The Orders Of St. John Care Trust

Hayward Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the last inspection on 11, 12 and 13 May 2015 we asked the provider to take action to make improvements on reporting important events to the Care Quality Commission, ensuring staff were supported and trained to meet people's needs and to follow guidance from healthcare professionals. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

Hayward Care Centre is registered to provide accommodation for up to 80 persons who require personal care. The service was arranged over five units and provided specialist dementia care in Potterne. The other units provided residential and nursing dementia care.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks were assessed and action plans were developed for identified risks. Members of staff knew the actions needed to minimise risks. However, we found staff had not consistently followed the guidance for monitoring people's fluid intake. We found the fluid intake records we audited for two people were not completed on consecutive days. We also found the target intake was not recorded on fluid monitoring charts. This meant staff were not always aware of people's target fluid intake and were not provided with an audit trail of people with poor intake of fluid. The registered manager described the systems to be introduced to improve recording.

We saw staff enabling people to make decisions from the options given. Staff said there were people who at times became aggressive towards each other and the staff. Clear guidance on how staff were to respond to incidents of aggression were in place. However, records showed staff were not following guidance. For one person staff were given guidance to administer, when required, medicines before delivering personal care but had not followed the guidance and the person had become anxious during these periods.

Staff said staffing levels were not appropriate on two units. We saw that on one unit, during the lunchtime meal, the staff were stretched and did not give people attention and assistance with eating their meals. Staff said there had been changes of staffing with the opening of a unit and for some staff this had created low morale. The staff said there was heavy reliance on agency staff. The registered manager said the staffing levels were consistent with the dependency needs of people.

Care plans were developed in line with people's assessed needs and for some people their likes and disliked were included. Life stories were not in place for all of the people living with dementia but were to be developed with the introduction of a staff member who was to be the dementia lead. Structured planned

activities were not taking place. Staff said activities were more ad hoc but were taking place such as baking and music.

The people able to respond to our request for feedback told us they felt safe and people we observed greeted staff in a positive manner and did not show signs of distress when staff were present. Members of staff were knowledgeable about the procedures for safeguarding people from abuse. They knew the types of abuse and the actions they must take for alleged abuse.

People were supported with their ongoing health. People had regular visits from their GP and there was partnership working with healthcare professionals such as the care liaison team. Medicine systems were safe. Staff said medicine systems had improved. Protocols in place gave staff instructions on administering medicines prescribed to be taken when required.

Staff said the training was good and a variety of courses were available. Some staff said specialist dementia training was needed to ensure all staff had developed the insight and skills needed for working with people living with dementia.

People's rights were respected. Members of staff were respectful towards people and the approach used depended on the situation. For example, some people responded to humour while others were more receptive when staff used logic and reasoning.

Quality assurance systems were in place which included internal audits and the necessary action was taken to implement change. Where there were shortfalls action plans were developed on how improvements were to be made to meet set standards.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew the actions needed to minimise risks identified and risk assessments were developed but action plans were not always followed. For example, fluid intake charts were incomplete for some people.

Staff said the staffing levels were not appropriate on each unit. They said the opening of another unit had caused changes in staffing. We saw during the lunchtime meal in one unit that people were not given the full attention needed to eat their meals.

Staff knew the procedures they must follow if there were any allegations of abuse.

Systems of medicine management were in place to ensure people received them safely. .

Is the service effective?

Good

The service was effective.

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was always assessed.

People's dietary requirements were catered for. People were offered a choice of meal at all mealtimes.

Members of staff attended mandatory training set by the provider. This training increased staff skills and knowledge on meeting people's needs.

Is the service caring?

Good

The service was caring.

People benefitted from a person centred culture and the staff were committed to providing a service which put people at the centre of their care and treatment.

People were supported by a team of staff who they were able to build trusting relationships with them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans in place were not consistently person centred. People's likes and dislikes and preferred routines were not always part of the care plans. Life stories were not always included within the care plans..

Activities were taking place and people were able to participate in group.

People were aware of the complaints procedure and felt able to raise their concerns with the registered manager

Is the service well-led?

