Livlife Uk Ltd

The Manor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 February 2016 and was unannounced.

We previously carried out an unannounced inspection of this service on 8 November 2013. Three breaches of legal requirements were found. This was because the provider had not maintained the environment and carried out suitable repairs and refurbishment, the provider had not completed mental capacity assessments or held bet interest assessments for people who lacked mental capacity. The provider had also not ensured that medicine records were completed accurately.

We undertook this inspection to check if the provider had implemented their action plan and to confirm that they now met legal requirements.

The Manor House is a care home that provides residential care for up to 16 people with a learning disability. The accommodation is over two floors, accessible by using the lift and stairs. At the time of our inspection there were 14 people using the service and one person was in hospital.

The Manor House is required to have a registered manager. 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, a registered manager was not employed at the service. The provider told us they were in the process of actively recruiting for a registered manager.

As part of this inspection we looked at the improvements made by the provider and to confirm that they now met the legal requirements.

People told us they felt safe at the service and with the staff that looked after them. Staff understood the safeguarding procedure and knew how to protect people from abuse and keep them safe.

People's care needs were assessed including risks to their health and safety. However, improvements were needed in relation to how risks to people's health and well-being were assessed and the guidance available for staff to provide safe and appropriate care.

People were supported to receive their medicines safely. However further improvements were needed to the storage and recording of medicines to reduce the risk of errors during the administering of people's medicines.

Staff were safely recruited to help ensure they were suitable to work in a care setting. Staff received an induction when they commenced work and on-going training to support people safely. We observed that sufficient numbers of staff were deployed within the service at the time of our inspection.

We found the requirements to protect people under the Mental Capacity Act and Deprivation of Liberty Safeguards had not been followed. Further action was needed to ensure a mental capacity assessment was carried out so that people's wishes were known and kept under review. Where a person lacks capacity to make decisions or are unable to do so, then the provider must act in accordance with their legal responsibilities to ensure that any decisions made are in the person's best interests.

People were supported to have sufficient to eat, drink and maintain a balanced diet. Meals were served individually and staff provided assistance to people who required it.

People using the service said the staff were well-trained and provided effective care and support. We observed staff were confident and skilful in their interactions with people and always talked to people as they supported them and put them at their ease. Staff told us they were satisfied with the amount and quality of the training they received.

People were well supported with their health care needs and records showed they were seen routinely and when required by a range of health and social care professionals.

People told us the staff were caring and encouraged them to be independent. People were offered choices and involved in their own care. Care plans were not always updated to reflect changes in people's needs.

People were supported to access the wider community and engage in one-to-one and group activities within the service. Activities included college courses, arts and crafts, shopping, trips to local facilities and pub visits.

The provider's quality assurance system was not applied consistently. There were limited audits carried out and those that were saw were ineffective. There was no recent recorded evidence that people in the service had opportunity to feedback on the running of the service. However people did confirm that they had attended meetings where they had been consulted and involved and felt able to give their opinion on proposed changes within the service. There was no evidence to demonstrate that the provider reviews, identifies where improvement is required and takes the necessary action to make improvements.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The risks to people's safety and welfare were not always assessed and managed effectively.

People told us they felt safe. Staff had an understanding of what abuse was and their responsibilities to act on concerns.

Medicines were administered by staff who were trained. However further improvements were needed to the storage of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The care and treatment people received was not always effective because the requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not consistently followed to ensure people's legal rights were respected.

People received effective care from staff who had the necessary skills and knowledge to meet their needs.

Staff understood people's healthcare needs and referred them to health care professionals when necessary.

Is the service caring?

Good

The service was caring.

Staff had developed positive caring relationships with people.

Staff supported people to make choices about their daily care needs and lifestyle choices.

People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs and preferences.

People felt confident to raise concerns and felt that they were listened to.

People were encouraged and supported to access the wider community and activities of their choice.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not have a registered manager in post. The provider was making efforts to recruit a registered manager.

The provider's quality assurance and governance systems were not robust. Audits were not undertaken consistently or effectively.

