Springfield Health Services Limited

Springfield Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 November 2017 and was unannounced. At our last inspection in July 2015 we found the service was not meeting the legal requirement for person centred care because they had not ensured staff were meeting people's needs in a timely manner. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to ensure they were meeting the legal requirement. At this inspection, we found staffing levels met the needs of people and there was no longer a breach. However, some staff expressed concerns about staffing levels which the registered manager and provider were aware of and had made changes to resolve this.

Springfield Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates up to 65 older people and some who require nursing care, across two adapted buildings. House 72 accommodates up to 36 people and does not provide nursing care. House 74 accommodates up to 29 people and does provide nursing care. The registered manager confirmed that House 74 was only accommodating up to 26 people at the time of the inspection, in order that people could have single occupancy rooms. However, if the need arose and people wanted to share a room this could be accommodated. At the time of the inspection there were 32 people living in house 72 and 21 living in house 74.

A registered manager was in post during the 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.

Staff worked well as a team although they did not always feel supported by the day to day management team. The provider had investigated this and implemented an action plan with the management team. The registered manager expressed a willingness to ensure this improved. There were systems in place to monitor quality and safety of the home provided, however no overarching development or sustainability plan was in place. People and their families were encouraged to provide feedback on the service through residents meetings and an annual survey. They were also supported to raise complaints should they wish to.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Policies were in place for care planning which guided staff to ensure people's diverse needs were considered and where needed support was planned. People told us that staff knew them well and this was apparent throughout our discussions with staff about people. Risks associated with people's needs were assessed and actions were taken to reduce the risk. It was evident staff responded promptly to people's change in needs and ensured they received a person centred service, although the records were not always updated to reflect this. Activities were delivered based on individual needs at the time of the inspection.

People and their relatives provided positive feedback about staff. Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion. Their privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

People told us they were always asked for their permission before personal care was provided and where needed people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). Care staff and the registered manager had received training in respect of the MCA and were able to demonstrate an awareness of the principles.

People were protected against abuse. Policies and procedures were available to everyone who used the service. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse.

No formal system was used by the provider to assess the level of staffing and skill mix needed and some staff expressed concerns about the staffing levels. However, our observations showed that staff responded promptly to call alarms and people's requests and there were sufficient staff to meet people's needs. The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home. People told us they felt staff had the skills and knowledge to care for them. Staff received supervisions and training.

People and their relatives felt the home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe and people were supported to maintain good health and had access to appropriate healthcare services.

In line with CQC's enforcement policy, the overall rating for a service cannot be better than requires improvement if there is a breach of regulations. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

People were protected against abuse by staff who understood their responsibility to safeguard people.

Risks associated with people's needs were assessed and action was taken to reduce these risks.

Medicines were managed safely.

The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home and there were sufficient staff to meet people's needs.

The home was clean, tidy and staff prompted good infection control management.

Is the service effective?

Good

The service was effective.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs.

People told us they were always asked for their permission before personal care was provided. Where needed people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA).

Staff received supervisions, appraisals and training to help them in their role.

People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring.

People and their relatives provided positive feedback about staff.

Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion.

People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

Staff responded to people's changing needs and ensured a person centred service.

People were provided with appropriate mental and physical stimulation.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications required by CQC were not submitted. Records were not always up to date and accurate.

Staff did not always feel supported by the day to day management team. They felt unable to raise concerns and were not confident these would be addressed. The provider and registered manager were aware and had plans to change this.

There were systems in place to monitor the quality and safety of the service provided.

The provider's values were clear and understood by staff.

People, their families and staff had the opportunity to become involved in developing the service.

Springfield Nursing and Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 23 November 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience of caring for older people living with dementia.

Before the inspection we reviewed information we held about the service. We looked at previous inspection reports, notification and the provider information return (PIR)document. The PIR 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. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with 20 people and 6 visitors. We observed care and support being delivered in communal areas of the home. We spoke with the registered manager, deputy manager and the quality manager. We also spoke with 12 staff including, ancillary staff, care staff and nursing staff. We spent time observing interactions between staff and people. We looked at the care records for 11 people and the medicine records for nine people.