Good

The service was well led.

Systems were in place to gather people's views.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems to monitor and assess the quality of service were in place

Hayward Care Centre

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 the 25, 26 and 27 October 2016 and was unannounced.'

The inspection was completed by one inspector. The provider completed a Provider Information Return (PIR) which was received subsequent to the inspection visit. 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 information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with five people, two relatives, six staff including an agency worker, the care service manager, the regional manager and the registered manager. We also spoke with community nurses. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection 11, 12 and 13 May 2015 we found important events that happened to people were not reported as required to the Care Quality Commission. The provider wrote to us following the comprehensive inspection telling us the actions they were to take to meet the requirements of the legislation. We found improvements were made with reporting events to the Care Quality Commission.

The systems introduced for managing risk were not consistently followed by the staff. Monitoring charts were used to assess people's nutritional intake and to provide an audit trail of re-positioning to relieve pressure to the same body part and to reduce the risk of pressure damage. We saw people's daily target and actual fluid intake was not always recorded or totalled at the end of the day. For example, on the 19 October 2016 the "fluid balance chart" for one person did not include the target intake and stated that over a 24 hour period 100 mls of fluid was taken between 4am and 6am and between 2pm and 6pm they had sips of fluid. On the 23 October 2016 this person had 200mls of fluid at 10pm, charts were not completed on the 24 or on 25 October 2016. A member of staff said "where people were not eating or drinking the staff made a record of their intake in the daily reports". We noted that information about people's poor intake of fluid was not always recorded on the handover sheets used by staff to pass on information about people's current needs. We also noted for one person the jug of squash was out of their reach. This meant records did not provide an audit trail on how staff were informed about people's poor intake of fluid.

The eating and drinking care plan for another person had their current weight and instructed staff to assist the person with eating and drinking. We found recorded in the review notes dated 3 September 2016 that the person had lost weight. A Malnutrition Universal Screening Tool (MUST) assessment was undertaken to determine the risk of the person developing malnutrition. The management guidelines for the risk level identified were not consistently followed. For example, a plan was not developed on how to improve the person's food and fluid intake. We saw the staff had documented for one person "chooses to have sugar in their coffee". There was no documented evidence on how staff were to support the person to manage their condition which included having a healthy diet.

The registered manager told us about the systems to be introduced to ensure people were having the target intake of food and fluid. In future "seniors" were to sign the charts. Staff were to receive training to increase their understanding of food and fluid intake. For example, the importance of fluid charts and how staff were to help people increase their intake of fluid.

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

Staff were knowledgeable about the systems for managing risks. A member of staff said people at risk of poor nutrition were weighed regularly, their food and fluid intake was monitored and referrals were made for dietician input. They also said for people at risk of pressure ulceration were repositioned regularly to relieve the pressure on the same body part. Another member of staff on another unit said for people at risk of poor nutrition the staff monitored the person's weight and for some people they were prescribed fortified

drinks. They also said risk assessments were developed for one person who wanted to go swimming.

Risk assessments were developed where risks of falls were identified. The falls risk assessment for one person stated their health was deteriorating and they were "unsteady". The associated moving and handling risk assessment detailed the number of staff needed and the equipment to be used for each movement. The mobility care plan described the walking aids used, the assistance needed from staff and regular repositioning to prevent skin damage. For another person identified at high risk of falls the risk assessment action plan listed the aids needed by this person to walk independently. There was evidence that a referral to the falls clinic had been made, pressure mats were used to alert staff of any movement and requests for medicines reviews had taken place. The mobility care plan for one person stated the person had sustained a fracture, there was a history of low blood pressure and this person used a walking frame to move around independently. The action plan advised staff to ensure the person had correct footwear and for a wheelchair to be used for long journeys.

