Care Quality Commission

Mid-Norfolk Mencap

Merle Boddy House

Inspection report

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Ratings

Overall rating for this service	

Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

The inspection took place on 21 July 2017 and was announced.

Merle Boddy House provides a home and support for up to ten people with a learning disability. There are bedrooms on both floors of the home with two sitting rooms, dining room and kitchen on the ground floor. There is level access to the garden through patio doors from one lounge. At the time of our inspection, there were eight people living in the home.

The home had been without a registered manager for about five months before we inspected. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The providers had appointed a manager who started work just over a month before our inspection. The manager was intending to register with CQC.

At our last inspection of the service in May 2015, we found that outcomes for people were good in all areas. At this inspection, we found that the lack of consistent leadership had led to the need for improvement and there were two breaches of regulations.

There were enough staff to support people safely. However, the provider's recruitment processes were not wholly robust in protecting people from the employment of staff who were unsuitable to work in care. Staff had enhanced disclosure checks on their backgrounds to ensure they were not barred from working in care services. However, other checks were not fully completed to contribute to protecting people and obtain the information the law requires. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's systems for overseeing the quality and safety of the service, particularly when there was no manager in post, were not effective. They did not result in shortfalls in the service being identified and addressed. There were some gaps in records and some records were not up to date. Where a contractor's report indicated the need for remedial work, the providers had not acted promptly. There was a lack of formal consultation with people, their relatives, staff and other stakeholders for their views to determine what improvements should be made. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Staff understood the importance of reporting any suspicions that people were at risk of harm or abuse. They were confident about contacting either the local safeguarding team or CQC directly if they could not raise concerns within the service for any reason.

Staff supported people with their medicines in a safe way so that they got the right medicines at the right time. Staff supported people to seek advice from health professionals about this and other aspects of their health and wellbeing. This included advice about their diet when this was necessary, and people had a choice of enough to eat and drink for their needs.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. Systems within the service supported their practice and staff understood the importance of following guidance about people's rights and freedoms.

Staff knew about people's interests, like and dislikes and supported them with active social lives. The manager was reviewing with staff, how they could deliver care that was more specifically centred on each person's individual needs. This included the way that risks to each individual were assessed and addressed.

People or their relatives expressed confidence that staff listened to their concerns and complaints, and took action where they needed to. They were hoping that the new manager would help improve things further, and that they would be more involved discussions about care.

The appointment of the new manager was very recent but staff welcomed the leadership, support and guidance they were now getting.

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.

There were enough staff to support people safely but recruitment practices were not as robust as they should be in contributing to people's safety.

Some assessments of risk lacked focus on the needs of individuals and how staff should provide each person with safe support.

Staff understood their obligations to report any suspicions that people were at risk of harm or abuse.

People received their medicines when they needed them and in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People received support from competent staff although communication skills and staff supervision needed improvement.

Staff understood the importance of seeking consent and from people about their day-to-day care and the importance of considering a person's best interests.

People had a choice of enough to eat and drink to ensure their wellbeing.

Staff supported people to seek advice about their health and welfare and understood how some conditions affected people's health.

Is the service caring?

Good

The service was caring.

Staff had developed warm and compassionate relationships with

people they supported.

Staff encouraged people to make choices about their care and daily lives and the manager was developing further ways of promoting independence.

Staff understood how to offer support in a way that respected people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

Staff knew about people's likes and dislikes and what they enjoyed doing and made arrangements for people to pursue their interests or hobbies as far as possible. The manager was reviewing processes to see how care could become more fully person centred.

People, or their relatives, were confident that the manager would listen to their complaints and concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's systems for monitoring the service were not fully effective in identifying where improvements were needed and supporting staff to make them.

There was a new manager in post who had a clear understanding of the management role and a vision for how the service could improve.

Staff felt that, although only in post for a short while, the manager had improved morale, staff support and guidance and the way they were empowered to express their views.

Care Quality Commission

Merle Boddy House

Detailed findings

Background to this inspection

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

The inspection took place on 21 July 2017 and was announced. We gave the service 24 hours' notice of our visit because this was a small service for younger adults who are often out during the day. We needed to ensure that someone would be in. It was completed by one inspector.

Before our inspection visit, we reviewed all the information we held about the service. This included the history of the management of the home and information about events taking place in the home and must be notified to us by law. We contacted the local authority quality assurance team for their views.

