Avery Homes (Nelson) Limited

Aran Court Care Home

Inspection report

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04 December 2017

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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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visits took place on 29 November and 04 December 2017. The first day was an unannounced visit, the second day was announced to enable us to speak with the manager and review documents.

The service is required to 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. At the time of our inspection the registered provider had not completed the process to replace the previous registered manager who had left the service in March 2017. This is a breach of Section 33 of the Health and Social Care Act 2008.

In addition during the inspection we found another breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The service was transferred in its entirety to the current registered provider in December 2016. The last inspection report for the service operated by the former registered provider was published in January 2017 and rated the service as Requires Improvement overall. The current registered provider had access to the findings in the report and the identified areas for improvement for the service they had taken over. We found that the actions required to improve the service had not been fully implemented.

Aran Court Care Home is a service registered to accommodate up to 86 adults who require assistance with personal care or require nursing care. At the time of our inspection visit 56 people were being accommodated, the majority of whom were living with dementia or physical disabilities. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Aran Court Care Home is divided into three separate units, one of which is used for people primarily living with dementia. Prior to our visit the provider had closed one of the nursing units due to difficulties in recruiting suitable nursing staff. The care home is adjacent to another of the provider's services and shares the kitchen and laundry facilities with it.

At this inspection we found

People felt secure and safe with their regular care workers and nursing staff.

People had risk assessments in place to identify and reduce the risk of harm; however these did not always reflect the current risks for people and potentially placed people at the risk of harm.

People were able to have their needs met on most occasions by care workers and nursing staff that had developed personal knowledge of them. However people were concerned that agency workers engaged by the provider did not have sufficient knowledge of their care needs.

The provider had recruitment procedures for the safe employment of care workers and nursing staff with processes which ensured they received the necessary induction and training to meet the care needs of people living at the service.

People were supported and received their medicines from specialist care workers and nursing staff who were trained and subject to regular competency checks.

The provider had failed to consistently comply with the legal requirements of the Mental Capacity Act 2005 and associated guidance. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People's ability to be involved in activities was sometimes limited by the support available.

People were provided with a choice of appropriate food and drink for their needs although the mealtime experience for some people was not always pleasurable.

People's mental health and physical health needs were assessed and people were supported to access health care professionals when required.

People living with dementia were not provided with an environment suitable for their needs. We therefore recommended that the service consider current guidance in relation to the specialist needs of people living with dementia.

People were usually supported by caring and respectful care workers and nursing staff who maintained their privacy and dignity.

People's support needs were recorded in care plans which were regularly reviewed but were not always updated to provide assistance to care workers or nursing staff who were unfamiliar with the person.

People and their family representatives knew how to complain about the service they received and were encouraged to make complaints and discuss issues of concern.

The provider had introduced new policies and documentation to improve the consistency of the service and to meet people's needs.

The provider had systems to assess and monitor the quality of the service but these were not consistently effective in identifying issues with the service requiring improvement.

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 safe not consistently safe

People were not always protected from abuse because although care workers understood the signs of abuse not all concerns were appropriately reported and investigated.

People had risk assessments in place but they did not always reflect the information held in care files and the current risks.

People were unsettled by changes of care workers and the continued use of agency workers at night.

Systems had been established to ensure people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's mental capacity had been initially assessed. Where people had variable capacity it was not clear which decisions were made in their best interests or where consent to care or treatment had been given.

People's food and drink needs were met, but the mealtimes experience for some people needed to be improved.

People were able to access healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring

People on most occasions were supported by care workers and nursing staff who demonstrated a caring approach when undertaking personal care.

People and their relatives were supported to express their views about their care and the service.

Care workers demonstrated an understanding of confidentiality,

privacy and dignity for people living at the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People or their legal representatives were involved in the planning and making changes to care provision on most occasions.

People living with dementia did not have their needs consistently met.

People were offered the opportunity to engage in arranged activities, further work was needed to support people to be involved in other activities that interested them.

Is the service well-led?

Requires Improvement

The service was not well led

The provider had not ensured the service was managed by a manager registered with CQC.

The service had clear senior management support to improve its performance and maintain standards; however the audits and monitoring systems did not identify all areas requiring improvement in the service.

The provider supported its employees and recognised their achievements and value to the service.