The provider encouraged feedback from people who used the service, their relatives and staff but there was little recorded evidence of action taken as a result of what people said.

The Manor House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 29 February 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at information we held about the service, which included information of concern received and 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also had contact with commissioners for health and social care, responsible for funding some of the people who use the service to gain their views about the service.

We spoke with three people who used the service. We also spoke with the provider and four staff involved in the care provided to people. Those included a team leader and a senior from another service which is part of the same provider group.

We looked at the records of three people, which included their risk assessments, care plans and medicine records. We also looked at the recruitment files of four members of staff, a range of policies and procedures, maintenance records for equipment and the building, audits, complaints and the minutes of meetings.

Good

Is the service safe?

Our findings

At our last inspection of 8 November 2013 we found that the provider did not have a documented planned schedule of maintenance, repair or refurbishment; or an effective procedure for the reporting of and prompt response to requests for repairs. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the action had been taken but further improvements were required. We saw that the provider had replaced floor coverings and decorated throughout the premises. We observed that building work was in progress to provide people who used the service with a new assisted bathroom and an open plan kitchenette area and dining room. We spoke with the on-site maintenance team who were able to tell us about the work being undertaken and proposed completion dates.

Although we saw that the provider had made improvements to the floor coverings and decoration of the premises, we observed that a number of chairs and seating areas in the communal lounge were stained or damaged. We raised this with the provider who told us that they intended to order new seating for the lounge area once building works had been completed within one week of our inspection.

At our last inspection the provider had not ensured people were being protected from the risks associated with the unsafe use and management of medicines. This was because we found that people's medicine administration records had not been completed accurately. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had made some improvements to the management of people's medicines but further improvements were needed.

We found that people's medicines were kept in a lockable cupboard for the purpose of storing medicines safely. Most medicines were stored in a lockable trolley in the cupboard. We saw that some medicines were kept in a designated fridge. However, we were unable to determine that medicines were stored at the correct temperature as the fridge thermometer had been disconnected on the day of our visit. We raised this with the team leader who immediately reconnected the thermometer to the fridge. We saw that a thermometer was in place to monitor the temperature of the medicine cupboard. However there was no evidence that staff recorded temperatures of the fridge or the storage cupboard on a daily basis to ensure that medicines were stored within the recommended temperatures. This meant that people who used the service could not be confident that their prescribed medicines were stored within the recommended temperature range.

We saw that controlled drugs were stored in a separate locked cabinet and records showed that these medicines had been counted, checked and signed for by two members of staff. However, the controlled drugs cabinet was not fixed to a wall as is required. We found that the light in the medicine cupboard was

not working and medicines were stored on a broken shelf. We observed that staff struggled to read information on medicines and records within the cupboard. This meant that people could not be assured that their medicines were kept securely or stored safely. We raised this with the provider who told us that they would ensure that repairs were carried out to the medicine cupboard whilst the maintenance team were on site.

We saw that where topical medicines were prescribed, a body map was included on the medicine administration record to show the areas where the topical medicine should be applied. We found several prescribed medicines in bottles and topical creams that were not dated when opened. This is important as some only have a limited expiry date.

We looked at people's medicine records and noted that people's PRN (as required) medicine protocols were included in their medicine records in the medicine trolley. This meant that staff had easy access to protocols when they were administering medicines. We saw that stock levels had been entered onto people's individual medicine administration records and staff had signed to confirm people had received their medicines. We found one occasion when staff had not signed to confirm a person had received their medicines. We checked stock levels with the team leader and found that medicines had been removed from the dispensing back but not signed for. Staff could not be sure that medicines had been given until they spoke to the staff member on duty. The team leader told us that all medicine records are audited at the end of each care shift and any discrepancies acted upon immediately.

During our inspection we observed people being supported to take their medicines. We saw this was done safely. The staff administering the medicines approached people individually and asked them if they would like to take their medicine, telling them what it was for. We saw that staff consulted with people to see if they required medicines that were prescribed as and when required, for example, for pain relief. Staff respected people's choice and recorded this in the medicine records. People were given time to take their medicines in the way they wanted to and no-one was rushed.

