Morleigh Limited

St.Theresa's Nursing Home

Inspection report

St Therese Close
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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 06 August 2015 and was an unannounced comprehensive inspection. St Theresa's Nursing Home is a care home that provides nursing care for up to 45 older people. On the day of the inspection there were 26 people living at the service. Some of the people at the time of our visit were living with dementia.

At this visit we checked what action the provider had taken in relation to concerns raised at our last inspection in April 2015. At that time we found risk assessments did not give clear guidance to staff as to how to minimise identified risks. Incidences of people falling were not consistently recorded or action taken to protect people from the risk of falls. Parts of the building were in need of decoration and one toilet was being used to store equipment. Although there were maintenance logs in place to record any problems with the building or equipment these were not acted on in a timely manner. People's personal preferences were not consistently taken into account. Activities were limited and were not planned in line with people's interests. Medicine Administration Records (MAR) were difficult to decipher and there were gaps in the records. No documentation could be located. Records associated with the running of

Summary of findings

the service could not always be located. After the inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. At this inspection we found the breaches had been met.

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. The manager in charge of the day to day running of the service was awaiting Disclosure and Barring Service (DBS) checks before putting in an application for the registered manager position. 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. People and staff told us the manager was available and had worked to develop the staff team. We saw systems had been put in place to carry out and record regular staff supervision and training. Records were easily located.

Risk assessments were in place for a range of areas including falls. Where people had been identified as being at risk of falling there was clear guidance for staff as to how to minimise the risk. When falls occurred these were recorded in incident logs which were audited monthly. This meant any trends could be highlighted and action taken to protect people from the risk of falling.

A problem with the roof of the building had resulted in leaks in the ceiling in various areas of the service. These had been addressed as they occurred. On the day of the inspection the manager told us the maintenance team had identified the root of the problem and would be carrying out the repairs within the next few days. There had been some redecorating and toilets and bathrooms were in good working order.

The manager told us they had recently had problems with reoccurring faults in air mattresses. As a result the provider had changed the system for supplying air mattresses to the service. This was now being done through the organisations own stock. The maintenance team were carrying out any repairs internally. There had recently been an audit of wheelchairs and hoists which had identified some were in need of repair. Arrangements had been made to bring additional equipment into the service to ensure people's needs were met safely. Staff told us there was sometimes a shortage of readily available equipment and we have made a recommendation to put systems in place to ensure people have access to well-maintained equipment at all times.

Medicine Administration Records (MAR) were well organised. People received their medicines as prescribed and at a time that suited them.

There were sufficient numbers of staff to support people. However staff were not always effectively organised in order to give people additional support during the lunch time period. Recruitment systems were not robust. Pre-employment checks were not consistently obtained to ensure new staff were suitable to work with the people who lived in the home.

Some people living at the service were subject to constant supervision and/or restrictive practices such as the use of bed rails and alarm mats. Legislation laid out in the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) requires that in these circumstances certain legal processes must be adhered to. This includes mental capacity assessments to identify if people are able to consent to the care provided and, where they are not, formal applications to obtain authorisation in order to restrict people's liberty should be made. We did not see any mental capacity assessments in people's care documentation. No DoLS applications had been made for the people living in the service since the last inspection.

Care plans were in the process of being updated. Where this had occurred the information was detailed and relevant to the individual. Life histories had been developed to help staff understand and know people.

An advocacy group had been started to give people an opportunity to voice their opinions about the service. Feedback from the first meeting had resulted in a barbeque and trip out being arranged. Information about how to complain was readily available to people and visitors to the service. A relative told us the manager listened to any concerns they raised.

Whilst some monitoring of records was taking place and improvements made, this had not identified the lack of mental capacity assessments and recruitment procedures not being followed.

Summary of findings

We identified breaches of the Health and Social Care Act regulations. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not entirely safe. Staff were not always effectively deployed in order to meet people's needs. Recruitment procedures were not robust enough to ensure new staff were suitable to work in the home.

Risk assessments guided staff on how to minimise risk. Where people were at risk of falls clear actions had been taken to minimise this.

Equipment was audited to help ensure it was in good repair. People were sometimes required to wait for equipment to be available.

