Four Seasons 2000 Limited

Burgess Park

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17 December 2015 and was unannounced. Burgess Park is a nursing home that provides accommodation and personal care for up to 60 people, some of whom are frail and live with dementia. At the time of the inspection there were 32 people using the service.

There was no registered manager in post. 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 last time we inspected this service in July 2015, they were rated inadequate. A number of breaches in regulations were found. This included breaches relating to person-centred care, need for consent, safe care, and treatment, premises and equipment, good governance, staffing and notification of other incidents.

Summary of findings

During this inspection, we found evidence that the provider had made some improvements. The provider had employed a new home manager who had implemented some actions to improve the service. Some of the improvements we found included; person centred care, dignity and respect, need for consent, premises and equipment, staffing and notification of other incidents. However, further action is required to meet all the regulations we inspected.

The provider had safeguarding processes and guidance in place for staff to keep people safe from harm. Staff had an awareness of the signs of abuse and demonstrated how they would raise an allegation of abuse.

People had sufficient staff caring for them. Recruitment processes in place ensured the safe employment of staff to work at the service. Employment checks took place before staff worked with people.

The management of medicines were safe. Medicines were stored safely. There were completed records for the administration of medicines for people. There were processes in place for ordering, disposal, administration, and safe management of people's medicines.

Staff had received training, supervision, and appraisals to support them in their roles.

People gave staff consent to receive care and support. People had their care managed within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager understood their role for caring with people in line with the Deprivation of Liberty Safeguards (DoLS).

People had food and drink that they enjoyed. A menu was available for people to choose meals they liked. People had their nutritional needs met because staff understood and met them.

People had access to health care services when their health needs changed. Staff made referrals to health care professionals for further advice and guidance to manage their health conditions. Staff followed health professional's guidance and recommendations for people.

Staff treated people with kindness and compassion. We observed examples where staff engaged well with people and their relatives. Staff had made contact with people's relatives to involve them in making decisions and in the review of their care. People had their dignity and privacy respected by staff.

People contributed to the development of their care. People's assessment identified their needs and a care plan developed to meet them. Staff had guidance from people's care plans to ensure that care delivered was appropriate. Assessment were carried out on people's changing needs were and care delivered was flexible to meet their changing needs. People were involved and contributed to the assessment or review of their care.

People were aware of the process to follow if they wanted to raise a complaint. The majority of people we spoke with said they were happy with the service.

People and their relatives, gave feedback to the provider. The regional manager then analysed these, for areas of improvement a plan developed to improve the service. The majority of people reported they were happy with the care and service provided.

However, we found the provider had not made enough improvements to meet the regulations. There were continued breaches in in relation to safe care and treatment and good governance.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

Staff identified risks to people's health and well-being. However, we found, risks assessments associated with fire safety did not protect people. The manager had not taken appropriate action to manage fire safety risks at the service. Regular fire assessment and audits of the service took place and the provider identified areas for improvement, however, prompt action to resolve fire safety concerns did not happen. The provider had completed regular monitoring and review of the delivery of the service to ensure care delivered was accurate and

Summary of findings

met people's needs. However, they did not identify the areas of risk we found. At the time of the inspection, people who required them did not have appropriate fire evacuation equipment available.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not always safe. Staff protected people from the risk of harm and abuse. Assessments identified risks to people but did not always give guidance to staff on how to manage those risks. The manger identified but did not act on risks associated with fire safety at the service.

There were sufficient levels of staff to care for people. Recruitment processes were thorough. The provider ensured staff had employment checks before they worked with people.

Medicines were managed and stored safely.

Requires improvement

Is the service effective?

The service was effective. Staff received training, supervision, and appraisals to support them in their caring roles.

Staff sought consent to care and support from people. The manager and staff had an awareness of supporting in line with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had meals of their choosing that met their needs and preferences.

People had access to health care when required. Staff followed professional recommendations and guidance.

Requires improvement

Is the service caring?

The service was caring. People were encouraged and supported to access services and social activities. However, staff did not act promptly on a referral to local voluntary organisation.

