HC-One Oval Limited

Gallions View Care Home

Inspection report

20 Pier Way
London
SE28 0FH

Tel: 02083161079

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16 February 2018

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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

This inspection took place on 15 and 16 February 2018 and was unannounced. This was the first inspection of the service after it was taken over by a new provider, HC-One Oval Limited.

Gallions View is a care home that provides nursing and personal care and support for up to 120 older people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection, 40 people were using the service across two units, the majority of whom were living with dementia.

At this inspection on 15 and 16 February 2018, we found breaches of the Health and Social Care Act 2008 (Regulated Activities 2014). This was because we found identified risks to people did not always have detailed guidance in place for staff to be able to manage these risks safely.

Incidents were not always logged and investigated appropriately detailing the incident and the outcome.

People and their relatives were not involved in planning their care needs and care plans were not always reviewed on a monthly basis to reflect people's current needs.

Regular staff and resident meetings had not taken place to give people information about the new provider.

Audits were not always effective in identifying shortfalls in the safety and quality of the service, such as issues we found during this inspection.

There was a manager who had been in place for three weeks prior to this inspection. The manager had applied to be 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.

There was a lack of leadership and staff did not feel listened to and morale was low.

The service had appropriate safeguarding procedures in place and staff were aware of the action to take if they had any concerns. Medicines were safely managed. Medicine records were completed and showed that people received their medicines as prescribed.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and asked for people's consent before they provided care. People received support from staff to eat and drink and records confirmed dietary advice had been sought from healthcare professionals, where appropriate. People had access to a range of healthcare professionals when required such as GPs, district nurses and speech and language

therapists.

Staff respected people's privacy, dignity and independence. People were encouraged to be as independent whenever possible. People were provided with information about the home prior to moving in so they knew what facilities and services the home offered.

People knew about the service's complaints procedures and how to make a complaint. Complaints were logged and investigated in line with the provider complaints procedure. People's cultural needs and religious beliefs were recorded to ensure that staff took account of people's needs and wishes, for example their faith or cultural needs. People's care plans contained a section on end of life care and their preferences and choices for their end of life care was documented.

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

Risks to people had been identified but there was not always guidance in place for staff on how to manage these risks safely.

Accidents and incidents were recorded but not always investigated appropriately

Medicines were safely managed.

People were protected from the risk of infections.

There were appropriate safeguarding and whistleblowing procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported in their roles through receiving up to date training and regular supervisions. However, not all staff had completed up to date refresher training.

Staff completed an induction when they started work and received appropriate training in line with people's needs.

Assessments of people's needs were carried out prior to them joining the service to ensure the service could meet people's care needs.

The manager and staff understood the Mental Capacity Act 2005(MCA). People were asked for their consent before they were provided with care and support.

People were supported to have a balanced diet.

People had access to a range of healthcare professionals when required.

Is the service caring?

Requires Improvement

One aspect of the service was not always caring.

People were not always involved in decisions about their daily care needs.

People told us staff were caring and kind.

People's privacy and dignity was respected. People were encouraged to be as independent as possible.

People were provided with relevant information about the service.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were not reviewed on a monthly basis.

Activities were not offered throughout the day for people to take part in.

People knew how to make a complaint. Complaints were logged and investigated in line with the provider complaints procedure.

People's cultural needs and religious beliefs were recorded to ensure that staff took account of people's needs and wishes.

People had access to healthcare professionals when required in order to maintain good health.

People had end of life care plans in place to ensure that their preferences and choices for their end of life care were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits were not always effective in identifying shortfalls in the safety and quality of the service.

Regular staff and resident meetings had not taken place to give people information about the new provider.

Staff did not feel listened to and morale was low.

There was a manger in post, who had applied to be a registered manager.

The home was working closely in partnership with other agencies such as the local authority.	

Gallions View 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 15 and 16 February 2018 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector, a specialist nurse and two experts 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.

