

MACC Care Limited

Church Rose Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

People did not always feel they received safe care in this service and were not always confident in reporting their concerns when they felt unsafe. Whilst the provider had procedures in place to keep people safe and staff had received training and were aware of the procedures some people felt they were not treated well and were concerned about staff's practice that did not support them in a safe way.

There were systems in place to ensure people received their medicines safely, most people received the support they needed with their medicines. However, some people had concerns about the way their medicines were handled. People's concerns indicated that staff practice did not always ensure people received their medicines as prescribed.

People did not always feel their needs were met in a consistent way. The provider had clear systems in place for handling complaints. However, people were not confident that their concerns were listened to and addressed.

People's rights were not fully protected. This was because staff were lacking in knowledge about how to ensure people's rights were consistently protected in regards to certain aspect of their care.

Whilst there were procedures in place to monitor the quality of the service, some people did not experience a quality service. There had been several changes of registered managers since we last inspected the service; this had led to some instability within the service. This had impacted on the provider's ability to secure and sustain the necessary improvements to the quality of care people received.

Risks to people's care was not always updated where people's needs had changed. People did not always feel there were sufficient staff to meet their needs. However, the provider had recognised this and had recently increased the staffing numbers and had plans in place to ensure this did not happen again.

Where incidents relating to people's care had happened the provider investigated and analysed the incidents and took action to reduce the risks of them happening again.

Staff were safely recruited to work with people and received training to do their job. The provider had recognised that the training provided was not always reflected in staff's practice and plans were in place to supplement the training. Staff were currently not consistently supervised and supported to undertake their role.

People had a choice of food and drink and were supported to maintain a healthy diet. People had access to health care professionals to ensure their health care needs were met.

Most people felt staff were caring towards them and respected their privacy and dignity. There were some people who felt they were not showed care and compassion by some staff and that their dignity was not

consistently maintained.

People were encouraged and supported to be as independent as possible. A range of activities were available for people to participate in if they wished and visitors were welcomed at the service. This enabled people to maintain contact with relatives and friends.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Procedures were in place to help keep people safe and staff knew the procedures. However, people did not feel they were cared for in a safe way.

Risks to people were assessed, but not always reviewed when needs changed. Staff that were suitably recruited to provide care and support to people. People were concerned about staffing numbers, however the provider had recently increased the staffing numbers

Procedures were in place to support staff to administer people's medicines safely. Not everyone felt they received their medicines as prescribed.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

People were not always confident that staff knew their needs. Staff received training, but did not receive consistent and effective supervision to support their practice.

People had a choice in what they ate and drank and staff supported them to maintain a healthy diet and health.

People's right to give consent to care and support and make decisions about their lives was maintained.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

People did not always experience support from staff that were caring and compassionate. People's privacy and independence was promoted, but their dignity was not always promoted.

People maintained contact with friends and relatives who were free to visit the home as they wished.

Requires Improvement ●

Is the service responsive?

The service was not consistently responsive.

Staff did not always respond to people's needs in a consistent manner.

Opportunities were available for people to pursue and take part in various social activities if they wished.

People were not confident that their concerns would be listened to and acted upon.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

Systems were in place to monitor the quality of the service, however people did not feel the care was of a quality standard at all times. Several changes in registered managers had impacted on the quality of the service.

Requires Improvement 

Church Rose Nursing 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 checked 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 6 and 8 December 2016 and was unannounced on the first day; we informed the provider that we would be visiting on the second day. The inspection was undertaken by two inspectors on the first day and one inspector on the second day.

Whilst planning our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We also reviewed any complaints and concerns received from people that used the service and their relatives. We contacted the local authority and the clinical commissioning group that purchased the care on behalf of people. We reviewed reports that the local authority send us on a regular basis.

The provider completed a Provider Information Return (PIR). This is information where we asked the provider to tell us about what they are doing well and areas they would like to improve. We looked at this information as part of inspection plan.

During our inspection we spoke with eight people that lived at the home, 11 relatives, the nominated individual, the provider, the manager and deputy manager. We also spoke with two registered nurses, five care staff, the activities coordinator and a domestic staff member. There were other professionals visiting the home during our inspection and we spoke with, the clinical commissioning nurse, an infection control officer and the chiropodist.

We observed how staff supported people throughout the inspection to help us understand their experience of living at the home. 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. After we visited the home we spoke with a GP about concerns they had about the care of people.

