Speciality Care (UK Lease Homes) Limited

Eden Court

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 2 April 2015 2015 and was unannounced.

Eden Court is registered to provide residential care for up to 40 older people. Bedrooms are situated on both the ground and first floor with communal lounges and a dining room on the ground floor. There were 40 people living at the home at the time of our inspection.

At the time of our visit the person managing the service had only been in post for seven weeks and was in the process of submitting their application to the Care Quality Commission for registered manager status. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff knew how to maintain people's safety. Personal emergency evacuation plans were in place. However there were not enough staff available to meet people's needs safely or in a timely manner.

Staff required further training to support them in meeting people's needs. This was particularly relevant to make sure staff worked within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Summary of findings

People enjoyed the food at the home but better monitoring of people's nutritional intake was needed.

Staff treated people with kindness and patience. However their ability to provide care in line with people's preferences was restricted by insufficient staffing.

Care was not planned or delivered with a person centred approach. The manager had identified this and was addressing it.

Activities were provided but these were not always accessible to all of the people living at the home. This was affected by insufficient staffing numbers.

Complaints and concerns were listened to and managed well.

People who lived at the home and staff had confidence that the new manager was putting systems in place to improve the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

There were not enough staff to meet people's needs in a safe and timely manner.

Improvements were needed in relation to infection control.

Risk assessments were not always kept up to date.

Evacuation plans were in place in case of emergencies.

Accidents and incidents were recorded and analysed for any trends or patterns.

Staff were recruited safely.

Is the service effective?

Requires improvement

The service was not always effective

Staff required further training to support them in meeting people's needs safely.

Mental capacity assessments were not always clear and procedures had not always been followed appropriately with regard to determining people's best interests.

People enjoyed the food but people's nutritional intake was not always monitored as needed.

Is the service caring?

Requires improvement

The service was caring but staff's ability to provide care in line with people's preferences was restricted by insufficient staffing.

People told us the staff were caring.

Support was seen to be task rather than person led.

Staff treated people with kindness and patience.

Is the service responsive?

Requires improvement

The service was responsive but some improvements were needed.

Care was not planned or delivered with a person centred approach.

Activities were provided but these were not always accessible to all of the people living at the home.

People felt able to speak out if they had any concerns and we saw that complaints were managed well.

Summary of findings

Is the service well-led?

The service was well led but some improvements were needed.

People had confidence that the new manager was putting systems in place to improve the service.

Systems for auditing quality of service were in place but these had not always identified issues where improvements were needed.

The senior management team demonstrated openness and accountability when issues were discussed with them.

Requires improvement

Eden Court

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 2 April and was unannounced.

The inspection was carried out by two adult social care 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 expert by experience on this occasion had experience in caring for elderly people, particularly those living with dementia.

Prior to this inspection we looked at all the information we held about Eden Court. This included the notifications of events such as accidents and incidents sent to us by the home and reports from local authority contracts and Infection control team visits. We had sent a provider information return (PIR) to the provider and this had been completed and returned to us within the timescale requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we spoke with 11 people who lived at the home and four visiting relatives, five members of staff, the manager, area manager and the regional operational director. We looked around the home, observed practice and looked at records. This included four people's care records, three staff recruitment records and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

During our visit we asked people if they felt safe in the home. Everyone who responded to the question said that they did. One person said they felt secure "…because of all the people around" and another said "I feel secure, like someone's got their arms around me. I feel that here I'm safe." We asked people if they were affected by any behaviour that other people living at the home exhibited. All of the people we spoke with said they were not. One person said "You do feel that everyone's your friend here" and another told us "I don't think I've ever seen any nastiness here."

We asked people if they thought there were enough staff. One person said "There are definitely not enough staff, especially at night. Getting people off to bed is slow." Another person told us "They could do with a bit more staff" and another said "I think they have enough staff – they seem to manage well for always being so busy." A visitor told us "I only come during the day, and there seem to be enough though they can be a bit strapped sometimes. Sometimes people have to wait for things, but not for long."

When we asked people about use of their call bells to get assistance, people told us "I often have to wait when I use it.", "I use my buzzer to get help. It always takes a while, sometimes I wait and wait." We spoke with three people in their rooms who could not tell us how they would get attention if they needed to. Whilst they had call bells positioned near to them or attached to their bedding they did not appear, when we asked, to know what these were for. One person said "I shout for help. I shout 'hello, is there anybody there?'". We saw that people in the lounges did not have easy access to call bells. We asked one person how they would get assistance as they could not move independently. They said "I just have to shout 'help'." Another person agreed that this was how people got help in the communal areas when staff were not present they said "I just have to shout for help."