Before the inspection we looked at the information we held about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. Usually we would ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to provide some key information about the service, what the service does well and improvements they plan to make. However, in this instance we did not request a PIR as we brought this inspection forward due to some concerns we received. These concerns included allegations of abuse and neglect. We also asked the local authority commissioning the service for their views of the service.

During our inspection we spent time observing the care and support being delivered. We spoke with 12 people using the service, five relatives, eight members of staff, the manager, the clinical manager, the resident experience manager and the area manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed records, including the care records of seven people using the service, seven staff recruitment files and training records. We also looked at records related to the management of the service such as surveys, accident and incident records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. One person said, "Yes, I feel safe here, the staff are friendly." Another person said, "Oh yes I feel safe." A relative told us, "My [relative] is very safe." Despite these comments we found people were not always kept safe.

Risks to people had been assessed in areas including medicines, moving and handling, nutrition, skin integrity, communication and falls. However, we found that appropriate guidance was not always in place for staff on how to manage assessed risks safely. For example, the risk assessments for three people who had been assessed as being at risk of choking contained no guidance on the action staff should take if they started to choke, placing them at risk of unsafe care. In another example there was no seizure protocol in place for one person identified as suffering from epilepsy to inform staff of the correct action to take in the event of them having a seizure. The registered nurse told us that they were newly qualified but and had not received any training regarding epilepsy or seizure management. The person suffered a seizure two months ago. The nurse said they did not know what action to take whilst the person was having a seizure. They said, "I was lucky because there was a senior carer working that day who knew what to do".

Risks to people were not always appropriately monitored or managed safely. For example, one person was at high risk of developing pressure sores; staff should have updated a body map each week when monitoring their skin condition. However body maps had not been completed at this frequency during the previous month, during which time, an ankle wound the person had sustained had deteriorated. The records lacked detail as to how and why the wound had deteriorated and staff had not made a referral to a Tissue Viability Nurse (TVN) for specialist advice despite the wounds worsening condition.

The home had a system in place to log incidents and accidents. Incidents were not always logged and investigated appropriately where they occurred in order to ensure people's safety was maintained. In January 2018 records showed that one person had left one of the units at the service. Whilst staff had completed an incident form, it had not been filed in the home's accident and incident file and a full investigation had not been carried out to establish how the incident took place, or to identify measures to prevent recurrence.

Staff did not always support people safely. For example, relatives told us, and other staff members confirmed, that they had observed one staff member using unsafe moving and handling techniques when supporting people to mobilise. We also found that information regarding people's current conditions were not always adequately shared between each shift in order to ensure they received safe support. For example, the home used a weekly document called 'At a glance' handover sheets that informed staff of people's current needs. We saw that the 'At a glance' handover sheets had not been updated since 2 February 2018 to ensure staff had up to date information about people's needs.

As risks were not being managed safely this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these concerns to the attention of the manager and area manager. They arranged for a TVN referral to be made in regard to the person's ankle injury during our inspection, and updated the care plan of the person suffering with epilepsy to include a seizure protocol and monitoring guidance.

The manager also updated care plans for people at risk of choking with guidance for staff on the action to take should an incident take place. We spoke to staff about people who were at risk of choking; they were able to explain the actions they would take should a person choke.

The manager told us that they were not aware that unsafe moving and handling techniques were being used. They confirmed that where required, staff would receive retraining in moving and handling and all staff had been issued with written documentation about unsafe moving and handling practices that were not to be used. During our inspection we saw both units had updated the 'At a glance' handover sheets that ensured that information on people's conditions was made available to staff during shift handovers. The manager was not able to comment on why the incident of a person leaving one of the units was not investigated in full, but told us they would carry out regular checks in the future to ensure all incidents were filed and investigated.

We saw there were sufficient numbers of staff on duty to meet people's needs. Staff rotas showed they were planned in advance so staff knew what shifts they were working. Rotas we looked at showed that there were enough staff to meet people's needs and there were sufficient numbers of staff on duty to meet people's needs. One person we spoke to told us, "There are enough staff." One relative said, "Yes there are more than enough staff".