During our inspection visit, we spoke with all of the people living in the home although some of them found it difficult to tell us their views in detail. We watched and listened to how staff interacted with people. We spoke with the manager, and four members of care staff. We reviewed care records and medicines records for three people, recruitment records for three staff and training records for the staff team. We also reviewed a sample of records associated with the quality and safety of the service, including health and safety checks and the manager's action plan for improvement.

After our inspection visit, and because people were not always able to tell us clearly what they felt about the service, we gathered views from relatives of three people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this service on 21 May 2015, we found that the service was safe. At this inspection, we found some aspects of safety needed improvement.

Staff recruitment processes were not robust in ensuring staff fitness for working in care and obtaining the records required by law. We found shortfalls in all three recruitment records we checked. For example, one staff member's information did not contain detail of their dates for previous employment. It did not contain their employment history before 2006 when the law requires a full history and an explanation of gaps. Another staff member had supplied their CV but this did not have reasons for leaving previous posts and had some dates missing. There was only one reference on their personnel file and not two.

For the third staff member, their application form gave details of two previous posts in care services. Letters requesting references were dated 20 July 2017 but the staff member had already signed part of their contract and completed shadow shifts by the time the reference requests were sent. The provider's human resources manager said they had chased missing references numerous times although there were no records of this on files presented or of attempts to obtain a telephone reference. The references remained outstanding at the point of our inspection, so there was no information about their conduct in previous caring posts.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, there were enhanced checks on the backgrounds of staff appointed with the Disclosure and Barring Service. This helped to ensure staff appointed were not barred from working in care services and did not have criminal records that might make them unsuitable for their role.

There were enough staff employed to support people safely. Staff told us that there had been some difficulties with staffing but they felt this had improved. A relative confirmed there had been some issues but they did not feel staffing levels had been unsafe. They said, "They have had issues about vacancies and been a bit pressed. It hasn't been unsafe and I think it is generally well staffed."

The manager was aware of one issue that had arisen due to a lack of clarity about which staff member was supposed to be providing one-to-one support for an individual. They had addressed this by ensuring that staff deployment was part of the handover process when senior support staff allocated duties for each shift. Staff and the manager told us how sometimes they needed agency staff to cover shifts, but tried to get consistent support from the same people. They explained that they used a regular agency staff member for night shift cover. They confirmed that the agency staff member had received the specific, emergency training that permanent staff completed, to support a person safely overnight.

Risks to the safety of individuals were assessed in part, such as risks associated with using the kitchen or behaviour that could challenge the service. However, although the assessments we reviewed reflected the

activities people might engage in, they were not specific to the needs and abilities of individuals. They did not take into account each person's understanding and communication. Information lacked detail about minimising risks and about any triggers to avoid that might increase risk.

Our discussions with the manager showed that they had already identified shortfalls in these assessments and guidance for staff. They were working hard to try to get to know individuals and discussing with the staff team so that they could develop guidance for safe support that was more specific to each person.

In the absence of a manager, staff had worked hard to ensure that they maintained routine checks on the safety of the premises, for example to emergency fire call points. However, they were not always able to keep up with this. The manager explained that they had not been able to locate records of fire drills since April 2016 to confirm staff practised what they needed to do in an emergency. There was a lack of information to show how issues identified at formal maintenance inspections were addressed. There were shortfalls in emergency systems for fire detection and safe evacuation of the home, which potentially compromised people's safety.

We found that a contractor's report completed on 28 April 2017 showed that a defective smoke detector needed replacing and two emergency lights had failed. These were in the main hallway of the home. The manager confirmed that the providers had obtained a quote for remedial work in May 2017. However, there was no action to initiate the work between the contractor's visit and our inspection. This meant the provider could not be sure the equipment would work properly in an emergency. The manager addressed this with the provider promptly when we raised our concerns, and agreed a date for urgent replacements.

There were systems in place to help protect people from the risk of harm or abuse. Three people told us how much they liked living in the home and the staff who worked with them. We observed that they interacted freely with the staff on duty, seeking out their company when they wanted it. No one showed signs of being ill at ease with the staff. A relative told us, "We have no concerns and are comfortable and confident [about the way staff support the person]." Relatives told us that staff treated people well and that their family members displayed no concerns or anxieties about using the service. They told us that their family members would be able to let them know if they were unhappy or worried about the way they were treated.