Staff we spoke with understood their responsibilities with regard to maintaining the safety of people who lived at the home and told us they had received training in this area. One member of staff told us of a concern they had about people's safety because they were being hoisted with slings not appropriate to their needs. We brought this to the attention of the manager during our visit and they assured us they would address the issue immediately.

Prior to our visit the Care Quality Commission had received concerns about staffing levels at the home, particularly during the night. During our visit he manager told us that staffing was arranged at two nurses and six care assistants during the morning, two nurses and five care assistants during the afternoon and one nurse and three care assistants during the night. The manager added that it was planned to have seven care assistants on duty during the morning as soon as ongoing recruitment was completed.

At the time of our visit there were forty people living at the home. The manager confirmed to us that thirty two of these people needed the support of two staff to meet their needs. We observed staff to be very busy. We saw they were still supporting people to get up and ready for the day at 11.30am. One person told us they had wanted to get up "for ages". When we asked care staff why people were waiting so long for support they told us it was just because they were so busy. They told us that they had been assisting people to get up but had also needed to provide people with their breakfast, mostly in their rooms and assist 13 people to eat.

Care staff told us that nurses did not assist people in getting up and ready for the day, nor did they assist with meals. When we asked the nurses about this they told us they had the medications to administer and one added that nurses have "enough to do."

We saw further demonstration of not enough staff to meet people's needs at lunchtime when we observed that some of the people who needed support with their meal had to wait for over forty five minutes from the time other people were served their meals. This was because there were only six staff available to serve people who were taking their meal in their room, support people in the dining room and meet the needs of 13 people who needed full support to eat their meals.

We saw from rotas that there was one nurse and three care assistants on duty during the night. The manager told us that the night shift started at 7.30pm which meant that only four staff were available to support people with supper and preparing for bed. The nurse would also have medications to administer which left only three staff to support people.

Requires improvement

Is the service safe?

Staff told us that the deployment of staff during the night was two care assistants working upstairs and a nurse and one care assistant working downstairs. This meant that when staff were supporting people who needed two staff to meet their needs on either of the floors, there were no staff available to the other thirty eight people living at the home.

Most of the staff we spoke with told us there were not enough of them to meet the needs of the people who lived at the home in a timely manner.

This demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the processes in place for staff recruitment. We looked at three staff files and saw that saw staff members had completed an application form and they had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

The manager told us about how the disciplinary procedure was followed when needed to make sure that staff worked in a professional and safe manner. We saw an example of this during our visit.

We saw that procedures for whistle blowing were in place and some care staff told us they had previously used this procedure to report inappropriate behaviour and attitudes of colleagues. Staff told us that previous managers had ignored them but they now felt that their concern had been dealt with appropriately and appropriate action had been taken. They were also pleased that they were kept informed of the progress of their complaints and that they had been acted upon promptly by the new manager.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. The manager told us they had been working closely with the supplying pharmacy in relation to management of medicines. We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored safely and only administered by staff that had been appropriately trained. We observed some people being given their medication during our visit and saw that staff supported people appropriately.

We looked at the medication administration records (MAR) file. We saw that MAR charts had been completed correctly.

We noted that for medicines given on an 'As required' or PRN basis, a separate PRN administration record had been put in place. This was for staff to record why the medicine had been administered and if it had been effective.

Prior to our inspection, the manager had notified the Care Quality Commission of a medication error. This had been managed appropriately and procedures had been followed to minimise the risk of repeat. This meant that medicines were managed safely.

We saw that accidents and incidents that happened in the home were recorded when the incident occurred and then recorded monthly on the provider's 'e-compliance' system for further analysis by the operations director and the director of quality for the company. This was so that any trends or patterns could be identified and action taken to reduce the likelihood of it happening again. The regional operational director told us that any person who had sustained more than two accidents in one month would be identified by the system and the operations director would then contact the home for more details.

Care documentation showed that risk assessments had been undertaken for such as; moving and handling, nutritional risk (MUST), infection control, tissue viability and medication. However we saw no evidence that these risk assessments had been reassessed as people's care needs changed.

