

# Gracewell Healthcare Limited

## Randell House

### Inspection report

Fernhill Road  
Blackwater  
Camberley  
Hampshire  
GU17 9HR  
Tel: 01276 31840  
Website:

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### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Good



### Overall summary

This inspection took place on 20 and 21 October 2014 and was unannounced.

Randell House provides residential care without nursing for up to 39 older people some of whom experience dementia. There were 38 people living at the service when we visited.

The service did not have a registered manager in place. 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. The previous registered manager left the service in February 2014. A new manager commenced her role on 25 June 2014 and is in the process of applying to the Care Quality Commission to become the registered manager for the service.

The service was last inspected on 30 July 2013 and was compliant with the regulations inspected.

# Summary of findings

## Safe

Staff had not always followed the provider's policies and procedures when people fell. Therefore not all incidents of people falling had been recorded. People had not always been monitored after a fall which left them at risk of further falls.

People's medicines had not always been managed safely. Not everyone had received their morning medicine at the correct time. The manager took immediate action to rectify this when we brought it to their attention. This ensured all people received their medicine as prescribed.

People told us they felt safe in the care of staff, who had undergone safeguarding training and had access to relevant guidance. Risks to people had been identified and measures taken to manage risks. People were kept safe by robust safeguarding processes and risk assessments.

There had been recent changes in staffing. Appropriate measures had been taken to recruit new staff and agency staff were being used in the interim. People felt more staff were required and the provider was making arrangements to increase staffing during busy morning periods. People were safe as robust recruitment checks were in place for new staff.

## Effective

The delivery of care of people who lived with dementia was not always effective, not all staff understood how to support the needs of people living with dementia.

Staff had not all received an annual appraisal of their work or regular supervision. The manager was aware of this and was taking action to ensure staff people were effectively cared for by staff who received an appropriate level of support.

Where people lacked the capacity to make decisions about their care the requirements of the Mental Capacity Act 2005 had been followed. An application to deprive a person of their liberty under the Deprivation of Liberty Safeguards (DoLS) had been submitted and the manager was considering if others were required. This ensured people's human rights were upheld.

People received good quality meals and the risks to people of becoming malnourished had been managed effectively. The process for serving meals resulted in some people having to wait for a long period of time to receive their meal which caused them frustration.

The service had good links with outside professionals who visited the service regularly. This ensured people's physical and mental health care needs were met.

## Caring

The majority of staff were caring towards people, including people who lived with dementia. However, not all staff were observed to be caring and considerate in the way they delivered care to people who lived with dementia and therefore they did not consistently receive caring treatment from all staff. Information to enable them to make choices had not always been provided in a format that met their needs. People's privacy had been upheld in the delivery of their care. People received their personal care from staff who were discreet.

## Responsive

The social care needs of people living with dementia had not always been met. The provider was aware of this and in the process of taking action.

People had care plans based upon their needs, personal history and preferences to meet their identified care needs. People were involved in planning their care. People or their representatives had been involved in planning their care. This provided them with the opportunity to express their preferences about their care.

Staff encouraged people to maintain their independence where possible. People felt supported by staff to make their own choices. There was a varied activity schedule but a lack of activities to meet the needs of people who experienced dementia. The manager was aware of this and was taking action to address this need.

Communication systems to ensure information about people was shared between staff were not robust. This meant there was a risk that information about risks to people or their needs might not be passed on. The manager was aware of this and was taking action.

# Summary of findings

People had been made aware of the complaints process. Where people had made a complaint they felt that they had been listened to and the issue dealt with. People benefited as learning took place as a result of complaints received.

People's views had been sought through meetings and surveys. However, there were no action plans developed to address any feedback received. Therefore there was risk that people's feedback on the service might not have been used to drive service improvement.

## **Well led**

There was an open culture in that people and staff were encouraged to speak with management about issues. Management at all levels were visible within the service and senior managers regularly visited the service. People felt able to express their views to the management.

Although the manager was new to the service they were experienced and demonstrated an understanding of the

challenges facing the service in order to improve the quality of the service provided. They had already begun to make changes to the organisation and running of the service. The manager was responsive to issues that were brought to their attention during the inspection. People benefited from a service that had clear leadership from the manager.

There were processes in place to monitor the quality of the service provided. Monitoring of quality took place both by the manager and through visits from senior management. There was a new service improvement plan in place to improve the quality of the service people experienced

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

# 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?

The service was not consistently safe.

