Hollywood Rest Home Limited

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Inspection report

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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 took place on 14 and 15 April 2016 and was unannounced. We last inspected the service on 23 October 2014 and found that the service required improvement and was in breach of regulations relating to gaining people's consent to care and treatment. This inspection identified that whilst improvements had been made some aspects of this regulation had not been met. Staff understanding of supporting people with limited capacity was in need of further development and improvements had not been made to meet this requirement.

Hollywood Rest Home is a care home that can accommodate up to 36 people. People living at the service had needs relating to their older age and some people were also living with dementia. At the time of our inspection there were 36 people living at the home.

There was not a registered manager at the service at the time of our inspection. The manager at the service had submitted their application for registration at the service. 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.

We last inspected the service on 23 October 2014 and found that the service required improvement and was in breach of regulations relating to gaining people's consent to care and treatment. At this inspection we identified that whilst improvements had been made, some aspects of this regulation had not been met. Staff understanding of supporting people with limited capacity was in need of further development to meet this requirement.

People told us that they felt safe living at the service. However, people using the service told us that there were not enough staff to support people and this compromised people's dignity and safety. We found that systems were not in place to investigate or reduce the risk of incidents and we saw that staff did not consistently follow risk assessments. We found that while steps were taken to maintain people's health, incidents and risk assessments were not robustly recorded and learned from.

At our last inspection, we found that staff had little understanding of supporting people who lacked capacity in line with expected code of practice. We found that staff still had limited knowledge of this area and that the provider had not taken the necessary action to ensure that where decisions were being made, that these were as least restrictive as possible.

We found that people enjoyed the food at the service and that they received their medication safely. Some staff told us that they had received lots of training and helpful supervision, however we found that staff had not received training to equip them to meet the needs of people using the service. The medication training provided a good example of effective training being applied well in practice but staff had not been equipped with the skills required to support people living with dementia.

We saw that staff did not always interact with people outside of times that they provided care. While we saw some very caring interactions between staff and people using the service, this was not consistent practice within the staff group.

People and their relatives told us that they were not stimulated and we saw that people were not encouraged to pursue their interests at the home. People who were less independent and able to engage in their own activities had less opportunity to participate in activities which they enjoyed. People and relatives told us that they were not involved in the planning of people's care, however the service supported people to have good access to health services as required. The manager had taken steps to introduce a complaints process and additional ways for relatives to share their feedback, and relatives had welcomed this improvement.

We found that while the manager had taken steps to introduce ways to receive feedback and monitor the quality of the service, this was not always effective. Some relatives and a professional told us that the manager was not always approachable. We found that systems were not in place to monitor and improve the quality of the service in order to keep people safe or to drive improvements to the quality of care provided. We also identified that the provider was operating outside of the conditions of their registration.

You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

People felt safe and staff could tell us how to report concerns.

There were not sufficient numbers of staff to meet people's needs.

Risks to people's safety were not always managed effectively.

Medicines were stored securely and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt supported in their role, however staff had not received training to equip them to meet people's needs.

Staff did not consistently seek people's consent when providing their care.

The provider had not improved staff knowledge around the MCA and had not taken the necessary action to ensure that restrictions to people were as least restrictive as possible.

People enjoyed the food at the home and were offered choices.

People had access to the healthcare support they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff were caring and compassionate in their approach, however we observed that this was not consistent practice within the service.

Some people told us that they felt listened to, however staff did not interact with people often other than when they undertook care tasks.

People were mostly treated with dignity and respect, however this area required improvement.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not fully completed or person centred and people had not been fully involved in developing these.

People told us that they lacked stimulation and we saw that most people were not encouraged to pursue their interests.

People felt comfortable raising concerns and the manager had taken steps to improve how the service involved people and gathered feedback.

Is the service well-led?

Requires Improvement

The service was not well led.

There was not a registered manager in place.

Systems and records were not robust to keep people safe and drive improvements at the home.

Relatives and staff told us that the manager was making improvements to the running of the service.

Hollywood Rest Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 April 2016 and was unannounced. The inspection was undertaken by three inspectors.

As part of our inspection, we looked at the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection. The local authority told us that they had no concerns with this provider.