We looked at the care records of four people. This included medication administration records (MAR) Other records looked at included safety records analysis of incidents, accidents and questionnaires and the provider's system for ensuring medicines were handled safely. We also looked at, compliments, complaints and safeguarding records. We looked at plans that the provider had for improvement and various audits completed by the managers.

Is the service safe?

Our findings

There were procedures in place to help staff to keep people safe from abuse and harm. All staff spoken with and records looked at confirmed that staff had received training on how to keep people safe from harm. Staff knew about the different types of abuse and the signs to look for which would indicate that a person was at risk of abuse. For example staff said they would observe for signs of bruising, change of behaviours or any signs of neglect, which could indicate that people were being mistreated. One staff member said, "Might notice mood changes, different behaviour, physical signs like bruising. I would report it straight away to the manager or whistle blow, the numbers are in our staff handbook." Another member of staff said, "I have never had any concerns about how residents are cared for here, they are a good company to work for and people are safe." Staff understood how to report concerns externally should they feel that the provider was not acting to safeguard people living at the home. One member of staff said, "No one is abused, if I saw anything, like bruises we need to record it and inform the nurse and they will report it to safeguarding; we make sure we record everything." Where the provider has been aware of safeguarding incidents, they have kept us informed and have followed the local safeguarding procedures.

Some people, relatives and visiting professionals spoken with during our inspection felt people were cared for safely. However, two people living at the home and two relatives felt people were not being cared for safely. One person told us, "I have been treated badly, and they physically manhandle me and I have bruises." A relative said that they had noticed bruising on the person. The person said they had not disclosed this to any member of staff and was reluctant for us to raise these concerns on their behalf, because they said they feared the staff would pick on them. We reassured the person that it was important for us to report their concerns, so they could be safe. We discussed these concerns with the manager who took immediate action to follow their safeguarding procedures and followed the local safeguarding protocol so that an independent investigation could take place. Another person commented that some staff were rough, but did not give any further information or specify which staff they were referring to. Another relative said they had reported unexplained bruising on their relative hand, but nothing had been done about it. Two people talked about medication being pushed in their mouth and one person and a relative told us about instances when people were left in soiled and wet incontinent pads for long period of times. One person's record we looked at indicated that this had happened on a recent occasion. The manager told us that there were no pressure sores in the home at the time of our inspection; this was confirmed by the lead nurse. This showed that some people received safe care and support. However, some people did not feel they were cared for safely and were not confident in raising issues about their safety with staff at the home. This indicated that the procedures for keeping people safe were not followed by all staff.

Most people said they received their medicines as prescribed and we saw that people received their medicines safely during our inspection. Medication administration records (MAR) that we looked at showed no gaps in medication recording which indicated that people received their medication as prescribed. Procedures were in place to ensure medicines were ordered, received stored and administered safely. Staff that were responsible for administering medicines said they have had training to do so and that the manager observed them to check they were competent to administer medicines. However, three people were concerned that medicines were not handled safely. One person told us they thought they had been

given double medication. A relative said they had found medication left on their relative table. The relative commented, "We have also come and seen that medication has just been left on the table, they [staff] have then come to try and give her evening medicines and I have had to say, well she hasn't had the earlier ones yet, they are still on the table; I know for a fact medication shouldn't be left on the table anyone could just walk in and take them." This indicated that whilst there were safe procedures in place to ensure people took their medicines, not all staff were following the procedures, so some people were not confident that their medicines were managed safely.

We saw that people had some risk assessments on their care files. These included moving and handling, falls, skin damage, medication and nutritional risks. The risk assessments detailed what actions staff were to take to reduce any risks, for example, what equipment was to be used to help move people safely. However, we saw conflicting information on people's records about risks. For example, we saw that one person, who recently had an incident was being nursed in bed, with bedrails in situ. We reviewed the records and saw that the person's risk assessment stated bedrails were not in use. This indicated that the risks to the person were not properly considered. However, we did see that increased monitoring had been put in place for this person.