People felt safe in the service and they had risk assessments in place to manage their risks. However, procedures in response to people falling had not always been followed. This left people at risk of further falls and serious injury.

People felt there was a need to increase staffing to safely meet their needs. The provider was making arrangements to increase staffing during busy morning periods.

People had received their medicines earlier than prescribed. The manager took immediate action to rectify this when we brought it to their attention.

Staff had undertaken safeguarding training and had access to relevant guidance to enable them to safeguard people.

**Requires Improvement**



### Is the service effective?

The care that people received was not always effective.

The care of people living with dementia was not always effective in meeting their needs.

Where people lacked the capacity to make decisions about their care relevant legislation had been followed.

People received good quality meals and were referred to various healthcare professionals when required.

**Requires Improvement**



### Is the service caring?

The service was not always caring.

Not all staff were seen to be consistently caring towards people living with dementia.

People or their relatives, had been involved in planning their care.

People told us that their privacy had been upheld when their care was delivered.

**Requires Improvement**



### Is the service responsive?

The service was not always responsive.

People living with dementia did not have activities tailored to their needs. Plans were in process to address this.

People had care plans in place based on their personal life history and preferences about their care. People felt that their independence was promoted by staff in response to their needs.

**Requires Improvement**



# Summary of findings

Staff communication systems to ensure the service responded to people's needs were not sufficiently robust. The manager was taking action to improve these.

Action plans in response to feedback from people were not in place to improve the service.

Complaints had been listened to and appropriate action taken.

## Is the service well-led?

The service was well led.

The new manager was aware of the challenges facing the service and had developed a service improvement plan to improve the quality of care people received.

The manager demonstrated good leadership. People told us they had confidence in the new manager.

There was an open culture in the service. People and staff felt that management at all levels were visible and approachable.

**Good**



# Randell 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 checked 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 20 and 21 October 2014. This was an unannounced inspection. The inspection was completed by an inspector with experience of working with older people and people living with dementia.

Before the inspection the provider completed 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 reviewed the information included in the PIR along with information we held about the service, including statutory notifications.

Prior to the inspection, we spoke with a social care manager, four health care professionals and representatives from two community organisations that were involved with the service.

During the inspection we spoke with five people using the service, four relatives, a care manager, three care staff, one agency care staff and the chef. In addition we spoke with the manager, the general manager and the care and quality manager. We also used pathway tracking, which involved looking in detail at the care received by two people.

We observed how staff cared for people including lunch time. We observed staff administering medication to people and attended a staff handover. As some people experienced dementia we used the 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 reviewed records which included four people's care plans, four staff recruitment records and supervision records. We also reviewed records relating to the management of the service.

# Is the service safe?

## Our findings

People told us they felt safe, one person said “It is safe here. Staff know what to do.” However people were not always protected from the risk of harm.

Incident forms had not always been completed when people fell, nor had their falls risk assessments always been reviewed following a fall. One person had been admitted to hospital twice following falls and another person had been treated by the district nurse following a fall. Incident forms to document how these injuries had occurred and to identify what measures were required to manage the risk of reoccurrence had not been completed. Falls records did not provide sufficient information about why people might have fallen. Staff had recorded insufficient information to enable effective analysis of the reasons why people fell and any trends in the falls people experienced to ensure the risks to people of falling again were reduced.

When people fell staff were required to monitor them using the post falls protocol in case their condition deteriorated. The protocol had not been used every time people fell; therefore there was a risk of people’s condition deteriorating and this not being identified by staff. The lack of effective falls and incident recording and post falls monitoring meant people’s welfare and safety had not been ensured. Management reviewed completed incident forms to identify actions required to keep people safe, and any learning points or trends. However, as not all incidents of falls were recorded the analysis was not accurate and this did not ensure people’s safety as they were potentially at risk from further falls or accidents.

This was a breach of Regulation 9 (1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had risk assessments and risk reduction measures in place in relation to pressure ulcer development, moving and handling and call bells. If people are unable to use a call bell to summon assistance this creates a risk of their needs not being met. There were call bells throughout the service and people wore individual alarm pendants to enable them to alert staff if they fell. One person said “The pendant provides me with reassurance.” If required people had alarm mats to alert staff that they were out of bed and moving about.

People had an assessment of their risk of choking. Risk reduction measures were in place for those identified at risk. For people identified at risk of choking relevant referrals had been made for example, to the speech and language therapists. The risks to people from choking had been identified and addressed.