Staff treated people with kindness and compassion.

People and their relative were encouraged to make decisions in the planning of their care.

Staff promoted people's privacy and treated them with dignity and respect.

Good

Is the service responsive?

The service was not always responsive. People were not always involved in the assessment or review of their care.

Staff acted on people's changing needs and people's care plans updated to reflect these changes.

Systems were in place for people to make a complaint or raise concerns.

Requires improvement

Summary of findings

Is the service well-led?

The service was not well led. The service undertook quality assurance of the service provision. However, action to improve the service did not always occur.

Staff understood the manager's expectation of them.

A new home manager oversaw the delivery of care to people.

Inadequate

Burgess Park

Detailed findings

Background to this inspection

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

This inspection took place on 17 December 2015 and was unannounced. Two inspectors, a pharmacist inspector, a social work specialist professional advisor, and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is in care homes for older people.

Before the inspection, we looked at information we held about the service, including notifications sent and a report of actions for improvements to the service. During the inspection, we spoke with 15 people using the service, one relative. We also spoke with the manager, three nurses, four care workers, a maintenance worker, and an activities co-ordinator. We spoke with a visiting health care professional. 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. We also observed people in the communal areas and the general environment of the service.

We reviewed 12 care records, 13 staff records, resident and relative satisfaction surveys, and 23 medicine administration records. We looked at health and safety records and other records for the management and maintenance of the service.

After the inspection, we contacted a commissioning and safeguarding officer from the local authority.

Requires improvement

Is the service safe?

Our findings

At our previous inspection on July 2015, we found that the service was not safe. Routine health and safety checks were not completed. People's medicines were not recorded safely or they did not receive their medicines as prescribed. Staff completed medicine audits daily in addition to monthly audits. However, these did not identify the areas of concerns with the management of medicines that we found. People's medicines were not handled appropriately. The environment was in a poor state of maintenance with peeling paint both externally and internally. Some people lived in an environment, which had an unpleasant odour of urine. We observed that staff did not wash their hands or use hand-cleansing gel when providing care and support to people with eating, assisting with drinks, or assisting people with their medicines. This increased the risk of cross infection for people. These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had made some improvements. We found people's medicines were managed safely, they were protected by the prevention, and control of infection and they lived in a well maintained of the environment. However, insufficient actions were taken to meet the regulations.

Staff kept people safe from harm and demonstrated awareness of the signs of abuse and actions they would take to report an allegation of abuse. Staff we spoke with were able to explain their responsibilities in detail including how they ensured people were protected from abuse by a robust whistleblowing policy and a mental capacity assessment that helped them understand the needs of each individual and their ability to make their own decisions.

People were cared for by sufficient numbers of staff. There were enough staff to keep people safe and staff responded to call bells promptly. Care staff we spoke with told us they felt staffing levels were safe although additional staff would help them respond more quickly to people when they used a call alarm or needed assistance. One senior care worker said, "Lots of people need two to one support for personal care so we are quite stretched if more than one person needs help to the toilet at the same time. It's safe, I'm sure of that, but we could give a better service with more staff."

People medicines were managed safely. We saw nurses giving people medicines in a safe and caring manner, taking time with people who needed it. However, on the morning of our inspection the medicines round on one floor took until 12:30, which meant that there was a risk people did not have their medicine on time. When we checked people's records, we saw that extra tests completed to check that one person who had received their insulin later than normal and pain relieving medicines administered as required. Staff had checked the person's health had not adversely affected by the late administration of their medicines. Nurses told us that when they began giving medicines in the home they worked with a colleague to shadow them. This was to ensure safe management of medicines and reduce the risks from medicine administration errors.

People had their medicines recorded safely. All medicine administration recording sheets (MARS) we looked at had photographs to identify the person, allergy information, specific information to support staff administering the medicines including for those prescribed 'as required' and audits to check the medicines left in stock. All MARS were completed at the time of administration with a signature for administration or code to show why a medicine had been omitted. Care staff that assisted people with their personal care applied creams and lotions. These were recorded by the care staff on a separate MARS. Care plans we looked at reflected people's treatment. For example, we looked at one for someone who was diabetic and could see that staff were following advice from the multidisciplinary team who looked after their care. We also saw that the local hospice supported staff to manage people at the end of their life. People had anticipatory medicines were prescribed and kept in the home in case people's health deteriorated.