People told us that they felt safe with the care provided and with the staff who looked after them. One person who used the service told us "The staff make me feel safe because they are always around to help me with I need it." Another person told us "Yes, of course I feel safe here." One person told us if they thought they or any of the people living in the service were not being treated well, they would speak to the deputy manager, the provider or their social worker.

The staff we spoke with told us that they had undertaken training in safeguarding adults and were able to describe what abuse was. They were able to explain the action they would take if they became aware of abuse which included contacting relevant external agencies if necessary. This showed that staff had an understanding of the provider's safeguarding procedures. Staff also said they felt confident in approaching the deputy manager and the provider if they had concerns about the well-being of any of the people using the service. The staff training records showed that staff were trained in safeguarding procedures as part of their induction.

People's care records showed risk assessments were completed. Assessments related to people at risk of falling when walking or moving around. Assessments also included moving and handling for people who were unable to walk independently or needed support to move safely. Risk assessments also included risks to people and to others through behaviours that may challenge. We saw that although risk assessments were in place, some assessments were limited and did not focus on the needs of the individual. For example, one person had been assessed as requiring a hoist and two members of staff to assist them to transfer. However, the assessment did not include how transfers should be undertaken or detail the equipment to be

used, for instance, size of hoist sling and type of hoist to ensure the correct hoist and sling was used for the person. Risk assessments did not take account of individual factors such as people's ability to understand and any sensory impairment which may affect people's safety and independence. This meant that staff may not always be aware of how to ensure risks to that person was minimised.

We looked at how the risks associated with behaviours that challenges were managed by staff. The service had assessed behaviours and included a behaviour management strategy in the person's care plan. The strategy detailed what the person's behaviour could look like and reasons why the person may exhibit behaviours that may challenge. However, in some instances behaviour strategies did not provide sufficient guidance for staff on how to intervene appropriately to keep people safe and prevent harm to themselves or to others. This meant that staff who were new to the service may not always know what to do if a person became agitated to support them as safely as possible.

We looked at staffing levels in the service. People who used the service felt there were enough staff around to meet their needs. Staff told us that staffing levels had improved following a recent turnover of staff and recruitment to vacant posts had proved successful. One person using the service told us "There has been a lot of staff changes and manager changes but I have no complaints. The new staff are very good and know what I need." Staff told us that staff absences were managed through re-deployment of staff from a neighbouring service owned by the provider. Staff who provided cover had worked previously in the service and were therefore familiar with the people who used the service. They told us worked consistently within the service and received information and read care records to ensure they were up to date with people's needs.

During our inspection we observed that care staff had time to socialise with the people using the service and support them to take part in activities. For example, one person was supported to attend college on the day of our inspection. Throughout our inspection staff were visible and went about their duties calmly. Staff were seen to work as a team and liaise with each other as necessary to provide safe care. For example, if a person needed two care staff to support them, there were enough staff on duty to enable this. The provider told us that they were continuing to recruit to remaining vacant posts which included the post of registered manager for the service.

The provider's recruitment process was being followed and records showed that the required employment checks were in place. Staff records we looked at showed that staff had the necessary documentation in place to demonstrate they were fit to work in the home. This included a check with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of 8 November 2013 we found that the provider had not completed mental capacity assessments or held best interest meetings for people who lacked mental capacity. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some improvements had been made. For instance, people told us that staff always sought their consent before they were supported and we observed this to be the case throughout our inspection visit. Staff were able to explain the different ways people were able to communicate their choices and decisions. They told us that they respected their right to decline care and make choices that may increase the risk to the person. Staff told us that they had undertaken training in the Mental Capacity Act (MCA) 2005and Deprivation of Liberty Safeguards (DoLS). We looked at staff training files and saw that staff training records confirmed this.