Risk assessments indicated how many staff were required to move people safely and one person said “There are always two people to hoist.” People had pressure relieving equipment in place to manage the risk of them developing pressure sores; no-one was being treated for a pressure sore at the time of the inspection.

People were protected from the risk of harm and abuse. Staff had received relevant safeguarding adults training which they had updated regularly. If staff had concerns about people’s safety there were policies and procedures in place to provide them with guidance. Staff understood what incidents should be reported as safeguarding and how to report them. People had been protected when safeguarding alerts had been made as appropriate action had been taken by staff. Changes had been made to people’s care plans following safeguarding incidents to ensure risks to them were managed; a health care professional confirmed this.

Two people’s relatives told us they felt more staff were required and one commented “I would like to see more carers as some people have more complex needs.” One person told us “No there aren’t enough staff. In the morning when I want to get up and have a bath it takes a while for staff to come.” The manager was aware of this need and was awaiting approval to increase the staffing level by six care staff hours in the morning, which would provide additional staffing when people needed the assistance most when they were getting up. The number of permanent staff had reduced due to staff recently leaving the service. The manager had recruited three new staff and continued to recruit to the remaining vacant posts; these included two full-time carers, a chef and a housekeeper. There were sufficient staff to meet people’s needs but the provider recognised people’s care needs could be met more efficiently with an increase in care staff hours which was being arranged.

At the time of the inspection a high number of staffing hours for people’s care was being provided by agency staff. The manager had reduced the impact upon people by using the same agency staff and pairing them to work with

## Is the service safe?

permanent staff, who knew people and their needs. Staff and people's relatives told us there had been some occasions when shifts had not been fully staffed. Staff rotas confirmed that occasional shifts had been short of one member of staff. For example, when there should have been seven care staff in the morning and five in the afternoon, there were occasional shifts where there were only six staff in the morning or four staff in the afternoon. The manager had recently become aware of this issue and now organised the rotas themselves to ensure the correct number of staffing was provided for people and there was a better balance of permanent and agency staff. People's care had not been impacted upon as the manager had taken appropriate action to reduce the impact of the use of agency staff.

People's medicine had not always been managed safely. People on the ground floor had not been receiving their medicine at 9:00am as indicated on their medicine administration record. People had not received their medicine at the correct time. Their medicine had been given to them by the night staff at 7:00am whilst people on the first floor had received their medicine later as it was administered by the day staff. The time people on the ground floor received their medicine had been determined by the staff workload rather than the time they required it. Night staff had been administering medicine at the end of their waking night shift. The manager took immediate action when this was brought to their attention and re-organised the morning medicine rounds to ensure that

people on both floors received their medicine at the required time from day staff. Not all people had received their medicine at the correct time but the manager took action to ensure they would do so.

People received their medication from trained staff who were assessed as competent to administer medications. Staff informed people of what medication they were given. Records were kept of what medication people had received.

Medicines were stored appropriately to ensure they were safe for people. Controlled drugs were stored in accordance with relevant guidance. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. The pharmacist and the provider audited medications and changes had been made as a result.

There were robust recruitment processes in place to ensure that people's care was provided by suitable staff. Staff had completed relevant pre-employment checks which included a disclosure and barring service (DBS) check, references, checks on their employment history, conduct and fitness to work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. People were protected as agency staff had been required to produce evidence that relevant pre-employment checks had been completed before they commenced work.



# Is the service effective?

## Our findings

Not all staff understood how to effectively meet the needs of people living with dementia. At lunch time staff showed everyone the choice of main meal using show plates; some people may not have required this visual prompt. The meals were not given to people until everyone had seen the show plates, so people had to wait too long before receiving their lunch. One person had chosen their meal and could not understand why they had to wait rather than being given the meal at the time they made their choice. They became frustrated banging their cutlery on the table. Staff provided reassurance but the person still had to wait and did not get their meal when they wanted. A care manager told us that they did not think the specific needs of people experiencing dementia could be met. Staff did not always understand how to effectively deliver care to people living with dementia.

The individual needs of people living with dementia were not always met effectively this was a breach of Regulation 9 (1)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Rotas demonstrated that on each shift there was a mixture of team leaders and senior carers who were qualified to National Vocational Level two or three, supported by care staff. National Vocational Qualifications (NVQs) are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability (competence) to carry out their job to the required standard. This ensured that there was an appropriate mix of staff to provide people's care safely.