Requires improvement

Is the service effective?

The service was not always effective. There were no legal authorisations in place to allow the service to deprive people of their liberty. This meant the legal requirements laid out by the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not being adhered to.

Action had been taken to improve the environment for people.

Staff had received appropriate training to support them to carry out their roles effectively.

Requires improvement

Is the service caring?

The service was caring. People's preferences regarding their routines were respected.

Staff were kind and sympathetic in their approach to people when supporting them.

People were able to make day to day choices about where and how they spent their time.

Good

Is the service responsive?

The service was not entirely responsive. Care plans were being updated.

Daily records lacked detail and were not consistently completed.

Activities were being arranged which were in line with people's interests.

Information in respect of how to make a complaint was readily available to people and visitors.

Requires improvement

Is the service well-led?

The service was not entirely well-led. Whilst some monitoring of records was taking place and improvements made, this had not identified the lack of mental capacity assessments and recruitment procedures not being followed.

There was clear leadership within the service.

Requires improvement

Summary of findings

The manager had introduced systems and processes to help ensure the effective running of the service.

St.Theresa's Nursing 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.

The inspection took place on 6 August 2015 and was unannounced. The inspection team consisted of two inspectors.

We reviewed information we held about the home before the inspection including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with six people who were able to express their views and one relative. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices. We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with four care staff, one nurse, the manager, the Head of Operations and the provider. We looked at five records relating to the care of individuals, three staff recruitment files, staff training records and records relating to the running of the home.

Requires improvement

Is the service safe?

Our findings

At our inspection in April 2015 we found staff did not have clear guidance on how to protect people who had been identified as being at risk from falls. Falls audits were not being carried out to help ensure those at risk were quickly identified and preventative action taken. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we saw improvements had been made. Risk assessments were in place to identify when people were at risk of falling and the level of risk. Where a risk had been identified there was clear guidance for staff on action to take in order to minimise the risk. For example one person's care records noted, "[Person's name] will ask other residents for help getting out of their chair……maintain good eyesight observations when they are sitting in the day room." Falls audits were carried out monthly. We saw this had resulted in one person having 1:1 support put in during the night time as the audit had highlighted an increased risk of falls during this period. This demonstrated effective systems had been put in place to protect people from the risk of falls.

At the inspection in April 2015 we saw the premises were not adequately secured to prevent people from leaving who may have been at risk if they did so. One person left the building during our inspection. The risk had not been assessed or any action taken to minimise it. Following the inspection the provider wrote to us outlining what action they would take to address this.

During this inspection we saw the front door was secured. This could be opened from the inside by turning the lock. We saw staff, including the administration assistant whose office overlooked the door, monitored the area throughout the day. This showed the area was secured to prevent people, who may have been at risk from leaving the building, while allowing those who were able to do so to leave independently.

Risk assessments were in place for a range of areas. For example, supporting people when using equipment and reducing the risk of pressure ulcers. These were updated regularly to help ensure they remained relevant to people's needs. Staff supported people to move around the building using the appropriate handling techniques and equipment such as walking frames or hoists as required.

At the comprehensive inspection in April 2015 we found there was a lack of effective systems in place in order to check the safety of the building and service. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we found improvements had been made. When we arrived at the service at 7:00 am, the manager arrived at 7:30 am. They told us they always started work at this time. One of the first jobs they undertook was a walk round the building to check on various issues including any problems with the environment and a visual check of the alarm systems, fire doors etc. Any problems were reported to the maintenance team. The manager told us; "They're good, pretty quick really." In addition formal audits of the premises were carried out regularly.

At the comprehensive inspection in April 2015 we found systems in place to ensure equipment was well maintained were ineffective. For example maintenance logs for wheelchairs showed one wheelchair had been reported as having faults for the previous three months. There was no evidence to show whether or not this was a reoccurring problem or the same fault which had never been addressed. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we found improvements had been made. The manager told us a full audit of equipment, including wheelchairs and hoists had been carried out the day before the inspection by an external company. Some equipment had been identified as faulty and this had been set aside for repair. The provider told us they would be bringing in extra equipment from the organisations own stock in order to ensure people had the equipment they required. The manager told us there was sufficient equipment to meet people's needs. One person's health needs had changed during the past 24 hours which meant an additional hoist was required. The provider told us this had been sourced and would be delivered to the service the following day. We heard staff discuss the support the person required to mobilise. Arrangements were made for the nurse on duty to support care staff when moving the person to check their needs were being met safely.

