Roche Healthcare Limited

Mansion House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 9 November 2015 and was unannounced.

The last inspection took place on 25 November 2013, the service was meeting all of regulations we looked at.

Mansion House is registered to provide residential and nursing care for up to 26 people. The home has a dedicated dementia care unit for 14 people. Mansion House is a detached house built on two floors. The upper floor is serviced by a lift. There are 26 single rooms the majority are en-suite. There is a secure garden which people can access.

At the time of our inspection the service did not have a registered manager. A new manager had been in post for two weeks and had applied to the Care Quality Commission to become the registered manager. 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.

Records related to people's food and drink were poor and contained significant gaps. Although there was evidence of some audits taking place these were not robust and

Summary of findings

when issues were identified there was no clear record of action taken to rectify them. This meant the provider did not have systems in place to ensure they were providing a good standard of care.

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

Staffing levels had been reviewed by the provider, they listened to feedback from staff and the manager to ensure they had sufficient staff to meet people's needs.

Staff knew how to protect people from avoidable harm. Staff had attended safeguarding training and the service had an up to date safeguarding policy which provided staff with clear instruction about the action they would need to take. The service had a whistleblowing policy which meant staff knew how to raise any concerns and who to contact.

People had risk assessments and risk management plans which staff followed to keep people safe. These were well developed and people, their families and the relevant health and social care professionals had been consulted. They provided staff with guidance about how to keep people safe. They balanced the need to keep safe with the right to freedom which meant people were not unnecessarily restricted.

The principles of the Mental Capacity Act (2005) were consistently followed by staff. Consent to care and treatment was sought. When people were unable to make informed decisions we saw a record of best interest decisions. There was a record of the person's views and other relevant people in their life. The registered manager had a clear understanding of the Deprivation of Liberty Safeguards.

People told us the food was good. We saw people had access to regular drinks, snacks and a varied and nutritional diet. If people were at risk of losing weight we saw plans were in place to manage this and the appropriate healthcare professionals had been consulted.

Care plans contained up to date information which included their preferences, likes and dislikes. Although we were told reviews took place and families were involved we did not see signed review records within care plans.

People had access to a range of activities and were very positive about the role of the activities co-ordinator. Activities were based on interests of people who used the service and we saw the activities co-ordinator was skilled at getting people involved.

People and their relatives told us they knew how to make a complaint but had never needed to. The service had received a variety of compliments. Feedback was sought from people as part of the review of their care.

The manager was keen to make improvements to the service and their staff team demonstrated confidence in them. People and their relatives told us they had met the new manager and even though they had only been there a short time they said the manager was approachable.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had recently reviewed the number of staff available to meet people's needs. Staff raised concerns about the changes. These concerns were monitored and reviewed and the staffing levels were returned to the usual level. This showed the service had safe systems in place to ensure there were sufficient staff to meet people's needs.

We saw evidence of medicines being safely administered, recorded and stored. The service had an up to date medicines policy. However, on the day of inspection the medication round took an excessive amount of time to complete as the nurse had to complete other tasks. This meant there concentration could be affected which could lead to errors.

Staff knew how to protect people from avoidable harm. Risks were assessed and risk management plans were in place to protect people.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before care or support was provided. Where people were unable to give consent staff followed care plans and we could see records of best interest decisions. This meant the service was following the principles of the Mental Capacity Act.

People received a nutritious, balanced and varied diet. They told us the food was good. Assessments took place to identify people who might be at risk of weight loss. People received support from appropriate healthcare professionals and we saw their guidance was used to inform care planning.

The environment had been designed to meet the needs of people who used the service.

Is the service caring?

Good

The service was caring.

We saw staff delivered kind and compassionate care to people they supported. Staff knew people well and we saw records of people's preferences. People were positive about the care they received.

People were supported to be as independent as possible and encouraged to maintain relationships with their family and friends. People's dignity and privacy was respected.

Summary of findings

Despite this end of life care planning required improvement. We did not see specific care plans in place in relation to people's needs as they approached the end of their lives. There was no record of people's spiritual or cultural needs.

Is the service responsive?

Good 

The service was responsive.