Staff felt supported in their role, one said "If I need anything I can speak with the team leader and the issue is resolved." The manager was aware that not all staff had received the level of supervision required by the provider. Arrangements had been made to complete staff supervisions to ensure that people were cared for by staff who were supported through regular supervision. Only 10 staff had received an annual appraisal of their work; therefore not all staff had received the opportunity to have their practice reviewed and to identify their development objectives for the coming year. This issue had been identified during the last quarterly quality audit. Plans were in place for staff to receive an appraisal in November 2014, to ensure people were cared for by staff who had received appropriate support in their role.

One person said "They seek consent" and this was confirmed by two relatives. Staff were observed seeking people's consent in relation to different aspects of their care. Staff had received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) to ensure they understood the requirements of the law when people lacked capacity. People had care plans in place in relation to their capacity to consent and it had been documented what assistance people needed to enable them to make decisions. It had been noted that although one person was living with dementia they were able to make decisions about their care. Assumptions about the person's capacity to consent had not been made on the basis of their diagnosis. Where a person lacked the capacity to make a decision their mental capacity had been assessed in accordance with legal requirements and a best interest decision made that involved their relatives.

People were happy with the quality of the meals they received. One person said "Meals are wonderful. We get two choices for the main meal and the choice of a full English breakfast." People were seen to enjoy appetising meals; the sweet trolley was brought into the dining room so people could choose from a range of options. Drinks and snacks were available to people across the day and night. The dining environment was pleasant for people, there were small tables to encourage people to talk to each other and they were laid for each meal, which created an inviting setting for people to dine in.

Risks to people in relation to nutrition were monitored and assessed. Care plans noted if people had specific dietary requirements for example, a fork mashable diet and the chef was aware of identified risks to people and their dietary preferences. No one was currently at risk of weight loss but people's weight was monitored and food/fluid charts were available for staff to use if they had concerns about people's weight. When people struggled to manage their meal their independence was promoted with the use of a plate guard or appropriate crockery. People's dietary needs and requirements had been met by staff.

People had their health care needs met by a range of health care professionals. One person told us "If someone is not well help is sought immediately." This ensured people's healthcare needs and how they were being met were reviewed and monitored with staff. People said "If people need appointments they are arranged." Health professionals reported that staff followed any instructions

## Is the service effective?

or advice provided in relation to people's healthcare; this ensured they received the support they required. People were referred to relevant services if staff had concerns and this was confirmed by health care professionals; this ensured people's healthcare needs were met promptly.

# Is the service caring?

## Our findings

People living with dementia were sometimes treated differently. Two permanent staff put drinks and meals down in front of people without speaking to them. They did not always show people the choice of drinks available and help them to make a choice but just poured people a drink. They did not always tell people that they were putting their lunch in front of them or what the meal was. People living with dementia experienced this care as task driven rather than as an opportunity for social interaction. A staff member put a protective cover on a person to protect their clothing without telling them what they were doing or why, they just said “Put your bib on.” The person said ‘no’ but staff carried on and put the cover on them. The person then took it off and the staff member put it back on without considering if the person may not have understood what was being done to them or that they were trying to communicate their wish not to wear the cover. The staff member then proceeded to feed the person in silence, only speaking to the person once and not responding when the person was trying to communicate. Another staff member was seen putting ice-cream in front of people and saying to other staff “These two will have soft,” speaking about people as though they were not there and not giving them a choice of soft puddings.

Information was not always readily available for people who experienced dementia in a format that met their needs. There was written information displayed about the service. However apart from pictures displayed on bathrooms there was minimal pictorial information. There was a lack of accessible communication to enable people who experienced dementia to understand what was happening or to make choices. There was no pictorial version of the menu or pictures of the day’s activities. There was no information to inform people of the day, date, season or weather. People had their names on their doors but there were no memory boxes to provide people with visual clues that had meaning to them to help them to orientate themselves to their room. Snack stations had been provided throughout the service but there was a lack of pictorial clues to enable people who experienced dementia to understand that these were foods they could help themselves to if they wished. Appropriate information to meet their needs had not been provided.

People living with dementia were not consistently treated with consideration and respect or provided with appropriate information. This was a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who were able to communicate with us were very positive about the caring attitude of staff, one said “Staff are wonderful they care” and “We are treated well.” A healthcare professional confirmed that they had found staff to be caring. Staff were seen supporting a person to transfer to a chair and they interacted with them, laughing with them and then gave them a hug. One staff member waved to people and stopped and chatted with them during lunch. Staff were attentive to a person who was distressed and spoke with them and supported them to join in an activity. Another person required support to cut their food up and staff gently took the person’s knife and fork and smiled at them as they cut their food. Although not all people living with dementia were observed to experience a caring attitude from all staff many other people did experience this.

