, they [staff] always called and asked my advice on things. They [staff] kept us [family] completely in the loop". Another said, "When I leave [relative] I have peace of mind that they are being well cared for". Family members and visitors were permitted to visit at any time, and were encouraged to do so.

People's privacy and dignity was respected. We saw that when staff were attending to people's personal care that doors and curtains were closed. One person said, "They do keep me covered up when they are helping me wash, they [staff] are very helpful". One person's care plan gave guidance to staff to consider privacy when their family visited. People's records provided guidance to staff on the areas of care that they could attend to independently and how this should be encouraged.

Requires Improvement

Is the service responsive?

Our findings

People's care records included care plans which guided staff in the care that people required to meet their needs. This included eating and drinking, communication, hygiene, continence, and social care needs. Though areas of the care plans were noted as having been reviewed on a monthly basis (staff signed a separate sheet in the care plan which said, "continue") this did not demonstrate that the care plan had been appropriately reviewed. The main pages of the care plan had not been updated with any new information so that it was clear that the information had been read through, considered and assessed to be appropriate and on-going. Providing more detail would also inform staff that it was the correct information about peoples current care needs.

Some information needed to be updated and completed in a more detailed way. For example, people's social care needs were not described in a consistent way. Some care plans contained a good level of detail on how to strike up meaningful conversations on subjects that the person would be interested in, whilst others just listed that the person had a son and a daughter. There was no other information about them, what they meant to the person, or how often they visited. Care plans detailed people's preferences for how often they would like to take a bath, but not the more personalised details such as their favourite lotions or which clothes they liked to wear and how they liked to be presented. Another care plan said that the person required support with personal care tasks, but no other information was provided on what help was needed. In order to make the plans more person centred they required the inclusion of more detail about people's life before they came to live in the service, their likes and dislikes, and the way people preferred to have their care delivered.

Staff told us, and we observed, that they knew people's preferences well as they had worked in the service for a long period of time. However, there were also agency staff working in the service who may not be so familiar with a person's individual preferences. We brought this to the attention of the registered manager, who told us they were aware that the care plans needed to be reviewed and updated, and had intended to review all care plans in October 2016. However, they had not had the time to dedicate to this task. One relative said, "I've seen my [relative's] care plan. It's rather old fashioned, and important information is not always at the front".

Staff attended a handover meeting three times a day which included the staff coming on duty. Information about people's general well-being and other relevant information such as people's health needs or upcoming appointments were discussed to ensure consistency of care.

There was not a dedicated activity co-ordinator in the service. The registered manager told us that care staff provided activity to people, but often people would not be motivated to join in, or it could cause them to become agitated. Some care plans did make reference to this, and in one we saw that the person had declined to go out on trips anymore, and had become less interested in engaging in activity.

We saw that when people did engage with staff they responded in a positive way, smiling and interacting in their own individual way. However, in between these times people were sat for periods of time with no

stimulation (other than the television which was on in the main lounge).

We spoke to the Huntington's disease advisor, who told us that engaging in activity can sometimes be difficult for people living with Huntington's disease, particularly group activities, and that one to one activity can be more effective, such as reading or just talking with people.

We spoke with one person who we saw had to hand their individual choice of hobby and activity preferences. The person also told us about nail therapy sessions which were held weekly in the service, and said they really looked forward to them. We met with another person who was in their room watching television. We asked them if they wanted to do anything else socially, and they declined, saying they chose to stay in their room and did not wish to do anything else.

One staff member told us about an activity they had recently trialled with three people, but this caused some people to become distressed, so they stopped doing this. However, where people were experiencing a decrease in motivation, or where group activity had not been successful, it was not always clear whether other options, such as sensory stimulation, had been considered or tried.

We recommend that the service explores current guidance from a reputable source in relation to the range of approaches and interventions which can be considered in meeting people's individual social needs.

The service had not received any complaints, but had a complaints procedure in place. One relative told us, "I wasn't happy about something that had happened with my [relative] so I spoke to [registered manager]. They attended a meeting with me to discuss my concerns, and since then communication has always been good, much improved". We saw some correspondence regarding an issue that was raised by a relative some time ago, and a response from the registered manager. However, details on how to complain were not displayed in the service, or details of who to contact in the event that a person or visitor wished to make a complaint. We brought this to the attention of the registered manager who informed us following inspection that this was now displayed in communal areas of the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had worked in the service for a number of years. They also worked as a member of nursing staff three days per week. This meant that they only had two days in which to carry out their registered manager responsibilities, such as ensuring the quality of the service, carrying out audits, staff supervisions, and ensuring staff had received appropriate training.