Care plans contained information about people's preferences and were up to date.

People were overwhelmingly positive about the activities available and we saw the activities co-ordinator had a structured programme in place.

People and their relatives knew how to make complaints. The service had an up to date complaints policy which was accessible. When complaints were made they were investigated and responded to in timely manner.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

At the time of our inspection the service did not have a registered manager. The new manager had been in post two weeks and was developing their knowledge of the service.

Record keeping required improvement. There were significant gaps in some records related to how much people had had to eat and drink. The service did not have effective systems in place to audit the service. This meant the provider could not be assured that people were receiving a good quality of care and support.

Staff were committed to providing good care and despite the manager being new in post they described feeling confident in their abilities. People and their relatives told us they had met the new manager and they found the management team 'approachable'.

Mansion House

Detailed findings

Background to this inspection

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

This inspection took place on 9 November 2015 and was unannounced. At the time of our inspection there were 26 people living there.

The inspection team consisted of one inspector, a specialist advisor with a background in mental health nursing and an expert by experience. The expert had personal experience of caring for older people.

Before our inspection we reviewed all the information we held about the service. We received 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.

We also reviewed notifications we had received. We spoke to the local authority contracts and commissioning team, and contacted Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided.

During the inspection we spoke with five people who used the service, and eleven visiting relatives. Not everyone was able to tell us their views verbally so we spent time observing interaction between people and care staff. We looked at four care plans and associated records.

We spoke with nine members of staff. This included; the manager and deputy manager, one nurse, a senior member of care staff and care staff, the activities co-ordinator and the chef. The providers compliance manager came to the home during the inspection and provided support to the manager who was new in post. We spent some time with the compliance manager who had recently provided some management cover to the home.

We looked at three staff files; which contained employment and training records. We looked at documents and records that related to people's care and support, and the management of the home, such as training records, audits, policies and procedures.

During the inspection we spoke with one visiting health and social care professional.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe and their relatives shared this view. However, staff expressed concern to us about changes to staffing levels within the service on an afternoon. Staffing levels had been reviewed and on the day of our inspection the staff team had been reduced from five members of staff to four between 3pm and 8pm.

The manager and compliance manager told us the service did not use a dependency tool to calculate the staff they required to safely meet people's needs. However, they said as it was a small service and they observed care practices across the service and would know if they did not have sufficient staff to meet people's needs. The manager told us the current changes to the staffing pattern would be reviewed every day to ensure they had sufficient staff to keep people safe.

The area manager contacted us after the inspection and told us there was a formal system in place to determine and review the number of staff and range of skills required to meet the individual needs of people who lived at the service. They also told us that staffing levels had returned to the previous levels within the first week of these proposed changes. This demonstrated the provider had systems in place to review staffing levels and to amend these to ensure there were sufficient staff available to meet people's needs.

We observed the medication round took a long time. Morning medicines were still being administered at 11.30 am. The nurse administering medicines sought help from the deputy manager who was not on shift, but was in the service on supernumerary time to complete paperwork. The nurse explained the medication round was not protected time, this meant they were called on to provide other support such as liaise with visiting health and social care professionals and arrange GP visits. They told us they ensured medicines which were time specific or needed a certain time gap before being re administered, such as paracetamol or other pain relief were administered first. Despite these measures the nurse had put in place we were concerned that being broken off to complete other tasks could result in mistakes being made and delays in people receiving their medicines in line with the prescribing instructions.

We spoke to the manager and deputy manager about our concerns. They told us the medicine round did not usually take this length of time and the day had been unusually busy. We did note there was a visiting social care professional who required a time from the nurse.

The service had an up to date medication policy. Medicines were stored of and disposed safely in line with the policy. Nurses administered people's medicine and we observed they were patient, offered explanations and reassured people. They explained some people did not like taking their medicine and they may refuse, they said they would go back later and try again. If the person continued to refuse this was recorded on the medication administration record (MAR).

MAR were completed correctly and we did not see any gaps in records. People who were prescribed sedative type medicines to reduce their agitation or distress were reviewed monthly by the pharmacist and doctor. The service had clear protocols in place for medicine which was administered as required.