During our inspection we spoke with 10 people who used the service and 19 relatives. We spoke with 10 care staff, the manager, the provider and three health care professionals. We carried out observations of how people were supported throughout the day and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We also looked at 11 people's care records, four staff files and at records maintained by the home about risk management, staffing, training and the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People using the service and their relatives told us that people were safe. One person told us, "I do feel safe, very safe, the staff don't hurt you in any way" and a visitor told us, "I would soon say if I had concerns about people's safety at the service". People told us that if they had concerns or worries, they would raise these with staff or the manager. One person told us, "I do know [the manager] and I would tell her if I was unhappy or wanted to complain and have every confidence in her" and another person told us, "If I have any concerns I just speak with the staff". Some staff told us that they had not completed safeguarding training, but they were able to tell us how to recognise if somebody were at risk. Staff told us that they would report concerns to the home management and to the Care Quality Commission if those concerns were not acted upon.

All entrances to the home were accessible through keypad or key only, however there was not a clear procedure in place for visitors. People were asked to sign in through the main entrance upon arrival, however we saw visitors also accessed the home through a separate door into the lounge. One visitor told us, "We have been coming here for over a year and have never been asked to sign in, when we have questioned it, we have been told, it's okay we know you're here." We saw that the risk of the informal process for visitors entering the building also exacerbated the effects of the restrictions on people's freedom. Some people using the service were aware that visitors used this entrance and they became increasingly upset when they were restricted from accessing this.

We reviewed records and found that although accidents and incidents were logged, there was not a consistent and robust way of reporting and investigating these events. Follow up actions were not consistently recorded and we did not see sufficient evidence of the provider investigating or learning from events. Records showed that some incidents reoccurred within a short space of time and we saw that some staff still did not always follow recommended guidance that would prevent further risk to people. For example, some people using the service were unsteady on their feet and their care plan guidance included a recommendation to use mobility aids to reduce their risk of falls. We frequently saw some people walking without their frames and identified inconsistent staff practice in how often they were observed or supported to walk. We also saw that walking frames were not consistently in reach for people who needed them, which stopped people moving freely around the home without risk.

We saw that the provider had effectively maintained the premises and ensured all relevant checks had been completed, including health and safety checks, gas and heating checks, lift checks and call bell system checks. Staff could explain what they would do in the event of an emergency, for example, a fire and this reflected what was expected of them. We saw that all fire extinguishers had been checked and had valid display labels on them. However, we identified a safety hazard at the home which could cause people to injure themselves. A metal brace was hanging from a window ledge near to the entrance to two bedrooms. The owner told us that they had not noticed this previously and that they would arrange for this risk to be reduced.

People told us that the recent high staff turnover rate and changes in the staff group had been unsettling. Staff we spoke with told us that they had not commenced working at the service until their appropriate

recruitment checks had been completed and we saw that recruitment records reflected this. People told us that there were not always enough staff available. The manager told us that staffing dependency tools were not formally used at the service. We saw that staff were not always deployed effectively during the day to meet people's needs, for example in ensuring that people were kept safe or received their meals in a timely manner. During one meal time, a person using the service told us, "We're fed up because we've had no food, where are the staff?" and we observed people waiting for their food for a long time without being informed of when they could expect it to arrive.

Staff and people using the service told us that there was not enough night staff support. People using the service told us they had to wait a "long time" for help when they used their call bell at night. This put people at risk of injury and did not support them to maintain their independence and dignity. One person told us, "I have to keep shouting when I need the toilet" and a staff member told us that they could not always respond to call bells in time to support people to use the toilet. Another person told us, "I wanted to use the bathroom and can't manage to walk without help but I got fed up of waiting and tried by myself and had a fall, I wasn't hurt and I won't be trying that again". The night book records showed that staff completed several deep cleaning tasks during the night shift, and one staff member told us that this "Can get in the way" of providing support for people.

