Malhotra Care Homes Limited

Addison Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 29 and 31 August 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

The service was last inspected in January 2017, at which time the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 12 (safe care and treatment). We found medicines were not managed, stored or audited appropriately at the previous inspection. At this inspection we found medicines were managed appropriately and a range of improvements had been made.

At the previous inspection of January 2017 we rated the service as good. At this inspection we rated the service as requires improvement.

Before the inspection in January 2017 we were notified of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result both this and the previous inspection did not examine the circumstances of the incident.

However, since the date of the last inspection a further review of the incident has been carried out and identified potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

Addison Court is a care home in Crawcrook, Tyne and Wear. It is registered to provide accommodation for up to 70 people who need nursing and personal care. It provides a service primarily for older people, including people living with dementia. There were 57 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

Improvements had been made to the storage, administration and disposal of medicines. This was generally found to be safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). Where there were individual discrepancies or errors, we found the registered manager's auditing system had also picked up on these areas and an action plan was in place. The registered manager's medicines auditing process was robust.

Treatment rooms were clean, tidy and temperatures were recorded. Other areas of the building were clean and some carpeting had been replaced with vinyl flooring to ensure it was easier to clean. Additional hours for domestic staff and new cleaning products had also been sourced.

Risks to people were managed through risk assessments and associated care plans. These risks were reviewed regularly and, where appropriate, included or made reference to advice from healthcare professionals to keep people safe.

Staff were knowledgeable regarding safeguarding principles and what potential signs of abuse to look out for. People we spoke with and their relatives consistently told us the service maintained people's safety. External professionals all agreed the service had improved in recent months and that they had no major concerns.

There were pre-employment checks of staff in place, including identity and Disclosure and Barring Service checks. There were enough staff deployed to meet people's needs safely.

Staff completed a range of training, such as safeguarding, health and safety, fire awareness, nutrition, dignity, moving and handling, dementia awareness, infection control and first aid. The system the registered manager used to monitor staff training demonstrated that training had not been delivered regarding breakaway training or the Mental Capacity Act.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The registered manager displayed a good understanding of capacity and we found the provider had followed the requirements in the DoLS. Best interest decisions however were not completed in line with MCA guidance, meaning the involvement of people who knew people's needs best, such as family members or clinicians, was not always documented.

Staff told us they were well supported and we saw supervisions and appraisals had happened or were planned.

Mealtimes were pleasant, with people given a choice of meals. The chef was passionate about providing high quality food to people's preferences and feedback regarding food was consistently strong.

Staff had built friendly relationships with people who used the service and people told us they knew staff well.

The premises benefitted from aspects of dementia-friendly design, such as tactile wall displays and clear signage, whilst corridors were bright and spacious.

Care planning documentation was sufficiently detailed and staff displayed a good knowledge of people's needs, likes and dislikes. Handover documentation was not sufficiently detailed and required improvement.

Group activities were planned by two activities coordinators and people who used the service told us they enjoyed these activities.

The atmosphere at the home was calm and people who used the service confirmed they felt at home.

Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and were confident in their abilities. There was a strong consensus of opinion that they were making positive changes to the service that would benefit people who used the service.

The registered manager and their deputy had not at the time of this inspection had sufficient time to focus on all aspects of auditing work and we found some quality assurance work had not identified some of the

areas for improvement which the inspection had. The registered manager had completed a number of shifts as nurse in charge, as had the deputy. The registered manager confirmed the deputy would be able to complete auditing and other support the following week, with the planned 11 hours supernumerary in place.

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.

Improvements had been made to the administration, ordering, storage and auditing of medicines.

There were sufficient staff on duty to safely meet the needs of people who used the service, although the provider had at times been reliant on the registered manager completing nursing shifts.

Pre-employment checks of staff reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental Capacity Act and breakaway training had not been delivered since the last inspection and associated best interests decisions were not appropriately completed.

Handover documentation required improvement, although staff demonstrated a good knowledge of people's medical, nutritional and behavioural needs.

People's nutritional and hydration needs were consistently met. People enjoyed the meals on offer and the chef was passionate about people enjoying meals which met their preferences.

The premises were well designed for people's needs, with aspects of dementia-friendly design and ample facilities.

Is the service caring?

Good

The service was caring.

People who used the service, relatives and external stakeholders agreed that staff were dedicated to meeting people's needs and did so in a calm and reassuring fashion.

Staff had built good rapports with people who used the service

and we observed a range of positive, reciprocal interactions.