Aran Court Care Home

Detailed findings

Background to this inspection

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

In preparing for this inspection we considered the information supplied to us by the provider regarding incidents at the service which had been reported to the local authority safeguarding teams or to the police. To determine if there were any on-going risks to people at the service we reviewed the outcome of the provider's investigations of the incidents and their response to other agencies investigations. The inspection visit allowed us to establish if the learning from the incidents had been reflected in the care provided to people.

The inspection visits took place on 29 November 2017 and 04 December 2017. The first day was unannounced and the inspection team comprised of two inspectors, a specialist nursing advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert used had experience of family carers of people with dementia. The second day was announced and conducted by one inspector. It was announced to ensure the manager was available to assist us with the review of documentation, and could receive the initial findings of the inspection.

In planning for the inspection we also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted local authorities who provide funding for people to ask them for information about the service. We were informed that any concerns identified by their own inspections and reviews were being addressed with the service.

During our inspection, we spoke with nine people who lived at the service and nine visiting relatives. Some of the other people we approached were unwilling or unable to speak with us we therefore observed the

interactions between people and care workers to contribute to our inspection findings. In addition 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 also spoke with a visiting health professional, the service manager, the area regional manager, nine care workers, two nursing staff, a chef and two of the activities coordinators.

We looked at and case tracked the care plans for seven people to see how their support and treatment was planned, delivered and risk managed. We also looked at Medication Administration Records (MAR), fluid charts and the medicine management processes and medication audits for the service.

We examined the recruitment files for two people and the training records maintained by the provider. We also reviewed records relating to the management and audit of the service, and the on-going maintenance requirements for the building and equipment used. In addition we reviewed the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of abuse. Leading up to this inspection the provider had sent us notifications of incidents of concern at the service. We found the provider had taken appropriate action to report the incidents of potential abuse to the local authority safeguarding teams or the police. Some of the incidents involved alleged thefts. We asked the provider to explain how the incidents were dealt with. The manager informed us that the police had decided not to investigate the incidents. The provider's investigations were unable to prove whether items had been stolen. The manager confirmed that staff, people and their relatives had been informed about the incidents. Photographs had been taken of valuables which people decided to keep at the service as a precaution to assist investigations should another allegation of theft arise.

All of the care workers we spoke with understood how abuse could arise at the service. A care worker told us about safeguarding, "It is looking after people to make sure they are safe against other people, staff, even themselves, safe from everything for example people hitting each other, giving the wrong medication, could be someone leaving the dementia unit unaccompanied." We found however some care plans contained details of other incidents which had not been reported or recorded on the provider's adverse incident forms; for example falls and potential risk of physical harm to people and care workers. The failure to report these types of incidents placed people at risk because action would not be taken to minimise or prevent reoccurrence.

People's needs were not always being met by sufficient suitable trained care workers and nursing staff. People told us that they were concerned about the use of agency care workers and nursing staff (agency workers), particularly at night. One person told us, "Lots of experienced care workers and nursing staff have resigned, the home is unsafe at night, they have been times when there has been only agency workers on duty who do not know the needs of the residents, where as I am perfectly capable of telling them the care I need there are other residents who cannot." A relative told us," There is a very high turnover of care workers and nursing staff, sometimes there are only two agency workers at night who do not know the residents' needs."

Prior to the inspection we had been made aware of the provider receiving complaints about the suitability of some of the agency workers. The manager and area manager told us that there had been a high turnover of employees during the year requiring the regular use of agency workers. Some care workers had been dismissed and others had left the service when a new care home was opened in the local area. We were informed that the recruitment of more permanent care workers and nursing staff was being progressed to reduce agency worker use. We observed on both days of our inspection that new recruits were undertaking their induction training.

We were provided with investigation reports which confirmed that agency workers who turned out to be unsuitable were dealt with appropriately and the supplying agency informed. We were also provided with the report of a scheduled night spot check of the service which took place on 01 December 2017. The report identified further concerns with agency workers, for example one agency worker was found lying down

almost asleep. The manager confirmed the findings from the spot check would be discussed with the supplying agency and appropriate action taken.

People's ability to undertake tasks were risk assessed. We saw that care plans contained risk assessments and were reviewed each month, however we found the assessments had not always been updated in a timely manner to reflect relevant information or changes. We found for example that changes in people's behaviour giving rise to a risk had been recorded by care workers in the daily notes but had not led to the risk assessment and care plan being updated. This placed people at risk of receiving inappropriate care and created a risk for care workers. This was a particular concern because of the provider's regular use of agency workers who would need to rely on the accuracy of the care plan. This failing may have contributed to people's belief that some agency workers did not know their personal care needs.