People were protected from avoidable harm. Staff were confident about identifying and responding to any concerns about people's well-being. They demonstrated a good understanding of how to safeguard people who used the service, and were aware of possible types of abuse and how to report concerns.

The manager understood their safeguarding responsibilities. The CQC had received seven notifications about safeguarding incidents since the last inspection. We reviewed the notifications with the manager and compliance manager who demonstrated knowledge of each situation. Four of the notifications related to one person whose mental health had deteriorated, we could see the service had sought advice and support from the community mental health team and had requested the local authority review their placement. All of the incidents had been investigated and we could see appropriate action had been taken and recorded.

The service had an up to date safeguarding policy, which offered guidance to staff. This had been updated in line with the introduction of The Care Act (2014). Staff also had an understanding of whistleblowing procedures should they have any concerns about practice within the organisation.

Good

Is the service safe?

We looked at the care plan, risk assessments and associated records for one person who required support to manage behaviour that could be a risk to themselves, or other people. The risk assessment and risk management plan provided staff with detailed guidance about how to reduce the likelihood of the behaviour occurring. They provided information about the support needed to ensure the safety of the person and others. The community mental health nurse was involved in supporting the person and the service. They had provided guidance for staff and been involved in reviewing the person's medicine. We could see they had been prescribed medicine to reduce their distress. The care plan recorded this should only be used after all other strategies had been tried and as a last resort. This meant people were supported based on the principle of the least restrictive intervention and their rights were respected.

Risk assessments and plans to manage risks had been completed for people in relation to falls, pressure area care and weight loss. These were reviewed on a regular basis. Relatives were aware of risk management plans. On relative said, "I know he is safe, especially at night when he is on two hour watch as he tries to get out of bed, the bed lowers to the floor so that he can't fall far and there is a pressure mat that rings an alarm so they know he needs help."

We also saw the service encouraged positive risk taking. One person was supported to manage their own medicine. They told us, "I do my own medicines three times a day. I take eight tablets a day and one tablet three times a week. They have all been explained to me and I know what they are for." We observed the nurse discussing with the person a change in their medicine which had been advised by the pharmacist. This showed the service supported people to retain their independence.

People had up to date emergency evacuation plans in place. There was a record of fire safety checks which we saw took place in line with the service's fire safety policy. The manager told us regular weekly checks took place and since they had started in post they had carried out a fire drill. This meant the service had plans to keep people safe if there was an emergency situation.

The service was clean and smelt pleasant. We saw staff use appropriated protective equipment such as aprons and gloves when providing personal care to reduce the risk of infection spreading. The service employed sufficient cleaning and laundry staff.

Good

Is the service effective?

Our findings

Staff told us they were well supported and had confidence in the new manager. Staff had not routinely had supervision. Supervision is an opportunity for staff to discuss any training and development needs or concerns they have about the people they support, and for their manager to give feedback on their practice. However, the new manager had started supervision with staff and we saw every member of staff was booked for a supervision session in the next few weeks.

New staff had to complete mandatory training as part of their induction; this included safeguarding adults, moving and handling training and dementia awareness. We spoke with a member of staff who had recently started work at the service, they said, "It feels like I've been here forever, in a good way. It is a really nice place to work, everyone is helpful and happy to be asked questions and don't make me feel silly. I had a four day training course when I first started to cover the basics and it gave me a good grounding." Staff who had worked at the service for longer had been supported to complete NVQ training courses in health and social care to build on the mandatory training they received.

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.

We saw staff routinely seek consent from people before care or support was provided. All of the staff we spoke with were aware of the basic principles of the legislation. Training records showed staff had received training on the MCA. Care plans contained MCA assessments and where people had been assessed as being unable to make their own decisions we saw the service had completed best interest decisions on their behalf. This meant the service was applying the principles of the Act and ensuring people's rights were protected.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The manager had a sound understanding of the legislation. Since they had started in post they had reviewed care and supervision which was provided to people and had applied to the local authority for DoLS for 13 people. These were in the process of being assessed. In addition to this two people had an approved DoLS in place.