Appropriate recruitment checks had been carried out. This included completed application forms, details of employment history and qualifications. References had been sought, proof of identity had been reviewed and criminal record checks had been undertaken for each staff member. However, one staff member did not have an appropriate criminal records check in place despite their role in providing care and treatment to people at the service. Following the inspection the provider confirmed that the staff member was no longer working with people on the units and was undertaking administrative work only whilst they waited for a new criminal records check to be completed.

Medicines were safely managed. We observed the lunch-time medicines round and noted that staff were aware of how people liked to take their medicines and provided them with appropriate support. People's medicines administration records (MARs) contained details of any medicines allergies they had and were up to date and accurate, confirming people had received their medicines as prescribed. There was appropriate guidance in place for staff to follow where people had been prescribed medicines to be taken 'when required.' Risks associated with the administration had been assessed and were managed safely. For example, we saw that liquids had been prescribed for some people who had swallowing difficulties and there was guidance from the hospital speech and language therapy team (SALT) about how best to support people.

Medicines were stored safely and securely in clinical rooms on each unit. Room and fridge temperatures were monitored and we found that these were all within the safe range for medicines. A nurse practitioner from the GP surgery visited the home twice a week and carried out reviews of people's medicines. We carried random medicines balance checks and found that quantities of medicines matched documented records.

There were appropriate safeguarding and whistleblowing procedures in place. Staff understood the types of abuse that could occur and who they would contact should they have any concerns. Staff were aware of the organisation's whistleblowing policy and told us they would use it if they needed to. One staff member told

us, "I would go to my manager in the first instance; if nothing happened then I would go to the CQC." Another staff said, "I am confident that management would investigate any concerns I had." We saw that safeguarding incidents had been properly recorded and the manager had submitted safeguarding notifications as required.

The home had an up to date infection control policy in place to protect people from the risk of infections. People told us staff wore personal protective clothing (PPE) when supporting them with personal care and we observed this to be the case during our inspection. One person said, "[Staff], wear gloves and aprons." One relative told us, "I always see staff wearing aprons and gloves when they are helping people." One staff member said, "It is a must that I wear PPE, I always make sure everything is hygienic." We saw there were cleaning schedules in place to ensure the home was kept clean and appropriately maintained.

Requires Improvement

Is the service effective?

Our findings

People said they thought people had the right training and skills to meet their needs. One person said, "Yes staff do have the necessary skills and training." One staff member said, "I have done all my training".

Staff had completed a programme of mandatory training, which included medicines, moving and handling, dementia, safeguarding, fire and first aid. However not all staff had received up to date refresher training. For example, out of 86 staff members, 52 had not received up to date refresher training in fire safety and 30 had not received up to date training in moving and handling training. We brought this to the attention of the manager and were told that the provider had identified staff that required training and were in the process of booking this which included moving and handling and fire training. The manager confirmed that a fire training video was being rolled out to all staff until they were able to attend the formal training. This meant by not ensuring that all staff members had up to date training the provider could not assure that staff remained equipped and competent in carrying out their roles properly.

Staff had completed an induction when they started work. All new staff were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new care workers. We saw that staff were supported through formal supervisions where they discussed training, safeguarding and people using the service. Nursing staff received clinical supervisions where they discussed training and peoples' current clinical needs. 'Ten at Ten' meetings were held on a daily basis where clinical issues were discussed as a team which included people's clinical needs such as skin integrity and food and fluid charts.

People were supported to have a balanced diet. People's nutritional needs and dietary preferences were included in their care plans. Charts were completed where required so people's food and fluid intake could be monitored. We saw that where necessary advice had been sought from healthcare professionals where nutritional risks had been identified. For example, where people were at risk of losing weight we saw that they had been referred to a dietician and had been prescribed food supplements to reduce the risks associated with malnutrition.

