Greasbrough Residential & Nursing Home Limited

Greasbrough Residential and Nursing Home

Inspection report

Potter Hill
Greasbrough
Rotherham
South Yorkshire
S61 4NU

Tel: 01709554644

Date of inspection visit:
09 March 2017

Date of publication:
10 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 9 March 2017. The home was previously inspected in May 2016 when we rated it as Good.

Greasbrough Nursing Home provides accommodation and nursing care for up to 60 older people, some who are living with dementia. The home is situated in the Greasbrough area of Rotherham. The home had two units both providing personal and nursing care. One unit was designed to support people living with dementia. At the time of our inspection 60 people were using the service.

The service did not have a registered manager in post at the time of our inspection. 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.

The provider told us that the deputy manager had been promoted and had started the process of applying to the Care Quality Commission to become the registered manager.

We received very positive feedback about most aspects of the service from people and their relatives. However, we also identified some areas that required improvement in the home. These included the practice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards and that the provider's quality assurance process had not identified shortfalls in the way the service was run.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that applications had not been submitted for several people, for whom it was necessary.

Some people were supported to make decisions about their care and their choice was respected. However, where people lacked capacity, decisions were made without documenting the 'best interests' process.

There was a need to review the staffing and deployment of staff. Although there were enough staff available to keep people safe, in order to meet people's needs, managers were often called upon to undertake support roles, taking them away from essential management tasks.

We looked at care plans and other written records and found that in most cases, they reflected people's current needs. However, there were a small number that were not completed in full, or presented contradictory information.

The service had had changes in the management team, which had also impacted on the frequency of some audits. In addition, the audits in place had not identified the shortfalls in people's written assessments, plans and records that we identified at this inspection.

The home employed an activity co-ordinator who was responsible for arranging activities and social events. We saw activities took place. However, there were few activities on offer for people living with dementia.

Not all staff had received training or refresher courses in line with their role in the organisation.

Some steps had been taken to make areas dementia friendly. However, there was room to further improve the environment for the people living with dementia who lived in the home.

People received a nutritious and balanced diet. Snacks and drinks were offered throughout the day. People told us they enjoyed the food provided at the home.

We observed staff interacting with people who used the service and found they were kind, caring and respectful.

The home had a safeguarding policy in place to protect people from the risk of abuse. Staff we spoke with knew the importance of reporting incidents of this nature without delay.

People's medicines were managed well.

There was an infection control policy and a procedure in place to ensure the risk of cross infection was minimised.

The provider had a complaints procedure in place. People felt they could speak with staff if they had a concern and told us they were happy with the service provided.

People who used the service and their relatives were able to contribute to the service and they felt listened to. Meetings and surveys gave them a forum to discuss their thoughts and ideas as well as the managers operating an open door policy.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this report.

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.

Although there was enough staff available to keep people safe, there was a need to review the staffing and deployment of staff.

A small number of risk assessments, care plans and written records had gaps and inconsistent information. This could potentially put people at risk of poor care.

The service had a policy in place to safeguard people from abuse. Staff knew how to recognise, record and report abuse.

We saw that people received their medicines in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received all necessary training.

The service was not meeting the requirements of the Mental Capacity Act 2005.

People praised the food very highly. People received sufficient amounts of food and drink to ensure a healthy balanced diet was provided.

Is the service caring?

Good

The service was caring.

On the whole, staff interacted well with people and found they were kind, caring and supportive.

Staff we spoke with were keen to ensure people's privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place which were relevant to their current assessed needs. These were reviewed on a regular basis.

On the whole, we saw activities took place and most people appeared happy and content. However, the activity schedule was limited and the people living with dementia lacked activities and stimulation.

The provider had a complaints procedure in place and people told us they had no concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had been through some changes since the last inspection. Additionally, the managers were often called to provide support the care rota and did not have time to undertake tasks associated with their management role.

Quality assurance audits had not always taken place regularly. Additionally, the audit system did not identify or address the shortfalls that we identified at this inspection.