People who could communicate their views told us they felt involved in planning their care. One person told us “They talk with us about what is in the care plan.” When people could not express their views people’s relatives had been involved in planning their care. Two relatives told us “Yes we did the care plan. They asked about dad’s interests, preferences etc.” This ensured that information about people’s preferences and life history had been sought from their relatives. One person told us “It’s entirely up to you when you get up. You can have staff to help you wash and dress” and another person told us “We exercise choice.” Staff confirmed people’s choices about their care were respected and gave examples, such as respecting a person’s choice to get dressed later in the day. People who were able to be involved in decisions about their care were supported to do so.

People told us that their privacy had been respected. One person said “Staff knock before they come in.” Another said “Yes staff always cover us. Doors are kept closed.” Staff discreetly assisted people with their personal care needs and their privacy was upheld.

# Is the service responsive?

## Our findings

Communication between staff was not as robust as people needed. Staff handovers took place across the day but limited records were kept. Staff did not receive a handover sheet to provide them with written information about people, but relied on verbal information and an allocation sheet that recorded what tasks needed to be completed for people for example, a bath rather than their care needs. Although agency staff worked at the service regularly they did not always receive sufficient information through the handover process to meet people's needs effectively. There was clear care plan guidance about managing the risks to one person which all staff needed to be aware of, however, one agency staff member we spoke with was unaware of this information. This placed the person at risk as not all staff were aware of the relevant information to keep them safe. The manager told us staff communication processes needed to be improved and was in the process of revising the handover sheet to ensure all staff received relevant information about people's needs. This would ensure staff were aware of all relevant information about people.

People's needs had been assessed prior to them being offered a service to ensure that staff were able to meet their needs. People had life stories in their care plans that documented their social networks, major life events, lifestyle, interests and previous occupation. This provided staff with information about people's backgrounds. People or their relatives were also asked to complete an interest checklist to document people's interests and inform staff about the person. Where people required additional assistance to participate in activities this had been recorded. It had been noted that a person liked to attend church and although a church service was held regularly they would need reminding to attend. This ensured staff were aware of this person's spiritual needs and the support they required to enable them to participate.

There were general activities to stimulate people however; there were no activities specifically tailored to meet the needs of people living with dementia. Activities for people living with dementia had not been tailored around their personal life histories and needs. Plans had been submitted to provide a specific room and associated activities programme to meet the needs of people who living with dementia if the existing activity programme was not suitable for them. The service proposed that this

programme would provide activities such as reminiscence to enable people to discuss their past lives and would supplement existing activity provision. People could participate in a varied activities schedule across the course of the week including weekends. Staff told us that people physically assisted in the garden if they were able to and were taken to the garden centre to choose plants for the garden. One person said "If I want to go and buy clothes they take me out."

People's feedback was sought through monthly residents' meetings, where people were encouraged to raise issues such as the menus. The service did not use specific communication methods to seek the views of people with dementia. Minutes from these meetings were limited and there were no action plans to identify issues and how they would be addressed. The manager was aware of this and was planning to make the recording of these meetings more robust. There were plans to introduce relative's meetings to ensure they had a regular forum to express their views. People were asked to complete an annual survey, which had just been circulated. The last survey showed a high degree of satisfaction but there was no action plan to look at how improvements could be made. The service had taken measures to seek people's views, however there was a lack of evidence to demonstrate people's views had been acted upon

Care plans recorded people's preferences about their care, for example, if they had a preference for a male or female carer. Staff rosters had been arranged to give people a choice of a male or female carer where possible. The care plan for one person documented their relative's preferences about their appearance. This request had been met, ensuring that the person's personal appearance was maintained as it had been prior to them living with dementia, thus maintaining their individuality. People's preferences about their care had been respected.

People told us staff encouraged them to be as independent as they could. One person told us "I always make my bed. Staff encourage me." Other people who used wheelchairs were seen to propel themselves around rather than being reliant on staff to mobilise them. One person's care plan stated 'Staff were to promote the person's independence in their choice of clothes and encourage them to wash and dress themselves'. This person confirmed to us that staff had supported them to achieve these objectives. People with a visual impairment were seen to be appropriately

## Is the service responsive?

supported by staff as they moved around the building. One person put their hand on the shoulder of staff so that they had physical contact with staff whilst they walked. Staff provided verbal information to the person about where they were going. The independence of the people we spoke with and observed was promoted.

