County Healthcare Limited

St Mary's Care Home

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**

Overall summary

This inspection took place on 12 and 17 November 2015. The inspection began at 4.30am and was unannounced. We had received information of concern that people were being assisted out of bed very early in the morning.

St Mary's Care Home provides care and support for up to 44 older people, some of whom may be living with dementia. The home is on one level and purpose built. At the time of our inspection there were 37 people living there.

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

At our last inspection on 10 February 2015 we found the service to be in breach of one legal requirement. We had identified that people's needs were not met in a timely way due to the poor deployment of staff. After the

Summary of findings

inspection the provider wrote to us to tell us what they would do to meet the legal requirements. The provider also told us when they were going to complete these actions.

During the inspection on 12 and 17 November 2015 we found the service had increased their staffing levels at peak times. However, improvements were still needed. People were, at times, still waiting too long for assistance.

At this inspection evidence showed four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to make proper assessments of people's needs and provide staff with the guidance required to support people safely. The nutritional needs of people with swallowing difficulties were not consistently met and the service was not effective in working with healthcare professionals. The service's quality auditing system failed to identify and mitigate risks to people's health and safety.

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

People were supported by staff who had undergone recruitment checks to ensure they were safe to work in care. However, staff had not consistently received the induction, training and competency checks required to ensure they were skilled in their roles. Although not all staff had received up to date training in safeguarding people, they demonstrated they understood how to protect people from harm. People received their medication as prescribed.

The service had used a dependency tool to calculate staffing levels and the amount of staff the tool dictated were in place. However, people told us they had to wait for assistance and that call bell response times were sometimes poor. There were not consistently enough staff available to meet people's individual needs in a timely way.

Although people had access to healthcare professionals, the service had not ensured that people's health and nutritional needs were reliably met. Recommendations from professionals were not always followed putting people at risk.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and report on what we find. Staff had a good understanding about people's capacity to consent to care but lacked knowledge of the MCA DoLS. The service had failed to make timely applications to the local authority in order to protect people's human rights.

People and their relatives, where appropriate, were involved in the planning of the care and support they required and these needs were reviewed regularly. However, the information the care plans contained was not always accurate and this put people at risk in relation to their health, welfare and safety.

Staff were respectful towards the people they supported and people told us they felt cared for. Staff understood the importance of people making choices about how they spent their day however staff were not always available to meet those individual needs. People's privacy was maintained but their dignity was sometimes compromised. Staff did not always have a full understanding of the needs of the people they supported.

People benefited from activities taking place but told us they would like more trips out of the home. The service told us they had plans to develop the activities programme to include this.

The home encouraged feedback from people on the quality of the service provided but did not always use this information to improve and develop. Although the home had a number of quality monitoring audits in place, these had failed to identify issues within the service.

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?

Requires improvement

The service was not safe.

People's individual needs were not met in a timely way.

The service put people at risk due to lack of staff understanding of specific medical conditions.

People were at risk due to staff not following healthcare professional's recommendations. People did not always receive the medical intervention they required.

People received their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's specific nutritional needs were not reliably or consistently met.

People were not fully protected by the Deprivation of Liberty Safeguards.

People were not consistently supported by suitably trained staff.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's individual needs were not always met as staff did not have a full knowledge of the people they supported.

People felt respected however their dignity was not always maintained.

Choice and independence for people was not always encouraged due to lack of resources.

Staff supported people to be involved in making decisions around their care and support needs.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Although people had their care needs reviewed on a regular basis, staff lacked clear guidance on how to support people safely and with individual needs.

The service actively encouraged people to comment on the service. However, people did not feel consistently confident that their concerns would be addressed.

Activities took place however some people felt isolated and wanted excursions to take place outside of the home.

Summary of findings

Is the service well-led?

The service was not consistently well led.

The service had failed to make the improvements they had told us they would following their last inspection.

Quality audits were not effective in identifying shortfalls that could affect the health and wellbeing of people using the service.

The service did not reliably support people in managing and mitigating any risks associated with any falls they may have.

Requires improvement

St Mary's Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 17 November 2015 and was unannounced. The first day of our inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The two inspectors arrived at 4.30am in response to concerns having been raised prior to our visit. The expert by experience arrived at 9am. The second day of our inspection was carried out by two inspectors.