Records confirmed that medicines training was up to date. A visiting professional told us that medicine management was effective at the home and that staff always ordered prescriptions on time. Staff told us that they did not manage medicines until they had been trained to do so and a senior person responsible for medicine control told us, "Only [another senior member of staff] and me have keys to the medicine room". The person responsible for medication control enjoyed this responsibility and told us that they were working hard to make sure the system worked effectively. We saw that staff spoke with and waited with people while they took their medication. We viewed the medicines room and saw that medicines were correctly recorded and monitored, however we saw that some medications were kept in storage for too long. The senior staff member responsible for medicine control told us, "I think this should be brought down to one month, so it's something we're working towards" and the manager told us that this process had changed recently.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that staff had little understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and had not received training in this area. Although we saw an easy read version of DoLS on display at the service and that staff had received training in this area, staff still demonstrated a limited awareness of MCA and DoLS.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Following our last inspection, we had told the provider that they must ensure where any restrictions applied for people who lacked capacity, that the appropriate best interest assessments had been carried out and that any restrictions in place were the least restrictive they could be and proportionate to the risk presented. Instances where the restrictions impacted on a person's liberty must be authorised by the local authority. We saw evidence that this action had not been taken. Although most people could move around the communal areas freely, some restrictions were in place which impacted on their ease of movement around the home, for example, there were locks on every entrance door and only staff could access the keys. We saw people trying to open the entrance doors and some people complained that they could not access the garden. One person said, "Can I go out please, I want to go out but the doors are locked". We saw that staff tried to distract people in various ways if they wanted to go out and that this often led to some people becoming upset.

The manager told us that they had introduced CCTV in the hallway and communal areas of the home and that they had done this to identify and review risks to people. The manager told us that CCTV was useful for reviewing people's falls and altercations when staff had not witnessed these incidents, and a staff notice stated that the CCTV was being introduced to improve security and provide additional safety for residents. We did not see evidence however of the analysis or review of such incidents. We also identified that the provider had not sought the appropriate consent to proceed with this nor had they followed the correct procedures to protect people's privacy.

The MCA DoLS require providers to submit applications to a 'Supervisory Body' to authorise the restriction of a person's liberty. Our last inspection identified that DoLS applications had not been made when people's liberty had been restricted. At this inspection we were advised that the manager had submitted DoLS applications for two people using the service. The manager told us that other applications had been submitted by the previous manager, however these were not recorded or tracked by the current manager or provider, and no authorisations had been granted. We saw that mental capacity assessments had been undertaken for some people yet these were not always appropriately recorded. We did not see evidence of

best interests decisions being made for those people who had been assessed as lacking capacity. Some relatives told us that they were not generally involved in care plans or making decisions to support the people living in the home.

We observed a variation amongst staff as to whether they sought consent from the people they were supporting. Staff and people we spoke with told us that staff asked people for consent before helping them and we saw examples of staff talking to people about the care they were receiving and offering them reassurance. Staff told us that for people who were not able to express their needs verbally, they looked for facial expressions and other signs from the person to identify their choices and needs. One staff member told us, "We can tell by [their] facial expressions and body language if [they are] uncomfortable or does not want to do something".

However we observed that not all staff consistently sought people's consent. For example, some people wore clothes protectors at meal times and when one person tried to remove theirs, staff continued to put this back on without their consent. When one person told staff members that they were, "Not quite ready" for lunch, staff returned after a few minutes had passed and stood over the person, saying: "Come on" to prompt them to stand up. We saw that this caused the person emotional distress and they were only offered some reassurance once they had stood up to go to lunch.

Staff had failed to ensure that when people lacked capacity that they acted at all times in line with the MCA and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been recent changes within the staff group and a high staff turnover at the service. A person using the service told us that staff are "pretty good, it's getting there, some are good, some aren't". Some people told us that staff knew them well and others told us that new staff members needed to get to know them a bit more. During our inspection, we observed a variation in how people received their care based on staff practice and skills. Staff had not received dementia training and one staff member was not aware that one person using the service was living with dementia. Another staff member we spoke with could not tell us best practice ways to care for people living with dementia. They told us that one person living with dementia was always asking for their relative and that they would correct this person if they became confused and mistook them for this relative. The manager told us that they had booked dementia training for staff following our findings at the inspection.

One staff member told us, "There is lots of training" and we saw that staff had recently received training in medicines management, moving and handling, First Aid awareness, infection control, fire safety and health and safety. Staff told us that they felt supported by the manager and provider and would go to them with any concerns. Some staff told us that they had not received supervision for a while, and a staff member told us they had received supervision and that this had been "helpful". New staff members were in the process of completing the Care Certificate, which is a new set of minimum care standards that new care staff must cover as part of their induction process. Staff told us they had completed a two-day induction, which involved shadowing staff before commencing their role. We saw a member of staff in the first day of their role however and they had provided care independently on several occasions throughout the day, without the support of a colleague or the manager.