Not everyone spoken with felt there were enough staff to provide the service and keep people safe. For example, one person told us, they had a chest pain during the night and it took staff thirty two minutes to respond to their call bell. Three other people talked about being left in soiled and wet incontinent pads for several hours. One person said, "If I ring the bell I have to wait for four to five hours for my pad to change." A relative told us, "I have been here and [Person's name] has rang the bell and has had to wait." We saw there were plenty of staff about on the days when we inspected, and staff responded to people in a timely manner, although we were told by a relative that it was unusual to see so many staff. The provider and the manager said that resource was available to provide the staffing needed for the home. The provider information return showed that there had been significant staff turnover in the last year, so people would have experienced inconsistency in staffing. A member of staff spoken with told us that additional staff were needed on nights in particular. The manager said she had increased the staffing numbers recently and some staff spoken with confirmed this. One member of staff said, "Yes we have enough staff now. Recently staffing has increased and I am pleased about that." The manager also said she was recruiting a member of staff to work a twilight shift to cover the period where people were having more falls. In addition the manager said there had been an extra trained nurse employed to cover the night shift. This showed that the provider and manager were aware of the need to increase staffing and was taking action to do so.

Where incidents relating to people's care had happened, we saw that a detailed analysis of the incident had been undertaken, showing improvements to practice that were needed to prevent the incident happening again. We spoke with a member of staff who told us about their learning from a particular incident and the follow up training and competency checks that had been put in place for staff following the incident. The manager told us that she had undertaken an analysis of the falls that had happened and had identified that these happened at particular times of the day. As a result of this the manager said she was recruiting additional staff to prevent these falls from happening. We saw other instances where incidents had happened and we saw that the risk assessment for the person had been reviewed and updated to take account of the risk.

Four members of staff told us about the fire safety checks that were done every Thursday, so people knew what action to take in the event of a fire. We saw that the home was well maintained and all staff spoken with and records sampled confirmed that all safety checks of the premises and equipment used had been completed and were up to date. We saw that equipment such as mattresses were audited and replaced as necessary and the provider had recently purchased a number of new mattresses for the home, to ensure the

safety of people. We saw that the provider had arrangements with a pest control company and clinical waste contractors to ensure that any risks arising from these were well managed.

We saw that the fire service visited in May 2016; however, a copy of their report and actions from that report was not available for inspection. Staff spoken with knew the procedures for responding to any emergencies in the home such as fire and medical emergencies. A member of staff told us, "If someone was unresponsive, I would press the emergency buzzer for the nurse to come, check pulse, recovery position, clear airways... I have never had to but confident in an emergency I think." This meant that the provider ensured that the home was safely maintained and emergency procedures were in place to ensure the safety of people that lived there. We saw that people were kept safe because they were looked after in a warm and well heated home.

All staff spoken with said the recruitment checks required by law were undertaken before they started working. Records looked at showed evidence that the required checks were in place. This included Disclosure and Barring Services checks, (DBS) references and various forms of identification. DBS checks are checks that the provider is required to undertake to ensure that staff are suitable to work with people. We saw that all nurses had up to date registration with the Nursing and Midwifery Council and the provider had an overview of when these were due for renewal. This showed that the provider ensured that the staff employed were suitable to work with people who required care and support.

Is the service effective?

Our findings

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. We saw that mental capacity assessments were in place for the people that may have limited capacity to make major decisions about their care. However, we saw one person's friend had signed important documents relating to their care. A member of staff told us that the person's friend had a lasting power of attorney, the staff member was not sure if this gave the friend the rights over the person's care or finances. When we asked to see the document we were told it was kept locked away in the administrator's office. This meant that staff were unclear about whether or not the rights of this person were being protected.

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). 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. The manager told us that DoLS authorisation was in place for three people and application for DoLS had been made for another person, but this had not been authorised to date. However, the staff that we spoke with were not aware of the DoLS that were in place. We saw that the conditions of the authorisation for one person had not been followed through. For example, the person required medication to be given disguised in food. The condition of the authorisation stated that a best interests decision needed to be taken, involving the person's family and GP. We saw that this had not been done and the authorisation had been filed away without being reviewed by staff. Two other people had confirmation of the DoLS, but the authorisation was not available on the record, so staff were unclear if there were any conditions to the authorisation for these people. This showed that whilst applications for DoLS were made, where these were granted staff's practice did not show they were working in line with the authorisations, so people's rights were not fully protected.

One person told us they didn't think staff understood their specific needs. This person said that there were days when they were not able to move and staff didn't appear to understand this. Another person said they were not sure if staff were trained, but commented, "They usually know what they are doing." Staff spoken with said they had received training in various topics to help them to do their job and understand the needs of people. This included caring for people living with dementia care needs.