Before we carried out this inspection we reviewed the information we hold about this service. This included statutory notifications that had been sent to us in the last year. A statutory notification contains information about important events that affect people's safety, which the provider is required to send us by law. We reviewed the two 'share your experience' forms we received regarding this service.

We contacted the local safeguarding team and the local authority quality assurance team for their views on this service. We also gained feedback from one social care professional and one healthcare professional prior to our inspection.

During our inspection we spoke with six people who used the service. We also spoke with three relatives. In addition, we gained feedback from a visiting health professional. Observations were made throughout the inspection.

We also spoke with the registered manager, regional manager, activities coordinator, two cooks, two senior carers and four care assistants.

We viewed the care and medication administration records for seven people. We also looked at records in relation to the management of the service including staff recruitment files, training records, risk assessments and the quality monitoring audit system.

Requires improvement

Is the service safe?

Our findings

During our inspection on 10 February 2015 we found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered persons had not ensured enough staff were deployed to safely meet people's individual needs.

After the inspection the registered persons told us more staff would be available to support people at particularly busy times. At this inspection we found the service had introduced more staff at these times however further improvements still needed to be made.

People told us there were not always enough staff to meet their needs. Of the six people we spoke with four felt staff did not respond to their needs in a timely manner. One told us "There is not enough staff to get things done. They have no time to help and I feel room bound". This person also told us they no longer felt in control of their life. A second person said "Because we have so few staff I can't get out of my room and I spend hours on my own. When we spoke with staff, they had mixed views on whether there was enough staff to meet people's needs. Four of the care staff we spoke with felt they needed more staff. One told us "The bells are continuous sometimes".

When we spoke to the manager, they confirmed they used a dependency tool to calculate staffing levels. The staff rosters we viewed showed that the amount of staff the tool calculated as sufficient to meet people's assessed needs had been on duty. When we viewed the call bell records for a twelve hour period, the average amount of time it took for a person's call bell to be answered was 4.6 minutes. However, there were four occasions where it took between 24 and 29 minutes for staff to respond to a call bell.

We saw that on 20 October 2015 concerns had been raised about one person's ability to take tablets as they had been seen choking whilst taking them. The records we viewed showed that the service had identified that the person was at risk of choking but not that they were at risk of choking whilst swallowing tablets. The records we viewed showed that the GP was to be consulted in regards to this. However, following the incident the person's risk assessment had not been updated and the manager could not provide us with records to show the GP had been consulted. We concluded that the service had not taken appropriate action to reduce the further risk of choking to this person whilst taking tablets.

In addition we noted that staff had recorded that another person had experienced an unwitnessed fall resulting in a swollen area to their head. The person had informed staff that they had hit their head during the fall. Although records showed staff monitored the person regularly, they did not show that medical intervention had been sought. When we discussed this with the manager, they told us that the procedure was to seek medical intervention for any head injury. The senior carer informed us they had discussed the head injury with the district nurse however there were no records to evidence what advice they had given. This meant there was a risk that the person may not have received the correct care from staff as there was no written guidance for them to refer to.

There was no care plan in place to guide staff on how to support one person who was living with epilepsy. Whilst it was recorded that the person had epilepsy, there was no information on how it affected them and what action the staff should take to ensure the person's safety during an epileptic seizure. One in three staff members we asked about this person did not know the person had epilepsy.

The service had a contingency plan in place in case of emergency situations. However, we noted that some information was out of date and needed reviewing. For example, the plan contained personal information on people who lived at the home. This was dated October 2013. This meant that, in the event of an emergency, people were at risk due to staff not having correct information available to them.

These concerns constituted breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with told us they felt safe living at St Mary's Care Home. One person said "I feel safe at the moment". Another person said "I feel safe with the girls who look after me". The relatives we spoke with also felt people were safe. Staff could tell us the different types of abuse and knew what to do if they suspected people were being abused.

Requires improvement

Is the service safe?

The service had completed appropriate recruitment checks to ensure the people they employed were safe to work in health and social care. This included obtaining two references and completing criminal records checks.

We viewed records that showed the service had identified, assessed and reviewed risks associated with the environment and work practices. For example, these included the risks relating to legionella, the use of moving and handling equipment and the risks associated with handling soiled laundry. These were reviewed regularly.