Medicines were stored securely in locked cupboards and trolleys. New clinic rooms were being created on each floor and the first floor one was completed. We saw that the new rooms would allow increased secure storage and private work space to manage medicines safely. Appropriate records and checks were kept of all medicines. One person had not received their pain-relieving patch the day before our inspection. We checked the MARS and the medicine stocks and could see that it had been missed. Staff took appropriate action to reduce the impact of the missed

medicine, and they ensured the person had the medicine as prescribed. All other records and medicines we checked were correct and people were receiving their medicines as prescribed.

Staff acted promptly to identify risks to people. Staff used a 'clinical hotspots' card at the beginning of people's care plans to indicate risk that related to a health concern. For instance, one person who was at risk of choking and of malnutrition had both of these concerns indicated prominently on a card at the beginning of their care plan. The clinical hotspots cards were good practice to help staff quickly identify potential risks to people. However, risks were not immediately identifiable or reflected in all care plans. For example, the provider's policy stated all people should have a monthly dependency assessment. On two occasions, this was not completed. This meant that there was no accurate and current information, which guided staff on the level of support a person required to meet their care and support needs.

Risks to people were not managed safely. Maintenance records showed three-monthly 'essential checks' had been documented that included an inspection of escape routes and the general environment. The manager did not follow up concerns or problems found during their checks. For example, a previous check had found that there was no system in place for controlling the amount of combustible materials and flammable liquids in the premises but there was no documented follow up action. When the responsible member of staff was on holiday, there had been no interim plan to ensure such checks still took place.

There was a risk that people would not be safe in the event of a fire. Records of previous fire drills indicated an inconsistent response from staff. For example, in July 2015, the member of staff conducting a fire drill had noted, "Staff slow to respond". Records stated staff had taken 25 minutes to find the location of the mock fire. Records stated that senior staff reminded staff to respond promptly when they heard the fire alarm.

A fire exit on the ground floor had a part missing and there was a pencil inserted into the door release. The missing part was an essential component to its emergency release system. We spoke with the maintenance staff about this. They told us, the part required to fix the door was on order from a local supplier. There was a risk that people would not be able to exit via the fire exit in the event of a fire.

People were at risk in the event of a fire because appropriate equipment was not available.

Each person in the home had a personal emergency evacuation plan (PEEPS) that included an assessment of his or her level of mobility and how much support he or she would need to leave the building in an emergency. The PEEPS had been updated in the six months leading to our inspection but contained information to staff that was inconsistent with equipment available in the building. We looked at six PEEPS that stated staff could assist the person to evacuate by using the evacuation chairs and sledges that were located at the top of each set of stairs. We looked at the top of the stairs in the building and found that there was no evacuation equipment in place.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in July 2015, people did not receive effective care. We observed that the training staff completed was not put into practice to meet the needs of people. Staff received supervisions but appraisals were not completed, The provider did not have an understanding of their responsibilities of how to care for people within the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Staff were unaware of the role of an independent mental health advocate (IMCA). People were not supported to make decisions regarding their health and care because their needs were incorrectly assessed. These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had made some improvements to the regulations. We found the provider had supported staff with their training, supervision, and appraisal. The provider had an understating of their role and responsibility within MCA 2005 and people were supported to make decisions regarding their care. However, the provider did not make all the required improvements to meet the regulation.

People were cared for by staff that were supported with their training, supervision, and appraisal needs. Staff had supervisions on a regular basis and a plan in place to complete appraisals. Staff told us that they had supervision from their line manager and were able to discuss their training needs and any concerns they had in their caring role. We saw examples of this in staff records, there were targets set for action to be completed. Staff skills and knowledge improved with guidance available to them. For example, staff completed training in dignity and respect. Training records showed that staff had completed mandatory or refresher training when required. Staff records had details of their completed training. People were supported by staff that had the opportunity to identify their training and professional development needs to enhance their caring role.