During our tour of the building we noted some problems with infection control. This included the use of shared slings and a lack of personal protective equipment such as gloves and aprons in communal bathrooms and toilets. In addition, we found gloves stained with faeces in a drawer in one of the bathrooms and a similarly stained cushion in another bathroom. Some of the toilets did not have any toilet roll provided. The manager addressed all of these issues during our visit.

Requires improvement

Is the service safe?

We noted that several rooms did not provide bedside lighting or access to lighting for people when they were in bed. The regional operational director told us they would address this issue without delay.

The care files we looked at contained individual evacuation plans. Most of the staff we spoke with told us they had received recent fire evacuation training and they also knew when the fire alarm was tested and assembly points. However one new member of staff told us they had not received any fire training nor did they know where the assembly point was for the home.

We found the activities trolley and a person's walking frame blocking one of the ground floor fire exits. When we pointed this out to a carer we were told that they thought it was there temporarily. We asked for them to be removed and this was done immediately.

We looked at the fire risk assessment and related documents. The risk assessment was provided by an external consultancy and was completed in October 2012, with provision that it be renewed in October 2013. The requirement for an annual review of this document was also stated in the home's policies. There was a copy of an internal review of fire risks filed with the risk assessment. This was dated in August 2014 and highlighted that the fire risk assessment was dated 2012. It was not clear whether all remedial actions relating to the 2012 assessment had been actioned. Other checks and tests appeared to have been carried out at a frequency that complied with procedures and statutory requirements.

Requires improvement

Is the service effective?

Our findings

During our visit we spoke with people who lived at the home about the staff who supported them and also asked their views about the food they were served. When we asked people whether they felt that the staff had the skills to meet their needs one person said "I am more or less safe when they hoist me. I'm not sure how well trained the people that do it are." Other people told us "The staff and manager know what they are doing", "We get well looked after" and "The staff know what they are doing."

People spoke positively about the food and felt that they were offered choice. One person said "There's a good choice of food. If you don't fancy it you just tell them and they change it." Another person told us "The choice of food is very good. If you don't like something they'll get you something else." We asked people whether they had ever been consulted about what was included on the menus. One person said "Never – but that would be nice."

All of the staff we spoke with told us they had received regular training to ensure they had the skills necessary to undertake their work. For example; dementia, palliative care, first aid, infection control, food handling, health and safety at work. They said that most of their training was via an online system. The manager told us that whilst online training would continue, they hoped to initiate more face to face training.

We spoke to a new member of staff, who told us they had undertaken extensive training in their previous carer's post. This included a trainer's certificate in training in moving and handling. They told us they were concerned about the quality of the training staff received with regard to moving and handling and use of equipment. We were also told that since commencing work at the home they had not received an induction programme so that they were unaware of the emergency procedures.

The manager told us they had already identified training as an area in need of improvement and provided us with information about training which had been planned for all of the staff. This included moving and handling training.

Staff told us they had received recent supervision from the new manager or deputy manager and with the exception of newer staff, they had also had annual appraisals. The manager told us it had been important to them to make sure they had met with all staff to assist them in planning support and training.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff told us they had had training in mental capacity and DoLS and when asked understood the implications for the people who lived at the home.

We saw in the care files we looked at that, where appropriate, assessments of people's mental capacity had been completed. However we noted they had been undertaken by a previous home manager who had also completed a best interests form. This is a form on which decisions made, following consultation with specified people acting on behalf of a person who lacks capacity, are recorded. We did not see evidence that people other than the previous manager had been involved in this process. We also noted that despite one person being assessed as being able to communicate their decisions, they were considered, according to the capacity assessment, to lack capacity to make decisions. This had resulted in decisions such as having their bedroom door left open and a request for a Do Not Resuscitate (DNR) assessment being made by the previous home manager.

It is important that these assessments are reviewed to make sure they accurately reflect the individual's capacity and that any decisions made have been as a result of proper process.

We spoke to people and asked if they felt there were any restrictions placed on them. None of the people we spoke with thought there were.