End of life training was in place for staff and an end of life care champion had been nominated, although they had yet to being their role.

Is the service responsive?

Good

The service was responsive.

Staff liaised promptly with external healthcare professionals and incorporated advice into care planning.

Activities were planned with the involvement of people who used the service and they were varied. The majority of people we spoke with found the range of activities sufficient.

The complaints process was readily available and people who used the service confirmed they were comfortable raising any concerns. We saw complaints had been comprehensively addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Whilst some improvements had been made, the shortfalls in core training and associated documentation had not been picked up by the auditing systems in place.

The registered manager and deputy manager did not always have sufficient time to undertake quality assurance work as they had been required to complete a number of nursing shifts.

People who used the service, relatives, staff and external professionals were complimentary about the approach of the registered manager and the changes they had made or were planning.

Addison Court

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.

We visited the service on 29 and 31 August 2017 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector, one specialist advisor and one expert by experience. The specialist advisor in this case had a background in nursing. An expert by experience is a person who has relevant experience of this type of care service.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the CQC. Notifications are changes, events or incidents the provider is legally required to let us know about. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

During the inspection we spent time speaking with people who used the service and observing people and staff in the communal areas of the home. We spoke with six people who used the service and four relatives. We spoke with 15 members of staff: the registered manager, the deputy manager, the head of compliance, two registered nurses, two administration assistants, the cook, a domestic assistant, two team leaders and four care assistants. We spoke with two healthcare professionals during the inspection and one subsequent to the inspection.

We looked at seven people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes, maintenance records, surveys and quality assurance documentation.

Good

Is the service safe?

Our findings

At our previous inspection of January 2017 we identified concerns regarding the storage and administration of medicines. We found the rooms in which medicines were kept were unclean and disordered, medicines were not stored correctly, medicines care plans were not always up to date, the ordering of stock was not effective and there were a range of medicines errors that had not been acted on, despite being identified through audits. At this inspection we found the registered manager had made a range of improvements. The treatment rooms we saw were well maintained, clean and in order, with temperatures monitored in line with guidelines. Systems were in place to ensure medicines were ordered, received, stored, administered and disposed of appropriately.

We saw the service used an electronic medicines administration (eMAR) system. The registered manager and the head of compliance confirmed the implementation of the system had proved problematic in terms of administration. We found the registered manager had a good understanding of the system and had proactively engaged with the provider of the system to raise their ongoing concerns. They had also implemented various workarounds to ensure they were able to provide people with appropriate medicines safely, for instance through using manual site maps for the application of transdermal patches, as the electronic system had no means of recording this.

We reviewed a range of eMAR records and found the administration of medicines, including time critical medicines such as Warfarin, to be administered as prescribed. We found the registered manager's auditing of medicines to be robust and had identified the issues we also found. We saw where issues had been identified there was an action plan in place.

Staff had been trained in the administration of medicines and additional pre-planned training was taking place on the first day of our inspection regarding medicines administration. During the inspection the head of compliance confirmed they would no longer be using the eMAR system and would revert to a paper based system.

Incidents and accidents were consistently and clearly recorded, with the registered manager demonstrating a strong oversight of these and taking remedial action where necessary.

We found, where an incident or an accident occurred, the registered manager ensured staff had the opportunity to reflect on the incident and were supported to do so. This meant the registered manager was actively developing a culture whereby errors were used as opportunities for learning and improvement.

We spoke with a Tissue Viability Nurse, who stated, "If we put a plan in place they follow it. I don't have any concerns about the service and staff are always helpful. Positional charts are always fine in my experience." The service used recognised tools such as the Braden Pressure Ulcer Assessment and the Malnutrition Universal Screening Tool (MUST) to assess the risks people faced. We also saw the registered provider's training manager had incorporated 'React to Red' learning materials into future pressure sore awareness training. React to Red is a recent NHS initiative aimed at increasing awareness of pressure sore risks in carers

and family members.

There were sufficient staff on duty to meet the needs of people who used the service, although there had been occasions recently where the registered manager and deputy manager had completed nursing shifts as the provider had struggled to source sufficient nursing staff. People who used the service and their relatives stated they felt there were sufficient staff to meet people's needs, as did staff. We saw people who used the service had individual dependency assessments and that these were factored in to the planning of staffing. One person who used the service said, "There are enough staff in general – things have changed for the better." One visiting professional said, "I've never been here when there are too few staff. I think they're looking at being a bit more flexible across the floors though." One member of staff told us they sometimes struggled if a number of people needed help at once. This was specific to the residential top floor and we saw the registered manager had acknowledged the need for additional staffing, with one more member of staff planned for this floor. A number of staff we spoke with stated one major improvement the registered manager had made was with staffing levels.