People gave their consent to receive care and support. Records showed that people gave verbal and written consent, which were decision specific. For example, people gave permission and consent for staff to have bed rails in place and they or their relative signed this. People made choices on the care received and gave informed consent to staff that supported them. People had mental capacity assessments completed to ensure they were able to provide informed consent.

Staff cared for people in line with legislation to reduce the risks associated with the unlawful deprivation of their liberty. The manager and staff had an understanding of how to care for people in line with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Referrals for and application under DoLS were made promptly to the local authority to consider an application for Deprivation of Liberty Safeguards (DoLS).

People had meals, which met their needs and preferences. For example, we observed the lunch service for people on the second floor of the home who were unable to eat in the main dining room. We saw that before people had their lunch staff checked and recorded its temperature to ensure it was within safe serving limits. Staff we spoke with during lunch told us that people were able to request culturally appropriate food. We observed when people requested this it was provided. Halal, Kosher and vegan food was available on request and at short notice. We saw that staff had a friendly and kind approach to people who ate in their bedroom and were able to encourage them to eat. For example, care workers greeted the person by name and told the person what was available for lunch. They said, “It’s a lovely lunch, look – I know you’ll enjoy it – try a bit.” The care worker’s interaction with the person had a positive impact and we saw that they were able to support the person to enjoy their lunch.

People had access to healthcare support when needed. For example, staff informed the GP when a person required a visit from them. Staff made a referral for specialist advice when needed. For example, staff made a referral for healthcare professional input when a person’s swallowing became difficult and impacted on their eating. Staff had worked with a dementia specialist to help understand the needs of a person who had become unable to communicate verbally. The assessment had indicated that the person could sometimes communicate in writing and staff left a pad of paper and pen within their reach at all times. We saw that a notice in the person’s bedroom to remind staff to leave the pad and pen within reach. During

Requires improvement

Is the service effective?

our inspection the pad and paper was on a table at the other side of the room from the person's bed and was not in reach at any time. We spoke with staff about this and they placed the pen and paper closer to the person.

Staff followed professional guidance for a person with a complex health condition. For example, a specialist nursed advised that the person needed regular repositioning during the day. The professional guidance was in place for staff. We checked the person's care records and found this recommendation in place. Their care records detailed what actions staff should take to support the person's health condition. Staff recorded actions they took or discussions they had with the district nurse or diabetic clinical specialist. Staff had taken actions to reduce the risk of the deterioration in health for the person.

Good

Is the service caring?

Our findings

At our previous inspection in July 2015, we found the service was not caring. Staff did not encourage people or their relatives to make decisions or to be involved with the planning of their care. Assessments focussed on the completion of tasks, such as weighing people, completing daily food charts, call bells and bed rail checks. The assessments for people were not person centred because they did not include their likes, dislikes, how they would like their care provided and what was important in their lives. These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff did not treat people with dignity and respect at all times. We observed staff did not understand people's cultural needs when providing care and support for them. These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements to the service, which met the regulations. We found people and their relatives were involved in decision about their care. For example, people told staff about their likes and dislikes, these were included in their assessments and care plan. This ensured people received care that met their needs and cared for in a way that they wished. Regular checks occurred as required and staff treated people with dignity and respect. Staff considered people's cultural needs when providing care to them. All people and relatives we spoke with said staff met their needs. One person said, "I am very well looked after" and another person said, "We're looked after all right". A relative told us, "They really care about my relative and they tell me how they are doing".

Staff showed people kindness and compassion. Staff responded quickly to assist people when required. For example, a person called for help and staff responded promptly to attend to the person's needs. Staff chatted and laughed with people and engaged well in conversations with them. One person told us that they knew the care workers well and said "staff were lovely". Staff managed and responded swiftly to people's concerns.

People had the dignity and privacy that they needed. For example, staff provided care for people in the privacy of their own rooms. Staff respected people's wishes to remain in their rooms during the day of their choosing. We observed staff seeking permission to enter people's bedrooms by knocking on their door. People could be confident that staff treated them in a way, which valued them.