People told us they received their medicines on time and had confidence in the staff administering it. The staff we spoke with had knowledge of good practice in administering medicines and could demonstrate the safety checks they made prior to, and during, medicines administration. We observed medicines being given and saw that these checks were completed. This included monitoring the person whilst they took their medicines and checking the medicines administration record against the medicines label. We concluded that people received their medicines as prescribed.

However, during our inspection we noted that a tin of drink thickener had been left in the dining room. This was prescribed to one person who was living in the home. Often people were in this dining room, but staff were not always present. Some people living in the home were living with dementia and were mobile. There was a risk that someone could accidentally ingest this thickening powder. If ingested, this could form a solid mass and obstruct a person's airway. Failing to safely store this medicine posed a risk to people's health and welfare.

Requires improvement

Is the service effective?

Our findings

People's nutritional needs were not being met. Information in the kitchen was inaccurate and incomplete. For example, we found inconsistent information relating to one person's dietary requirements. A whiteboard said the person was on a 'cut up and moist' diet, a clipboard showed 'soft fork mashable, thickened fluids' and a nutritional preferences sheet showed the person had a 'normal diet'. There was no copy of the person's Speech and Language Therapist (SALT) assessment in the kitchen until after we had raised the issue of poor individual dietary information in the kitchen with the manager.

This person had been assessed by a SALT in June 2015 as needing a fork mashable diet. Two care plan reviews in September 2015 stated that the person 'needs assistance to cut meals in smaller pieces' and 'does have food cut up'. This description of how the person's food needed to be prepared was not consistent with a fork mashable diet and could give misleading information to staff caring for the person.

Another person's nutritional needs care plan stated 'It has been deemed they can have a soft fork mashable diet but with thickener for drinks.' However the nutritional care plan did not contain a copy of the person's SALT assessment which would show how much thickener they required in their drinks. Although the assessment was available in the person's care folder it wasn't easily accessible for staff. This meant the person could be at risk if staff did not know how much thickener the person was prescribed.

The kitchen was not always producing food for people with the required texture in accordance with dysphagia diet guidance. One person who required a thickener for drinks was given a slice of arctic roll for dessert, which includes ice cream. Ice cream turns to liquid in the mouth and consequently could pose a risk of choking. Dysphagia dietary guidance for people on a fork mashable diet who also use liquid thickeners states that a person should not be given ice cream.

One of the cooks we spoke with during our inspection was unable to identify the guidance regarding dysphagia diet food textures in their documentation folder. They told us it was the carer's responsibility to make sure people received food in the required texture. However, when we spoke with the manager, they informed us it was the responsibility of both the cook and carers to ensure people received the correct textured food.

The nutritional needs of people with swallowing difficulties were not always being met. The provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, on the second day of our inspection a different cook was on duty. They were able to describe in detail how they prepared food for people on special diets in a way that they enjoyed which was also safe for them to eat and how they ensured that specially prepared meals went to the right person.

The people we spoke with had mixed feelings on the quality and choice of food. One person told us "The meals are reasonable. There is not a lot of seasoning and we get chicken too often". Another said "The food here is not too bad. I think they know what they're doing". Two people were positive about the food. One said "I love the food here. I like the choices and the scampi was lovely today". The relatives we spoke with were also positive about the food. One told us "The food here is very good as we often eat with my relative". We saw that people had choice in what they wanted to eat and drink and that plenty of drink was available to people throughout our two day inspection.

People were not consistently supported by staff who had received adequate training and induction. The people we spoke with gave us contradictory views on the ability of staff to support them. One person told us "Just a few are well trained – the night staff are not so good". One relative said "Some of the staff need more training". However, others said "The staff are very good at what they do" and, "The staff certainly know what they are doing and how to do it".

Half of the staff we spoke with told us that their training was out of date. One person told us they had received no training since starting in post a few weeks earlier. Another staff member told us they had refused to work with people who had not received manual handling training as it was unsafe. When we asked for the individual training records for seven staff members, the manager could only provide us with records for two of these. These showed that both staff members were not fully up to date with the training

Requires improvement

Is the service effective?

the manager considered to be mandatory to their role. Additional records we viewed showed that just half of the staff were currently trained in the practical aspects of moving and handling. When requested, the manager could not provide us with completed induction documents for the cook who lacked knowledge in the description of a dysphagia diet.