In addition, since the inspection of April 2015 we had received information of concern regarding the availability of pressure mattresses in the service. The manager told us they had recently terminated their contract with the company supplying and maintaining pressure mattresses.

Requires improvement

Is the service safe?

The maintenance team had been trained to maintain mattresses and the provider had their own supply for use throughout the organisation. During the inspection visit two air mattresses were delivered to the service. The manager told us there were sufficient working mattresses to meet people's needs. They told us; "There was a problem with mattresses continually breaking but it's sorted out now." Staff said equipment was not always readily available when needed and they sometimes had to wait to get it. On the day of the inspection there was only one stand aid and two hoists available for use. One of the hoists had a 'sticky wheel.' We discussed this with the manager, Head of Operations and provider. They told us the problem with the wheel had only developed the previous day and arrangements had been made to replace it. The Head of Operations had informed us prior to the inspection that they had asked the manager to inform them of any equipment shortfalls immediately so these could be addressed. The provider assured us equipment was readily available within the organisation and could be provided to St Theresa's as required.

At the comprehensive inspection in April 2015 we found Medicine Administration Records (MAR) were incomplete and difficult to decipher. Alterations to the records had been made but not signed, supporting documentation was incomplete and the records contained gaps. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we found systems for recording the storage and administration of medicines was robust. MAR's were completed correctly and effectively. People received their medicines as prescribed including those medicines which were time specific or needed to be taken before food. Additional safeguards were in place to help ensure people who required pain relieving patches received them when needed and that they remained in place until changed. Where medicines were required to be stored more securely, or to be refrigerated, these medicines were stored appropriately in the nurse's office. Temperature checks were carried out on the refrigerator to help ensure medicines were stored at the temperature required. However we did note some gaps in the checks. We highlighted this to the nurse on duty who said they would take steps to ensure this was addressed. Medicine audits were carried out regularly. Arrangements had been made for a local GP to visit the service weekly to address any medicine issues and review people's needs. The GP had arranged to have remote access to people's records to allow them to make any changes or requests while on site and ensure these were met in a timely fashion.

Following the previous comprehensive inspection we received information of concern relating to staffing levels within the service. On the day of the inspection 26 people were living at the service. There was one nurse on duty and six care staff, one of whom was a new employee doing a shadow shift. For most of the day people's needs were met quickly and we saw staff taking time to speak with people and enquire about their well-being. One person told us; "They always come when I ring the bell." However, during the lunch time period the number of staff available to support people was reduced because staff were taking lunch breaks. Their breaks were staggered over the lunch time period. This meant there was usually only one member of staff on a break, but for short periods two members of staff were absent. Some people needed assistance to eat their lunch. One table of four people waited for periods of between 35 and 45 minutes before getting their lunch as staff were busy supporting others to eat. We discussed this with the manager, Head of Operations and provider who said they would rearrange how breaks were allocated to ensure people were supported effectively.

Staff recruitment files for most people contained interview records, job descriptions and job offers, conditions of employment and records of pre-employment checks. However there was no file in place for one new employee. The registered manager and Head of Operations told us Disclosure and Barring Service (DBS) checks and references had been applied for. They said telephone references would have been carried out while awaiting written references. We did not see any record of the telephone reference. There were no records of an Adult First check having being obtained. This is a service provided by the DBS which, in certain circumstances, can allow a person to start work before a DBS Certificate has been obtained. This meant the worker was supporting people without the appropriate pre-employment checks in place. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

One care worker told us they didn't believe new workers had enough shadowing time and they thought the training could be more practical. A relative commented; "They could do with more practice before starting."

People told us they felt safe living at St. Theresa's Nursing Home. Comments included: "Yes, I feel safe" and, "I am happy living here."