The manager told us that they had recently introduced some additional support for a person with behaviour that may challenge staff or other people. Staff could tell us how to deal with people's behaviour but we did not always see this working effectively in practice. A professional who had visited the service told us that they did not see staff proactively support all people and that they had questioned the patience of staff in

supporting people with behaviours that they considered challenging. The professional and some relatives expressed concerns that staff did not always provide encouragement and support to help people maintain their independence in respect of managing their own personal care, grooming and activities of daily living.

People told us they enjoyed the food at the home and one relative told us it was, "Excellent". One person told us, "I think the food is very good… The soups are very good here, they're different every day" and another person laughed and told us, "You won't go hungry in this place; there is always plenty to eat". We saw that food was well presented and people were offered choices. We saw that staff took a trolley around in the morning and afternoon with tea and biscuits or cakes for people which they seemed to enjoy. One person told us, "I love my piece of cake in the morning and sometimes I may be cheeky and ask for two pieces." We saw people being offered a choice of meals and one person who chose to eat in their room told us, "Staff come round every day to ask what I want to eat, there is always a choice."

The service was one of a number of care homes receiving nutritional guidance from the NHS and the service had referred to NHS Community Healthcare guidance to help them to manage people's nutritional needs. There was a lead staff member in place for monitoring weights and we saw that the service had consulted a dietician and speech and language therapy support based on people's needs. Although there were records from a malnutrition universal screening tool in place for every person using the service, we saw that some people's weights were not monitored as regularly as had been recommended based on their risk levels. We also saw that people's fluid and food intake was not consistently or effectively recorded, including people who had conditions that required their intake to be monitored.

People were sufficiently supported to eat with staff helping them in a caring way and staff were aware of people's dietary requirements. A relative told us that the service accounted for their relative's meals well to ensure that these were culturally appropriate. We saw one person being supported to eat their meal and a staff member encouraged them to sip their drink and have a rest as required in between eating their meal. We saw that some people enjoyed a chat at lunchtime and staff regularly asked people if their meal was nice.

People using the service and their relatives told us that the home was good at helping them to access healthcare services when they needed them. One relative told us they were pleased with how "responsive" and "proactive" the service had been in an emergency. We saw that people were able to receive on-going healthcare support and people using the service told us that district nurses visited them regularly. A chiropodist visited the service regularly and one person told us, "If you want them, just ask". There was regular communication with healthcare professionals and this was documented in people's care plans.

Requires Improvement

Is the service caring?

Our findings

People told us that they were well looked after. One person told us that the staff were "Smashing" and "They look after me" and relatives told us that, "Care staff are always welcoming with a smile and a hello". Staff shared examples with us of how they spent time with people and one staff member told us, "One person likes playing his guitar so I sit down and listen to him".

Although we saw some very caring interactions when some staff supported people, we observed a variation in how staff approached people when providing them with support. Some staff gave regular reassurance and encouragement when helping people to move around the service, yet we saw occasions where staff were less caring, and supported people to move without clear communication, eye contact and reassurance. We observed that a person using the service was more responsive to a gentle, encouraging approach from a staff member, however this was not a consistent practice within the staff group. On one occasion, we saw staff reassuring somebody with more complex needs and telling the person what was happening as they supported them to sit more comfortably. However on another occasion, we saw that another person using the service became confused and upset. The provider told us that this person needed time to, "Settle in", however we did not see evidence of staff supporting this person to take part in any activities or helping them to relax.

We saw that interactions between staff and people mostly happened when staff were engaged in supporting people with care. There were only some occasions when interaction was not related to providing care or support. One relative told us, "You don't see them [staff] walking around to people… they have breakfast and that's it… what's got to be done but I don't think a lot goes on in between". We asked a person using the service if staff took the time to get to know people and what they liked. They told us, "There are so many people around and not time to really converse with someone… I don't think they do know me". The provider had failed to ensure that the care and support provided was focussed on the assessed needs of people who used the service to ensure it met their needs and personal preferences. We saw that the manager had recently introduced a residents meeting to help people shape the way they want to live and share their views of the service. However, we did not see evidence in records of people being involved in making decisions and planning their own care and relatives told us that they had not been involved in these processes.

Staff were able to provide us with examples of how they respected people's privacy and dignity and people told us that they felt treated with dignity and respect. One staff member told us, "I don't discuss people's issues in front of other service users". We saw that people's family and friends were able to visit the service when they wanted and they had the space they needed for private conversations. Some relatives told us that people's belongings had gone missing and that some people's bedrooms were not always clean and well looked after.