Staff confirmed that they had training to recognise and respond to possible signs of abuse. They were clear about their obligation to report concerns and any poor practice. They told us they could contact the safeguarding team directly if there was any reason they could not raise it with the manager or provider's representative.

Staff managed, stored and administered medicines safely. A relative confirmed they felt this was the case. They described how records sent with the person when they visited their family, were complete and clear. Staff confirmed that they had access to training to manage medicines safely and records supported this. The manager explained they had arranged additional training for senior staff in advanced medicines management.

One person was prescribed a medicine for occasional use to help if they became anxious or distressed. A letter from a health professional stated that the service needed to develop guidance about its use for staff to follow. This had not yet happened. However, staff knew how and when they would consider using the medicine and records showed that the person did not often need it. We discussed with the manager the need to develop the guidance about the use of that medicine to minimise the risk of any misunderstanding.

Staff understood the importance of seeking people's consent to administer medicines. One person did

receive medicine covertly in a drink sometimes, because they did not understand the risks to their health from not taking it. This was properly authorised as a restriction on their freedom and agreed with health professionals. As agreed in the authorisation, staff monitored the frequency with which they needed to give it covertly. They confirmed to us how they always offered the medicine openly at first.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2015, we found that the service was effective. At this inspection, we found that, in the absence of appropriate leadership, some aspects of the service needed improvement. The new manager had a grasp of what these were and was making progress so we did not identify a breach in regulations.

People received support from staff who were trained to meet their needs. A relative told us that they felt staff were competent to meet their family member's needs, including complex health issues. They told us, "Staff do seem to have a good amount of training. The training in basics is good." However, they did comment that some staff had less experience and so were sometimes less successful in delivering care a person required. For example, they recognised that, on occasion, their family member could be fixated on items of clothing that were not always appropriate for their activities or weather conditions. They felt that experienced staff were more skilled in addressing the person's welfare if they did not understand the implications of their choice. They felt this would improve now there was an experienced manager in post who could guide staff better in their roles.

Staff told us that they had access to good training and that time-limited training, such as health and safety or first aid, was updated promptly when necessary. They also told us they were able to obtain qualifications in care if they wished to do so.

However, the manager recognised the need to improve alternative methods of communication, such as using pictures, for people who found it difficult to express themselves verbally. They understood that people might become frustrated or angry if they could not make themselves understood easily. Three of the four staff spoken with felt more training in communication would be useful, including the use of Makaton. This is a sign language sometimes used by people with a learning disability. They told us that a few people using the service did use some of the signs. We concurred with the staff view that this training would be helpful in developing better communication with people they supported and anyone who may move in to fill vacancies.

In the absence of a manager, staff felt that they had worked well together as a team, because they needed to pull together. However, they felt left without proper, formal support. Some staff had not received effective support through supervision to discuss their performance and development needs. Records supported that this needed improving.

Senior support workers told us that they had tried to deliver regular, formal supervision to support workers. This had not always been possible to sustain when they had needed to take on management tasks. Senior support workers themselves had lacked consistent support and guidance. One told us that they had not had supervision with the previous registered manager and had been without that support until the new manager took up their post. Another senior support worker said they had received no support through supervision for nearly a year.

The new manager had already provided some formal supervision for staff and were scheduling dates for others. They had also initiated a programme of staff meetings so that staff had the opportunity to discuss their work and their roles as a group. Our discussions with the manager showed that they recognised the importance of supporting staff both formally and informally. Staff told us that they valued this approach and could seek support between meetings and supervision if they needed to. They were very positive about the improvements being made to address the shortfalls.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the 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.

People's capacity to make a range of individual and specific decisions, was not well represented in their care records. The manager recognised the poor quality of some care plan information. Increasing the range of communication methods staff could use would help to support people's understanding of more complex decisions as far as possible. This is before concluding whether or not a person has the capacity to make a specific decision about an aspect of their treatment.

However, our discussions with staff showed that they were aware of the importance of seeking people's agreement and consent to deliver their day-to-day care. They respected people's decisions but also explained how they took into account people's best interests, for example if they needed essential support with personal hygiene. They described how they would ask the person at different times, or different staff would try to secure their consent. We observed that staff asked people what they needed support with. Where one person had earlier declined assistance with a bath, staff returned later in the day and gained the person's agreement.