The provider had an established recruitment process which was managed by its human resources team for all of its services. Care workers told us they had not started work before the appropriate checks and right to work entitlement had been confirmed. We saw the recruitment files confirmed the checks were undertaken and also recorded checks in respect of nurse registration. The manager told us agency worker checks were undertaken by the employing agency. The area manager explained agencies used were independently vetted and monitored to ensure their recruitment processes complied with current employment legislation.

People received their medication from appropriately trained care workers and nursing staff. One person told us, "I used to administer my own insulin and cream, but now I prefer it to be done by the nursing staff." Another person said, "I am a diabetic and staff always make sure that I receive my medicines on time." We saw medication given to people was recorded when given and we found there were no gaps in the records. There were also appropriate systems in place to order and store medication, and to dispose of unused medication. Although we found that some best practice was not being followed regarding the recording of medication remaining there were no missed or additional doses given to people.

The provider had satisfactory protocols for the use of "as required medication" (PRN). We examined the use of PRN for behaviour management and were satisfied that no one was receiving them inappropriately.

People lived in a clean environment and were protected from the risk of infection. We saw care workers and nursing staff wore aprons and gloves which were removed and hands cleaned after each person was seen. A number of people at the service required the use of slings and hoists to be moved. We saw and it was confirmed by the manager that people did not have individual slings. This potentially created a risk of infection and the risk of harm to people if an incorrect size sling was used. The manager told us there were disposable slings available for care workers to use. However the care workers we spoke with could not satisfactorily explain how the risk was managed. A care worker told us, "We have slings in different sizes, some people have one sling, but not everybody has their own slings. So we use the slings that are in the store. After I use the sling I put it back in the store."

The provider had systems in place to check the safety of the building and equipment used. We saw records to confirm regular checks were being made of the building and equipment, including electrical equipment in people's rooms. Fire equipment had been tested and personal evacuation plans were in place for care workers to assist people to safe zones if a fire occurred. Where advice had been given by independent contractors to reduce risks we saw there was a record of action being taken, for example the reduction of legionella risks by regular flushing of the water system.

The provider had taken action to learn from previous incidents and concerns about people's safety. We found that the provider had a system to record incidents which was reviewed by the manager and area

manager for trends. We saw that action plans were prepared and reviewed regularly.

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.

We saw that care plans contained assessments which gave an initial overview of people's mental capacity. We also saw that best interests decisions for most personal care tasks were completed. Some people were identified as having variable capacity, we found that the care plans did not identify which decisions the person could make or consent to. Care workers we spoke with told us about obtaining consent. One care worker said, "I ask people and they tell me…I ask people first if everything is ok." Some people at the service were unable to speak to confirm consent. A care worker told us, "I get eye contact and see body language I would certainly know if [resident] did not agree."

We examined the covert medication procedures to establish how consent was obtained. Covert medication is the administration of any medical treatment in disguised form; this usually involves disguising medication by administering it in food and drink. As a result the individual is unknowingly taking medication. One person was receiving medication covertly at the time of our inspection visit. We found the doctor's agreement was recorded on a standard form produced by the provider. The form did not however record evidence of discussions with relevant people, in particular a pharmacist to confirm the method of giving the medication was appropriate. Covert medication must never be given to someone who may be capable of deciding about medical treatment. We informed the nursing staff and the manager that we were unable to find evidence of the required discussions in a care file. They were unable to confirm if the relevant people had been consulted about the decision.

People without capacity had legal representatives to act on their behalf and make decisions regarding their health and finances. We saw the names of representatives were recorded in the care plans. However we found that care workers had not understood the difference between the next of kin status and legal representatives. We saw that some decisions, for example the removal of bedrails, which should have been discussed with or approved by the legal representatives, had effectively been made by people's next of kin. This may have been a breach of the person's legal rights.

The provider had failed to consistently ensure that appropriate consent was obtained for care and treatment in compliance with the MCA and associated guidance. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person

of their liberty were being met. We found the provider had made DoLS applications for any person at the service who lacked mental capacity or had variable mental capacity. A system was in place to check the progress of applications and to identify when they needed to be chased, or when the DoLS authority needed to be renewed.