Staff had received training in safeguarding adults and were able to describe to us the procedure for reporting suspected abuse. They had no concerns regarding unsafe working practices and were confident they would report any concerns they had. Staff told us they believed managers would take appropriate action to ensure people's safety if necessary.

We recommend that the service identify and instigate systems to ensure people have access to well-maintained equipment as and when they need it.

Requires improvement

Is the service effective?

Our findings

During our inspection in April 2015 we witnessed one person leaving the building independently. Care staff immediately followed the person and stayed with them, accompanying them on a walk around the building. This demonstrated to us that the person was unable to leave the building without supervision. There was no capacity assessment in place or authorisation to deprive the person of their liberty as required by the legislation laid out in the Mental Capacity Act (2005) (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Following the inspection the provider sent us an action plan outlining what action they were taking to meet this legal requirement. This included a review of all mental capacity assessments and making any subsequent DoLS referrals as required.

At this inspection we checked to see if the action had been taken as outlined in the action plan. No mental capacity assessments had taken place in the care plans we reviewed. No DoLS referrals had been made since the last inspection. One person was under constant supervision due to their risk of falling. During the night time they had 1:1 supervision and their care plan stated; "Ensure that [person's name] is being observed at all times." No capacity assessment had been carried out to evidence whether they were able to consent to this supervision. Some people had bed rails in place in order to protect them from the risk of falling from their bed. However, no capacity assessments had been carried out to establish if they were able to consent to this restrictive practice. There were no DoLS authorisations in place for anyone living at the service. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in April 2015 we found food and fluid charts were not being completed when people had been identified as being at risk due to poor diet or fluid intake. Following the inspection the provider wrote to us outlining what action they would take to address this.

During this inspection we found the improvements had been made. Food and fluid charts were being completed for people who had been identified as being at risk because of poor food and/or fluid intake. New forms had been put in place and staff were recording the amounts of food and fluid taken. However, these were not consistently totalled at the end of the day and the amount of food and fluid individuals should have been taking during the day was not recorded. This meant staff might not be aware when people were not getting the right amounts to maintain their health and well-being. We discussed this with the manager who told us they had arranged training for staff regarding the importance of recording information to take place before the end of September. They assured us steps would be taken immediately to accurately record information about how much people should be eating and drinking.

Where people had been identified as being at risk due to poor nutritional intake they were weighed weekly in order to monitor any decline in their health. One person had lost 8.2 kg over the previous month. This had been identified and the GP informed. Medical tests were being carried out to try and establish any underlying contributing factors. We heard the manager remind staff to weigh people, particularly one person who had just come out of hospital who the manager thought looked as if they might have lost weight.

Care files recorded people's needs and preferences in respect of food. For example one person was a vegetarian and others required a soft diet to aid swallowing. People told us they were satisfied with the food provided. Comments included; "It's all right, there's nothing wrong with it. The quantities are right." A relative told us; "The cook is very good. They will do what [relative] wants." Drinks were readily available throughout the day and staff frequently checked if people wanted further drinks.

At the inspection in April 2015 we found parts of the building were in need of redecoration. For example there had been a leak in the foyer resulting in the artex on the ceiling becoming blackened and sagging. One toilet was being used to store equipment. We saw some bedrooms overlooked garden areas which were overgrown and did not enhance people's environment. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we looked around the premises and found improvements had been made. Some parts of the building had been redecorated. The ceiling in the foyer had been repaired and repainted. We had received concerning information there was a leak in the ceiling of one of the toilets. The manager told us this had since been repaired. There was a leak in the manager's office at the time of the inspection visit. During the inspection maintenance

Requires improvement

Is the service effective?

workers informed the manager they had identified the source of the leaks and would be attending to this the following day. All the toilets were available and in a good state of repair. Some furniture had recently been replaced and the chairs were comfortable and in a state of good repair. Signage had been put up around the building to assist people to move around independently within the environment. Outside areas adjacent to bedrooms had been tidied up to make the outlook more attractive for people.

All staff, no matter how long they had worked at the service, were working to complete the new Care Certificate which replaced the Common Induction Standards. This is training designed to give workers in the care sector a wide theoretical knowledge regarding good working practice within the sector. One person had recently completed the training and this had been celebrated by the manager and staff team demonstrating the importance attached to the training. The manager told us; "I want them to know I appreciate it."