Staff understood who was subject to restrictions on their freedom because they lacked capacity to understand risks to their safety and welfare. We reviewed one authorisation granted under DoLS in some detail and found that the conditions attached to it were being met. This contributed to upholding the person's rights under the law.

People had a choice of enough to eat and drink to meet their needs. Two people told us they liked the food and one said how much they enjoyed making cakes. One relative did express concerns that perhaps a person's lunchtime "pack up" could contain more variety. However, they acknowledged that their family member prepared this with staff support and could choose what they wanted. They went on to describe how they had been able to join their family member for an evening meal and, "That was delicious."

We saw that people could use the kitchen, with staff support if required, to get drinks of their choice. Staff prompted and offered this as well. Staff also gave us consistent information about how they prepared one person's food and about the cup they needed to use for drinking so they could eat and drink safely. They knew the person and one other was at risk of losing weight or might not eat well, and monitored their food intake.

The manager said they intended to make changes to the menu to improve the way that people were involved in planning and choosing their meals. They also intended to increase the use of photographs for people who might find it difficult to express their food choices verbally.

People were supported to get advice from health professionals when they needed to. A relative told us how staff supported a person to attend a specific clinic and acted upon the advice they were given. Staff were able to tell us in detail about one person's specific and complex health condition and the support they needed with this. They gave us information that was consistent with the person's records and a relative's account. Another relative told us that, after diagnosis and treatment for a serious condition, "We couldn't fault the care." This contributed to the person receiving effective support to maintain their health and wellbeing.

Staff were also able to describe how they had recently supported people who were coming to the end of their lives. They could demonstrate they acted on advice from the GP and district nursing team about managing conditions.

We saw from people's care records, that staff supported people to attend appointments. This included for example, accessing their doctors, specialist learning disability staff, hospital appointments, dieticians and speech and language therapy.

Good

Is the service caring?

Our findings

At our last inspection in May 2015, we found that the service was caring. At this inspection, people continued to receive good, caring support.

People received support from staff who had developed warm and compassionate relationships with them. Not all of the people we met during our inspection were able to tell us about the care and support they received due to their complex needs. However, they did indicate to us either verbally or with a 'thumbs up' sign that they liked staff. Three people told us how much they liked being at Merle Boddy House. For example, one person said, "I like it here and the staff."

Relatives told us that they felt staff were kind. One commented how their family member always referred to Merle Boddy House as "…home". They felt that staff were very supportive to the person and themselves. Another relative said, "We're very pleased. [Family member] is very settled and happy there." They went on to say, "It's a nice family atmosphere… I think they [staff and the service providers] are in it for the right reasons." A third relative described staff as compassionate in their approach. They valued the continuity and security that arose from having a core of long standing staff who had built up good relationships with people.

We saw that there were friendly interactions between staff and people living in the home and lots of chatter and laughter when people returned from their daytime activities. Staff made time to talk with people about their day. We also saw that a staff member sat chatting with one person who had taken longer than others to finish their evening meal. The atmosphere was relaxed and unhurried. During our interviews with staff and the manager they spoke with warmth about the people they supported and how much they enjoyed being with them. They also understood what was important to people and about their histories so they could talk with them in a meaningful way.

Staff were able to tell us how they offered people choices in their every day care such as what they chose to wear or eat, where they wanted to spend their time and what they wanted to do. One staff member and the manager described how they were intending to develop further the use of pictures and photographs. This was to encourage people to make choices more easily or to express their likes and dislikes. We saw that the manager had provided photographs for people to make a choice about a summer celebration. We saw people engaged with staff in looking at these to help them decide. We saw that people were able to choose where they spent their time in the home and whether they wished to be in company or alone.

Staff told us that they spoke with people about their care and also encouraged them to be a part of meetings or appointments if they wished to. The manager explained their intention to improve how people's care plans reflected that they were involved in developing them and setting their personal goals. They were seeking to increase staff understanding of their roles as keyworkers so they could support people more in this. The manager told us how they had also been in contact with Equal Lives. This is a local organisation aiming to involve and empower people with disabilities to be more independent. The manager had identified that this could be useful in seeking out best practice and increasing people's opportunities and

choices.

Staff supported people in a way that respected their privacy and dignity. One person told us how staff knocked on their room door. They said that they had their own key for their bedroom but chose to leave that in their bedroom door rather than keep it with them. A relative told us, "I think they balance privacy and safety well. [Person] is comfortable with that." They went on to describe how staff had supported the person with a health condition that required some intimate support with personal care. They felt that staff had handled that well. We saw that when staff supported one person with personal care, they offered support discreetly and ensured they closed the bathroom door.