People living with dementia were not provided with an environment designed to meet their needs. The provider had redecorated the building on taking over the service. However the choice of colour and design was not reflective of the recommended environment for people living with dementia suggested by guidance supplied by agencies such as the Department of Health. The environment was less likely to assist people living with dementia to get around and feel comfortable. We also observed that there were no tasks that people could access themselves or see that would help to stimulate their memories or provide an individual activity.

We found there was also a conflict of sensory input in the unit which could further distress or confuse people living with dementia. People who sat in the lounge to watch television could still hear the general music playing in the unit. One person in the lounge started singing along to the music rather than watch the television. No adjustments were made to the level of the sound by the care workers or nursing staff.

The manager and area manager told us the provider employed a dementia specialist. We saw the dementia specialist had visited the service on several occasions and provided reports for improvement of the dementia unit. We were shown an example of a memory board being introduced to all of the provider's services. The boards were intended to help people recollect important events in their lives, and to assist care workers to talk to people about their interests.

We recommend that the provider further considers current guidance in relation to the specialist needs of people living with dementia at the service.

People were provided with a choice of food and drink at regular times during the day. We were satisfied that the shared kitchen facilities with the adjoining care home did not reduce the ability to meet the needs of people living at this service. People were asked to choose their meals for the next day on the day previous; they were however entitled to choose a different meal if they wished. One person confirmed, "Care workers have gone out of their way to make me an omelette and drinks are here for me throughout the day."

We found that there was a difference in the mealtime experience of people on each unit. We saw some people were enjoying their meal and joking with care workers but for others it was not a pleasurable experience. This was more evident on the dementia unit. We saw that some people were not given a choice or shown the other meal options. A care worker confirmed, "The residents have a choice for their meals and we ask them the day before, but we don't have photographs to show them the food, we just ask." We also saw that at times on both units there were insufficient care workers in the dining areas to respond to the needs of people. We saw for example that on both units people were waiting for assistance with their meals potentially resulting in food going cold and some people had to wait for drinks or food. Care workers were unable to assist in the dining area because they were engaged in assisting people receiving meals in their bedrooms. We found the management of mealtimes required improvement.

People received care from care workers and nursing staff who had received suitable training. The care workers and nursing staff we spoke with confirmed they were up to date with their training. We saw that the majority of care workers and nursing staff were recorded as completing the provider's mandatory courses for safeguarding, infection control, health and safety, and moving and handling. The manager confirmed agencies were required to confirm agency workers had also received training on the mandatory subjects.

The provider required new employees without appropriate health and social care qualifications to complete the Care Certificate as part of their induction. The Care Certificate is the minimum training, supervision and assessment that employees new to health and adult social care should receive as part of induction before they start to deliver care independently. A care worker told us about training, "The training was informative, particularly dementia awareness. It was eye opening because we were shown a video from the perspective of someone living with dementia to understand their needs."

People coming to live at the service were assessed for suitability to ensure their care needs could be met. The manager told us a new admission assessment process had been introduced to refine the categories of health conditions the service could safely deal with. The area manager confirmed, "Assessments also look at the impact the person will have on other service users and resources." The manager told us there had also been a review of the needs of people currently living at the service. Some people were identified as suitable for alternative care services which may meet their needs better. The manager said the relevant people or their representatives were spoken to but the people chose to remain at the service in the knowledge that some of their needs could not be met fully all of the time.

We were informed prior to the inspection that one of the service's nursing units had been closed. The people involved had been assisted to move to more suitable services. The manager told us the unit had been closed because recruiting nursing staff with the requisite skills for intensive nursing needs had proved very difficult. A visiting health professional told us, "The manager was right to close the top floor nursing unit because there was no nursing staff."

People were assured of the continuity of care during periods of absence from the service. Care plans contained hospital passports to assist hospital staff understand people's needs and to ensure they receive the right care. We saw that on return from hospital admissions checks were made to ensure the person was returned with the correct medication. We also found care plans were reviewed and updated following return to the service to reflect any changes in care needs.

People's access to healthcare services was supported. We saw care plans confirmed there was regular contact with mental and healthcare services and the doctor's surgery. One person told us, "The GP visits twice a week and you can request to see them." The manager and area manager told us that issues with the healthcare services being provided to people had been resolved by meetings and regular communication. A doctor told us," My rounds are much better now; there is continuity and good communication. When I arrive I have a chat with the manager or deputy manager who brings me up to speed with what has been happening. Then I discuss the people in order of priority with the senior staff on the ward. There is a significant improvement in the follow up and the notes. This is very encouraging."