People felt they had a voice and were able to contribute their ideas and suggestions.

Greasbrough Residential and 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 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.

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 the on 9 March 2017 and was unannounced. The inspection team consisted of 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. A representative of the local authority commissioning team also took part in the inspection, as part of a joint working approach.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service. Before the inspection, the provider completed a Provider Information Return (PIR). 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.

Before our inspection we reviewed all the information we held about the home. We also spoke with the local authority to gain further information about the service.

We spoke with 12 people who used the service and eight relatives, and spent time observing staff supporting people.

We spoke with six care workers, the interim general manager, the nurse manager, the deputy manager (who had just been promoted to manage the service) and the owner of the company. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at seven people's care and support records including their plans of care. We saw the system used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

.

'

Requires Improvement

Is the service safe?

Our findings

We spoke with people who used the service and their relatives about the safety of the home. We asked people if they felt safe in the home. They told us they did. For instance, people's comments included, "Yes I do. The people that work here are very kind", "I feel safe. If there was a fire I would know what to do", and "I have been here ten years and I feel very safe."

When we asked one person's relative if they felt their family member was safe living in the home they responded, "Definitely, and cared for." They confirmed that they would know who to speak to if they saw anything that concerned them. They had not had any issues.

There were 21 people living with a diagnosis of dementia at the time of our inspection, and on the ground floor there was a unit specifically catering for people living with dementia. We were told there were usually four staff in attendance in this unit during the daytime. The rotas we saw for February 2017 showed the staffing levels were consistent. However, some staff told us there were not always enough staff on duty. For instance, one care worker said, "At times we are short staffed. Lately, this has happened a lot. I think over the last few months. We try to pull together as a staff group to sort it ourselves, but if not, we end up with agency workers. At times there can be as few as two staff, when there should be four." On the day of our visit one of the staff on duty was an agency worker, who was unsure of their role. They were left supervising people in the lounge of the unit, while the permanent staff attended to people's personal care needs. They did not really engage with anyone, so people were left just sitting.

People we spoke with who used the service said there were times when there were not enough staff. For instance, one person said, "I don't think there are enough staff a lot of the time. It varies." Another person said, "Usually, in the day there are enough, but at night, maybe not. But, not dangerously so." One person told us, "They [staff] have the right skills and experience, but we could do with a few more staff", Another person said there were not enough staff and that staff did not have any time to spend with them. They told us, "No. They [staff] seem to be doing different jobs all the time." When we asked if one person's relative if they felt there were enough staff they responded, "There are now, but recently, no. However, there is always care available."

During our inspection we observed staff interacting with people. Although we found that people's care needs were met, staff had little time to spend with people. We discussed with the provider, and with the new manager, the need to review the staffing and deployment of staff, in light of the changes in the management arrangements, and the feedback we received at this inspection.

We saw a poster displayed in the entrance area regarding safeguarding people from abuse. This gave the contact number for the local council and the Care Quality Commission. We saw that a record was kept of any safeguarding incidents that had been reported to the local authority safeguarding team. Staff we spoke with had training in safeguarding people, knew how to protect people from abuse and knew the process to follow to report any safeguarding concerns, if required.

We saw that the home was appropriately equipped with hoists and other aids to help people mobilise and transfer. The equipment we saw was clean, well maintained and, where necessary, had been portable appliance tested, commonly known as PAT tested. We did find there was a need to order a small number of new slings and the new manager took action to respond to this immediately.

We saw that risks associated with people's care were identified in care records. These were about risks such as falls, pressure area care and nutrition. The hazards were highlighted and also the likelihood of it occurring. People had personal emergency evacuation plans (PEEPs) to ensure they could be evacuated from the building in a safe manner if required. However, not all of the personal emergency evacuation plans (PEEPs) we saw had been completed in full.