We review staff recruitment records for three staff and supervision and appraisal records for four staff. Staff training records as well as management records such as complaints, safeguarding, incident and accident records, rotas, policies and procedures and governance records.

Good

Is the service safe?

Our findings

Feedback from people told us they felt safe and comfortable living at the home. They felt cared for in a clean environment by staff who knew them well.

At the last inspection we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there had been a failure to support people in a timely fashion. At this inspection this had improved and was no longer a breach. No formal system was used by the provider to assess the level of staffing and skill mix needed to ensure people's needs were met and we were told that if the registered manager identified a need for additional staff this was always agreed to by the provider. The registered manager told us they did this by observing and listening to staff. Prior to the inspection CQC had received concerns that staffing levels may not be appropriate to meet people's needs.

People did not tell us of any concerns about staffing levels although they did comment that you could never have enough staff. Some staff expressed concerns about the staffing levels in house 74. One staff member said, "When there are six carers on it's fine, but not with five. I think some people have left so it happens quite often now". Another staff member told us, "It feels like a bit of a novelty to have six on now. Half the week, there are five and sometimes four in the afternoon like today. It feels relentless then". A third staff member said, "I'd say about a third of the time there aren't enough staff. It can mean someone who wants a bath doesn't get one that day". Whereas the feedback we received about the staffing levels in house 72 was positive. The registered manager and provider told us a review of the call bells was undertaken following the concerns being raised. As a result some key times of days were identified when it took staff longer to respond. As such, changes had very recently been implemented, including staggering staff breaks to resolve these issues and ensure effective deployment of staff.

We did not observe any concerns about the staffing levels throughout our inspection. Observations showed that staff responded promptly to call alarms and people's requests.

People were protected against abuse. Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Staff said they were confident to do so and felt that the registered manager and provider would take prompt action to address any concerns related to people. Records were held when referrals had been made to the local authority and incidents were investigated and appropriate action was taken.

People could be confident they were supported by staff who understood their needs. Any risks associated with people's needs were assessed and action was taken to reduce the risks. For example, for those people diagnosed with diabetes, staff had a good understanding of the risks this could present and what they should monitor for. Their blood sugars were checked as needed and we saw staff consulted with health professionals when they had concerns. In addition we found evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health.

For people who had been assessed as at risk of developing pressure sores, action had been taken to reduce the risks. This included providing people with a specialist pressure relieving mattress, the pressure of which was calibrated and regularly checked.

Where needed care plan files contained detailed information for staff concerning the various chronic and acute medical conditions people lived with, including epilepsy and Huntington's disease. There were also clear and concise details about the management of oxygen therapy, used by a person living at the home.

Documentation related to falls, accidents and incidents was maintained. They contained detailed information concerning the frequency, time and place of incidents, in addition to staff actions. They enabled the registered manager and provider to identify trends and causality, with a view to reduction or prevention. We noted there was also detailed action planning in the documents, outlining a decided course of action. For example, one person was referred to their GP for review after a recent addition to their medication had caused an increase in falls.

Equipment was managed in a way that supported people to stay safe. Regular maintenance checks took place of equipment, such as hoists and lifts. Window restrictors were in place where these were required. A maintenance worker was present in the home on a daily basis to attend to any repairs that were required and to carry out safety checks, including fire and water. Where it had been assessed that a person required the use of bed rails, staff ensured that protective bumpers were also in place to prevent any injuries. The bed rails were checked regularly by staff to ensure they were safe and working correctly.

The premises were not purpose built and as such presented significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP) in care plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood.

People said they received their medicines when they needed them. The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. Controlled drugs were safely managed according to the legislation for the administration and storage of CDs. Storage of medicines was safe. Medicines trolleys were locked when not in use, were not left unattended when unlocked and medicines were not signed for until taken by the person. The temperature of storage was monitored daily to ensure that this did not impact on the effectiveness of medicines.

A system was used for monitoring and auditing of medicines, disposing of medicines and ensuring medicines were reviewed. Medicines audits were regularly conducted. Staff were aware of those people who were prescribed medicines on an 'as required' (PRN basis). They told us when these medicines may be used and how they would assess if it was needed. We saw PRN medicines for the management of behaviours was used as a last resort. There were no gaps in MAR charts.