We saw that the provider had a planned approach to staff training. Records looked at showed that staff had received training in various topics relating to the job they did. A member of staff told us, "I think staff get the training, but it's putting it into practice." The manager said she planned to supplement the training staff received, as a number of these training topics were currently done on line. The manager felt there was a need to introduce more face to face training with staff to support their learning and ensure training was embedded in their practice. Staff spoken with confirmed that this was being introduced and felt this style of

training would be much better for them. The manager talked about using staff meetings to introduce hot topics, and senior staff taking on lead roles in particular areas to support staff's knowledge. A member of staff said, "We are starting practical training on Wednesday ... it will be better face to face, we can ask questions." A member of staff told us they did the care certificate training on line. This is a framework for good practice for the induction of staff and sets out what they should know. However, they had not been awarded the certificate, because they had not completed all the modules. This meant that training was provided for staff. However, the provider recognised that further training was needed to enhance staff practice and was taking steps to address this.

Some staff said they had supervision and team meetings. One member of staff said, "No supervision here, we do have team meetings." All staff talked about the effects of the changes in registered managers that had taken place and the impact on their support. One member of staff told us, "The new manager is pushing for positive change. She has told us we can talk to her about anything." This indicated that staff felt that the support mechanism may improve with a settled management structure. The manager also said she had plans to ensure staff supervision was practiced in a more meaningful way, so staff would benefit from the process.

During our inspection we were told about an incident where a visitor had observed a member of staff physically restraining a person. The manager told us that the organisation's policy was that with the exception of the use of bed rails where required, physical restraint was not used in the service. The manager told us she had recently suspended a member of staff for using physical restraint and was in the process of investigating the incident. The manager said she saw the member of staff holding the person because the person was agitated. The manager said this was contrary to the policy and she was organising further training, so that staff understood how to support people in an appropriate manner.

People said they had a choice of foods and we saw people being offered choices during our inspection. Most people thought the food was good. One person said, "I've had my breakfast; I always have cornflakes, toast and marmalade and a cup of tea". "They do give us a choice but they know what I like and I always have the same." Another person told us, "The food is quite good." We observed that people enjoyed their meal and the meal served was hot.

We saw that where people needed support with eating and drinking this was offered in an appropriate manner, with staff being fully engaged with the person they were supporting. For example, we saw a member of staff supporting a person to drink, the staff member sat next to the person, calling them by their name and encouraging them to have the drink. The manager told us she was aware for that the cultural appropriateness of the food needed to improve due to the needs of people living in the home, and she had plans in place to address this. We saw people being offered a choice of hot and cold drinks throughout the day. Staff knew about the specific diets that people had. One member of staff told us, "Some people are on pureed diet, diabetes, vegetarian, or don't eat certain meats, we know what people like, also initial assessment with family tells us what people need and like." This meant that people's dietary needs were supported to ensure they remain well.

Staff knew how to support people at risks of poor nutrition and dehydration. For example they told us and records showed that people's nutritional needs were assessed, their weight was monitored. Staff said if necessary people would have fortified food and drinks and health care professional such as the GP, and dietician would be involved in supporting their care.

People told us they saw the doctor and other health care professionals when needed. We saw that the chiropodist was visiting during our inspection, and told us that they visited every Month to ensure people's

feet were cared for. We saw one person that required medical attention on the first day of our inspection and staff ensured that this was provided. This showed that people's health needs were met.

Is the service caring?

Our findings

Two people said they were not happy living at the home and a relative told us they were worried about their relative being there. This relative commented that staff were attentive to people on the day of our inspection and said they thought it was because we were there. This relative said, "I have made lots of complaints and all they do is just say it's been recorded, but then there is another issue, and another... like I have been here and the staff have pulled the call alarm out of the wall. We have come and Nan has been sat for hours in a wet or soiled pad and we have had to manually assist her ourselves, they tell her to wee in her pad...we shouldn't have to do that." This showed that some people felt they did not always experience care and compassion from staff at all times.