One person living in the home was living with epilepsy. Staff had not received any training to support this person in the event that they had a seizure. Only the manager had undertaken up to date practical training in first aid. They told us that all senior carers were supposed to have had this training as well.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Not all staff had received training in the MCA. Although the manager had knowledge of the MCA and DoLS, the staff we spoke to did not all have an understanding. One staff member said they had never heard of DoLS. Another said they had little knowledge of what it meant. However, staff understood the importance of choice, gaining people's consent and using options that least restricted people.

Due to the inconsistency in providing mandatory training, people were not always supported by staff who were suitably trained and competent to carry out their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection the service had made some applications to the local authority in respect of people who had been identified as potentially being deprived of their liberty in order to keep them safe. On the second day of our inspection, we saw that the manager had identified 19 people whose capacity was in doubt. Out of those 19, the manager had assessed the capacity of three people and made applications to the supervisory body to deprive them of their liberty. These had been completed following the first day of our inspection. This meant that potentially people may have been deprived of their liberty without the full protection of the DoLS.

We could not be sure people had timely access to healthcare professionals and the advice they offered. A healthcare professional told us that the care the service provided was variable but that it was "…generally good". They told us that the service was inconsistent in applying advice and making recommended changes. The records we viewed showed the service was variable in requesting healthcare intervention.

Requires improvement

Is the service caring?

Our findings

People did not always feel their independence and freedom of choice was maintained. Two of the people we spoke with felt they were confined to their room. One told us "I'm a bit lonely because I can't get out of my room because I need someone to push me". Another said "I never go up to the dining room or the lounge. I did go there when I could walk but now I am in the wheelchair I am so limited and they (staff) don't always help me". During our inspection, we observed staff assisting and encouraging people to move independently.

During our inspection we saw a board in the foyer which gave people feedback on issues they had raised. The issues and responses had been mixed up so did not make rational sense. We also observed that the staff on the duty board was incorrect and showed that the name of the maintenance man was against the manager and vice versa. As there were people living with dementia residing in the home, this could have been confusing for them. We also observed a container with a number of items of clothes in it by the front door. The clothes could not be identified and there was a sign requesting relatives to go through it to see if they could recognise any items of clothing. We also observed a catheter bag on the floor of someone's room. We concluded that people's dignity was not always maintained and respect for people's views was not being promoted.

The people we spoke with said the staff were caring towards them. One person said "The staff are very polite to the residents and nothing is too much trouble for them". Another told us "The staff are very caring here". The relatives we spoke with agreed staff were caring and compassionate. One told us their relative was happy in St Mary's Care Home and that they were "…very impressed" with the care. However, one person said that staff "…sometimes say they will come back but they don't which worries me". During our inspection we observed staff interacting with people in a kind and courteous way. For example, during breakfast we saw a staff member assisting a person with their meal. The staff member was committed to the person they were supporting and involved them in light conversation. The staff member made sure the person understood what was happening and that they were all right. The interaction was warm and friendly with laughter between the two.

The people we spoke with felt respected. One person said "The staff are very respectful and speak to me so nicely". Another told us "They (staff) certainly treat me with respect". One relative told us that the staff had made an effort to talk to their relative in the language of the country they were born in which they appreciated. During our inspection we saw staff interacted with people in a polite, caring and compassionate manner. However, we also observed the manager remove a drink from a person's hand without explanation or any interaction. It was left up to an inspector to explain to the person why the drink had been removed and what was happening.

People were involved in the planning of their care. The people we spoke with said they had seen their care plan and were involved in making decisions about what support they needed. The relatives we spoke with also confirmed they had been able to discuss their family member's support needs with the service. One person told us "My [relative's] care plan is currently under review and we are fully involved". A person who used the service said they were happy that the request they had made to have a shower every day was listened to and acted upon. The care plans we viewed showed people and their relatives had been involved in the planning of care and support. We also saw that the service had advocacy information in the foyer to signpost people to organisations that could speak on their behalf should they need it.

People were encouraged to maintain relationships with those important to them. The service had no restricted visiting hours and we saw visitors come and go as they pleased.

Requires improvement

Is the service responsive?

Our findings

Although people's care plans were detailed and had been evaluated regularly to account for people's changing needs, the information they contained wasn't always accurate which put people at risk. The care plans were lengthy and complicated. One member of the care staff told us they felt inundated with information and that the care plans were too big. They told us they didn't get time to read them.