The services' quality assurance and training records were kept manually rather than on a computerised system. This compromised effective oversight and review of the service and its procedures. For example, where training was recorded in a note book, it was time consuming to see which staff were overdue training and which training sessions were required. It was not clear what training was periodically required for registered nurses and for non-registered staff working in the service.

Five staff had recently received refresher training in PEG feeds. The registered manager told us that they did observe staff to ensure they were competent. However, documentation relating to the observation of staff to ensure they were competent in practice when administering food or medicine via the PEG was not available. The registered manager told us that they did observe staff, but had not had the time to write up the outcomes of these observations. Additionally, they had not undertaken recent training themselves.

Two nurses in the service took responsibility for catheter care, but there was not a designated clinical lead to oversee all nursing related tasks, which would be one option to ensure staff were competent and best practice was being followed. There was no evidence that competency checks of staff had been undertaken. This meant that the registered manager was not ensuring that any training undertaken was being correctly put into practice by staff. Having more up to date systems in place will support the registered manager to monitor the service more effectively. Providers should continually evaluate and seek to improve their governance and auditing practice.

Some audits had been undertaken, such as accidents and incidents which had occurred in the service, and actions taken to reduce risk were documented. However, the registered manager told us they felt under pressure and did not have time to complete all of the audits and governance tasks associated with the role. The registered provider did not take an active role in the governance of the service. As a result, there was a lack of regular auditing and analysis of quality assurance systems to continually ensure that the care people were receiving was of a high quality. For example, the registered manager had recently carried out an audit on MAR charts but told us they had not had the time to analyse the results. One staff member told us, "[Registered manager] needs a lot more support than they get".

Audits of care plans were not being monitored effectively to ensure people were receiving good quality care. For example, care plans were signed to say they had been reviewed monthly, but the main pages of the care plans had not been changed to reflect that the detail was still relevant. This was an area the registered manager had already identified as needing to be reviewed but had not had the time to do so.

We were advised that the registered provider did not regularly visit the service. This was identified at the

previous inspection in December 2014. This did not ensure robust oversight of the services operations, and ensure that the service was being run effectively. We were concerned that the registered manager was not receiving adequate support, and that the registered manager responsibilities were not being completed thoroughly enough as they were not given the time to do so. The registered manager had not received regular supervision and had not met regularly with the provider.

All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the service knew who the registered manager was. One person said, "The manager is great. They are a good nurse". Another said "[Registered manager] is good, I feel I could raise an issue and would be listened to".

We saw that staff meetings had been carried out recently and relevant items were discussed, such as infection control, COSHH (control of hazard substances), medical devices which would be beneficial to the nursing needs of people, and reminders to staff to do regular maintenance checks on pressure relieving equipment. Advice was sought in relation to best practice for Huntington's disease, by the advisor who visited the service every three months. There was also an infection control lead in the service, and we saw that they had regularly attended the link meetings in the local area. The infection control team also advised us that the service had sought advice from them when needed.

Annual surveys had also been issued to people, staff and relatives. We saw that the majority of the feedback was positive from people and relatives, and concerns were acted on. For example one person and their relative wanted their room to be redecorated in a different colour, and this was actioned. Staff had requested that laminate flooring was installed so it was easier to manoeuvre moving and handling equipment. This was being actioned, with only two more rooms to complete.

Staff told us they felt able to raise issues with the registered manager, and spoke positively of them. One staff member said, "[Registered manager] is lovely, so approachable. I couldn't ask for a better manager". Another said, "I get on well with the manager. I'm always listened to and I feel appreciated in my role". Relatives also spoke positively of the registered manager. One relative told us, "I give [registered manager] ten out of ten". Another said, "I can't fault them [registered manager]. I always know what's going on with my [relative]. I'm always consulted".

The registered manager had completed a leadership qualification, and was registered with a professional body. In order to renew their registration they told us that they were working through the revalidation process (a new process to renew professional registrations). Revalidation demonstrates the ability to practice safely and effectively. They told us they were also supporting the registered nurses in the service with the process.

Following the inspection the registered manager kept in contact with us to inform us that they had begun work on some of the areas we found as requiring improvement, such as updating the care plans and organising training sessions for staff. They had also secured more hours in their role as registered manager after discussion with the provider.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and governance processes were not being routinely analysed to monitor the quality of the service. The registered provider did not ensure adequate time was given to the responsible person to undertake these tasks. 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate documentation relating to employment checks were not available for new staff working in the service. 19 (1) (a)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not receiving periodic supervision and appraisal.

18 (2) (a)