Three people were receiving their medicines covertly, that is without their knowledge or consent. We looked at documentation related to these people. We noted in each case that a mental capacity assessment had been carried out and best interest decisions taken. Staff told us how they ensured least restrictive practices were applied in these cases. They told us they always offered the medicines first and only gave this covertly when absolutely needed. However, no consultation with the pharmacist had taken place to ensure that the medicines was administered in a way that did not impact on it effectiveness. In addition, one of these people's medicines care plan was out of date. The registered manager told us they would take action to address this.

New employees were appropriately checked through the provider's recruitment processes to ensure their suitability for the role. Records showed prospective staff completed an application form and had a face to face interview. Staff were asked care focused questions during interviews, such as the management of safeguarding issues. Following this the provider sought references to check the person was of suitable character and applied for a Disclosure and Barring Service (DBS) check. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people. New staff did not commence their role before this information was returned. Copies of other relevant documentation including full employment histories, evidence of up to date professional registration for nurses and interview notes were held in staff files.

The premises were cleaned daily to ensure the risks of infections spreading were controlled. One person told us "They're always cleaning here it's very good". Cleaning records were maintained and regular audits of the cleanliness of the environment and equipment were undertaken. Staff received infection control training and protective personal equipment was available and in use. We observed the home to be clean, tidy and odour free. Staff used personal protective equipment, such as gloves and aprons when providing personal care and serving meals. Staff were aware of their responsibilities with regard to infection control.

Good

Is the service effective?

Our findings

People told us they were always asked for their permission before personal care was provided. They said they felt they were cared for by staff who were knowledgeable of their needs and helped them to access other health professionals if needed.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. One person said: "I actually visited here with my son and spoke to the staff. Then I came here for a week to see if I liked it here and have been here ever since". The preadmission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs. People and where appropriate their relatives were involved in this process.

Following admission to the home care plans were developed. The provider had policies in place for care planning which guided staff to ensuring a person centred service in which people's diverse needs were considered. Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. Couples were supported to remain living together in shared rooms. Staff told us how, for example, a chaplain regularly visited to carry out services and some people chose to attend. Although not included in care records, they were able to describe another person's religious beliefs in depth and how they ensured these were respected. For another person their care plan contained information and consent forms concerning their wish to give their body to a teaching hospital for research and education after their death.

People were supported by staff who received training to enable them to effectively care for people. Staff were supported to access training that was relevant to their role and that equipped them with the skills and knowledge they required to care for people within the home. One member of staff told us "The training is okay. There's always training to do".

Records showed that staff had accessed training in key areas on a regular basis and the registered manager and provider had a plan in place to ensure that training was updated periodically. Staff applied their learning from formal training courses on a day to day basis. For example, staff used appropriate moving and handling techniques and good communication skills when supporting people.

The registered manager and staff told us how new staff were inducted and supported to work effectively in the home. The induction for new staff included a period shadowing where they worked alongside more experienced care staff to gain the skills and competencies that they required to work within the home. In addition staff who were new to care were required to complete the care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The registered manager told us how champion roles had recently been created in the staff team. The plan was that these staff would be responsible for leading and promoting specific areas of care. For example, these included, end of life care, dementia, dignity and nutrition. The registered manager told us how staff

would be trained to have the skills and knowledge to undertake these roles.

People provided mostly positive feedback about the food, although one person said that some food items could be cold. People said they were offered choices of meals. One said "Yes, there's a good choice of food here. I like porridge every day and toast." And "The soup is good and is available every day". A second said "I don't tend to eat much after lunch. There is a choice of meals- I think they would be happy to get you something else if you wanted it".

Staff were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves. The care plans we looked at reflected this. We noted a variety of referrals and assessments had taken place, including those involving dieticians and speech therapists. There were several people living at the home who had lost weight recently; however none were related to malnutrition or poor food intake. Staff monitored people's weight and if this was a concern made referrals to other professionals to ensure this was managed. This included ensuring supplements were provided and their meals fortified to support good nutrition.