All bar one of the people we spoke with felt the staff understood their preferences. One person told us, "The staff who care for me know what I like and what I don't like and always try and make sure I get it". We saw that information on people's lives and past histories was documented. This assisted staff in developing relationships with the people they supported and to have meaningful conversations. We also saw that people had a journal in place that staff and others could write in. This captured feelings, conversations and any other social interaction and activities that assisted the staff in understanding the person they were supporting.

However, the staff we spoke with could not consistently tell us the needs of the people they supported. For example, one carer was unaware that a person they supported had epilepsy. Another was aware of the diagnosis but did not know how this condition affected the person. A member of the kitchen staff was also unable to tell us the correct dietary needs for a number of people. One relative we spoke with told us "The staff are proficient in what they do, but I don't think they fully understand my [relative's] needs".

Prior to our visit, we had received information that people were being assisted out of bed very early in the morning. On our arrival at 4.30am, we saw no evidence that people were being assisted up at this time without their consent.

The service had an activities coordinator in place and a programme of activities was displayed in the foyer. However, three of the people we spoke with felt isolated. One person told us, "We don't go anywhere; we just stay in the home". The second person said, "I would love to go out more. When I go out with my family I dread coming back". The third person said, "I do get out when my son comes to visit, but I don't get any other visits out". However, another person we spoke with was positive about the activities on offer and told us, "We have lots of activities which help us to keep busy".

When we spoke to the activities coordinator they explained their plans for development which included trips outside of the home. They were also able to tell us people's likes and dislikes. The activities coordinator demonstrated they respected people's wishes that chose to stay in their rooms and explained how they met those people's needs.

During our inspection, we observed a quiz taking place. Eleven people participated and we saw that people enjoyed themselves. People had drinks available and we saw that the activities coordinator met people's individual needs. For example, they ensured a person with a hearing impairment was sitting where they could hear the questions.

People were encouraged to provide feedback on the service. People and their relatives told us there were regular meetings where they could voice their opinions. We saw minutes of meetings that showed they were held regularly. People told us they knew who to speak to if they had any worries. However, two of the people we spoke with felt nothing would change as a result of a suggestion or complaint. One person said, "It's no good complaining; it's a waste of time". We also saw that an electronic tablet was available in the foyer for anyone to provide feedback at any time. The manager also told us that the tablet was made available to the people who used the service on a weekly basis in order for them to provide regular feedback. Staff assisted people to use it as required. During our inspection, we saw a relative make a verbal complaint. We saw that the service's administrator dealt with the issue immediately and responded appropriately. We also saw the administrator update the complainant on what was happening with their concern. This was done in a timely manner.

We concluded that although feedback was encouraged, we could not be assured that people felt confident their concern would be addressed.

Requires improvement

Is the service well-led?

Our findings

During our inspection on 10 February 2015 we identified that the service did not have enough staff suitably deployed to meet the needs of people using the service. Following the inspection, the provider sent us an action plan to tell us what improvements they planned to make to address these concerns. The provider told us that senior staff would work alongside care staff once the medicines administration was complete. They also told us staff would be better deployed at times when people's needs increased.

When we carried out our inspection on 12 and 17 November 2015 we found that although extra staff had been employed during busier periods, further improvements were still required. People told us they still had to wait for assistance. One told us "I feel safe with the girls that look after me but sometimes they don't come fast enough when I ring the bell". Another said "The carers come and say they will be back but they never do". When we spoke with staff about whether senior carers work alongside care assistants once they had finished administering medicines, one told us "Seniors very rarely help on the floor".

We concluded that the service had not made all the improvements they told us they would make.

Although there were systems in place to monitor the quality of the service these were not always effective. This was because the internal audits had not reliably identified key issues that put people's wellbeing at serious risk as highlighted in this report. These included oversights in ensuring people received the care they required in relation to eating and drinking, medical conditions, falls and ensuring people's human rights were protected under the MCA. Audits did not identify shortfalls in staff training.

For example, the health and safety audit for October 2015 had concluded that all new staff had received training in the safe use of moving and handling equipment and had their competencies assessed. However, there were new staff working within the home that had not received this training. This audit also stated that all new staff had received appropriate emergency response training.

However staff told us they hadn't received this training. When we asked to see records to demonstrate staff had undertaken this training, the manager was unable to provide these.