Call bells were responded to promptly throughout the inspection, and staff assisted people in a calm, patient fashion throughout the two days of our inspection.

Where bed rails and lap belts were used, we found these were supported by specific risk assessments. When we asked staff about people who needed these particular pieces of equipment in place they demonstrated a good awareness of how to keep people safe and why the equipment was needed. Other risk assessments we saw included falls risk assessments and nutritional risk assessments and plans. We saw actions were in place to mitigate the risks and ensure staff knew how to help support people.

We found there was a systematic approach to monitoring and reviewing the upkeep of the premises. The registered manager conducted regular walk around inspections of the service and the chef completed monthly kitchen audits. We found the premises to be in good order.

Staff we spoke with had been trained in safeguarding and displayed a good understanding of their safeguarding responsibilities. They described potential types of risk, abuses and what they would do should they have concerns. People who used the service and their relatives told us they felt safe and we saw this corresponded with recent survey results.

We reviewed a range of staff records and saw pre-employment checks including references, identity checks and enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. This meant that the service had in place a thorough approach to vetting prospective members of staff and so reducing the risk of unsuitable people being employed to work with vulnerable people.

We found the home to be clean and free from odours, including bedrooms, communal areas, the laundry and kitchen. At the last inspection we noted a malodour in on area of the service and raised this as a concern with the provider. At this inspection we saw a number of rooms had had carpets replaced with vinyl flooring for ease of cleaning, with more planned. Additional hours had been allocated to domestic staff since our last inspection. One member of domestic staff told us, "They've got better products in and we're on top of things." This demonstrated people were protected from the risk of acquired infections.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Whilst DoLS applications we saw were appropriately completed, we found training with regard to the MCA had not been effectively implemented, with the majority of staff not having received this core training course. The registered manager and head of compliance confirmed the training was planned but acknowledged it had not been delivered. We found there was an impact on associated documentation and considerations. For example, the mental capacity assessments and best interests decisions we reviewed were not always accurately or appropriately completed. Some best interest decisions had been completed by the nurse on duty, with no documented involvement of the person's family or a clinician. The Mental Capacity Act 2005 Code of Practice (2007) states, 'The views of other people who are close to the person who lacks capacity should be considered' (5.13) and, 'Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision, setting out: how the decision about the person's best interests was reached; what the reasons for reaching the decision were; who was consulted to help work out best interests; what particular factors were taken into account' (5.15). This meant the service could not always demonstrate the decisions taken in a person's best interests had been made in line with good practice.

At the previous inspection of January 2017 we noted staff had not received training in how to safely disengage from people who were, due to their illness, showing signs of aggression. We found at this inspection that the provider had yet to implement this training. The head of compliance showed us correspondence with a training provider, which demonstrated they had enquired about a training package, but staff still had not been given the necessary skills by the provider. We saw three people who used the service regularly displayed behaviours that could be seen as aggressive and, whilst staff we spoke with were aware of their needs and could explain how they supported people, they had not been trained how to safely breakaway from a person should they need to. One member of staff told us, "I've learned as I've gone along – I've had a couple of bumps and punches along the way." This demonstrated the training was necessary but had not yet been implemented.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Other staff training was managed with a training matrix in place to track who required refresher training and

when. The service had a cinema room which was regularly used as a training room. Staff demonstrated a good knowledge of other training courses and topics we spoke with them about, for example, Positive Minds in Care training (a dementia awareness course), first aid and end of life care. Core training for staff included fire safety, health and safety, moving and handling, dignity, infection control nutrition and first aid.

We saw regular staff supervision and appraisal meetings had taken place. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. Appraisals are an annual review of staff performance. Staff we spoke with confirmed they were supported to raise concerns and thoughts about their future development. Staff confirmed they were well supported by the registered manager and that staffing levels and deployment had improved since their arrival.

People who used the service and relatives were complimentary about staff knowledge and experience. One relative told us, "They take time and pay attention to my wife – this place has improved a lot recently." One person who used the service said, "I have no complaints about the abilities of staff." Opinions from external healthcare professionals were more mixed and generally reflective of a service that had seen some recent turnover of staff but was being managed in the right direction. Representative comments included, "They do seem to be heading in the right direction. The qualified staff in place now seem to be asking the right questions and requesting appropriate support which has vastly improved from where they were."