Staff we spoke with said they would encourage people who could do things for themselves to continue to do so to promote their independence. One staff member told us, "We try to let them do as much for themselves as they can. I encourage people to bathe themselves". One relative told us how the service had helped their

family member to recover well and returned to eating and mobilising following a hospital admission, "The Hollywood staff have helped [them] to get back on the move".

We saw instances where staff would lead people around the service, rather than walking alongside them at a pace that suited their abilities. We saw one staff member trying to encourage a person to move into the lounge by trying to take them by the hand to move them, and this person avoided the staff member's hand a number of times. We highlighted to the manager that we had observed that some staff demonstrated a very caring approach towards people. We also highlighted the inconsistency in staff practice and the manager told us they had booked training for staff which was to be focussed on improving practice in relation to people's dignity and providing person centred care, following our inspection findings.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were generally responsive to their needs. Records showed however that people had not been involved in their care plans and we saw that care plans were not fully completed to reflect how people would like to receive their care and support. Some relatives told us that they had not been involved in contributing to care plans, however comments from one relative indicated that they had been consulted with, although they had found that the setting where the meeting took place was not suitable and "not as professional [as expected]".

When we asked a person using the service if they had the opportunity to do things they enjoyed, they told us, "They said they were going to do a game of bingo, it's never happened… I get fed up of sitting here". Another person told us, "People just looking as though they're sitting there, then they go to sleep." The manager told us that they had been trying to recruit an activities coordinator for months without success. We asked a staff member what they thought the service did well and they told us, "Everyone seems nice to the residents. Diets are good. We play music and sing with them, but there's not enough time to spend quality time with them".

One person told us, "I read the paper, do a quiz, crisscross, look at the telly" and we saw other people reading. There was a weekly exercise class at the service and we observed staff throwing a ball and dancing with people using the service. There was no evidence that information held by the service about the previous and current hobbies and interests of people was being used by staff to inform and provide activities of interest on a day to day basis. We observed that many people using the service who were less independent, were left to watch television while the radio played loudly in the same lounge area. One relative told us, "I've never ever seen them doing anything" in relation to entertainment or activities at the service and that they felt, "So sorry for people just sitting there". We observed people regularly walking around the home without being occupied or having things to do. People did not have unhindered access to the garden and those people who expressed a wish to go into the garden and spend time there could not do so, except when staff were available to support them. The garden was not sufficiently secure to prevent people from risk of injury.
The provider had failed to ensure that people who used the service were supported to have their individual care and support needs met and be supported to have access to activities that were of interest to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a weekly Catholic service taking place at the home and people who participated enjoyed the service and had a good relationship with the visitor leading the prayers. We saw people laughing, having a pleasant conversation and taking part. The person leading the prayers told us that the service was "always a very welcoming home" and that if people were unwell and couldn't attend, the service had cooperated and enabled people to receive Holy Communion in their rooms. The service was busy during both days of the inspection with visitors coming in regularly and staff told us that members from local churches came to visit people using the service.

We saw that the manager had taken some steps to reduce incidents when the behaviours of some people

were difficult to manage in the home. Relatives told us that this seemed to be working and that it had assisted to settle people. There were some people living at the service with a hearing impairment. We spoke with one person with a hearing impairment and they told us, "It's difficult to hear anything and I don't find other patients like me [with a hearing impairment]… I get very lonely." We saw people watching television while the music was playing loudly in the lounge. One person told us, "The music's blaring, it can get you down. Blasting".

People using the service and their relatives told us that they would be comfortable raising concerns with staff or the manager. One person told us that they would complain to staff if they had a problem or were unhappy about something and another person told us that the service listened to them if they complained.

A person using the service told us that they felt listened to and one person told us, "Staff ask me what I want and some listen more than others". However, one person using the service told us that staff had stopped fulfilling one of their care needs and they felt less confident and independent as a result of not having this support. They told us they had received no information about why this support had been stopped and told us, "Staff are very hard and could've put it better or explained". With the individual's permission, we spoke to the manager about this and identified that staff were inconsistent in whether they provided this support to the person. The manager told us that the person should be encouraged to be more independent, however we highlighted that this had not been addressed clearly with the person. The person instead received inconsistent care without clear communication and gradual support to become more independent. This created an unclear message for this person and caused them distress.