A daily meal order form was completed to inform kitchen staff of people's choice of meals. There was a monthly menu in place that offered a variety of different meal options. We observed a lunchtime meal being served in the home and noted that the atmosphere was relaxed. There was a pictorial menu on dining room tables to support people to choose their meals and if they did not want what was on offer we noted that they were able to request an alternative. Meals looked appetising and people were served in a timely manner. When required staff were on hand to support people to eat and drink. People who remained in their rooms were served their meals at the appropriate time. One relative told us, "Staff offer [my relative] a choice of meals. They are also on a soft diet and have thickener in their drinks." Another relative said, "Staff know people well and know what they want to eat." Different drinks were available throughout the day to keep people hydrated. One staff member said, "I know one person does not like chicken but I know they liked corned beef. You get to know who likes what food."

Kitchen staff had a current list of people's dietary needs and preferences which identified for example which people needed a low sugar or low salt diets, or which people required fortified meals. Fridge and freezer temperatures were recorded and monitored on a daily basis to ensure food was stored safely

Assessments of people's needs were carried out before they moved into the home to ensure the service was able to provide them with appropriate support. These were used in developing people's individual care plans and risk assessments. For example, the equipment people needed to mobilise was listed in care plans.

People's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA).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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements of DoLS and had submitted applications to a 'Supervisory Body' to request the authority to legally deprive people of their liberty when it was in their best interests. We saw that applications under DoLS had been authorised and that the provider was complying with the conditions applied under the authorisation.
Mental capacity assessments were completed to assess if people did, or did not have the capacity to make specific decisions such as in relation to personal care and medicines. Staff understood the need to gain consent when supporting people. We saw staff seeking people's permission before assisting them. One person said, "Oh yes staff always ask for permission before assisting people. I also tell me what they are doing." One staff member said, "I do ask people if they would like me to assist them. I do not force them if they say 'No', as it is their choice. I always explain to people how I will be assisting them." Another staff member said, "I ask for people's permission before helping them."

People had access to healthcare professionals when required such as the doctor, optician and chiropodist. We saw referrals had been made to other health care professionals such as dieticians' and speech and language therapists when people required them. Records of these appointments and the outcomes were maintained in people's care files. One person said, "A doctor comes every Friday".

We saw people's bedrooms were personalised by furniture, pictures and photographs of their choice. People had memory boxes outside of their rooms, so those living with dementia could orientate themselves as much as possible.

Requires Improvement

Is the service caring?

Our findings

People and their relatives said that they were treated well. One person said, "[Staff] always manage to make me feel more comfortable. They are kind and caring." Another person told us, "Yes, [staff] are caring; they give me enough time when giving me care." One relative said, "Oh I think [staff] are caring, they are very good."

We saw that staff interacted with people in caring and compassionate way. They took their time and gave people encouragement whilst supporting them. The majority of staff were knowledgeable about people individual likes, dislikes and preferences. This included the times people got up and went to bed, or what their favourite food or drink was. However, improvements were needed as people and their relatives were not always involved in decisions about their care. Regular reviews of care plans had not been carried out where people could express their views and make changes to the care needs if necessary. One person said, "I don't always know what is happening, [staff] just turn up and tell me what they're going to do." We brought this to the registered manager's attention who told us that people and relatives are informed immediately if there are any changes to their care needs and people and their relatives would shortly be invited to a care plan review meeting.

People's privacy and dignity was respected. One staff member said, "I shut people's bedroom doors and curtains when helping them with personal care." Another staff member said, "I never enter people's room without knocking and wait for them to say that I can enter." During our inspection we observed staff knocking on people's doors before entering and saw that bedroom doors were closed whilst staff provided them with support. One person told us, "[Staff] respect my privacy and dignity. They close the door and the curtains." A relative told us, "Staff do respect [my relative's] privacy and dignity; I have no issues with this."

Staff knew about people's equality and diversity needs. Care records showed that people's choices and preferences including their religion, interests and preferences were recorded. For example, a priest from a local church attended the home every week so people who chose to were able to practice their faith. We saw another person enjoyed Indian cuisine and another person enjoyed Caribbean food. We saw the chef regularly cooked curry dishes that they enjoyed.

People were given information about the home and the service it offers in the form of a service user guide which included the complaints procedure. This guide outlined the standard of care to expect and the facilities provided at the home.