Staff encouraged people with their independence. We saw that they engaged people in daily activities such as participating in preparing drinks for themselves or others, getting ready for a trip out, and preparing their meal. One person told us how they enjoyed making cakes with staff. However, a relative did say that sometimes there might be a lack of awareness of less experienced staff in this area. They described how purchasing clothes with difficult fastenings had meant that their family member was not able to be as independent as they could in dressing. The relative did say that they felt this would improve as the staff developed under the new manager. Our discussions with the manager showed that they aimed for staff to encourage and enable people further with their independence.

Good

Is the service responsive?

Our findings

At our last inspection in May 2015, the service was responsive to people's needs. At this inspection, we found it remained so. Relatives felt that the care team understood and could meet people's individual needs, including social and recreational needs. One relative commented that staff were "…interested…" in the person and their welfare.

The manager told us about their intentions for further review of processes to ensure care was more comprehensively person-centred for each individual. We discussed with the manager the practice of weighing each person every week. While this enabled staff to respond to changes in people's weights, it did not reflect a fully person-centred approach to monitoring people's individual nutritional status and risk. Staff and the manager were receptive to suggestions about a formal tool they could use to help address this and focus on individual need.

Staff understood people's likes, dislikes and preferences and were able to tell us about the things that were important to them. Individual care plans included information about these. Staff were able to tell us in detail what support they needed to offer people and each staff member gave us consistent information about care needs. Two members of the care team had received training in care planning using the computer system and were working to update these to ensure they reflected people's current needs. We spoke with staff about how they accessed information about people's needs. From discussion, there was a lot of reliance upon support and advice from colleagues, some of whom had worked at the home for a long time and understood people's needs. However, staff said that they would refer to people's plans of care if they needed more information.

One relative did comment to us that, although they were involved in formal reviews of care with health professionals and Norfolk County Council, they had less involvement at local review with the home's staff about their family member's needs. The manager told us about their intention to further develop the involvement of people, with support of their families if they wished.

Staff had a good understanding of people's hobbies and interests. During our inspection visit, some people had attended day services or a 'drop in' centre they said they enjoyed. One person told us they were proud of having attended college and showed us the work they had completed. They were enthusiastic about what they had achieved in their computer class.

Relatives told us that staff tried hard to make sure people had active social lives. For example, one commented to us, "They [staff] do make an effort to go out, socialise and take [person] where they want to go. [Person] has a good social life. We're very satisfied with that side of things."

People could be confident that their complaints would be listened to and addressed. Those who were able to tell us said that they did not have anything they wanted to complain about. In practice, most people using the service were likely to need the support of their relatives or staff to raise concerns or complaints.

Relatives told us that they had not needed to raise any formal complaints. One relative told us, "If we had any concerns, we would certainly get in touch and feel confident that our concerns would be addressed." Another commented that if they raised anything informally staff addressed it. They told us that they could not remember seeing anything formal about the provider's processes for managing complaints. However, they said they were confident to speak out. They told us they expected that the staff team and the new manager would take their concerns seriously and act upon them to improve where it was necessary. They understood the 'line management' structure for the service and who else they could contact before escalating complaints if they did not feel they were investigated robustly.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2015, we found that the service was well-led. At this inspection, we found that the provider's systems for monitoring the quality and safety of the service needed to improve.

There had been a registered manager in post from September 2014 to May 2015. After that, no one had successfully registered with CQC until June 2016. However, that registered manager did not remain in post long and cancelled their registration early in 2017 having left the service. There was no manager with day-to-day responsibility for leading the service until the recent appointment. The provider's oversight of the service during that time was not robust enough or sufficient to maintain the standards we found at our last inspection.

The new manager was not yet registered with the Care Quality Commission (CQC) and had only been in post for approximately a month before our inspection. They stated their intention to complete their registration with us. The manager was previously registered with CQC in respect of a different care service, which was compliant with regulations. Our discussions showed that they had a good understanding of their role and responsibilities. In the short time they had been in post before our inspection, they had already identified a number of issues and concerns about the operation of the service and what they needed to do to address them. The arrangements now needed to consolidate with the support of the provider, so that the service people received was improved.