Overall, the risk assessments and care plans we looked at detailed people's needs and how best to support them. They were reviewed on a regular basis and on the whole, were up to date and reflected people's changing needs. However, there were some gaps in some people's plans and assessments and some were not signed and dated by the staff member who had completed them. We also found some instances when people's written information was inconsistent. For instance, the details written for one person's diabetes in their risk assessment differed from their care plan. This could potentially put people at risk of poor care.

These issues had not been identified through an effective monitoring system. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

We looked at systems in place to manage people's medicines. Medicines were administered by nurses and senior carers. The nurse confirmed that all staff who administered medicines to people had received appropriate training before doing so. Medicines were stored safely and securely. Storage temperatures were monitored and where necessary, medicines were dated when opened, to make sure they were disposed of at the right time.

The records we saw in relation to medicines management were accurately completed. Each person had a Medication Administration Record (MAR) which included the person's name and photograph, the name and a photograph of the medicine, along with the dose and the time it should be taken. Each nurse or senior care worker had signed to say medicines had been given, or if a medicine had not been given, a reason had been recorded.

We observed that staff who administered people's medicines explained to people what the medicine was for and offered them drinks appropriately. We asked some people if knew what medicines they were prescribed, and if they got their medicines on time. Most people confirmed that they did. For instance, one person said, Yes, I know. Yes, [staff member] makes sure I get it." One person did say they didn't know what their medicines were for, but added, "They [staff] always give them to me on time.

We looked at recruitment files for staff and found the provider had a safe and effective system in place for employing new staff. Files we looked at contained pre-employment checks which had been obtained prior to new staff commencing employment at the service. These included two satisfactory references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

We completed a walk round of the home and saw that in the main it was clean, tidy and odour free. However, two staff told us they sometimes ran short of personal protective equipment (PPE), such as gloves and aprons, along with some continence aids for people who used the service. The provider and the new

manager said there was a system in place that provided sufficient resources of this kind, while preventing waste. The new manager told us they would discuss this issue with the staff team at the next staff meeting.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Some people who lived at the home were not always able to make important decisions about their care due to living with dementia and some people's capacity varied from time to time.

Some work had been undertaken to ensure that the home worked appropriately within the MCA. For instance, there were forms on each person's file about their capacity to make decisions. However, these tended to be generic best interest decisions, covering most aspects of people's care. This was not in line with the Mental Capacity Act 2005 which informs that best interest decisions should be time and decision specific. We spoke with the manager about this and were told that this was to be updated and replaced with new forms, and henceforth, each decision would be recorded separately.

People we spoke with told us staff asked for their consent to any care and treatment offered, and respected their choices. This was confirmed by the records we saw showing that in the winter, people had been asked if they wished to consent to having a flu jab. In most cases, people had the capacity to decide this for themselves. However, where people were assessed as lacking capacity, people's relatives had been asked to consent on people's behalf. As people's relatives have no real, legal right to consent to treatment on their family member's behalf, a best interests decision, in line with the MCA code of practice would be required.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that some applications had been made to the supervisory body and three people using the service had granted DoLS authorisation in place. However, they had not been made for everyone who met the 'acid test', including those living in the dementia unit. An acid test is an indicator of whether a person is being deprived of their liberty.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 as the provider had not always acted in accordance with the Mental Capacity Act 2005.

We discussed the DoLS applications with the provider and the new manager. The new manager told us they would ensure that all necessary applications were made as a matter of priority. We also found that very few staff had received training in MCA and DoLS. The new manager told us they had received training in this area and were keen to make sure this was also provided to staff.

We asked people if they thought that staff had the right skills and experience. Comments included, "Absolutely", "They are very well trained." and "I feel fortunate be here."

We saw staff received supervision sessions on a regular basis. These were one to one meetings with their line manager. We also saw that staff received appraisals on a yearly basis. The four newest staff were undertaking the care certificate as part of their induction. The care certificate is a nationally recognised programme of training for care workers.