We observed the service of lunch in both the main and smaller dining rooms. We also saw people in the lounge supported on a one to one basis with their meals. People were offered choice of main course whilst seated at the table, and this was plated for them table by table. People could not choose which vegetables they had with their meal or whether they had gravy or how much or where on the plate this was placed. One person told the member of

Requires improvement

Is the service effective?

staff serving them "I didn't want vegetables with it. Whilst the plate was taken away and the vegetables removed the person would have been presented with a meal that was immediately more appetising to them had they been offered this choice. People were offered more when they had finished and given a choice of dessert when they were ready. People appeared to be enjoying the meals and plates were mostly empty when they were cleared away. Staff asked people if they required assistance in cutting up their meals and gave assistance as requested. One person asked for their food to be cut up as they could not see clearly. Whilst the member of staff did this, there was no additional assistance such as describing where the components of the meal were located on the plate. We saw one person request toast rather than the meal offered. This request was met in a timely manner.

There was little to set any atmosphere over the lunchtime and whilst staff interactions with people were warm and genuine these were mostly limited to tasks in hand.

We observed staff supporting people with their meals in the lounge area. This was done in a very supportive and dignified manner. We saw one member of staff telling the person what was on the fork each time they took it to the person's mouth. When the person gave indication that they wanted to hold the fork themselves, the staff member supported this with patience.

We noted that, due to the number of people who needed support, some people had to wait for long periods of time for their meal. For example, one person who was assisted to eat their meal in the lounge had to wait forty five minutes longer than another person. We also noted that nursing staff were not present at all during the service of lunch.

People who spent their time in the lounges told us that they were able to have drinks and snacks during the day; both as part of a regular round and on demand. In the morning there were jugs containing both orange and blackcurrant juice in several places in the lounges, however there were no glasses until the mid-morning drinks round, meaning that people would have been unable to serve themselves.

We spoke with people who spent their day in their rooms and asked about access to fluids and food outside of meal times. One person could not tell us about how they would get a drink. There was an empty adapted tumbler on a table beside the person's bed together with a jug of juice, which the person was not able to lift. Another person did not have any drinks in their room and told us they did not know how they would get a drink.

We saw that people who were in bed during the morning did not receive mid-morning drinks or snacks.

We examined the intake records of some of the people who were being nursed in bed. We found that, for some people, records had been made of the amounts of fluid offered but no record of amounts consumed. On other charts we saw records of fluid consumed that day but saw drinking cups, still in people's rooms with varying amounts of the drink recorded as consumed, still in the cup. This meant we could not be confident that people's records of fluid and food consumption were accurate, that people's food and fluid intake was sufficient, or that it was monitored and evaluated by the nursing staff.

We looked at the dietary intake sheets for one person whose care plan stated they were to be provided with fortified drinks and snacks between meals because they were at risk of poor nutrition. On the three days records we looked at there was no record of the person being offered these. In addition on one of the days the records showed the person had not had any lunch and had eaten only half of their tea time meal. There was no evidence that these charts had been monitored to make sure the person was receiving the nutrition they needed.

Whilst we did not see evidence of people losing weight, it is important that staff monitor people's diet and fluid intake, particularly where people are nutritionally compromised.

We spoke with the manager about this who said they would look into the issue. Following our visit the manager contacted us to say they were confident that people received the food and fluids they needed but the problem was with recording. They confirmed to us that they had introduced better ways of recording and monitoring people's intake.

We saw from people's records that the advice of healthcare professionals including GPs, district nurses, falls specialists and dieticians were sought as needed. This meant that people's healthcare needs were met.

Requires improvement

Is the service caring?

Our findings

People spoke positively about their relationships with staff in the home. People told us "The staff like us to have a bit of fun", "They are very caring. They try their best to talk to us", "The carers know you and all help you; they're good" and "Everybody here is nice, I know them all. Some of the staff are comical funny."

People told us that they felt able to talk to the staff at any time and felt that they were listened to. One person said "If there was something worrying me I would talk to a member of staff and they might take it to the manager." A person visiting their relative told us "They take an interest in what the residents think."

Most people could not tell us about how they exercised choices in their care other than expressing preferences about when they got up and went to bed and input into the frequency and timing of bathing or showering. People said "You can choose bed time to a certain extent, but you have to fit in with the staff", and "You can say when you're ready to get up or go to bed but the staff are so busy you probably have to wait." One person who could not move independently said "Basically they decide when I get up." We spoke to one person who was in bed, but appeared to be in day clothing. We asked if they had wanted to be in bed. They told us "I'm not sure that I do."

People told us that the frequency of bathing or showering might be tailored to their preferences. They said "I have a bath when I want one", "I think there's some choice (about time of baths) depending on how many staff there are and how busy they are" and "You just have to say when you want to have a bath."