Senior staff had tried their best to maintain audits and checks within the service but without much leadership or guidance about what they needed to do. For example, a staff member told us how they had done their best to audit medicines but was not shown properly how to do this. There were gaps in records of some of the routine monitoring, for example in relation to food safety.

Some care records were not checked to ensure they continued to reflect people's current needs. For example, one person had a support plan in relation to their reactions to situations that made them anxious or distressed. This was developed in September 2014 and marked as due for review in March 2015. The record did not show this had not happened to check whether it required any amendments. The provider's monitoring systems had not identified and addressed shortfalls in records, which the manager was now addressing.

The provider's records did not show they acted promptly in response to concerns, such as the contactor's report on fire safety. This presented a potential risk to people's safety and welfare in an emergency. The manager arranged for this work to happen while we were present. However, until we pointed it out, the provider had not acted to ensure they were carried out. Systems for monitoring recruitment processes were not robust in ensuring that the information required by law was obtained before staff were employed.

The provider's representatives were not able to supply any results from a survey of people who lived in the home, their relatives or staff. They could not therefore demonstrate how they empowered people to express their views or show action taken in response to suggestions for improvement. The only information the

provider's head office staff located for the manager was a survey for a community service they operated, completed in 2014. Relatives told us they had not been asked to complete a survey of their views for a long time.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers of the service had not taken any action to display the rating given to the service at the last CQC inspection as required by law. They did however address this after we pointed it out.

The manager recognised the difficulties experienced by the service in the absence of a manager. They rightly praised the efforts that the staff team had made to ensure that people received appropriate support. They were very open with us that they had found recording and monitoring systems were not as expected. They told us, "The staff did not previously have much guidance or support and the last manager left at short notice. Staff upped their role, but recording hasn't been great. No one brought them [staff] up to date." The manager had started to review the information available in both care records and management records, to highlight what they needed to improve.

The manager recognised that the involvement for people using the service was not as they expected. They were considering how they could improve the arrangements for taking into account people's views in the way the service was running.

Relatives were aware that there had been many management changes and for some time, there had not been a manager in post. One relative told us, "Leadership was lacking when there was no manager. Communication wasn't always good… but it has got better. We're hoping the new manager will help to fill in the gaps. We've been pleased with the manager's attitude and involvement when we've met."

Another relative commented about the departure of a previous manager in whom they were confident. Our records showed this happened in 2014. They told us, "Since [that manager] left, we have been feeling a bit isolated by management." The relative went on to say, "The email from the new manager introducing herself came out of the blue and was a breath of fresh air, as she was the first manager to get in touch with us since [manager] left."

Staff told us that they had struggled under previous management arrangements and in the absence of a manager this year. For example, one commented, "A lot fell on seniors and there was not much by way of guidance or support." Another staff member told us, "It has been a bad few months. The only way is up and we have done the best we can, coping on our own."

The manager was aware of staff feelings and how they had not felt listened to. Because of this, they had arranged staff meetings and a schedule of supervisions. They had involved staff in looking at their roles and responsibilities. They could also show us how they had discussed with staff, the standards CQC expects the service to meet. The manager told us, "We had a seniors' meeting about two weeks ago. We're going to start them every week. They [staff] are being listened to and that's what they wanted."

Staff told us that they found the new manager was building up good relationships with both the staff team and people who lived in the home. They described the manager as approachable and receptive to their ideas. The staff team all spoke positively and passionately about their work. They felt that they had all worked well together as a team to maintain care and support in what had been difficult circumstances.

One staff member told us, "We've had lots of management changes but we put the residents first." They welcomed the appointment of the new manager and expressed confidence in the changes being made. Another staff member said, "I think it's going in a positive direction now. The manager has listened to us and we're clearer about what we're doing." A third staff member said, "Now [the manager] is in, I'm not going home worrying. We coped, but it is other people's lives. [Manager] is a breath of fresh air."

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes for monitoring and improving the quality and safety of the service and for sustaining compliance with regulations, were not working effectively. They did not provide for prompt mitigation of risk, accuracy and completeness of records and for seeking and acting on feedback from relevant persons. Regulation 17(1), (2)(a), (b), (c), (d), (e) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operating fully effectively to check the suitability and fitness of staff appointed in all regards, and to ensure the required information about those appointed was obtained. Regulation 19(1)(a), (2) and (3) and Schedule 3