Most people spoken with said they thought the staff were good. One person said, "Staff are good you know they help me when I need it." Another person said, "I get on well with staff, if I have any problems I talk to them." We saw that staff talked to people in a kind and caring way and all interactions that we saw between people and staff were positive. For example we saw staff using a hoist to move a person, we saw that the staff member explained to the person what was happening and reassured the person. A health care professional told us, "I have been visiting the home for two years and I have never seen anyone suffering or not being cared for." A relative told us, "She, [Nan] knows most of the staff and have a good relationship with them." We saw that some people's relatives had sent compliment cards to the home expressing their views on the care their relative received. One compliment read, "[Person's name] has been in Church Rose nearly 10 months. During this time I found the attitude of cares to be friendly, helpful and attentive....When asked by my mother who are you; staff reply I am your friend. What a lovely thing to hear." This showed that most people had positive experiences and felt staff were caring towards them.

Most people told us and we saw that staff respected people's privacy and dignity. One person told us, "Oh yes, my privacy and dignity is respected." We saw that in the main people's dignity was respected by staff. For example, we saw staff used a dignity screen to support a person that was sitting in the lounge area, with their personal care. We saw that staff knocked people's doors and waited to be invited into people's rooms. We observed one person being supported with personal care, the door was ajar and we saw a member of staff that was passing by, closed the door to preserve the person's dignity. However, one person told us, "I can use the toilet, I have a commode, but need to be hoisted, so they just say, you've got a pad on." This did not promote this person's dignity. Staff spoken with gave good examples of how they maintained people's privacy and dignity. For example a member of staff told us, "I always knock doors and wait to be invited in and always explain to people what we are about to do..." Another member of staff said, "Its dignity, we close curtains and doors, knock on doors before we go in to a room, cover people over to keep things private, we look after people here." This indicated that whilst most people experienced care that respected their privacy and dignity, staff practice was not consistent in maintaining people's dignity.

One person told us that they did their own personal care and was supported by staff to go to the shops. Another person talked about going to church independently. People told us they had a choice and made decisions about their daily routine. Another person said they were able to wash and dress themselves, and staff offered support to them if necessary. Staff said they try to encourage people to be as independent as

possible. This showed that where possible staff encouraged and enabled people to be independent.

People maintained relationships that were important to them. People told us that friends and relatives were able to visit the home as they wish. One person told us, "Plenty visitors, I have about 50 visitors per month." Another person said, "I have visitors and I spend time in the day room with the others." We saw many people visiting the home whilst we were there. A relative told us they visited the home every day and spent several hours with their relative.

Is the service responsive?

Our findings

Some people felt their needs were being met. One person told us, "Staff are good you know they help me when I need it. I can wash myself... but if I press my buzzer they will come and help me with washing my back. They are good like that." A health care professional spoken with said they had no concerns about the needs of people they visited. However, other people did not feel staff were responsive to their needs. One person told us that staff were not fully aware of their needs. For example, they said they had an ulcer that needed to be dressed three times weekly and that they had not had their dressing done for one week, because staff did not know that this was needed. This person also told us that, they suffered from cold feet and if they ask some staff to cover their feet, they just walk away. After the inspection we spoke with a GP, who raised similar concerns about a person's dressing not being done and staff not knowing about the person's needs. The GP told us they had been asked to visit the person for an existing need that staff should have known about. They told us when they got to the home, staff had hoisted the person from the chair to the bed, the person was in a lot of pain and they did not have a dressing on their wound. The GP said they checked the person's records and there was no evidence of the dressing being done for three weeks. We spoke with the manager about this, she said the ulcer had been dressed, but it had not been recorded. The manager said she was reviewing the way the nurses were allocated to ensure better monitoring of agency nurses to ensure these instances did not happen again and she was fully investigating the concerns raised by the GP.

People's needs were assessed before they moved into the home. This was followed by a post admission assessment. This involved discussions with the person, their family members or significant people in their lives. A relative told us, "My mom helped with the initial assessment." We saw that care plans were developed for each area of needs identified, these were reviewed and updated as people's needs changed.

We saw that staff responded to people's needs whilst we were at the home. For example, we saw that people were appropriately supported with eating and drinking and we saw that call bells were responded to in a timely manner. We saw that people were dressed in individual styles; these individual styles enabled them to express their individuality. People were wearing clothes that reflected their age, gender, the weather and personal taste. This showed that staff maintained people's individuality.