Some staff said staffing levels were poor. A member of staff said "we like working on this floor but there is a lot of lifting and repositioning. We work hard including the seniors. There are four staff on this floor including the senior. The opening of the unit downstairs meant the staff went to cover. When the senior is off the floor is more difficult. We work hard we manage anything you throw at us." Another member of staff said "its stretched there is a lot of pressure. Seniors are not always on the floor. People need interaction to prevent isolation". The registered manager told us staffing levels were consistent with people's dependency needs. The registered manager told us opening of the unit and changes of staff had ensured staff's skills were being used more appropriately.

Staff on other units said the staffing levels were good and there was sufficient time to spend chatting with people. A member of staff said agency staff were used in their unit at the weekends. They said the same agency staff were used. Another member of staff said on their unit predicted absences, such as annual leave, were covered which ensured staffing levels were maintained.

We observed the lunchtime meal on Potterne unit and we saw staff struggled to support people with eating and monitoring those people who had left the table. Although the meal was not rushed the atmosphere was not calm. We observed a member of staff encouraging people to sit at the table and said to one person "I will get a lovely lady to sit with you." People were shown the meal choices and staff offered some assistance with eating but were not able support people to eat all their meal. We saw one person eating the meal of other people at the table. Staff had recognised this and offered the person more to eat. However, people sitting at this table were not supervised with eating. We also saw people leave the table and not return. Staff said they kept an "eye" on people that left the table and made sure they had their meal.

People we spoke with said they felt safe. The people we observed were comfortable with staff and did not show signs of distress when the staff were present. People smiled when they saw staff approach and welcomed their attention.

Safeguarding of vulnerable adults procedures were in place and the staff we spoke with were able to describe the types of abuse and the actions they must take for alleged abuse. A member of staff also stated that they felt confident to raise concerns to the registered manager. The people we spoke with told us they felt safe living at the home.

One person told us the staff administered their medicines. Medicines were kept in lockable cabinets in people's bedrooms. We saw the Medicine Administration Records (MAR) charts were signed to indicate the medicines administered. Protocols for when required medicines known as PRN were in place to give staff

guidance on administering these medicines and included were descriptions on when to administer the medicines.

Medicines were audited daily to ensure the safe handling of medicines. Body maps were used to indicate the location for the application of creams and ointment. A member of staff said medicine errors were rare and were mainly for missed signatures on MAR charts.

Care plans were developed for the management of pain. The pain control care plan for one person detailed the person's ability to express pain, prescribed medicines for pain relief, and the causes of pain for example, sitting in one position for long periods and the person's ability to reposition themselves.

We observed a member of staff administering medicines and supporting one person to take their medicines. The member of staff took time and attempted a variety of methods to coax the person and eventually the person agreed to take their medicine.

Good

Is the service effective?

Our findings

At the last inspection dated 11, 12 and 13 May 2015 we found members of staff were not appropriately prepared for the roles they were to perform. Staff were not enabled to deliver appropriate care to people living with dementia because training was not provided to all staff. Staff did not benefit from one to one meetings with their line manager to discuss concerns, their performance and training needs and the impact on people. We also found people were placed at risk because staff were not following the advice given to them by external health care professionals. The provider wrote to us telling us how improvements were to be made and we found improvements had been made at this inspection.

At this inspection one person said the staff were "nice". Another person said "the girls [staff] I love most are good. The staff will do anything I need. Staff are lovely."

A member of staff described the induction programme followed when they started work at the service. This member of staff said they were shown around the building on their first day, there was a six week induction which increased insight into the care needs of people; and they shadowed more experienced staff. They said the induction had prepared them to perform the expectations of the roles and responsibilities.

Staff said the training provided was good. A member of staff said there was dementia training which included distress reaction. This member of staff said they were assigned the dementia lead role and were looking at providing more specialist dementia training to the staff. They said training was centralised and some staff found it difficult to attend the training as travelling to the course venues was difficult. The training matrix in place showed staff had attended safeguarding adults from abuse training, Mental Capacity Act (MCA), equalities and diversity and living well with dementia training.

Staff told us training was available and future training courses were publicised within the home. The dates and the training courses were on display on the noticeboard. A member of staff said where the dates conflicted with their work patterns they swapped shifts so they could attend the training. Another member of staff said the training programme at the home was good but the dementia training needed to be more specialised for managing situations where people became resistive to personal care.