We looked at care plans for people who were unable to make decisions about their care and treatment. We found that there was no evidence in their care records to show that they had been asked to give their consent before care and treatment was provided or that they had capacity to decline care in their best interests. For instance, one person had declined urgent medical treatment based on a long-standing fear of medical procedures. Staff had not pursed if the person had mental capacity to understand the implications of the decision in their best interests, We saw that another person regularly declined support with their personal care after lunch. The person used a wheelchair for their mobility and was reliant on staff for all transfers. We saw that their risk assessment identified that they were at risk of pressure sores. Although staff respected the person's choice, they had not investigated if the person had mental capacity to decline care and treatment in their best interests. The correct procedure had not been followed to protect their rights under the MCA.

People can only be deprived of their liberty to received care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this is in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any applications under the DoLS had been made for people using the service. Where people had declined care and treatment, or were under constant supervision, there were no best interest meetings or assessments in the person's care plan. A staff member told us that the deputy manager was in the process of submitting applications to a supervisory body on behalf of people using the service who may require authorisation under DoLS.

This was a continued breach of Regulation 11 under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that they enjoyed the meals provided. One person told us "The meals here are lovely." Another person told us staff always gave them their preferred breakfast as they knew it was what they liked. They told us this made them very happy.

Throughout the day we saw that people were offered regular drinks and snacks. When lunch was served all the people using the service were invited to come to the dining table. We saw that people were served food in a way that suited them and was safe. For example, staff asked people if they would like their meal cut into manageable portions to enable them to eat their meal independently. Where people needed assistance to eat we saw that staff provided this whilst supporting the person to do as much as they could for themselves.

Care records showed that each person had a nutritional risk assessment which detailed any nutritional risks and preferences. We saw that one nutritional risk assessment detailed the person's cultural needs in terms of meals to be provided. Another assessment detailed the level of support the person needed to eat their meals. People using the service were weighed monthly. We saw that where there were concerns about people's weight, they were referred to their GP or a dietician.

Staff had the training and support they needed to enable them to provide effective care to the people using the service. They had general training in care provision which included courses in manual handling and personalised care. They also had the specialist skills necessary to provide more complex support where necessary. For example staff had undertaken training in supporting people to manage health conditions such as epilepsy and diabetes in addition to training in behaviour that challenges us.

Staff training records confirmed staff had completed training in a range of courses relevant to their role, One member of staff told us "I was new to care when I started here and I have attended lots of training which has really helped to develop my knowledge and understanding. As part of my induction I also learnt from more experienced staff by shadowing them which I have found invaluable." Another member of staff told us "I have had lots of training. The training here is really good."

Throughout the inspection we observed staff supported people effectively. We saw they were confident and skilful in their interactions with people. They always talked with people as they supported them and put them at their ease.

People told us that they were well-supported with their healthcare needs. One person told us that they were going to see their GP. We observed a member of staff escort them to the GP to support them to manage a health condition. Care records showed that people were seen routinely and when required by a range of health and social care professionals including GP's, community psychiatric nurses and dieticians. There were recorded examples in people's care plans of staff liaising with other agencies to support people's physical and mental health and well-being. Staff demonstrated that they were knowledgeable about people's health needs. For instance, one staff member told us how they had supported a person using the service by arranging a hospital admission as a response to a health crisis.

Good

Is the service caring?

Our findings

People using the service told us that staff were caring and kind. One person told us "The staff care about me and have fun with me. They make me happy. " Another person told us "I like the staff, they let me do what I want. I wanted a lay in this morning and the staff let me do this."

Staff knew the people using the service well. They were able to explain their support needs, individual personalities and likes and dislikes. We saw that staff spoke with people and consulted them before providing support to them. We observed shared humour and verbal and non-verbal conversations between people and staff. Staff spoke in a respectful way with people and addressed them in the way their care plan said they preferred.

People said they felt the care staff treated them with respect. One person told us that they were encouraged to be as independent as possible, for example managing their personal care as far as they were able. Staff were friendly and helpful and showed warmth and affection towards people. We observed that staff reassured a person about a doctor's visit they were anxious about. This showed that staff understood the importance of meeting people's emotional needs.