People had the opportunity to pursue social activities and hobbies. One person told us they were actively involved in one of the local churches before moving into the home. They said they were able to maintain their involvement in the church and living in the home did not prevent this. One person told us, "I spend a lot of time in my room, they do ask me if I want to go to the lounge-I usually say, I'll go for half an hour as long as I haven't got to do any talking- I don't really get on with the others, I like my own company." A member of staff said, "We try to encourage people to socialise but not everyone wants to and people have the right to make their own decisions and choices." We saw people playing bingo in the upstairs lounge area and people were having a sing along down stairs. A health care professional told us, "I see people come in to do activities and exercises." We spoke with the activity coordinator who told us about support from the local community and voluntary groups in ensuring there were enough hours for social activities in the home. This member of staff said there was input from local church groups, schools and health exchange in supporting

the activities provided. The manager said she was recruiting a member of staff to support the activity coordinator.

The provider had a complaints procedure and complaints that we sampled had been investigated and responded to in line with the provider's procedure. Some people felt they could speak to staff if they were unhappy about their care. One person said, "If I had a complaint I would tell the manager." However, not everyone spoken with was confident that their concerns were listened to. For example, a relative told us they had raised several concerns and did not feel they had been addressed. This relative said they felt the new manger seemed more responsive. Another relative said, "I have made lots of complaints and all they do is just say it's been recorded." This indicated that people were not assured that their concerns and complaints were acted upon.

Is the service well-led?

Our findings

We saw that there were systems in place to support monitor the quality of the service. These systems were organised and included various quality audits. These audits included, health and safety, infection control, pressure ulcers, complaints and medication. However, not everyone living at the home and their relatives were happy with the standard of service they received and some people did not feel they were cared for safely. Some people felt that the culture of the home was such, that when they raised concerns about their care, these were not always acted upon.

There was no registered manager in place and there had been three changes of registered manager since we last inspected the service. The last registered manager left November 2016, the provider kept us informed of the changes as they are required to. In addition the provider information return told us that there had also been a turnover of care staff. Some people were aware that the last registered manager had left; however, people said they did not know who the new manager was. The new manager had been in post since the beginning of November 2016. One person said, "Don't know who the new manager is. I would speak with [staff name] if not happy and something is done." We discussed this with the manager who said she had introduced herself to people, and frequently walked round the home so people should know her by now.

The provider is required to notify us when authorisation has been granted to deprive people of their liberty. We saw that information was available on people's record which showed that three people had been confirmed as being deprived of their liberty, with documents available to confirm the conditions of the authorisation for one person. The provider information return submitted to us did not tell us that authorisation from DoLS had been granted for these three people. We did not receive a notification about this in a timely manner. The manager said before our inspection she realised that we had not been informed and had submitted the notifications.

Staff spoken with also talked about the various changes in managers and the impact this has had on the service. One member of staff told us, "There have been lots of changes, [previous registered manager name] was a nightmare, but [the last registered manager's name] was brilliant, really good, staff were comfortable. I looked forward to coming to work, nice atmosphere, but now, this new manager, I am not sure... it is too early to tell really but there have been lots of changes very quickly, too quickly I think and people are on egg shells, not a nice atmosphere really now...but maybe it will calm down a bit." This member of staff then said they felt there was no point in raising concerns. Another staff member said, "I have not had supervision for over a year now but I can speak to the new manager. I know she is going to get on top of supervisions as well I have confidence in her." Another member of staff told us they felt the new manager was trying to put changes in place. This staff member said, "The new manager is pushing for change and I think we do need the changes, she has told me I can talk with her about anything."

We saw that the provider had an improvement plan in place to secure better outcomes for the service and enhance people's experiences. The new manager told us about disciplinary actions she was taking against various staff members in order to improve practice and ensure that people's experience of using the service improves. The manager also said there was a high turnover of staff and monitoring staff sickness was not

taking place so the provider was unable to determine the root cause at this time, but this analysis would be introduced. The manager said her policy is to recruit staff at 20% above the numbers of staff needed to cover for unforeseen eventuality. This would ensure that there were staff available who knew people and their needs.

The provider and manager told us that the resources were available to improve the standard of service. We saw that the provider had analysed recent surveys from people and their relatives. The manager said an action plan would be developed to address the key points from the survey. This showed that the provider was aware that changes were needed to the service and had plans in place to support those improvements.

We saw that confidential information relating to staff supervision records were kept in an unsecure manner, where they could be accessed by anyone. We spoke with the manager about this; they told us the records should have been securely archived. The manager took immediate action to secure the records. The manager also acknowledged to us she was aware that record keeping needed to be improved.