Requires Improvement

Is the service caring?

Our findings

People told us that they liked their regular care workers and nursing staff. We found however that the deficiencies in the provider's systems and processes were inconsistent with a fully caring service.

We observed that care workers and nursing staff demonstrated a caring approach, looking at people, asking them how they were feeling and speaking directly to them when undertaking a personal care task. A relative said, "I am pleased with the care, the regular care workers here are very good, kind and helpful. The residents are treated with respect." Another relative confirmed, "The care workers are very kind here." All the care workers we spoke with understood how to provide a caring service. A care worker told us, "The wellbeing of the people comes first. I know the things I do will make their lives easier, for example finding jackets, getting them their hat, it is all about people's wellbeing."

We saw that some people were left on their own and not spoken to when care workers were not involved in personal care tasks with them. One person told us, "Carers don't talk, there is no conversation with them, they come when I need them." Most care workers we spoke with confirmed they would like to talk to people more. A care worker told us, "We don't always get time to speak to people during the day, although usually around 6pm there is time to sit and chat to people." Care workers did however demonstrate a good knowledge of the people they cared for describing family relationships and important events. The area manager and manager informed us that work had already been commenced with care workers to encourage them to manage work better to create the time for people to be spoken with more often.

People were supported by care workers and nursing staff who treated them with dignity and respect. We found however that people and their relatives were not satisfied with the approach of some of the agency workers engaged, referring to their lack of knowledge about people. A care worker told us, "Agency workers should be working with experienced care workers who would know the people being cared for, but this was not always possible."

People were able to express their views of the service. We saw the provider had introduced a residents committee to seek the views of people and improve the service. In addition regular relatives meetings were also held. We saw that the manager completed several walks around the building to speak to people about their day and to ask if there were any concerns. One person told us, "If I had concerns I would speak to the manager or deputy manager. I have seen an improvement in the home since the manager has been in place."

People had the opportunity to be alone or meet privately with friends and family. We saw the manager had rearranged communal rooms to create quieter areas for people to meet. There was also a coffee area on the ground floor which we observed was being used by people and their visitors. We saw throughout the inspection that people were being visited and that the visitors were welcomed by the service and spoken to by care workers in a friendly manner.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were regularly reviewed by nursing staff and contained information about people including their assessed care needs, family history and their interests. A relative told us, "[My family member] has only been here for a short time… I was asked all about [my family member's] likes and dislikes, we are very pleased with the care." A care worker told us, "I found out from the care plan that a person liked football, next time I spoke to the person we spoke about football. Another care plan said a person was in a choir and we would sing together."

In addition to the main care plan a summary care plan was available for the use of care workers and agency workers. The summary plans were intended to contain key information to quickly assist care workers to provide the care needed. We found the summary care plans they did not accurately reflect the current needs of people. We saw for example that a summary care plan did not refer to a person's limited sight and hearing. This created a risk of misunderstanding and a failure to respond appropriately to needs. We were satisfied that permanent care workers had developed sufficient knowledge of people to know how to approach care for the person. We were however unable to conclude that agency workers would be able to gain the same knowledge from the summary care plan supplied to assist them.

Some people were able to be involved in the activities arranged for them, for example pamper days or birthday celebrations. On the first day of the inspection we saw a painting and pottery activity taking place and people were encouraged to join in. We observed that each unit had a display of pictures taken at other events held at the service. We saw however that there were other people who were unable to undertake group activities who were not provided with any other activity. The activities care worker told us, "We try and do as much as we can and encourage as many residents as we can to join in, we have ponies and other different animals visiting the home it is very popular, the animals go into their rooms so it involves the residents who cannot get out of their rooms."

People were not always able to undertake the activities they wanted because they needed assistance to be more independent. One person said, "The carers do take some of us shopping, I really like that but we only be out for a short time and sometimes it's not long enough." A relative told us, "The care here is good but care workers do need to try to encourage [my family member] to be more independent, [my family member] could do some personal care tasks with assistance."

People were assisted to maintain important relationships. Friends, relatives and partners were free to visit throughout the day. We saw that minutes from a relatives meeting confirmed the relatives had independent access to the service. The provider did not however provide the facility of internet access in the building to make it easier for people to communicate with family or friends using social media.