The system that was in place for monitoring and analysing people's falls was not consistently effective. For example, we noted from the care plan that one person, who had been identified as at risk of falls, had had two falls in the month of September 2015. However, these had not been recorded on the falls outcome record within their care plan.

During the inspection we asked the manager for the falls analysis records that covered all the people using the service. The records we viewed did not demonstrate that falls had been consistently analysed. For example, the records we were given did not show the service had identified any contributing factors to prevent further occurrences nor what action had been taken as a result. Following our visit, we asked the manager for further falls analysis records. Different records were sent to us that included an analysis of the falls that had taken place over a one month period. We therefore concluded that the service did not consistently identify any contributing factors that could potentially prevent further falls.

We saw that there were two separate discrepancies in the stock counts of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw that the discrepancies had been identified by the manager. However, when we spoke with the manager on one of the days of our inspection they could not provide us with written documentation on the investigations they had undertaken. The manager told us they had investigated the issues and that no one had come to harm as a result. However, they could not verbally tell us how they were assured no one had received either too much or too little medicine. Following the visit the manager emailed us written confirmation of the investigations.

The service had failed to implement effective systems that mitigated the risk to people's health, safety and welfare. These concerns constituted breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post at the time of our inspection and the conditions of registration were being met. The manager could tell us the types of events that

Requires improvement

Is the service well-led?

they would need to report to the Care Quality Commission via a statutory notification. We know from the information we hold about this service that statutory notifications have been submitted appropriately in the past.

The people and staff we spoke with had mixed views on the quality of the management team. One person told us, "It's not as well run as it used to be when I came [number] years ago. It was more orderly when I first came". However, the relatives we spoke with were positive about the management of the home. The staff we spoke with had contradictory views on how supportive they found the management team. Out of the three staff we discussed this with, two did not feel the manager was supportive. One told us they did not feel valued or acknowledged. The second staff member told us that when they had approached the manager with concerns the manager had been annoyed with them. However, a third staff member said they felt confident the manager would address any concerns they may have. We concluded that staff did not consistently feel empowered to, or confident in, expressing their views.

We saw that the service encouraged feedback from people. We viewed records that showed two relatives had fed back about the amount of time it took for call bells to be answered. One relative said "Getting fed up with how long it takes for someone to come and get [relative] ready at night for bed – very poor!" Another said "[Relative] sometimes doesn't have assistance to change their top if needed". On asking the manager what improvements they had made as a result of feedback they were unable to give us a direct answer and told us the improvements were 'general'. We also saw the provider's regional manager's audit for October 2015. It stated that the manager had not reviewed the 16 recent comments that had been made as part of the feedback system. We concluded that although the service encouraged feedback, it did not consistently respond and learn from people's experiences and concerns.

We asked the manager how they lead their staff team and ensured good practice was being delivered. The manager told us they completed night audits and spot checks at weekends. They told us they made sure they were visible and that they knew and understood their staff. Staff meetings were held regularly where staff could voice their opinions. However, the manager told us they were aware that not all staff were comfortable in doing this so they made sure all staff had regular one to one sessions also. We saw records that showed staff received regular one to one support sessions. We also saw a notice in the foyer that informed people that the manager was available on one dedicated afternoon per week to discuss any issues or concerns they may have.

The people and staff we spoke with had mixed views on the team working ability of the service. People we spoke with told us they felt confident in the staff that supported them but that they often had to wait for assistance. Three members of the staff team told us that they felt some of their colleagues did not work as part of a team. However, care staff told us the senior carers were supportive and that they felt able to approach them with any concerns or for advice.

The manager told us they felt supported and valued in their role. Their line manager visited them regularly and was available via the telephone at other times. The manager told us they kept up to date with their knowledge through attending training and meetings. In addition they used the provider's monthly bulletins and were signed up to various sector specific email alerts for information. For example, this meant the manager was alerted to information such as recalls on medical equipment and medicines.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Although the service had identified the risks to people, these had not been consistently acted upon in order to keep people safe.** **Regulation 12(1) and (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional needs of people with swallowing difficulties were not always being met.** **Regulation 14 (1) (2) (4)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Due to the inconsistency in providing mandatory training, people were not always supported by staff who were suitably trained and competent to carry out their roles.** **Regulation 18 (1) and (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The service had failed to implement effective systems that mitigated the risk to people's health, safety and welfare.

Regulation 17 (1) and (2)(a)(b)