People told us they were free to make their own decisions. One person said, "I decide when to go to and get up out of bed. When the weather is nice I can go out on my own in my wheelchair, I let them know, and I just go around the block."

People were supported to have a varied and balanced diet. We saw people's nutritional needs were assessed and any additional support required was provided. People were weighed routinely each month. Where people had lost weight or were at risk of weight loss they were weighed more regularly. One person had been referred to the speech and language therapist for assessment because staff had been concerned they were at risk of choking. The guidance they had provided had been updated in the person's care plan. They were provided with a pureed meal and a member of staff supported them to eat. This was done in a kind and patient manner. The member of staff sat beside them and took their time to feed them making sure the person safely swallowed their food before providing more.

We observed staff asking people if they wanted clothes protectors whilst they ate and people's decisions were respected. Everyone we spoke with said they had enough to eat and drink. We saw drinks were provided throughout the day.

At lunch time in the general dining area we saw jugs of juice. However, people were provided with a hot drink with lunch, these were mainly untouched as people ate their meals. This meant the drinks went cold and were then taken away by staff, therefore it would have been better if a drink had been offered later in the meal. In the dementia unit people were provided with soft drinks. On both units we saw people were encouraged to have soft drinks throughout the day.

Good

Is the service effective?

One person said, “The food is alright and if I want something different they do it. We have a hot meal at lunch time and usually salad or sandwich for tea although sometimes we have chips at tea-time or an omelette.” Another said, “The food is nice.” A relative said the food was, “Generally very good and you can ask for something different if you don’t want what is on the menu. But the food could be a bit warmer at times. If it is not very warm when he gets it, as he is slow eating, it is really cold before he has finished.”

The service had a separate dementia unit. The corridors were brightly painted with handrails and doors painted in different colours to enable people with dementia to be able to get around as independently as possible. The walls had dementia friendly activities and displays on them. This meant people who spent time walking up and down the corridors had things they could connect with.

Some of the paintwork across the environment was tired and needed updating. One of the main lounges had recently been redecorated. The wall had a mural of a 1960’s street with terraced houses on it. This would have been a familiar scene to people from the local area and showed the service considered décor which would enable people to have familiarity and spark conversation. New furniture and carpets had been provided. People’s bedrooms were personalised and homely.

People were supported to maintain their health and well-being and had access to health services as needed. Support plans contained clear information about peoples’ health needs. There was evidence of the involvement of healthcare professionals such as a GP, dentist or community nurse. We saw one person had been referred to the wheelchair service for a specialist wheelchair.

Good

Is the service caring?

Our findings

We saw positive care practices between staff and people who used the service. Throughout our inspection all of the care we observed was kind. Interaction between staff and people who used the service was consistently warm and friendly. People told us they were well cared for. We observed people to be relaxed and at ease in the company of staff. One relative said, "[Relative] used to live with me but came in for respite care three years ago, we then looked at two other homes but chose this one. [Relative] is not very well now but has been well looked after."

People were treated with dignity and respect. One relative said, "The carers are good but some have that bit extra, he likes his carers, but occasionally he can get [agitated] but they seem to know how to manage him." Another relative told us, "They treat him with dignity and ask him if it is ok before assisting him. For example they check with him before they help him move using the hoist."

One person explained they were worried about how their relative would settle into the service, They said, "We were worried moving might upset and agitate her but she has settled really well. She seems happier [than in hospital], here she is walking around, trying to talk and smiling much more, it is lovely to see her like this." After their family had left we saw a member of staff sitting with the person and holding their hand. When they became restless the member of staff walked with them around the room until they were more settled. The member of staff responded well to the person's needs, they were affectionate and kind to them.

On the day of our inspection 11 relatives visited the service. The lounges were lively with a buzz of activity, it was clear relatives knew staff well. The atmosphere was lively and friendly and people enjoyed being able to walk around and interact with different people. We saw people ate meals with their relatives and they told us they were encouraged to visit whenever they wanted. One person said, "I visit every day and always have lunch and sometimes tea. I can go in and out any hour, no blockages." Another person told us their relative's room was large, and always clean they said, "It is good because it is big enough for me to bring my children too at any time to see their great Gran."