We noticed on arrival and during our tour of the building that the majority of people were in bed in their rooms where they had had their breakfast and their curtains remained closed until they were supported to get up and go to the ground floor lounge.

Prior to our inspection we had received some information of concern about night staff having been instructed to assist people to wash and dress but assist the person back into bed to wait for day staff. We were told this was because day staff did not have enough time to assist everybody to wash and dress in the morning. The manager told us that they had suggested this as a way of providing care to people who had woken and needed support to wash and change. This method of support appeared to be more in response to a lack of staff rather than meeting people's choices in relation to their care.

We noticed that some of the people in bed were not able to reach their possessions such as glasses or drinks. We saw that people could not see their clock from their position in bed. This coupled with the fact that curtains remained drawn and the room dark would make it difficult for people to orientate to the time of day. On the wall of one person's room we saw a notice instructing carers to ignore the person's preferences relating to when they were in bed on the instructions of the family. We also noted that the majority of bedroom doors were wide open giving full view of the person in bed from the corridor. We could not be confident that this was the wish of the person in the room as we had seen, in one person's file, that the decision to have the bedroom door open had been made by the previous manager on behalf of the person.

During our tour of the building we heard some popular music coming from peoples rooms which seemed to be inappropriate for their age range. One person, who according to the care plan liked listening to classical music, did not have any music playing during the day. The care plan stated the aim for this person was to maintain a "sense of self", however the only recorded action for staff was to be aware of the person's ethnic origin. This lack of detail would not help staff in understanding how to support this person in maintaining their "sense of self".

We observed many instances of staff treating people with care, patience and respect and care staff told us about how they enjoyed supporting people. However staff's ability to provide care in line with people's preferences appeared to be restricted due to insufficient staffing levels.

An example of this was when staff were supporting people to return to the lounge from the dining room. We saw staff assist people who used wheelchairs into the room but then leave them, sometimes without explanation, whilst they assisted other people into the lounge. This left a number of people waiting in their wheelchairs to be assisted into their chairs. When staff were available, all of these people were assisted. This demonstrated task, rather than person led care.

We brought an issue of concern to the attention of the manager on the day of our visit. This was when we had

Requires improvement

Is the service caring?

noticed that a person we had been visiting in their room needed support to wipe their face as their nose was running heavily. When we told a nurse about this they replied “It’s always like that” but did not take action to assist the person immediately. The manager contacted us the day after our visit to inform us of the actions they had taken in response to us raising this as a concern. We were satisfied that appropriate action had been taken in this regard.

One of the care files we looked at included a care plan for end of life care. This contained good detail of how staff should support this person. We noted however that another care plan for this person mentioned their close relationship with, and daily visits from, their spouse. When we looked further into the care plan we saw record that the person’s spouse had died recently. It is important that care plans are updated to reflect up to date information so that staff are clear about the person’s circumstances.

Requires improvement

Is the service responsive?

Our findings

We spoke with people about what there was for them to do in the home. Awareness of the activities programme amongst the people with whom we spoke was low. People said "There's not much to do – I can't get about much so don't mind", "There's not a lot for me to do. I like to watch the television" , and "I don't think there's anything for me to join in with." One person told us that they spent their days in their room. When we asked how they passed the time they told us "Watch television." A person visiting their relative told us about their understanding of the activity programme. They said "It has changed for the better since the new manager came – it's not the TV blaring out all the time. There were activities before, some basic games, but there wasn't much interaction. (My family member) is playing bingo at the moment. (My family member) pretty much gets 1:1 with the activities person."

We also asked people about whether they knew how to make a complaint. People said "I would tell a member of staff, and they would probably take it to the manager" and "The staff would make sure that everything was alright." One person told us about having made a complaint about a member of staff who still worked at the home on the day of the inspection. They told us "I made a complaint to my key worker; I needed to write a statement and the manager spoke to me about what had happened. I think the situation was resolved well."

The visitors we spoke with had not had need to make a complaint, but said that they would be happy speaking to the manager about anything which concerned them. One visitor said "She has an open door policy and I think she would resolve any issues professionally."

We looked at the process in place for managing complaints or concerns about the home. We saw these had been documented, investigated and followed up with the complainant. This meant that people were listened to and could be confident that their concerns would be taken seriously and managed appropriately.