Staff working in the dementia unit told us they had suggested additional specialist dementia training at the last staff meeting. A member of staff said the people living with dementia in the unit had complex needs and the training needed to be more specialised. The member of staff with the dementia lead role said training was to be cascaded to staff.

Supervisions with a line manager were held regularly to discuss any personal development, concerns and training needs. A member of staff said their supervision was with a "senior" and at their supervision sessions they discussed performance and training needs which they found helpful. Another member of staff said the 'Trust' were moving away from structured regular supervision to "ongoing" supervision.

"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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people were subject to continuous supervision and DoLS applications were made to the supervisory authority. One person told us their liberty was restricted and they were not able to leave the home without staff support

We checked whether the service was working within the principles of the MCA. The MCA assessment completed for one person at risk of falls listed the best interest decisions taken which included providing the person with a low bed, sensory mats to alert staff and moving the position of the bed to reduce the need for bed sides.

A member of staff said there were some people at the home with capacity to make all their decisions. They explained where people had capacity the consequences of their decisions were explained and where people refused they were not forced to accept personal care.

Do not actively resuscitate (DNAR) orders were in place where appropriate and signed by the GP and the person where they had capacity. Where people lacked capacity their representatives were involved in the decision. DNAR orders included a summary of the person's medical conditions that were considered to reach the decision to allow a natural death without intervention.

Staff said there was involvement from the Care Liaison team who provide an important link between the professionals and the home. They said the team were helpful and made weekly visits to provide advice and guidance on strategies to use for people who at times became aggressive. A member of staff said there were people who at times resisted personal care and the practice was to give the person time to change their decision and for other staff to offer assistance.

The emotional care plans for one person with mental health care needs described the impact their condition had on their behaviour. The staff documented on the evaluation notes that the person at times "shouts at staff". The behaviour action plan stated staff must listen to the person, give them time, offer when required medicines and complete charts which helped staff identify triggers to develop strategies on managing aggressive incidents.

One person told us the food was "reasonable." Another person said the food was "moderate". A relative said the past issues with food had been resolved.

A member of staff said at lunchtime there were two choices and to enable people to make decisions the choices of meals were shown. The chef explained people's dietary requirements were catered for at the home. For example, fortified diets were served for people with poor nutrition. They said Speech and Language Therapist (SaLT) gave staff guidance on the texture of meals to be served for people at risk of choking. Low carbohydrate meals and minimum amounts of sugar were used in food preparation to avoid serving separate meals to people with diabetes. It was also stated the registered manager had suggested the tea-time meals needed to be altered as they were too light and people needed more to eat. They said "the registered manager told me if you need it, have it, it's on my head if you go over the budget."

Dietary forms which included people's likes and dislikes were completed and provided to the catering staff which gave them advice on people's dietary requirements. The eating and drinking care plan for one person included their medical condition and how this was managed.

The eating and drinking care plan for one person listed the person's preferred meals, the assistance needed from staff and the adapted cutlery used to improve their independence with eating.

The records of healthcare visits showed people had visits from their GP and had regular check-ups for example, dental visits. People were referred for specialist support and to community services for district nurse input and for Occupational therapist support to improve mobility.

Good

Is the service caring?

Our findings

A member of staff said knowing people's history, which was built over time, provided them with topics to "spark" conversation. Relationships were also built with relatives involved in the care of their family member. Another member of staff said the staff respected people, they had empathy, they listened to people and shared information. Relatives said the staff were caring and gave us an example to show this. They said a member of staff had bought a book to help their relative communicate as their relative is deaf. The notice board on the ground floor gave visitors information and raised awareness of environmental risk factors, the implications and the people at risk.

We observed in one unit members of staff assisting people to eat their evening meal in the lounge. A member of staff said "we didn't have enough time to get people to the dining room". While staff said they were short staffed, we saw people were having a positive experience. We saw a calm atmosphere, there was good interaction between people and staff and these individuals were comfortable with the changes in meal setting. We saw people were being assisted to eat at their preferred pace and we observed staff sitting on footstools to be at eye level assisting people to eat.