People were supported to maintain contact with family and friends who were not able to visit. One person said, "I have my own telephone line so that I can ring family and friends." They told us they were setting up skype to help them keep in touch with a relative who lived in another part of the world.

The service had considered people's individual preferences. We looked at one person's care plan and could see they liked a calmer atmosphere. They spent time in their bedroom and staff had spoken to the person's relative about what music they enjoyed.

Staff knew people well and spoke about them with kindness and respect. One member of staff said, "I try to treat people how I would like to be treated, I have been a carer [for two relatives] before I came here so I treat the residents the same as them." All of the staff told us they thought people received a good standard of care. We asked people if they would be happy to have a loved one live there if they needed this type of service and all of the staff said yes.

People were encouraged to retain their independence. One person said, "I am encouraged to do as much as I can for myself, I couldn't walk or speak when I arrived here, some of the girls helped me with walking and speaking. They would help me walk slowly for a short way at first but then go further every day."

A visiting health professional told us their impression was that staff knew people well, staff were proactive, could tell them about people's needs and they followed the advice provided. They said, "There are always staff around, it seems well organised and I regularly see the tea trolley."

We reviewed the care plan for one person we were told was receiving end of life care. There was key information recorded such as contact details for their relatives, solicitor and funeral directors. However, there was no information about the person or families' (or just family) wishes at the end of their life. It did not include information about their religion or any specific cultural needs. We saw a brief record from the person's doctor which referred to the person approaching the end of their life, and that the family would be contacted to discuss the person's end of life care needs. There was no other discussion recorded regarding this. There was no specific care plan in place related to the person's choices and wishes about their end of life care. However, people had the equipment they needed to meet their end of life care needs and had access to specialist palliative care support via their doctor.

Good

Is the service responsive?

Our findings

People received support which was responsive to their needs. Pre admission assessments were completed by the manager. This meant the service considered whether they could support the person before they agreed they could move in. We spoke with the relative of a person who had recently moved into the service. They said, "We chose this home because it is so homely. When I visited to look around I got a sense of what it was like and it felt comfortable, everyone was friendly. I'm amazed and pleased how well Mum has settled, the staff have been very good. When we arrived they asked how Mum likes to be addressed and approached, what her likes and dislikes are. The move has gone so much better than I thought and she seems happier."

Care plans contained information about people's life before they moved into the service and what was important to them. However, some of the information within care plans was generic and task focused. However, staff knew people well and they were able to tell us about people's preferences and routines.

Care plans were reviewed and updated and we saw some people were involved in this. One person said, "My care plan is kept downstairs and they do review it with me." Other care plans showed people's family had been involved in reviews.

The service employed an activities co-ordinator who worked from 10 am until 4 pm five days a week. The activities co-ordinator explained to us they spread the five days across the whole week to make sure there was an opportunity for people to be involved in specific activities on a weekend. They had a well-developed programme of activities and we saw records within people's care plans of activities they liked and what they had been involved in. There was a planned programme of activity which people knew about.

We observed the activities which were going on in the morning. The activities co-ordinator had a large scrap book which had been going around the country to different care homes. People were encouraged to share information about their service and the local area. People enjoyed this activity and reminisced about the area and the jobs they had. The activities co-ordinator ran this session with enthusiasm and skill and helped people to be involved. After the session ended they spent time with people who had chosen not be involved and talked with them.

We received positive feedback from people and their relatives about the range and variety of activities on offer. One person said, "The new activities co-ordinator is very good, so I'm hoping they'll stay. We were making poppy wreaths last week for Remembrance day." We were told a remembrance service was planned for the 10 November. This was due to be held in the service by a local vicar. Then on the morning of the 11 November the wreaths would be displayed, a poem read and the last post played at 11 am.

Activities ranged from taking residents to a 'Songs of Praise Service' at the church opposite to a Burns Night and a 'Bake off' competition. Outside entertainment was booked for 26 November. This was an 'ABBA sing along' and a Carol service for one evening in December. Relatives told us they were encouraged to attend events. We were told that the home had a cosmetics agent so that people could choose their own toiletries, cosmetics and gifts and any commission made went into the resident's fund.