The new manager had introduced systems to ensure all staff received regular supervisions. This comprised of face to face meetings and observations. The manager told us they aimed to hold sessions bi-monthly.

People were supported to access external healthcare professionals as necessary. Records showed people had contact with GP's, opticians and dentists. Specialists had worked with the service to support people with specific health needs. For example one person had received input from a nurse specialising in Parkinson's Disease. Arrangements had been made for the local Complex Care Dementia Team to work with the service to develop personal profiles for three people. This demonstrated the service was willing to work with others to develop new ways of supporting people.

Good

Is the service caring?

Our findings

At the inspection in April 2015 we found people's personal preferences were not always considered. For example we heard of an occasion when a care worker had turned off a person's television and switched off their light without any discussion. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we found improvements had been made. Care plans had been developed and now contained sections entitled 'My day'. These contained descriptions of how people liked to organise their time including preferred bed times. People told us they went to bed at a time of their choosing. One person told us; "I go to bed at 10:00. I like that time because I get to watch the TV I like." Daily records showed people were assisted to bed at various times according to their personal preferences. For example, 'Assisted to bed at 23:30 hrs as declined to go to bed earlier.' During the shift handover we heard the nurse telling care staff what time people had requested to be supported to bed. We found the breach of regulations was now being met.

Following the inspection in April 2015 we had received information of concern stating people were being woken early in the morning to receive medicine. On arrival at the service at 7:10 am the medicine round was underway. The nurse on duty told us 18 people had said they would like to receive their medicine while still in bed but only if they were awake. They told us they would not wake people in order to administer medicine unless they were time dependant. One person had not yet had their medicine because they were still sleeping. We saw the list of people who had stated they wanted to receive their medicine early and saw this corresponded with those who had received their morning medicines. Some people told us they would prefer to get up earlier. We discussed this with the manager, provider and Head of Operations who told us people were supported to get up according to the time recorded in their 'My day' plans. They told us they would review these to help ensure people were supported to get up at their preferred time.

Some people living at St Theresa's had a diagnosis of dementia or memory difficulties. This meant their ability to make day to day decisions could fluctuate. Care plans contained life histories outlining people's past preferences and interests. This meant staff were able to access information which could enable them to get a sense of the kind of decisions people might have made in the past and the things that might have interested them.

During the shift handover staff discussed people's emotional needs as well as their health needs. For example we heard the nurse tell care workers; "[Person's name] likes to engage a lot, just talking." The manager in response said, "Make sure those on duty in the lounge area spend some time with them."

Care plans contained information regarding what people might become distressed about and how best to reassure them. For example one person's plan listed areas which the person might become anxious about such as finances and the whereabouts and well-being of their partner. It suggested stock phrases which could be used to calm the person and noted, 'They sometimes find it hard to accept reassurance….please be patient.' When one person showed signs of discomfort staff spoke calmly with them and helped them to reposition, offering extra cushions and pain killers. They then brought them a cup of tea and checked they were still comfortable.

People's bedrooms contained photographs and personal possessions to help people create a familiar atmosphere. A relative told us their family member had been given a different room with a better outlook as they liked to stay in their room and, "watch the world go by."

Relatives and friends were able to visit when they wished, sometimes bringing pets with them. Many relatives lived in the local area and told us they liked being able to pop in during the day at different times. People were able to spend time with their visitors in the lounge area or their own room if they wished to have privacy.

Requires improvement

Is the service responsive?

Our findings

At the inspection in April 2015 we found activities were not being organised in line with people's preferences and interests. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we found improvements had been made. An advocacy group had been set up for people living at St Theresa's which was led by the activities co-ordinator. Minutes of the initial meeting showed people had expressed a wish to have a barbeque for residents, families and staff to attend. There had also been a request for a trip out to a local attraction. The manager told us arrangements were in hand to organise both these events. The barbeque was set for early September. A taxi company with an accessible vehicle had been identified to transport people on the trip out. This meant people using wheelchairs would not be excluded from the opportunity to attend.