People were encouraged to maintain relationships that mattered to them. We spoke with people who told us that their friends and relatives were welcomed to visit them at the service. People told us, they were able to maintain links with the local church. A priest came regularly and there were visitors from the local church. There was a Mass weekly on the activity programme and people had the opportunity to take part in religious ceremonies with other people on their own in their rooms if they wished. Staff supported people to maintain their links to their local community thereby reducing the risk of social isolation.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection on July 2015, we found people and their families did not always contribute in the planning and delivery of their care. People's assessments had missing information and were incomplete. Their needs were not accurately assessed and at risk of receiving inappropriate. People did not have activities provided for them that met their interests. These issues were in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found some actions taken by the provider improved the quality of care. People contributed to their assessment and their health and social care needs assessed and managed.

Before living at the service staff assessed people's needs so appropriate care and support was in place for them. People had regular reviews of their assessments and care plans. Their care records were personalised and detailed the personal histories and their likes and dislikes. Care plans were reviewed regularly in line with the provider's care plan policy. The manager had been proactive in encouraging the involvement of relatives in reviews. Staff supported people to contribute to their reviews. People's personal care choices informed the planning and delivery of care. We saw that each person had a detailed 'pen portrait' displayed in their bedroom that included information about their life and what they wanted staff and visitors to know. This meant that staff could understand what was important to people if they found it difficult to communicate. We asked care workers about this. They told us, "We sit down with each person when they move in and help them write their own life story. If they can't communicate, we involve their closest friend or relative who helps us write this with them."

People had activities provided which they enjoyed. Staff encouraged people to take part in activities that took place in the activities craft room. For example, we observed people taking part in a craft activity with care staff supporting them with it. People appeared to be enjoying the activity and laughter and discussions were taking place. People appeared to enjoy listening to music and some people were singing along with the songs playing on the radio. Staff supported people to use the garden when they chose. People and their relatives had been encouraged to attend social events provided by the home, such as barbecues and tea dances. The service had activities which people enjoyed and met their interests.

However, care workers told us care was not personalised to meet all peoples' social needs. For example, people took part in activities if staff took them where activities took place. One care worker told us, "The people who are stuck in their rooms need more one-to-one time with staff for stimulation. We need some dementia-friendly activities or even just some audio books." Another care worker said, "People who want to take part in a scheduled activity have to be ready for 9am when activities begin." A person's care record reflected the concerns of the care workers. An entry in their records stated, "[We are] looking at getting more sensory items so that [person] will get a bit more enjoyment." We spoke with the member of staff on duty about this. They told the person did not have the suggested equipment in place. Their person's care records did not detail action taken by staff to arrange for specialist equipment for the person. We found this at the last inspection and staff had not made improvements to social activities for people who were unable to access the activities provided. People were at risk of social isolation due to a lack of individualise social activities for them.

We recommend that the service seek advice and guidance from a reputable source, regarding how to provide social activities for all people using the service.

There was a system in place for people to complain about the service. Staff had and awareness of the service's complaints policy and were able to support people in its use if needed. People we spoke with said that they did not have any complaints about the care or the service.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in July 2015, the service was not well-led. There was no registered manager in post. The provider did not keep the Care Quality Commission (CQC) informed of incidents, which occurred at the service. The provider had arranged for regular internal audits on the quality of the service. Audits did not find or manage risks associated with the management of people's medicines, which we identified. Care delivered to people was not monitored and no action taken to make improvements promptly. People and their relatives gave feedback to staff. The manager analysed their comments, however, there was no process in place to ensure all people living at the service provided feedback. People's records were not regularly audited therefore the accuracy of people's assessments could not be assured. These issues were in breach of regulation 17 (CQC Registration) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made some improvements to the service. The provider had employed a home manager to manage the service on a daily basis. The manager kept the CQC informed of notifiable events, which occurred at the service and took action to resolve them. For example, when the lift in the service was broken the provider took prompt actions to fix it and CQC received a notification. Regular monitoring and reviews took place to improve the quality care for people. However, the provider did not make all the required improvements to meet the regulation. We found new and continued breaches of regulation 17.