We consulted staff on how they developed relationships with people to make them feel they mattered. During our conversations one person living with dementia overheard our comments and responded for the staff. This person said the staff made them feel they mattered.

The daily reports for one person showed the caring way staff respond to people's needs. We saw recorded "gently washed legs. Asked if she wanted legs creamed. Spent time chatting. Helped open gifts."

A member of staff said patience, active listening and eye contact reduced people's anxiety. We observed a member of staff intervene in a disagreement between two people living with dementia. The member of staff offered both people a drink which resolved the disagreement. On another occasion we observed a member of staff attract attention from one person who was becoming agitated. The member of staff touched the person's shoulder and offered assistance.

A member of staff said respecting people's rights in relation to people's privacy and dignity was a "basic" principle of caring for people. They said they ensured people understood the tasks they were to undertake, ensured consent was gained before undertaking tasks and for delivery of personal care ensured this was delivered in private. For example closing curtains and bedroom doors. Another member of staff said they explained to people the tasks they were to perform and waited for consent before they carried out personal care.

Requires Improvement

Is the service responsive?

Our findings

When we audited the care file for one person we found information on delivering personal care was recorded in separate places which may be overlooked by the staff. For example, we found recorded in the emotional care plan that to gain consent to deliver personal care staff were to offer reassurance and there were times of the day when this person became agitated. When required medicine was prescribed and to be administered an hour before personal care was to be delivered. However, there was no evidence the "when required" medicine had been administered as prescribed. We looked at the Medication Administration Records (MAR) which showed "when required" medicines were prescribed to be taken up to three times daily but was administered in the morning. On the 2 October 2016 staff had documented in the daily reports "told he would be left for 15 min. and on 24 October 2016 the person had become aggressive at 6:15 am, 7:00 am and 8pm. Staff said there had been some confusion about the medicines to be administered before delivering personal care. They said the advice given by professionals was contradictory.

The Antecedents, Behaviour and Consequences (ABC) charts used by staff to identify triggers to then develop behaviour plans showed staff were not following guidance and lacked understanding of people's conditions such as dementia. For example, a member of staff had recorded on the ABC chart that staff had tried to explain they "were trying to help but this didn't help" on the 9 September 2016 staff recorded "explained about why it was not nice to say what he did and he understood" and on the 2 October 2016 staff recorded three staff needed to deliver personal care.

"This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014"

One person showed us their life story book which they had developed with the help of the staff and family members. A member of staff with the dementia lead role told us life stories were to be developed with people living with dementia. The care records for another person detailed the things that were important to the person and how best to support them. For example, maintaining relationships were important and walking with the person to ensure they didn't fall was how best to support them.

The personal care plan for one person included the number of staff needed to assist them with their personal care and the person's ability to manage aspects of their care. For example, they were able to wash their hands and at times shave. It was also documented that this person "can become agitated". The assistance staff were to provide was not included within the care plan. The communication care plan for another person gave detailed guidance on how staff were to support the person which included the position of the staff when they were having a conversation.

A member of staff said keyworkers (specific member of staff assigned to people) developed care plans and were monitored with the line manager during supervision. They said the "care plans were built as staff get to know the person." A relative said the staff kept them informed about important events. They said they were invited to care plan reviews and their suggestions were taken "on board".

A member of staff said handovers took place but the information was not detailed about people's current needs. They said communication between teams needed to improve. Staff on other units said there were handovers when they came on duty. The daily reports for one person included the assistance staff provided, their visitors and meals served.

One person told us "I do a lot of knitting. I have visitors and someone comes in everyday." Another person said "my family can come and see me. If I haven't got her [daughter} my life would not be complete".