The manager had recently established a relatives' meeting to provide an opportunity to share information. The manager had also recently introduced a noticeboard and a complaints and compliments book into the service. The noticeboard displayed information about relatives' meetings, details of a regular exercise class and details of the service's complaints procedure. Notes from relatives in the complaints and compliments book included, 'It's nice that we can record our ideas in this book' and 'New noticeboard and suggestions book are most welcome'.

Relatives we spoke with had mixed views as to whether their concerns were always proactively acted on by the manager and provider. One relative highlighted to us that some issues were dealt with reactively if they had complained and that concerns were not resolved and prevented in the longer term. We saw that the manager had recently taken steps to improve the way that people's personal funds were kept safe. Another relative told us that they were happy with the improvements made to this system.

We saw that the service had a complaints procedure in place, however records of complaints showed that complaints had not been recorded since 2013. We saw that the manager was developing processes to make sure that people had an opportunity to share their feedback and concerns. The manager had recently sent out a questionnaire to gather feedback from family and friends and some relatives confirmed that they had received this. However at the time of our inspection, there was no evidence of complaints being investigated or recorded, or improvements being made as a result of people's feedback.

Requires Improvement

Is the service well-led?

Our findings

The provider and manager did not have robust records and data management systems in place. Some of the service's documentation was out of date and the manager advised that they were taking steps to update this. Records such as care plans and risk assessments were not sufficiently completed and the provider and manager had not developed a way of recording which DoLS applications were yet to be authorised and how many had been submitted for approval. Although information was recorded, there was no evidence of information being analysed or used to drive quality within the service. We saw that there was not an effective system in place for managing and learning from risks to people using the service and people were not always kept safe as a result. Some staff were aware of risks to people and things to look out for, but they did not consistently act to reduce risk to people using the service.
The manager had recognised the need for people to have ways to share ideas or concerns about the home, however quality assurance systems were not yet in place to drive improvement at the service. There was not an effective system in place to assess and manage risks or to monitor and drive up the quality of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a not a registered manager in post at the time of our inspection. The manager had joined in September 2015 and had submitted their application for registration. Care providers are obliged to notify us about certain changes, events and incidents affecting their service or the people who use it, however the provider or manager had failed to notify us of all incidents and occurrences as required by the regulations. We also identified that the provider was in breach of their registration conditions. An additional person was living in a separate part of the service building and they were receiving care and support from staff at the service. The person was receiving support with management of their medication and on occasions received personal care from staff. The provision of a regulated activity that is not part of the registration conditions is a breach of Section 33 of the Health and Social Care Act 2008.

A person using the service told us, "The manager is here quite a lot". One relative told us, "I think the new manager is lovely". People told us that they would feel comfortable approaching the manager if they were unhappy about something. The manager told us that it had been a "turbulent time" in the service with a high staff turnover and that they were either changing or introducing systems and processes that had not been formally in place previously. The manager was at the early stages of taking steps to help people and residents become more actively involved in developing the service. The manager told us that they had recently established a residents' forum to help people shape the way they want to live and to share their views and opinions of the service. The minutes of this meeting showed that people had been welcomed and encouraged to share their feedback about the service and were told that the service would look at ways of overcoming any issues.

The manager had begun to introduce values and develop a vision for the service and told us that staff said that they viewed things differently now. The provider told us that there had been "Lots of change to care" in recent years and that the service needed to move with these developments. The provider told us that they were supporting the manager and were in agreement with changes they had recommended. For example,

the manager had brought in a deputy manager role and laundry staff roles to relieve carers of the responsibility of some laundry tasks so that they could spend more time with people using the service. The manager told us that they had been encouraging the staff to take accountability for their roles and working more proactively, and one staff member told us they felt "empowered". Staff told us that they knew what was expected of them in their roles and we saw that staff meetings were used to reiterate those expectations.

Some relatives made positive comments about the manager and the way they were managing on a day to day basis. One relative told us they trusted the manager, "To be honest I was dubious when she first started but she is making changes for the better and these are working now." Another relative told us that the manager was "Very efficient" and that they had held a meeting recently which they thought was "Well organised and well-handled and encouraged us to raise any points we had about the running of home and how people are dealt with".

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 9 HSCA RA Regulations 2014 Person-centred care People who used the service were not supported to have their individual care and support needs met and people did not have access to activities that were of interest to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had failed to ensure that when people lacked capacity that they acted at all times in line with the MCA and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not an effective system in place to assess and manage risks to people using the service, or to monitor and drive improvements at the service.