The management team used a training matrix to monitor the training staff required, when it had been completed and when it required updating. The administrator recorded staff member's training on the matrix. They told us it was likely that a number of staff had completed more courses than were recorded, as they had not yet brought in their certificates.

The matrix showed that most staff had completed essential training such as fire safety, first aid, food hygiene and safeguarding people from abuse. We also saw that many of the staff had attained a nationally recognised care award. However, we saw that some staff were overdue certain training updates. This included essential training such as health and safety, moving and handling, food hygiene, fire safety, infection control and care of substances hazardous to health (COSHH). Several newer staff also had not yet been provided with training in working with people living with dementia and in equality and diversity.

Members of the management team told us further training sessions had, or were being arranged as soon as possible, to address the shortfalls. A training coordinator from the local authority had recently met with staff and managers to support them to update training at the home. All staff had been allocated with an e-learning password and access to the website. The provider said he would look into ways to address the issue that a number of staff did not have access to a computer, or had limited access to the internet.

People told us the quality of the food in the home was excellent. For instance, one person said, "[The food is] Fantastic. It's all freshly cooked. Two good cooks." Another person said, "I love it, because it's nice. I eat in the dining room, and if I don't want what's on, they [staff] give me something else."

We asked people's relatives what they thought of the food served in the home and if the service managed their family members' diets appropriately. They all gave very positive feedback. For instance, one relative said, "Absolutely. [My family member] likes a fried egg sandwich for breakfast and sometimes has it in bed."

We looked at people's care plans and found these included their dietary requirements and preferences. We saw that snacks, including fresh fruit, were available throughout the day, as were a selection of drinks. We observed lunch in both dining areas. Lunch was nutritious and appetising. In one dining area people were offered a choice of meal and the menu was displayed in a written format. However, in the dining area for people living with dementia there was no menu displayed. Staff in the unit told us they asked people what lunch option they wanted each morning, and then let the cook know the numbers. As staff didn't have time to actively offer alternatives during lunch this system gave people living with dementia little opportunity to change their minds about the meal they wanted. However, we did note that staff were supportive and discrete when supporting people with their meal.

We asked people how easy it was to have access to their GP and other healthcare professionals. People told us that they were well supported by staff who were responsive and quickly made sure they had access to any healthcare service that they needed. For instance, one person told us that a staff member had called the GP for them that day. Another person said, "It is easy. I ask whoever is on duty and they get in touch. The records we saw confirmed this. People's care plans showed that people had been referred to services in a timely manner when required. We saw professionals such as speech and language therapy, physiotherapy and their own doctor were involved in their care when required.

We asked people's relatives if they were happy with the level of communication from the staff, including if they were kept informed about hospital appointments. They confirmed that they were. For instance, one relative said, "Yes, and I always go with [my family member]."

The home had developed a separate unit which was decorated in a dementia friendly way. For instance, the doors to people's bedrooms had been painted in different colours and there were some landmarks, such as artwork on the walls. However, there could have been more use of contrasting colours to help people to orient themselves and distinguish things like light switches. The unit was a clean, well decorated, light and airy, and a pleasant, spacious environment. However, the seating was not arranged in a way that encouraged people to engage with one another, or their environment. There were few dementia friendly accessories to add interest, or that would help with people's orientation, such as clocks or 'easy read' calendars. There were no reminiscence materials, items of interest, or tactile items that people could pick up or engage with independently. The service for people living with dementia was an area the new manager was aware needed further development.

Good

Is the service caring?

Our findings

We asked people if they felt the staff cared about them. Most people felt they did. One person said, "Oh, they do. I'm extremely happy." Another person said, "[Staff member] has looked after me for four and a half years. Yes, they care." For instance, one person said, "They [the staff] are very respectful and caring." However, another person said, "Some do care, but some are not quite so caring. There seems to be different staff sometimes." Another person also mentioned that they didn't like it when staff shift changes took place."