We saw that people's relatives were encouraged to visit with people at the home. During our inspection relatives people using the service and were welcomed by staff. One relative said, "I come almost daily, the staff are welcoming."

Requires Improvement

Is the service responsive?

Our findings

There was a lack of meaningful activities on offer. There was one full-time activities co-ordinator during the week, who split their time between the two units on a daily basis. There was also a co-ordinator who provided activities over the weekend; they also split their days across the two units. There were limited activities on offer at the home for people to participate in and to promote their well-being. Activities were not consistently offered on a daily basis. We saw there was an activity planner in place but it was not always followed. For example, a scheduled afternoon activity of reading magazines and completing puzzles did not go ahead as planned on one of the days of our inspection, and was not replaced by anything else. We also saw that one unit had a sensory room for people living with dementia, but did not see the room being used throughout our inspection. A staff member said, "We just don't use the sensory room; one activities co-ordinator cannot provide the range of activities that should be on offer. This meant that people were not provided with meaningful activities including people living with dementia.

The activities co-ordinator told us that the home used to have two full-time co-ordinators before the new provider took over which made it easier for scheduled activities to take place. It also gave the co-ordinator the opportunity to spend quality one to one time with people, which was not possible now. The activities co-ordinator said it was very difficult for them to split their day on two units and carry out scheduled activities. This meant people were not offered adequate social stimulation.

On one of the units we observed that after lunch staff had situated people around the television in the lounge and that the volume was too loud to enable people to talk with each other. One staff member said, "After lunch the carers push all the residents in front of the TV which is too loud, and then people are left there all afternoon." Another staff member said, "All the residents are put in front of the television and left there." We saw that people were not fully engaged and stimulated so had fallen asleep in front of the television.

Failure to provide person-centred activities is a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

We obtained mixed reviews from people and their relatives about whether or not they involved in reviewing their care needs. One person said, "Yes, I have a care plan, but I don't have anything to do with it. They get on and deal with it. I've not signed anything." Another person said, "Yes I have a care plan and know what's in it." A relative told us, "Yes [my relative] has one, but it's old, there should be another one." We found that care plans had not always been reviewed on a monthly basis in line with the provider's policy to ensure plans are reflective of people's current needs. This meant there was not always up to date information in people's care plans about their care needs, for example there was no epilepsy protocol for one person who was at risk of epileptic seizures.

We noted that the area manager had identified this issue of care plans not being reviewed regularly during a recent care plan audit. An action plan had been put in place to ensure all care plans had been reviewed by 28 February 2018.

We saw people's care plans addressed a range of needs such as communication, personal hygiene, nutrition, physical needs. Each person also had a personal profile in place, which provided important information about them, including their date of birth, gender, ethnicity, religion and next of kin. Staff were knowledgeable about the people they supported. For example, what people's dietary preferences were.

There was a complaints policy in place and people and relatives knew how to raise a complaint if they needed to. The home had a system in place to record and investigate complaints. We saw the provider had received one complaint December 2017. The complaint was investigated in a timely manner, the outcome and actions taken were clearly recorded. People told us, "I know how to make a complaint I go down to the office". One relative told us, "Yes, I know how to complain but I have never had to complain". Another relative said, "I have no complaints so far".

People had end of life care plans in place. The service recorded what was important to people and if a situation arose where someone may be approaching end of life, relevant individuals, including their family members would be consulted to ensure people's preferences and choices for their end of life care were acted upon. At the time of our inspection the home did not have anyone on end of life care.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found whilst there were some systems in place to monitor the quality of the service, the provider's had either not identified the issues we had found in during this inspection, or had not acted to address identified issues promptly. This included medicines, moving and handling techniques, monitoring charts, staff training and daily monitoring of the two units. Risks to people were not managed adequately. For example, moving and handling audits had not identified that unsafe moving and handling techniques were being used by staff and approved by a manager.