The areas for improvement raised were regarding paperwork rather than practice and this was reflected in our inspection findings. For example, the handover documentation we reviewed was lacking in detail regarding people's DNACPR status, whilst one person's notes had not been fully completed, with their name written in pen over the top of another person's name.

DNACPR stands for Do No Attempt Cardiopulmonary Respiration and is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. The registered manager stated nurses in charge were aware of people's DNACPR status and we found this to be the case when we spoke with them. The registered manager however acknowledged that care staff would not necessarily know a person's DNACPR status without checking with a nurse, meaning the decision whether or not to perform CPR may not be made quickly. The registered manager agreed to review the handover documentation and we saw the first version of this during our inspection. We also arrived early on the second day of the inspection to observe the staff handover. This demonstrated that, whilst the handover documentation required revision, the information shared verbally between staff demonstrated a good awareness of people's changing needs.

We sampled DNACPRs and found them to be in date and correctly completed by the clinician, with involvement from relatives and social care professionals.

The premises were appropriate to the needs of people who used the service. Corridors were wide and bright, with sensory installations in some corridors. Bedrooms were spacious and with an en suite. There was sufficient space in communal dining areas for people who used the service.

We observed mealtime interactions and found them to be pleasant, with sufficient staff to support people who required it. Staff interacted patiently and in a reassuring fashion with people. We observed staff asking people for their consent to various aspects of care throughout the inspection. Some care files did not clearly evidence that consent had been sought however the registered manager and head of compliance agreed to review the documentation of consent alongside their review of best interest decision-making.

The chef demonstrated a good knowledge of people's favoured foods, their dislikes, and whether they were on a specialised diet, such as a soft diet. They were passionate about people being able to choose the meals

they wanted and had attended residents' meetings to ensure they incorporated the preferences of people who used the service into menu planning. Comments regarding the food were consistently positive, for example, "The food is lovely and there is plenty of it – we think the chef makes a real effort" and, "The cook is very good and will cook you an alternative if you don't want one of the main choices." The chef had recently started using new moulds for people who were on soft diets, which made food look more appetising. They stated they felt people were eating more now than before.

People were supported to access primary health care, such as GP visits and dentist appointments, along with secondary health care such as chiropody.

Good

Is the service caring?

Our findings

People who used the service and their relatives gave us consistently positive feedback about the caring and patient attitudes of staff members. One person said, "We like the staff - they do a hell of a lot of work but they do it very well," whilst another told us, "The staff are very patient and we know each other very well. They are always helpful and caring." Relatives were similarly positive, with one stating, "I can't fault the staff at all – they give me peace of mind and are always sensitive," and another saying, "The staff seem very caring and concerned. They know how she likes her independence."

During our inspection we observed one person who used the service display behaviours inappropriate to the dining environment. We observed one member of staff discreetly distract the person and encourage them to move away from the dining area. Likewise, during another part of the inspection we observed one person who used the service becoming increasingly anxious about not having seen a person they were expecting to. We observed staff engage with them sensitively and discreetly in a way that calmed the person and gave them reassurance. In both instances people's dignity was maintained and it was clear staff were aware of how to calmly support people in ways that meant their behaviours did not escalate.

We saw the 'dignity do's' plainly advertised in a communal areas and people told us they were treated with respect. The dignity do's are ten nationally agreed principles which, when delivered, enable people to receive care in a dignified manner. There were policies to ensure people were not discriminated against and staff had received dignity training. One relative told us, "I find the staff respectful towards my friend and I know her privacy is looked after."

We observed personable and reassuring interactions between members of staff and people who used the service during the two days of the inspection. One person who used the service told us, "They spend time and talk if they are not too busy. We talk about politics and world affairs." People who used the service acted comfortably with members of staff and vice versa, and we found the atmosphere to be relaxed and calm. We observed staff supporting people in line with the details of their individualised care plans, including specific communication plans which detailed how people preferred to be spoken with and how staff could best ensure they could be understood. This demonstrated staff had a good understanding of people's needs and had built rapports with them.

Staff had received end of life care training and the provider had relevant policies and procedures in place. We saw people's care plans described their preferences as they approached the end of their lives. The registered manager told us about their plans to have and end of life champion and, when we spoke with that member of staff, they demonstrated a good knowledge of this area of care and were keen to make a difference to people's experiences through this role.

Compliments and thank-you cards had been kept and demonstrated instances of positive feedback about people's experiences, for example, "Thank you for your professionalism, empathy and bringing light into a situation," and, "Thank you for all the care, respect, love, laughs, smiles and happiness." We reviewed recent survey results, which contained further positive feedback regarding the caring attitudes of staff.