Staff were discreet when offering to provide personal care to people. Staff gave examples of how they promoted privacy and dignity, such as knocking on doors and being discreet if they thought people needed assistance with their personal care.

We looked at people's communication passports which was included in their care plans. Communication passports provided staff with guidance on how the person communicated their choices and decisions. Those that we saw showed that people used a range of methods to communicate including signing, facial expressions and physical reactions. We saw that staff followed communication passports when communicating with people. For example, we saw that one person used hand signing to request assistance before they left for an appointment. We saw that staff responded promptly to this request and communicated with the person through their preferred method.

People told us that they felt supported to be as independent as possible in the service. For instance, one person regularly took walks around the grounds of the service as this was important to them. We saw that the person was able to choose when they wanted to go out for a walk. They told us this was important to them as they liked being outside. Staff recognised that the person needed time alone and supported them by prompting them to wear suitable clothing. Another person told us that they had the key to their bedroom door and were able to come and go as they pleased. They told us they could receive visitors in their bedroom or staff found a quiet area for them to meet with their visitors if they preferred.

People's records we looked at had information about how they wished to be cared for. Their individual choices and preferences were recorded but not always reflected in the care plans. We were told that the service was in the process of reviewing all care plans and records and updating them to a new format which was more person centred. We looked at one person's care plan which had been transferred to the new

format. We saw that the person had been involved and consulted about their care and their choices and decisions had been recorded in the care plan.

People told us that meetings were held with the people who used the service and their advocates. These meetings provided people with an opportunity to share their views about issues such as catering and social outings. For example, the service proposed to change the catering facilities for the service and consulted people who used the service before implementing the changes.

Good

Is the service responsive?

Our findings

People had an assessment of their needs when they moved to the service. The information from the assessment was used to develop the care plan. For example, one person's care plan recorded that it was important to them to be able to celebrate Easter. We observed that staff involved the person in making Easter cards to send to their friends and relatives. The person told us they had made them very happy. Although some people's care plans contained up to date information about their needs, we found a number of care plans where information was not sufficiently detailed or up to date to reflect the person's needs. We saw that the provider was in the process of reviewing and updating people's care plans in a format that was more person centred. We looked at one person's care records which had been reviewed and updated. The plan included guidance on what was important to the person, what people liked and admired about them and how best to support the person. The care plan also included a section 'This is me.' This section supported the person to record their involvement in their care planning including pictorial information and recording what the person's best and worst day would look like.

Where people's care plans had not yet been updated to reflect a change in need staff were knowledgeable about their needs through sharing verbal communication during handovers. Care records, including daily logs and records of handovers, showed that they were providing the care they needed. Staff told us they learnt about the help people needed and what was important to them when they started to support people. They told us that team leaders and the deputy manager were always helpful if anything needed explaining or advice was needed. This meant that people received care that was personalised and met their needs.

Discussions with people showed that people accessed the wider community as and when they needed to, both independently and with staff support where required. One person told us they were going to college later that day as they were studying cookery. Staff were supporting them by arranging transport and providing an escorting member of staff to support them during the activity. Another person told us that they were supported by staff to attend a local community group each week. Other people spoke about community activities with a clear favourite being visits to the local pub. We observed people using the service supported by staff to engage in group discussions about current affairs.

We observed that people were supported to be involved in an in-house arts and crafts session making Easter cards. Some people were engaged in the activity whilst others chose to observe. We saw that staff were not able to be consistently present throughout this activity and that people became frustrated or bored waiting for staff to return to help them. Where people required support to participate in the activity, there were insufficient staff to provide the support which meant that they were isolated in the session.

There was no formal record of the review of people's care or who took part in the review. Care records within the care plan were signed with a date of review but it was not clear what if any changes were agreed. There was limited evidence to show that people had been involved in the review of their care in a meaningful way and that their views had been sought about the care provided. We saw that people's views were sought and recorded in the care plan that had recently been reviewed to the new format. For example, we saw that the person was able to express their views on what was important to them and what changes they would like to

make to their care plan.