On the first day of the inspection we found that both the hot water and cold water taps were broken in one of the communal bathrooms on one unit. There was no sign to say that the bathroom was out of order to stop people accessing it. The maintenance person was unaware of the issue and told us that maintenance issues were not always reported to them. The resident experience manager was required to undertake a daily walk around twice a day, to identify any issues that could have an effect on people's safety and well-being. Records showed that either the walk around did not take place twice a day or maintenance issues including broken equipment were not picked up and reported appropriately. This meant people were at risk from unsafe equipment.

Staff told us and records confirmed that most weekends there were no unit managers on duty. This meant staff had use the on-call service to contact a senior staff member if they required advice and support. One relative told us, "I am concerned there are no managers at the home on weekends. I have called to speak to a manager about my [relative] and there are just none available on weekends." Staff told us that some senior members of staff continuously came into work late and left early. Records we reviewed confirmed this to be the case on some occasions. This meant that the home was not always supervised by a senior member of staff.

A failure to have effective quality assurance processes is a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

During our inspection we saw that the hot and cold taps in the communal bathroom had been fixed. The registered manager told us that going forward they would be ensuring there was a unit manager on duty on weekends to support staff and be available to talk to family members.

There was a lack of leadership and guidance that affected staff and staff morale was low. There had not been any formal staff meetings since the new provider took over. Staff did not always know who was managing the service and the communications about management support since the new provider took over was poor.

Following the change in provider in December 2017, we saw that the provider had sent the home bulletins for staff about the new provider. However, staff told us that there had not been any formal team meetings with the new provider in attendance following the takeover in December 2017. For example, there was a staff meeting held on 15 December 2017; however the new provider had not attended. Some staff told us they did

not know what the new management structure was and who was in charge of the home on a day-to-day basis. They also told us that they were unsure of who their line manager was as they had not been told. We attended a team leaders meeting on the second day of inspection and heard one staff member telling the home manager that they did not know who their line manager was. This meant staff were not always clear about the new management structure of the home. We saw that the first formal planned staff meeting with the new provider took place with the area manager in attendance on the second day of our inspection. Staff were informed about the hierarchal structure of the home including names of unit managers and senior managers.

There had not been any residents and relatives meetings since December 2017 in order to provide people with information about the new provider. One person told us, "The previous provider had resident's meetings, but not this new one." A relative told us, "I always attend these meetings but there haven't been any since the new [provider] took over." We saw that the first residents and relatives meeting had been arranged at the end of February 2018 for the new provider to formally introduce themselves.

The home had a manager who had been in place for three weeks prior to the inspection. People and their relatives told us that the new manager was not visible around the home and had not introduced themselves. One person said, "I don't know the manager, I haven't met them." Another person told us, "I don't know who the manager is." A relative said, "I have been visiting here for many years and I am a little concerned that I don't have the same communication with staff/management that I had before the changeover." Another relative told us, "I have not seen the manager." This meant that people did not know who the manager was so they knew who to approach and speak to should the need arise.

We brought this to the manager's and area manager's attention. They told us that they were aware that staff morale was low and staff and had recently met with their human resources department and had made their complaints known. They told us they would be addressing the issues raised and would put an action plan in place. They also told us that the manager would be visible on both units from hereon in. We saw the manager put this into practice by meeting with people and staff during the remainder of our inspection.

The manager was aware of their responsibilities about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014. Notifications were submitted to the CQC as required.

Resident feedback surveys had not been sent out by the provider to date as they had recently taken charge of the home. We saw an action plan detailing that the home's annual survey would be sent out later in the year.

The registered manager told us that they work closely with the local authority, to meet people's needs. The local authority confirmed this. The registered manager told us the ethos of the home and the duty of all staff members was to provide people with a comfortable life and concentrate on delivering individual support to meet their care needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regular and varied activities were not provided for people on a daily basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were either not reviewed or not updated to show a change in people's needs. Staff had used unsafe moving and handling techniques. Staff handovers were not always effective. Incidents were not always investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service were not effective. Regular staff and resident meetings did not take place to inform people about the new provider. Staff and residents were not aware of the management structure and did not know who the manager was. Staff morale was low.