At the previous inspection we noted some people's confidential records were left on display in communal areas. At this inspection we found they were kept in cupboards at the nurses' stations.

Good

Is the service responsive?

Our findings

All care files we reviewed had a pre-admission assessment included, which meant staff had the relevant information available to put in place each person's care planning. Likewise, we saw in each file we reviewed that a 'This is Me' document had been completed. 'This is Me' is a tool produced by the Alzheimer's Society which lets health and social care professionals know more about people's needs, interests, preferences, likes and dislikes. We found care files contained a sufficient level of person-centred information and, when we spoke with staff, they demonstrated a sound knowledge of people's needs and preferences. For example, one person living with dementia was extremely anxious and worried about their dog. A staff member responded in line with the care plan, talking to the person about their dog and reassuring them about who was looking after the dog. This meant staff were able to implement person-centred strategies to ensure people were supported.

The service had two activities co-ordinators in place and we saw there was an activities plan displayed in communal areas, as well as photographs of previous events. During our inspection we saw people relishing a reminiscence session, as well as enjoying the visit of a relative's dog. Recent planned events included a 'bushtucker trial' day, whereby members of the local fire service attended, quizzes, coffee mornings, crafts and film screenings. People who used the service told us they enjoyed these activities. The activities co-ordinators occasionally met with co-ordinators from other homes the provider was responsible for in order to share ideas about what had/had not worked well.

During the handover we observed, all staff were encouraged to take responsibility for encouraging individual activities. The registered manager told us they wanted a culture whereby the responsibility for ensuring people had a good quality of life through meaningful activities fell to all staff. Feedback regarding activities was mixed, with most people and relatives content with the level of activities available. One relative and one external professional thought more could be done to provide regularly stimulating activities.

We saw the registered manager held relatives and residents meetings and was keen to ensure people who used the service and their relatives were involved in care planning, review and more general issues regarding the home. Relatives we spoke with confirmed they had been invited to meetings and felt they were a good idea. The registered manager showed us letters they had sent to relatives, encouraging them to take part in these aspects of the running of the home. They acknowledged that the manner by which they gathered people's views, and the views of important people such as relatives, was yet to be fully established, but they demonstrated that they valued the input of people who used the service and their relatives.

We saw Emergency Health Care Plans (EHCPs) were in place. An EHCP makes communication easier in the event of a healthcare emergency, should people's needs change. For instance, we saw specific conditions were described in these EHCPs, with instructions set out to help staff and visiting professionals ensure they followed the planned care path. One relative told us about how difficult they and their spouse had initially found the move to a care home but stated staff had been flexible to their needs. They said, "They were sensitive with the transition and knew it was a difficult time for me as well as my [person]." This meant people's changing needs had been considered and acted upon.

Daily notes we reviewed were mostly concise and up to date, containing information about basic care, hygiene, continence, mobility and nutrition. Where people displayed behaviours that could be seen as challenging we saw there were specific strategies set out in their care plans to enable staff to understand why they may behave in a particular way, and how they could best support that person.

Individual care plans had been assessed by staff on a monthly basis. We found a number of care files however whereby the '6 month review' document had not been completed. We asked the registered manager and the head of compliance about this. They stated the review paperwork was currently being revised and reviews would take place annually in future. This did not account for the fact the existing 6 month review documents remained incomplete and the registered manager addressed this during the inspection.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas and in the service user guide. People we spoke with and their relatives knew how to make a complaint and who to approach. One person told us, "Don't worry, I would let them know if there were any problems," whilst another said, "I know how to complain if I need to." One relative told us that the registered manager had been extremely responsive to their concerns recently and that they were happy with how their concerns had been managed and responded to. We saw complaints were recorded in a specific log so the registered manager could track any patterns developing. We reviewed a sample of complaints and found they had been dealt with comprehensively and in line with the provider's policy, with internal investigations and follow-up actions where appropriate.

Surveys were used as a means of routinely gathering feedback from relatives, people who used the service and visiting professionals. Overall, we saw recent responses were positive regarding the standard of care, staff and facilities.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care and demonstrated a sound knowledge of people's needs, preferences and medical conditions, as well as the day-to-day workings of the service. They had been registered as manager since February 2017.

There was a consensus of opinion from both staff and external professionals that the registered manager had made recent improvements to the service and had appropriate plans in place to ensure the service could deliver a good quality of care to people. One relative told us, "The culture is changing but [registered manager] needs support."