We asked people if they were confident to raise concerns about the service. People who we spoke with told us they would speak to the deputy manager, staff or to the provider. One person said, she [the deputy manager] is very good and I can go to her with any problems or concerns. We saw that the provider had a complaints policy in place. The provider had not received any complaints within the last twelve months.

Requires Improvement

Is the service well-led?

Our findings

The provider had processes in place for monitoring and improving the quality of the care people received. However, we found that audits were not carried out consistently or effectively. For example, cleaning schedules were in place to monitor the hygiene of communal bathrooms and toilets. We saw that staff were not signing consistently to confirm they had undertaken checking and cleaning of the areas. This had not been identified in audits. Staff told us that team leaders undertook an audit of medicines at the end of each day to identify and respond to any medicine errors promptly. The manager also carried out monthly audits on medicines. We found that on one medication administration records (MARS) there were missing signatures for a person medicines. We also found that audits had not identified that medicine systems were not robust. For example, topical medicines and liquids did not have a date of opening and improvements were required to the storage of medicines. This meant that audits were not carried out effectively to keep people who used the service safe.

We saw that although satisfaction surveys had been undertaken with people who used the service and their relatives in February 2015, no recent surveys or feedback had been sought.

We spoke with the commissioning department of Leicester City Council and asked for their views about the service they commissioned on behalf of people. They told us they had undertaken a quality audit on the service and found a number of areas required improvement. We saw that the provider had made some progress in making improvements to the service but had not met all the action points required as a result of the audit.

We spoke with the provider about the further development of the quality audit system. We discussed the need to ensure that any audits were carried out effectively and any shortfalls identified by them or external agencies were recorded and acted upon. The provider told us that management changes within the service had had a direct impact on quality assurance as they had fallen behind in some areas of monitoring and auditing. They told us that they were discussing how this could be improved with the deputy manager.

We saw that there were systems in place for the maintenance of the building and equipment. This included maintenance of essential services, which included gas and electrical systems and appliances along with fire systems.

All the people we spoke with were happy to be supported by the service and expressed no concerns with how it was managed. One person told us that they had seen a lot of staff changes and changes in managers but felt that the staff team was good and the deputy manager was approachable.

Staff felt that things had improved since the deputy manager had been in post. They told us that the deputy manager was approachable and they were not afraid to talk to her. They also felt that they could contact the provider if they had any concerns. Staff told us that the deputy manager was 'hands-on' in the service and had started to make changes which had improved the service. These changes including recruitment to vacant care staff posts and providing more guidance for staff.

At the time we inspected the service still did not have a registered manager. We discussed this with the provider who told us they had recruited to the post previously but the appointment had been unsuccessful. They discussed how they intended to recruit to the post. We acknowledged that the provider was taking action to fill this post as a recruitment priority.

All the staff we spoke with felt that the recruitment to vacant posts and consistent staffing had had a positive impact on the service. One staff member told us "Things are better now. The staff who have been recruited are more mature in attitude and overall we work well together. If we have any concerns about a staff member's performance we can tell the deputy manager and she takes action straight away."

We observed some good examples of team working during the inspection. Staff communicated well with each other to ensure people's needs were met. During our inspection we constantly observed staff interacting with people and making sure they had everything they needed. There were times where staff were very busy but worked well together to problem solve and make decisions.

Staff told us they had had some supervision sessions but these had been irregular due to management changes. Records showed that sessions had taken place on an infrequent basis and for some new staff there were no supervisions on record. This meant that staff may not receive the support they need to discuss concerns or objectives to develop and improve their knowledge and skills.

Staff meetings were held between the deputy manager, the provider and staff. We looked at the minutes for these. We looked a previous staff meetings which were well-attended and provided those present with up to date guidance and information to carry out their roles. For example, topics such as improving working practices, training opportunities and recruitment of new staff were discussed. Staff told us that they had opportunity to discuss changes and be involved in the running of the service through the deputy manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards by carrying out mental capacity assessments; sought information in relation to best interest decisions made and kept those under review.