People's relatives said they felt the staff really cared about their family members. For instance, one relative said, "Yes, absolutely." They said staff treated people as individuals and supported people to be independent. They also confirmed that staff knew people's likes and dislikes, and confirmed that people received personalised care. Another relative told us that each time they had visited they were witness to staff being kind and patient, and asking after people's welfare.

We observed staff interacting with people and found they showed a kindness and care towards people. While we saw that all staff were gentle in their approach, some staff did not have quite as much knowledge as others, in working with people with more complex communication needs, often related to living with dementia. This was a reflection that staff training in this area needed to be improved, rather than on the staff concerned, who showed a considerable amount of kindness.

People told us staff talked to them and involved them in decisions. For instance, one person said, "Yes. I am not ignored. They [the staff] are wonderful." One person told us, "I need a lot of help. They [staff] are kind and considerate." The care plans we saw included information about people's likes and dislikes. This included a list of people's food preferences. Pen pictures also gave information about people's family history and important memories.

We asked people if staff treated them with kindness and respect. One person said, "Absolutely." Another person said, "Always." However, one person said, "Ninety nine percent do."

Staff we saw respected people's privacy and dignity, making sure they knocked on people's doors and keeping doors closed when providing personal care. We saw that five staff had signed up as 'dignity champions'. The five staff had made a commitment to uphold people's dignity, influence their colleagues in this, and to challenge disrespectful behaviour.

People confirmed that their family members and friends were able to visit and were made welcome by staff. People's comments included, "My [relative] visits twice a week and is made very welcome." "Yes they are. Nearly every day my [relative] comes. Recently I have been poorly and she comes every day." People's relatives confirmed they could visit anytime. For instance, one relative told us, "Anytime. There is never a time when we aren't welcome. Only once, when there was a bug going around we were asked to limit visits."

We asked people if staff maintained their privacy and dignity. People told us they did, For instance, one person said, "Absolutely. I need hoists to bathe and they look after me." Staff told us they tried to make sure

people's dignity was maintained when providing personal care.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place which were reviewed on a regular basis. We spoke with people and their relatives and they told us they were involved in their care plan and were happy with the support they received from staff. One person told us they were involved in their plan. They added, "I am always having a laugh and telling them [the staff] that I have been good." Some people could not recall if they had a care plan. We asked if one person's relative if they were involved in care planning and discussions about their family member's care. They responded, "Yes I recently asked that [my family member] have an afternoon rest and [the nurse manager] immediately brought the care plan and amended it."

We asked people's relatives if they felt the staff understood their family member's needs. They told us they did. For instance, one relative said, "Yes, although it took a while at the beginning." People also told us they had choice and control over their daily routine. One person said, "I am up and about early. A lot of people lie in bed. I don't want to."

People told us there were some opportunities for them to be involved in social and leisure activities and to maintain their hobbies. One person said, "We have children from [a local school]. I teach them how to play drafts, chess and the game, 'four in a row'.

There was an activity person employed in the home on a part time basis. They were not at work on the day of the inspection. We saw that several people had the capacity to socialise and choose what they wanted to watch on the television. However, on the day of the inspection some people, who were in their bedrooms, or those living with dementia spent very long periods without any social stimulation or interaction.

There was an activity plan in place and activities took place on a regular basis. This included movie afternoons, quizzes, and sing-a-longs. However, we did note that visits from the hairdresser were regularly included as the sole activity for the day.

People who needed more support had very little, or no opportunity to be involved in social or leisure activities. For instance, in the unit for people living with dementia, when we asked about the opportunities for activities for available staff told us that the activity coordinator worked around the home, but not usually in the dementia unit. The previous registered manager had introduced hours for an activity worker, specifically for the people living with dementia, but this resource seemed to have been lost during the transition of managers. We saw there were games and puzzles on a table in the corner, including board games and dominos. However, at the time of the inspection staff were too busy to prompt or support people to use these.