Staff and the registered manager spoke with us about how they worked well as a team to ensure everyone was aware of any changes in a person's support needs. Internally they used a verbal handover system between shifts. A diary and a communication book was used each day to share messages and ensure that where a person needed something, such as a health professional appointment, this was booked and staff were aware of when they were visiting so they could ensure staff availability.

People were supported to maintain good health and had access to appropriate healthcare services. People's records confirmed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs.

People were cared for in an environment where adaptations had been made to meet their needs. Signage was in place to provide guidance to people about the purpose of rooms and this was in both written and pictorial format. Rooms were laid out to enable people to understand the purpose of the room. For example, the dining room in house 72 was laid out in a similar format to that of a café, with laid tables. The outside of people's rooms was personalised with signage to show the room belong to the person. This contained photos and other items of interest specially related to the person. People were able to personalise their rooms. The environment was regularly checked for safety and maintenance issues.

Staff were aware of the need to seek consent before undertaking care for people and we observed them doing this throughout the inspection. 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. Staff had a good understanding of the Mental Capacity Act (MCA) (2005) and had undertaken training in this area. All could tell us the implications of the Act and of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. Where needed, time and decision specific mental capacity assessments had been completed and there was evidence of best interests decisions with relevant parties.

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. Staff and the registered manager understood their role and responsibility under DoLS. Applications had been made but at the time of the inspection, none of these had been assessed or authorised by the supervisory body.

Good

Is the service caring?

Our findings

People and their relatives provided positive feedback about staff. One person said "They are nice and help you with anything". Another told us "they wouldn't do things that made you feel uncomfortable" and a third person said "I always say if you can't be at home than this is the next best place".

Observations reflected people were comfortable and relaxed in staff's company. Staff spoke with people with kindness and warmth and engaged positively throughout our visit, laughing and joking with them. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. We found the atmosphere in the service was warm and friendly. Staff ensured people felt important and comfortable. One person had recently celebrated their birthday. They showed us a card they had received from the staff and told us about their birthday cake. During the morning of our inspection a new person moved into the home. Staff greeted them in the hallway and welcomed them in a kind and friendly way. They immediately offered choice, by asking "What would you like to do first? You could go into the lounge or go upstairs to your new room".

People were encouraged to express their views and to make their own choices. Staff understood the importance of respecting people's choice. They told us how they ensured that people were able to retain as much independence by making their own choices. This was evident in many aspects of their care; for example supporting people to choose the clothes they wished to wear, where they wanted to eat their meals, and how they wanted to spend their time. We observed staff offering choices throughout the day. People told us they felt staff respected their decisions and we observed this. For example, one person had chosen to have a bath in the middle of the afternoon rather than the morning, staff supported this. Others had chosen to return to bed after breakfast and this was respected. Staff respected people's decisions if they wanted to spend time in their bedrooms and were checked at regular intervals to identify if they needed any support.

Care plans and risk assessments were reviewed regularly by staff and there were also yearly care reviews to which relatives and representatives were invited. Records of contact with family members were also kept and people or their representatives were involved in initial care planning.

Resident meetings took place and minutes of these reflected people's involvement in discussions about the environment and their care. For example, discussions took place about ensuring space was available for visitors as well as menus and activities that people wanted to do.

People and their relatives described staff who respected people's privacy and dignity. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the actions they took to ensure people's privacy and dignity was respected when supporting them with personal care.

The registered manager told us they were not aware of the Accessible Information Standard (AIS). The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement

for all providers to ensure people with a disability or sensory loss can access and understand information they are given. However, the registered manager told us how communication systems had been implemented based on individual needs. For example they described how for one person staff had used a whiteboard to communicate with them due a hearing impairment. They described the use of flip chart picture systems for another person to aid with their communication.

Good

Is the service responsive?

Our findings

People told us that staff knew them well and this was apparent throughout our discussion with staff about people. Staff were aware of people's histories, their likes and dislikes. They adapted the service they delivered to ensure people received care they wanted and needed. We saw that equipment had been adapted where needed to meet people's needs. For example, where people were unable to use their hands to operate call bells, adaptations had been made to enable them the use alternative parts of their body to call for support.