Information about the complaints process had been made available to people in a written format and people felt able to make a complaint if required. One person told us “Yes, I feel complaints would be responded to.” Six complaints had been received this year and action had been taken in each instance, with the complainant receiving written

feedback or a personal meeting in accordance with the provider’s guidance and procedures. Two relatives told us “We raised an issue of missing clothes; we feel action has been taken.” Management confirmed that complaints about laundry had been received, action had been taken and they now ensured people’s clothes were labelled. A person’s representative told us they had raised an issue about the person’s personal care and they felt this had been addressed. People’s complaints had been investigated and acted upon. People’s quality of care improved as learning took place from complaints through discussing them at staff meetings.

# Is the service well-led?

## Our findings

People's relatives told us the "New manager seems good." The new manager demonstrated a clear understanding of the challenges facing the service in terms of improving the experience of people living with dementia, staffing the service and improving internal staff communications. A service improvement plan had been written, which addressed issues such as communication, care planning, activities provision, mealtime practices, staff support and quality assurance. Management had been made more visible and accessible to people by re-arranging the roster so that the deputy manager now worked two shifts on the floor. The manager understood that staff morale had been low when the previous manager left, as confirmed by the general manager. The manager had re-introduced the 'employee of the month programme' in order to recognise and value staff input. Staff were encouraged to voice their views to the manager for example, in relation to the staff roster. They told us that they also ensured staff welfare was promoted for example, by ensuring staff took their breaks.

The quality of people's care was regularly monitored and audited. The manager was required to submit monthly quality indicators which encompassed various aspects of people's care areas such as pressure sores, nutrition, infections, incidents, restraint, notifications, deaths, safeguarding referrals, complaints, feedback from residents' meetings and audits. There was an accompanying narrative which provided details, for example, of who was on a food/fluid chart and why. This enabled senior management to have a more detailed understanding of incidents. There were monthly provider visits by the general manager who also audited aspects of the service as part of their visit for example, care plans, medication or nutrition. The quality director completed a quarterly quality audit which had just been adapted to encompass the CQC key lines of enquiry. The provider was ensuring that their monitoring of the quality of the service reflected the areas inspected by the CQC. The quality of the care provided to people had been kept under review and actions taken when issues had been identified.

People told us that there was an "Open and nice atmosphere" People's relatives and a health care professional commented on the culture being 'Open and transparent.' People felt able to speak with the manager as

they wished. One person said "You can go to the office for a chat anytime." People's relatives told us that the new manager had introduced themselves when they started so they knew who to go and speak with. The general manager also visited the site weekly and ensured they spoke with people and staff as part of their provider visits. Provider contact telephone numbers were openly displayed for staff or people to ring if they felt they needed to raise an issue outside the management of the service. Staff felt they could voice their opinions. One said "I can talk to the team leader, issues are resolved." When staff raised issues such as the management of the roster they had been listened to and changes implemented to improve the delivery of care. The manager had listened and changed the roster to ensure there was more even balance of agency and permanent staff. This reduced the impact upon people of the use of agency staff. People benefited from a service that encouraged people to speak to management.

Communication was open within the service. People were able to voice their views at the residents' meetings and the manager was in the process of re-introducing residents' meetings to ensure they had a forum to formally voice their views. In the interim people's relatives felt they had been communicated with and told us "There was a change of provider and we were given details of the change." People had been kept informed of changes to the management of the service.

The provider had a set of 'Living values' which were behaviours they expected staff to demonstrate in their practice, to ensure people were treated with kindness and respect. These were covered with staff in their induction and the staff handbook. Staff confirmed "We have talks on values and choices." The new manager had spent time observing staff practice and interactions between people and staff and understood the culture of the staff teams.

The new manager had applied to become the registered manager of the service, as required by the Care Quality Commission. Required notifications had not been submitted in relation to the person who was admitted to hospital twice following falls. The manager took immediate action to submit these when they became aware of the two incidents. Records demonstrated that CQC had been informed of other notifiable incidents as required. Not all incidents had been reported at the required time.

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 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services  People had not been protected against the risks of receiving care or treatment that was inappropriate or unsafe as the planning and delivery of people's care did not always meet their individual needs or ensure their welfare and safety. Regulation 9 (1) (b)(i)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services  People who experienced dementia had not always been treated with consideration and respect or provided with appropriate information and support in relation to their care. Regulation 17( 2) (a)(b).