The activities co-ordinator told us they had been asked by the managers to get co-ordinators in other homes in the organisation together to develop a standard programme for activities across the homes. This showed the service was keen to share good practice across the organisation and develop new ideas from other services.

The service had an up to date complaints policy which was on display in the entrance to the service. This meant it was accessible to people and their relatives should they need to raise any concerns. The manager showed us the complaints file and we could see complaints had been investigated and responded to within a timely manner. There was a record which showed the person was happy with the response provided.

All the people we spoke with said they would speak to a staff member if they had a complaint or concern. One relative said, "We really love it here, there is always someone around and to speak to or ask if you have a concern, they [the staff] are all really helpful." All of the relatives we spoke with told us they would happily raise any concerns with a member of staff. They told us they had confidence they would respond positively.

Requires improvement

Is the service well-led?

Our findings

The service had experienced a period of change over the last few months. The registered manager left the service in March 2015, since this time the service had not had a registered manager. A member of staff had been in the role of manager but had taken the decision to return to their previous role. There had been a period of time when the service was without a manager and the providers compliance manager had spent time at the service to support staff.

Two weeks ago a new manager started in post. They had previously worked as an agency nurse at the service so that had some existing knowledge of people, the staff and the service overall. They told us they had applied to the CQC to become the registered manager of the service.

Since the manager had started in post they had commenced a 'manager's walk around' this involved a tour of the service and highlighted any issues which needed to be resolved. However, when issues were identified there was no record of who needed to rectify the issue, a timescale or evidence it had been completed.

We reviewed the food and fluid charts for three people and found significant gaps in the records.

This meant although we saw people had access to drinks the poor records meant we could not be sure people had been supported to eat and drink an adequate amount. A member of staff told us, "Staff do not have time to complete the records."

We were told by the compliance manager that care plan audits were completed monthly. Some care plans contained old information which needed to be archived. If robust care plan audits had been in place these issues would have been addressed.

Staff spoke with us about their concerns about the safety and effectiveness of the call bell system.

The compliance manager advised there was no facility to audit call bell usage and response times at present. One member of staff told us they worked yesterday and a call bell went off, it had not been pressed by anyone and staff were unable to turn this off. They told us there was a key code because the call bell numbers did not match the bedroom numbers. Another member of staff explained one bedroom did not have a call bell because it had been moved to another person's bedroom. We spoke with the manager about this who told us this issue had been logged and they were awaiting a replacement.

All of the above meant the service was not keeping all of the records required up to date. Audits were not effectively identifying issues where improvements were required and risks to people who used the service were not effectively managed.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Service was in the process of updating policies which were to be shared with staff. We reviewed these and they contained relevant guidance and information on recent legislation. This meant staff would have access to policies which reflected up to date legislation.

Despite the concerns we had about the overall management of the service, the majority of people and their relatives told us they were aware there was a new manager. They told us they had met them. One relative said, "The management team are approachable." During the inspection we saw the manager spent time around the service interacting with people and staff. All of the staff we spoke with expressed confidence in the new manager's ability to improve the service. One member of staff said, "The new manager is fab, they will make a go of it."

The manager was helpful and provided us with the information we required to complete our inspection. They understood their responsibilities and were aware of the requirement to submit notifications to CQC

We spoke with the manager and compliance manager about their view of strengths and areas for development within the service. The compliance manager told us this was a small service so the management team and staff knew people and their relatives well. The manager told us the staff team were positive and felt they would be supported to implement any changes they had planned. The manager had arranged a staff meeting to ensure staff had the opportunity to contribute to the running of the service. The compliance manager showed us audit templates which were linked to the fundamental standards however, these had not yet been implemented within the service.

Requires improvement

Is the service well-led?

We could see they had already started to implement improvements within the service. One example was arranging for accessible flower beds to be fitted in the garden. On the day of the inspection we saw one person enjoying spending time out in the garden and helping the maintenance person plant spring bulbs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service was not keeping all of the records required up to date. Audits were not effectively identifying issues where improvements were required and risks to people who used the service were not effectively managed.