Whilst not everyone knew if they had a care plan they said staff listened to them and knew what they needed. One person told us how they were always asked what they prefer. They said "I prefer a female carer to help me at bath time. They always ask you if you'd prefer a bath or a shower. If I'm watching something on the television I can say no-I'll have it later please".

Care plans in place were legible and securely stored. They were mostly individualised, person centred and up to date although some improvements were needed to the records in House 72. For example, one person medicines care plan was out of date, another person religious beliefs and support were not included, although staff knew exactly how to support these people.

It was evident that staff responded to people's needs as they changed. For example, one person had choked on their meal. In discussion with the person, staff immediately changed the support this person was provided with to ensure they were safe when eating. They made referrals to appropriate external professional's for specialist support and followed the advice they were given. For a second person whose mobility at night had changed, we saw care plans and risk assessments were updated and additional equipment was implemented to aid staff monitoring of this person's movements at night.

Staff spoke to us about a significant change in this persons care. They were aware that certain elements of support caused the person a great deal of anxiety and as such, had worked with the person to understand what caused them distress. They had made changes to the way in which their personal care was delivered to ensure this was how the person preferred and did not cause them anxiety. As a result medication that had been prescribed to manage this person behaviour was no longer being used.

People provided positive feedback about the activities provided. One person told us "The activities are very good here. Yesterday there was an excellent male singer, he was very good. And: "There's a mobile shop here to-day which is very useful, there's scrabble this afternoon". Other people told us "There's two lots of fitness classes and chair exercises" and "We have very good entertainment here". Several people and visitors talked about a Christmas Fayre that was held recently at the home. One person said "It was lovely. People's children and grandchildren came in. I really enjoyed it".

Staff were employed to provide social support and activities for people. A planned programme of activities was in place and people had their own copies of this. People told us "We get the opportunity to go out shopping, they get a bus here it takes us, it's nice to get out. We go sometimes to the garden centre".

Reminiscence boards were seen in their Home. One board was all about the 1930's with pictures of film stars, theatre posters and comics of the period.
Activity staff took pride in their work. They had been supported to undertake training courses that would help them in their role and actively engaged with people to ensure they delivered activities people wanted to do.

The providers had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. All of the people we spoke with told us they knew how to complain and were confident to speak to both staff and the registered manager. The registered manager told us that when concerns were raised they dealt with them straight in line with the provider's policy.

A recent complaint raised to the provider had been thoroughly investigated and a clear action plan for improvement had been discussed with the registered manager and was being implemented. The provider intended to review this plan in three months to ensure positive changes had been made.

At the time of the inspection the registered manager told us no one was receiving end of life care. They were able to tell us about what they would need to consider and how they would engage with other health professionals to ensure people received the appropriate support at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

People living at Springfield told us they were happy living there. The atmosphere was calm, warm and people appeared content. One person said "The boss of the home is very good and pleasant". A relative said "I always ask to speak to one of the sisters in the office when I come in to check that everything is ok. If there's any problem they will ring me up", another said "They take it on board if you have something to say".

Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse or police investigations. We had not received notification of some incidents that had occurred in the home. For example, we had not been told about an incident reported to the police and we had not been told about a safeguarding concern raised to the service by an external health professional.

The failure to notify CQC of these significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 .

Although staff were knowledgeable about people and their care requirements, at times no formal plans of care had been developed. For example, for one person had been assessed as a high risk of skin breakdown, although action to reduce the risk was taken, no plan of care had been developed. In addition, for one person who was diagnosed with diabetes their care plan lacked information about hypoglycaemia (low blood sugars) what to look for and what action to take. Although it did contain this information for hyperglycaemia (high blood sugars). The plan provided no guidance about this person usual blood sugar range, making it difficult for staff to determine when they may need to take action. Although the PRN protocols were in place and staff administering medicines understood what these were used for, the protocols contained minimal information to guide staff about when to consider the use of this medicine. For one person their care records contained no information which reflected their religious beliefs and the support staff should provide. The management team and staff were aware of the need to make these improvements to the records but there was no clear plan about how this would be addressed. Although care plan audits took place these did not always identify the issues of concern that we had with the records.