Regular audits of the service took place to monitor and review health and safety. The findings from a health and safety audit did not manage and act on risks associated with fire safety. For example, the audit found fire safety risks, and a proposed action plan was developed to resolve them. The audit identified that the lock on the fire exit door was broken and needed repairing. The maintenance worker told the manager and recorded this finding. However, the manager had not taken action to arrange for the repair of the lock. Therefore, people were at risk of harm because repairs to the fire exit door had not happened. This increased the risk that people would be unable to use the fire exit door to evacuate the building in the event of a fire or in an emergency.

A second finding of the fire safety audit identified that fire safety equipment for people who needed them should be available. The fire safety audit also found that people needed fire evacuation chairs. The maintenance worker told us and records confirmed they had made a request to the manager following health and safety meetings held on 8 July 2015 and 17 September 2015 to purchase fire evaluation chairs. We spoke to the manager about this at the time of our inspection; they told us they had ordered the fire evaluation chairs. We asked the manager for and we received confirmation of the order. The date of the order was 22 December 2015, after the date of our inspection. This meant people were at risk from harm because the provider did not have suitable equipment to assist people to exit the building in the event of a fire or an emergency and had not acted promptly to put these in place.

People were at risk because the service did not carry out regular health and safety checks. We looked at the fire safety records book. Three-monthly 'essential checks' had been documented, for example, the inspection of escape routes, and the general environment. We asked the maintenance worker for the arrangements to ensure such checks still took place when they took annual leave. They told us there was no interim plan in place. Records showed that there had been periods of up to three weeks where no checks took place of the fire safety systems in the home. We asked the manager about this. They told us, a colleague from another of the provider's homes would visit to complete those checks. We asked for a copy of this interim plan, we did not receive this. People were at risk from harm because arrangements for regular essential safety checks did not happen; improvements were not identified and actioned as necessary.

People's care records were not routinely monitored and reviewed. We found that there were gaps and missing information in people care records. We asked the manager for a copy of the outcome of the service's care plan audit. The manager told us that audits of people's care records did not take place; therefore, a report was not available. People were at risk of receiving inappropriate care because staff did not review and monitor care records for their effectiveness and accuracy. These issues were in breach of regulation 17 (CQC Registration) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. CQC

Inadequate

Is the service well-led?

is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

The manager encouraged open and clear communication with staff. Staff we spoke with told us they felt more supported since a new manager had started in the home and they felt she was approachable. One care worker said, "The new manager is very approachable. She's pleasant and the deputy [manager] is great too, they're a good team, both very helpful." Another care worker told us, "Weekends are much less stressful since the new manager started. We had a chat about the high levels of sickness amongst care staff on a weekend and she implemented plans to change this straightaway. Since then it's much better."

Staff had an awareness of their role. Staff told us, they were happy with the recent changes in the management of the service. Staff told us, they felt more involved with the development of the service and the manager considered their opinion and views. For example, some staff felt able to discuss their concerns with the manager. Staff we spoke with told us they were confident that the manager would listen to and act on their concerns.

Staff were encouraged to participate and contribute to team meetings. The manager held daily senior management meetings and regular staff team meetings. Staff had the opportunity to discuss issues and concerns at the service and strategies to manage them. Care staff told us that the care team had stabilised with the start of a new manager. They told us, agency staff were used less often, sickness levels had reduced and mandatory staff meetings were organised every one to two months.

There were quality assurance systems in place. The staff team undertook internal audits on the quality of care and support, food, activities and the home environment. These identified areas of concerns and developed an action plan from this. For example, a senior member of staff on duty undertook audits of the service during a daily walk around the service. People were encouraged to discuss any concerns or issues they had and a record of these with the actions taken and recorded. This provided staff with the opportunity to identify areas of concern and implement solutions so people received a quality service.

People's records were stored securely. A locked filing cupboard kept people's care records. Staff kept people's personal and private information safe and only those with authorisation had access to these. Staff had access to people's records when required.