The service had a complaints procedure in place and it was displayed in the main area of the home. Although one person said they didn't know how to make a complaint, they qualified this by adding that they had not had any complaints to make. One person's relative said, "I would be OK complaining, if necessary." They also added that they had not had to raise any major concerns.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of our inspection. The previous registered manager left in 2016 and the provider had appointed an interim general manager along with a nurse manager, until a new manager could be appointed. They were supported by a deputy manager, nurses and senior care workers. At this inspection the provider told us that the deputy manager had been newly promoted to manager, and had started the process of applying to the Care Quality Commission to become the registered manager.

During the inspection we spoke with the interim general manager, who was keen to return to their substantive post. The nurse manager told us they had given in their notice. Although they told us they were considering staying on, in a nursing role, on a part time basis. We met and spoke with the newly appointed manager and spoke briefly with the provider. One person who used the service told us, "[The general manager] is fantastic. We get on very well. He never has the hump, always on top of the world." Another person said of the provider, "He is a very kind man. I can talk to him anytime."

The nurse manager told us they provided nursing cover during shifts and had very little or no time during their working hours for their management responsibilities. Hence, they were working very long hours, as well as undertaking tasks, such as planning rotas, in their own time. They expressed concern that there were sometimes not enough care staff to provide the care people needed, so the nurse manager and deputy manager spent a lot of their time in a supporting role, in order to free up the care staff to undertake personal care tasks. This contributed to the pressures of time for the managers.

The provider had a system to assess and monitor the quality of service provided. Although, we saw that some elements of this had slipped during the interim period, since the registered manager left. For instance, members of the senior team each had areas of responsibility and were leads for certain topics and had completed the audit for their designated area. However, some audits had not been completed since 2016. This included audits of people's weights and malnutrition screening tool results (MUST), and pressure sores and wound audits.

We found that the provider had not identified the negative impact on the service of management staff not being provided with enough time to fulfil their management responsibilities, or the negative impact on people living with dementia of a reduction in activity staff hours. The audit system had failed to address the shortfalls in staff training and had not identified the shortfalls in people's written assessments, plans and records, which we identified at this inspection. We also found that the staffing levels were not effectively monitored to ensure there were sufficient staff that were effectively deployed at all times. Therefore, we found that the provider did not have systems that were effective to assess, monitor and improve the quality and safety of services.

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

The provider was unable to locate copies of medication audits at the time of the inspection, although all of the senior team confirmed that they had been undertaken. We were provided with copies immediately after our inspection visit. These audits did identify areas to improve, and improvement actions were monitored by members of the management team.

There was evidence that people who used the service were listened to and their views respected. People's relatives told us they had been asked to fill in surveys, and the managers and staff listened to their opinions and comments. People's relatives also told us they had been invited to attend relative's meetings and the managers kept them aware of any forthcoming meetings. The records we saw confirmed that residents' and relatives' meetings took place.

We also saw that satisfaction surveys had been sent out regularly. These questionnaires were sent to people who used the service and their families and professionals who visited the home. We saw comments such as, 'We enjoy the informality of the regime. Staff are all exceptionally kind and thoughtful' and 'We are happy with the care you give. [Our family member] is safe and well looked after.' However, one person had fed back, that they had, 'noticed a shortage of available staff.'

We asked people if anything about the service had been improved by them talking to staff. One person said, "I don't trouble them too much." They qualified this by adding, "I couldn't ask for more." People's relatives told us there was a positive culture in the home and that they felt that they could approach the managers and the staff and expect to get a positive response.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in accordance with the Mental Capacity Act 2005. This is a breach of Regulation 11(1)(3) (Need for consent).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. Quality assurance audits had not always taken place regularly and the audit system did not identify the shortfalls with people's written records that we identified at this inspection. Staffing levels were not effectively monitored to ensure there were sufficient staff that were effectively deployed at all times. The provider had failed to identify the negative impact of not providing management staff enough time to fulfil their management responsibilities. The provider had failed to identify the negative impact of reducing activity staff hours for people living with dementia.