A failure to ensure accurate, up to date records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager sent us a template care plan audit that had been developed as a result of our inspection. We were unable to assess this audits effectiveness. In addition, they sent us a sample of some records which had been amended as a result of our feedback.

Prior to our inspection, we had received concerns about the management of the home. The provider had also received these concerns. We asked staff about the managerial support they received through the supervision and appraisal process. One staff member said, "I have worked here for five months now but I don't think I've had supervision". This was confirmed by our examination of staff records. Another staff member told us, "I can say what I like to my line manager". However, a further two staff told us they felt they were not listened to by the management team (registered manager and deputy manager) and felt the

supervision process was more a 'paperwork exercise'. Supervision records were in place but at times these lacked input from the supervisor. For example, for one staff member there was no indication in their supervision records about how they would be supported to make the changes they wanted to make. Staff did not feel supported by the day to day management team. They did not feel listened to or confident that suggestions, feedback or concerns they may have would be listened to.

The provider had completed a thorough investigation into the concerns raised and received some feedback which indicated a divide between staff and the management team. They had discussed this with the management team and had developed an action plan to address the concerns and make improvements. This had only taken place the week before our visit and as such the impact of the changes was not fully seen. However, some staff did tell us that the registered manager had appeared to be making more of an effort to engage with, talk to and listen to staff. Staff spoke very positively about the provider who they described as open, approachable and easy to talk to. They were confident that if they raised concerns with the provider directly action would be taken. Whilst they said the provider visited weekly, they told us that staff were not always comfortable to talk to them while they visited the home because the day to day management team would know. They also said they did not have a direct contact for the provider to talk to them away from the home. The provider told us they would address this and ensure that they could be contacted by staff more easily.

The registered manager openly discussed the feedback they had received with us and said they were determined to ensure their staff team felt more supported, listened to and able to talk to them. They were discussing ways in which they would do this and said they would ensure they had a much more visible presence on the floor. The provider was monitoring the situation closely and planned a formal review of the action plan with staff involvement in three months' time. Although staff talked about the divide between them and the day to day management team, there was an effective staffing structure in place which provided a good network of support for people who lived and worked at the home. There was a strong sense of team work in the home as staff moved around the home working together to promote good quality care. It was also evidenced that staff did not hesitate to share concerns about practice as we observed records where this had been done and saw that the registered manager had taken action to address the concerns.

In addition the concerns raised prior to the inspection suggested that registered nurses may not be receiving effective clinical support. We found registered nurses provided informal peer support to each other and in regularly held clinical meetings. The provider had also recruited a clinical lead who was due to start employment shortly. This was to ensure nurses had the clinical support they required.

Staff understood their roles and responsibilities within the home and strived to ensure they delivered a service that people wanted and that met their needs. They said they felt the service was truly person centred and that the provider ensured people were always at the forefront of what they did. The registered manager told us how they held informal monthly breakfast meetings with other external agencies, including fire officers, hospices, solicitors which were used to share knowledge, updates and good practice. In addition they had been asked to hold a registered managers forum which they were planning to advertise across other services. They said this would be another opportunity to share good practice and learn from other services.

A variety of audits were carried out in the home by the management team, including cleanliness and infection control, health and safety and moving and handling. The management team undertook night visits to the service to ensure the service was safe at night. Actions were identified as a result of audits and actions were completed. For example, a care plan audit identified the need to ensure power of attorney documents were seen and this was completed. Following the audits there was no formal system implemented to

monitor and sign off as when the improvements were made which meant they were not consistently tracked to ensure sustainability and ongoing development. The registered manager told us they would implement a development and sustainability plan for the home. The provider told us they did not have a strategic plan in place but would look at this alongside the registered manager's day to day plan.

People and their relatives were encouraged to contribute and share any concerns or feedback they had through resident meetings, day to day conversations and regular feedback surveys.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify CQC of significant events. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to ensure accurate, up to date records. Regulation 17