An activities coordinator to provide a regular programme of activities was not employed at the home. Staff said while an activities coordinator was not employed they "tried our best". They said there were coffee mornings, church services and movie nights. A member of staff said the staff on duty provided ad hoc activities. Another member of staff said adhoc activities were better than a structured programme on the unit for people living with dementia. It was also stated there was "no time for regular activities". Singing and dancing was the main activity in the unit where people living with dementia were accommodated. Another member of staff said the people in their unit participated in activities such as baking. The registered manager told us an activities coordinator was appointed and was to work full time hours once their recruitment checks had taken place.

One person told us they had complained in the past about "things they had disagreed with". Relatives said they were confident to approach the registered manager with complaints. A relative said they had raised concerns with the registered manager and a follow up discussion was to take place. We saw complaints were investigated and resolved to a satisfactory conclusion.

Good

Is the service well-led?

Our findings

Quality assurance arrangements in place. A whole home audit took place and where there were shortfalls an action plan was developed on how to meet the set standards. For example, the catering audit was not in place. The action plan dated August 2016 included the progress made and the dates when the actions were achieved. The area operation manager visited monthly to conduct a full audit to ensure standards were met. External audits were conducted to assess the set standards.

The registered manager explained information to identify trends and patterns was analysed which was captured through the audits of each unit. Audits of people's weights and for people at risk of falls were completed. We saw each unit prepared an analysis of the people at risk of falls and on the number of falls people experienced. Where people had falls the cause was investigated and actions taken to prevent further reoccurrences.

Audits such as the number of supervisions meeting with staff were in place to ensure all staff had an opportunity to discuss personal development. Medicine audits were undertaken and from the audit dated September 2016 the systems were rated at 94 percent and within the acceptable scoring for medicine systems. We discussed the audit system of the home with the registered manager and we were shown the records from staff confirming documentation had been appropriately completed. We saw staff had reported that monitoring charts were completed and were up to date. The registered manager explained how systems were to be improved.

The views of people and staff were gathered through team meetings and surveys. Trust wide surveys were used to gather feedback and the registered manager told us the analysis did not include specific services. One relative confirmed surveys were used to gather their feedback about the service.

Staff meetings were organised and were specific to the roles of the staff. Team meetings were organised in each unit and attended by the senior team. The registered manager said these team meetings needed improving. Senior team meetings happened two weekly and the registered manager said they strived to attend these meetings. Daily "flash" meetings were held daily for heads of department and were present for the applicable area of responsibility. For example, catering staff were only present during discussions on food and meals and not when issues of care and treatment were discussed.

People were supported to receive various services to meet their healthcare needs. The registered manager and staff worked in partnership with other professionals to ensure people received specialist care and treatment as required. We spoke with a member of the care liaison team and they told us there were good working partnerships. They said the staff followed guidance; records were up to date and accurate. The records provided evidence of partnership working with other services such as, community nurses, speech and language therapists and GPs.

A member of staff said the team worked well together and stated "we were a strong unit, there were changes with staff, seniors and managers. Morale was low. I like the manager XX has been fair and has approached

me if there has been issues." Another member of staff said there was good working relationships between staff in their unit. They also stated that the manager was good and "listened when I wanted to change (working in the previous unit)." However, three managers had left in quick succession and stated "there had been a lot of changes." The registered manager explained following the inspection "only one manager[registered] had left, a peripatetic [manager] employed by the Trust took over the running of the home until I [current registered manager] joined the Trust in November 2015

The registered manager told us the staff team was large and each unit had a senior which meant they became aware of issues quickly. They said there was more accountability on what was happening. Staff were assigned lead roles which included safeguarding, Mental Capacity Act (MCA) assessments, mental health and infection control. A member of staff said having lead roles ensured they had a good overview of the systems which ensured processes were correctly completed.

A registered manager was in post. The registered manager said they were "dedicated to care, empowering individuals, securing the future of the service and promoting people's rights".

Staffing levels were discussed with the registered manager. The registered manager said staff retention was explored to establish the reasons for the turnover of staff to where appropriate develop staff's experience of employment. They said exit interviews had taken place and reasons for leaving were not related to their employment. It was explained that 17 staff were recruited and had started their employment, the recruitment process was in progress for five staff and one activities coordinator was employed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Members of staff were not following the to ensure people's needs were met.