The provider had policies in place for equality, diversity and human rights. The manager told us about a number of recent discussions with people and employees concerning these issues. The manager agreed further work may be needed to ensure the values behind these policies were promoted by the provider to employees and to the people living at the service.

People were supported and prepared for a dignified end of life. The provider had an end of life policy which we saw required the involvement of all relevant parties in discussing plans. A relative told us about the end of life process, "It was very distressing but the home had been very good."

People or their relatives knew how to raise concerns or complain about the care provided. The provider had a process in place to deal with complaints. We found that the majority of complaints were dealt with in accordance with the procedure and outcomes of investigations were notified and discussed with the relevant parties.

Requires Improvement

Is the service well-led?

Our findings

The registration of this service is subject to a condition to have a registered manager in place to manage the regulated activities. The provider had not replaced the registered manager who had left the service in March 2017.

This was a breach of Section 33 of the Health and Social Care Act 2008.

The provider had introduced systems to audit, monitor and improve the quality of care and support people received. We saw the manager had been provided with a schedule of audits to be completed each month and the outcomes of the audits were reported to the provider. The actions required to resolve concerns and make improvements were monitored by the area manager. We found however the systems was not effective because they failed to identify or respond promptly to concerns identified or highlighted by this inspection for example accuracy of care plans and obtaining appropriate consent.

People and relatives we spoke with knew who the current manager of the service was. The service had suffered a period of instability and a number of people had been involved in the management of the service. We saw on one of the manager's walk around the building that people on both units knew the current manager. We observed the manager demonstrated a good knowledge of people and their backgrounds. We also saw that people were comfortable to say whether they were happy or say if they had any concerns. Care workers and nursing staff we spoke with were also positive about the role of the current manager. A care worker said, "I hope that [the manager] stays for a long time because [the manager] has brought a lot of good things to this place." Another care worker told us, "The manager is very approachable, very proactive, takes action and gives advice."

The provider was increasing the number of permanent employees. On taking over the service the provider had identified an issue with the quality of care workers and nursing staff employed by the previous owner. Unsuitable employees were dismissed if their performance could not be improved, and recruitment had been increased to fill vacancies. The area manager told us, "The provider is very clear what is expected, we have therefore targeted experienced staff in recruitment and encouraged them to challenge themselves to get better. We are building a team and want staff to feel part of the team, for example being involved in memory walks and charity events."

Supervisions were taking place and appraisals were being used to encourage care workers to take on greater responsibilities, for example becoming champions to promote good dementia care. The provider had also made efforts to acknowledge the work of its employees. A care worker told us, "The provider holds events and parties, there are staff meetings, supervisions and appraisals. It is nice to work for the company and I like how the provider does things, it seems organised." Another worker said, "I stayed over my hours last week, the manager took the time to thank me that goes a long way."

The provider also recognised and rewarded achievements, for example a care worker told us, "We are taken out for a meal if we pass an exam." The area manager told us the provider had recently introduced a benefit

scheme for employees to have access to subsidised goods and services.

The service maintained a good working relationship with service commissioners, mental health services and local health professionals. This had resulted for example in improved systems for the reordering of prescriptions with the local GP surgeries and reduced incidents of bed sores due to its relationship with tissue viability nurse team.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The previous registered provider of the service was required by the Coroner to take action following an adverse incident involving a glove. We saw the current provider had responded to the concerns to reduce the risk to people at the service. A policy had been introduced and care workers and nursing staff were clear what they needed to do to avoid a similar incident occurring. A care worker said, "No gloves are allowed to be on the floor or on trolleys. Gloves must be kept on the care worker's person. Care workers are told about it when they start work."

We found the manager understood the legal responsibility for submitting statutory notifications to CQC regarding events and incidents affecting the service or the people who use it. We were able to confirm these had been reported to us as required. The provider had conducted a number of investigations into concerns deriving from the notifications. We saw people and their relatives were involved in the investigations, and that the provider demonstrated a willingness to be available to discuss concerns.

We also found that the management team had been open in their approach to this inspection and co-operated throughout providing all the information requested. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to consistently comply with the legal requirements of the Mental Capacity Act 2005 and associated guidance.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 33 HSCA Failure to comply with a condition The registration of the service was subject to a condition to appoint a manager registered with the CQC to manage the regulated activities. The service has been without a registered manager since March 2017.

The enforcement action we took:

Fixed penalty notice issued.