The registered manager had yet to complete some of the aspirational work they had planned, but they were passionate about being able to progress this work when core areas of the service were stable. For example, they planned to introduce champions in end of life care, dignity, dementia, moving and handling and falls prevention, amongst others. This is considered good practice and can help instil a stronger team ethic as well as build knowledge for staff. We saw the head of operations had enquired with the local vanguard regarding the involvement of the registered manager, to see if the service could benefit from the findings of this work, specifically regarding falls prevention. The vanguard is one of six projects nationally, supported by NHS England and aims to find ways to improve integration between health and social care, as well as reducing hospital admissions. Whilst the details of this work were yet to be finalised, this again demonstrated a keenness on the part of the registered manager to ensure the service had regard to best practice.

With regard to documentation and auditing, this was an area that, whilst improvements were evidently being made, required further attention. We found medication auditing to be strong, whilst infection control, mattress checks and health and safety auditing also proved effective. Some other areas of quality assurance were not always to this standard. The incomplete '6 month review' forms we identified in a range of care files had not been identified prior to our inspection, whilst there were deficiencies in the handover documentation. DNACPR arrangements and training requirements (specifically breakaway training, Mental Capacity Act training and the associated best interest decisions) demonstrated that the auditing regime in place was not yet fully effective.

The registered manager had worked a number of additional shifts as nurse on duty as it had not been possible to recruit nursing staff in time. This meant there was a risk aspects of management such as audits could not be progressed as effectively as possible. We saw they were actively recruiting new staff on a rolling basis to ensure this was not a long-term problem. Relatives we spoke with praised the commitment of the registered manager, stating, for example, "They are fabulous". The majority of staff confirmed the registered manager had brought about improvements since taking over, particularly regarding staffing levels and accountability.

We saw the deputy manager had also been supporting with the day-to-day running of the service and, at the time of the inspection, had not had the planned supernumerary time to support with areas such as auditing. The registered manager confirmed this would be happening from the week after the inspection. This meant the registered manager and their deputy had not always had time to conduct audits with the required analytical focus to identify and address underlying problems. This meant they had not identified a number of areas that required attention.

Visual checks of the service were strong, with the registered manager conducting daily walk arounds and observing mealtimes, feeding back any issues to staff directly. The registered manager played an active part in the day to day running of the service and staff and relatives we spoke with commented on their visibility and approachability. We saw the registered manager made themselves available until 8pm one day per month, should relatives want to call them about a particular issue and were unable to during the day due to shift working or other commitments.

The manager held meetings with relatives and residents, and planned to send out surveys on a six-monthly basis, to gather feedback regarding the service. They also met with registered managers from the provider's other services to share feedback and discuss any concerns or areas of best practice.

External professionals agreed that the registered manager had made improvements. They stated, for example, "Things are much more stable," and, "There have been real improvements since the turn of the year. The regular nurses know patients well and, whilst staffing used to be a problem, that has improved."

One relative we spoke with explained how the registered manager had kept them informed at all stages of an internal investigation regarding a concern about their relative. They confirmed the registered manager had promptly and openly updated them and acknowledged where the service could have been better. This meant relatives had experienced the registered manager acting with due candour when a mistake had been made.

Staff agreed the registered manager kept them aware of changes and developments, and described them as, "A good leader – you know where you stand with them." Another consistent comment from staff was that the registered manager was, "Firm but fair." We saw they had recently implemented a new means of sharing information with staff. Rather than having all-staff meetings, they met daily with heads of service, who disseminated relevant information, then shared a 'key messages' document with all staff. The registered manager told us they would review the effectiveness of this system after trialling it.

The registered manager discussed how they planned for staff to be more flexible across floors so that people who used the service could have their needs met more responsively. This was dependent on ensuring staff were familiar with the system and the registered manager acknowledged it would take time to ensure this culture was instilled. Some staff we spoke with stated they had received additional training in order to become team leaders and were looking forward to working more flexibly.

We found the registered manager's office and the administrator's office to be organised, with appropriate levels of administration support. Documents we asked for were readily accessible, although some care documentation required updating, as noted above.

The registered manager had sent appropriate notifications to CQC, ensuring they were sufficiently detailed.

We found the registered manager to be strong leader with a hands-on approach to improving the service. They were keen to continue improving the service and to ensure the culture was one focussed on meeting

people's care needs in a dignified fashion.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not appropriately trained in relation to the Mental Capacity Act 2005 and breakaway training.