The advertised activities for the day of the inspection were bingo in the morning and armchair skittles in the afternoon. Whilst the Bingo took place, it was not available to all of the people who lived in the home because many of them were still in bed awaiting support to get up. Staffing arrangements of only four staff after 7.30pm at night meant that people would not have the opportunity to engage in evening activities.

One care plan we examined relating to a person whose records showed that they had always been nursed in bed; stated under lifestyle that they were to socialise downstairs. Another care plan we examined for a person we saw to be in bed, said they enjoyed watching people work. We saw that although the door to their room was open, their bed was positioned so that they looked into the room and therefore could not see people unless they entered their room.

Another care plan contained details about the person's hobbies and interests. However we did not see any evidence that the person had been supported to maintain these. We saw this person had a 'recreational activities' record, in their care file, for the current year. We found this to be blank. We saw another blank record in another person's care file.

Two of the care files we looked at included an 'all about me' record. This should be used to enable staff to get to know the person and understand about their lives before moving into the care home. Although these records contained some relevant details, two of the ones we saw described the person as retired but did not give any information about what job they were retired from.

The manager told us that the current care plans had not been developed with a person centred approach and therefore were to be reviewed and rewritten.

We saw this to be the case when we looked at care plans. We also found there were no clear summaries of the support staff needed to provide for people. Although care staff told us they had a role of key worker for people who lived at the home, they told us that they had not read people's care plans because there was not enough time and they thought they were for the nurses. Care staff told us that they told the nurses what support they had provided so that the nurses could complete people's daily records. Care staff did complete people's personal care records that were kept in the rooms. None of the care plans we looked at evidenced that the person concerned had been involved in its development. This system did not reflect a person centred approach because it did not involve the person concerned, or the staff delivering their care.

Requires improvement

Is the service well-led?

Our findings

People we spoke with were not able to tell us much about how they were involved in the running of the home or what opportunities they had to give opinions or feedback. One person told us "We don't have meetings but there's plenty said between us here." However, another person said "They do have some meetings – I've been and joined in. The thing I remember most is people complaining about the food."

When we asked people about who was in charge of the home people said "Clare? She's lovely", "The staff and the manager know what they are doing" and "The staff and the manager are fine, it's the hierarchy, the people above them who don't know what they're doing." A person visiting their relative said "You do see the manager around. She's hands on when staff don't turn in. She mucks in." When asked if they thought the home was well run one person said "I couldn't be anywhere better."

The new manager was well respected by the carers and deputy manager alike. They told us they "did not want to lose her" and "she is great". One person said it's been amazing since they had come in to post and "I know things will change". They described the manager as being "so calm". They were confident that the new manager would improve the home and that they could work well together.

At the time of our visit the person managing the service had only been in post for seven weeks and was in the process of submitting their application to the Care Quality Commission for registered manager status. Despite the short time the manager had been in post staff told us they had made many changes for the good of the service and said they had confidence in problems being dealt with promptly.

We saw that since their appointment, the manager had held a number of meetings with staff from different departments within the home and had a meeting for people who lived at the home and their relatives planned. The manager told us that these meetings helped in becoming familiar with the home and what changes could be made to improve the service for people living at the home.

The manager told us about their visions for the future of the service and the improvements they had planned. This included more effective staff deployment and development of the care staff role to improve care planning and delivery.

We saw that audits of the service were taken on a regular basis. For example, monthly audits of accidents and incidents, environment and health and safety were in place. The regional operational director showed us how audits were recorded electronically for review by themselves and/or the director of quality for the company. Any actions or learning points identified from the audit process were documented and followed up on the next audit.

The deputy manager told us they had 12 hours supernumerary time in order to manage the nurses and undertake the home audits such as care plans, medication and the company's key performance indicators. Despite this we were concerned that records relating to care, for example diet and fluid records, were not always being reviewed to make sure care was being delivered in line with people's needs.

We saw that quality monitoring visits were completed on a monthly basis by a member of the senior management team and an action plan produced for any issues identified.

Whilst we could see that the new manager was in the process of addressing issues such as care planning and person centred care, we were concerned that the issue of staffing had not been identified and addressed. The regional operation director showed us the dependency tool they used for assessing what staff hours were needed. They told us that they would review this as a result of our findings.

All of the management team we spoke with demonstrated openness and accountability for the issues raised during the inspection process and have contacted us since the visit to let us know of actions they are taking to make improvements.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met. Staff were not available in sufficient numbers to meet the needs of the people living at the home.