Some people chose to stay in their room and not take part in organised activities. Care plans recorded when this was the case and guided staff on action to take to protect people from becoming socially isolated. For example we saw in person's plan, "Staff to check on them hourly if in their room to check they are OK and if they would like any company. Encourage to come out and join in activities."

At our previous inspection in April 2015 we found care plans were in the process of being updated. At this inspection we saw this process had not yet been completed. The manager told us they had been working on the care plans to identify what needed completing and we saw the files had front pages indicating what sections required updating or adding. Information was organised into sections such as communication, nutrition, hydration and weight, personal hygiene and orientation, memory and comprehension. Where care plans had been updated these were informative and contained information specific to individual's needs. For example one person sometimes experienced hallucinations. Their care plan contained information regarding hallucinations and delusions generally as well as some information to help staff support the person according to their needs. This included statements such as; "If [person's name] appears distressed by their hallucinations then gently reassure them that they are not real. They recognise this and know that they are part of their condition."

One person could sometimes behave in a way which staff could find difficult to manage. In order to try and establish when this was more likely to occur, behaviour monitoring records had been introduced. These contained detailed information in respect of the person's moods and descriptions of behaviours.

Handovers took place at the end of each shift to help ensure staff coming on duty were up to date with people's needs. These were an opportunity to inform staff of any change in people's needs, information about what they had eaten and/or drank, any appointments or general well-being. During the handover we heard one person being discussed. The nurse commented, "She's looking pale." The manager asked that arrangements be made for the person to be checked over by the GP.

Daily records were not consistently completed and there was very little detail within them. The Head of Operations told us a new format had been introduced which would give better guidance for staff as to what detail should be contained within the records. The manager stated they had arranged for some training to emphasise the importance of effective record keeping.

People and their families were given information about how to complain. Details of the complaints procedure were displayed in the main entrance to the home. Relatives told us whenever they raised any concerns these were listened to and dealt with promptly.

Requires improvement

Is the service well-led?

Our findings

At the inspection in April 2015 we found there was a lack of leadership at the service. The manager had left the service the week preceding the inspection without giving notice. No-one had oversight of the service and staff were unable to locate various records during the inspection. Staff told us they felt unsupported and staff meetings and supervisions were not held regularly. Following the inspection the provider wrote to us outlining what action they would take to address this.

At this inspection we checked if the provider had made the necessary improvements to comply with the regulations. Whilst some monitoring of records was taking place and improvements made, this had not identified the lack of mental capacity assessments and recruitment procedures not being followed.

There was a manager in place who was awaiting Disclosure and Barring Service (DBS) checks to be completed before applying for the registered manager position. Staff told us the manager was supportive and accessible. Throughout the inspection visit we saw the manager spoke with people and staff regularly. A relative told us; "They are always there to talk to." One person commented; "The manager comes out among you more. You can make yourself known." Records we requested to see were located quickly and were well organised.

Staff meetings and supervisions were being held regularly. Staff meetings were held for nurses, care staff and kitchen staff. The manager started work before the night shift went off duty. They told us this was so they could ensure they had a relationship with night staff and a working knowledge of the culture of the team. Staff told us they found the manager to be supportive and accessible. One commented; "She talks to residents and takes an interest. Any issues you can go to her any time and she'll listen."

The manager told us they were well supported by the Head of Operations who visited the service on a weekly basis, usually with the provider. They were also able to contact them at any time by phone and email and said, "I always get a response." The manager submitted a monthly report to the Head of Operations to keep them informed of any issues or developments within the service.

The manager told us they were planning to introduce a key worker system in the service. This would mean staff would be identified to work closely with specific individuals. They would share responsibility with nurses to review and update people's care plans. The manager told us they believed this would result in creating more of a team approach to the development of care records and draw on the experience and knowledge of care workers. They said; "It's a way of acknowledging their value and knowledge."

Incident reports were completed following any accident or out of the ordinary event. The reports described the incident and any action taken to avoid a repeat occurrence such as more frequent monitoring. Audits of the reports were carried out monthly in order to highlight any trends.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had not established whether service users had capacity to consent to their care and treatment. The service was not acting in accordance with the Mental Capacity Act (2005) Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Recruitment procedures were not established and operated effectively Regulation 19(1)(2)(3)