Four Seasons 2000 Limited

Woodview

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on 11 February 2015 and was unannounced.

Woodview is registered to provide accommodation and personal care for up to 63 older people or people living with a physical disability. There were 49 people living at the service on the day of our inspection. The service is divided into two areas, Woodview for older people and people living with dementia and Greenwood for people living with a physical disability who require nursing care.

There was 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.

At the last inspection in July 2014 we asked the provider to take action to make improvements to respecting and involving people, to their care and welfare, safeguarding them, cleanliness and infection control and how they ensured the quality of the service. The provider sent us an action plan and told us that these actions would be completed by October 2014. On this inspection we found that the provider had made improvements.

Summary of findings

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves or others. At the time of the inspection the registered person had made referrals to the local authority for DoLS authorisations.

People felt safe and secure and staff knew what action to take to report any concerns about the safety and welfare of people in their care. However, we found that there was not always enough staff on duty to respond to people's needs in timely manner. We also found that the management of people's medicines was not robust.

People were looked after by kind and caring staff who supported them to have nutritious and well-presented food. We found that there was a menu choice and the availability of snacks and hot and cold drinks to ensure that people always had enough to eat and drink.

People had a good rapport with staff who treated them with dignity and respect. We found that people had their care planned in line with their individual needs and preferences.

People were supported by designated activity coordinators to take part in hobbies and pastimes of their choice. People told us that they enjoyed being involved in the local community and maintaining contact with family and friends.

Staff were not happy in their work and told us that the registered manager was not always approachable. Although the provider had made some improvements to their quality assurance processes, these were not always effective.

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?
The service was not always safe.

There were not always enough skilled and experienced staff on duty to respond to people's needs in a timely manner.

Staff did not always follow correct procedures to administer medicines safely.

Requires Improvement

Is the service effective?
The service was effective.

People were supported to have enough to eat and drink and have a balanced diet.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had received appropriate training, and had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards

Good

Is the service caring?
The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Good

Is the service responsive?
The service was responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were encouraged to maintain their hobbies and interests and supported to maintain links with the local community.

Good

Is the service well-led?
The service was not always well-led.

Staff were unhappy at work and did not always find the registered manager approachable.

We found that although audits had been undertaken, it was unclear what actions had been taken to make improvements.

The provider sought the views of people who lived at the service and their relatives to make improvements to the service.

Requires Improvement

Woodview

Detailed findings

Background to this inspection

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

The inspection took place on 11 February 2015 and was unannounced.

The inspection team was made up of two inspectors, an expert by experience and a specialist professional advisor. A specialist professional advisor is a person who has expertise in the relevant areas of care being inspected, for example, nursing care. We use them to help us to understand whether or not people are receiving appropriate care to meet their needs. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection we looked at previous inspection reports and other information we held about the provider

We looked at a range of records related to the running of and the quality of the service. This included staff training information and staff meeting minutes. We also looked at the quality assurance audits that the registered manager and the provider completed which monitored and assessed the quality of the service provided. We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspection

During our inspection we spoke with the registered manager, the area relief manager, two registered nurses, two housekeepers, six care staff, the chef, and the activity coordinator. We also spoke with 13 people who lived at the service, three visiting healthcare professionals and six visiting relatives. We also observed staff interacting with people in communal areas, providing care and support. Following our inspection we spoke with another activity coordinator by telephone.

We looked at the care plans or daily care records for nine people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We asked the local authority and commissioners of healthcare services for information in order to get their view on the quality of care provided by the service

Requires Improvement

Is the service safe?

Our findings

During our inspection in August 2014 we found that the registered person did not ensure that service users and person's employed for the purpose of carrying out the regulated activity and others who may be at risk of exposure from carrying on of the regulated activity were protected against acquiring an infection because they did not maintain appropriate standards of cleanliness and hygiene. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had been made. For example, damaged commodes and shower chairs had been replaced, the housekeeper's room and sluice had been upgraded and a cleaning schedule and audit programme had been introduced.

Overall, we found that the provider had made sufficient improvements and was no longer in breach of the regulation.

We also found during our inspection in August 2014 that the registered person did not always make suitable arrangements to ensure that service users were safeguarded against the risk of abuse by taking reasonable steps to identify the possibility of abuse and prevent it before it occurs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had been made. For example, staff were now familiar with the safeguarding policy and knew what action to take if a person was at risk of abuse. Care staff told us they had undertaken safeguarding training and were able to identify the signs of abuse and the action required if they had cause for concern. They said that they would initially report it to the nurse in charge or the registered manager. Staff felt confident that their concerns would be acted upon, but said they would escalate their concerns beyond the registered manager if they felt they were not being listened to.

All areas of the service that we looked at were clean. People told us that they thought the home was clean. One person said, "Everyday my room is cleaned." The duty rota identified that there were five housekeepers on duty each day. We spoke with a housekeeper who said that they were able to complete their daily cleaning schedule. They added that there were enough housekeeping staff to complete the monthly deep cleaning rota for each bedroom and keep up to date with other non-scheduled cleaning duties. One housekeeper had been appointed as the infection control lead for the service and told us that this had a positive impact on staff and people.

The registered manager told us that since our last inspection the standard of cleanliness had significantly improved and the risk of spreading infection had greatly reduced. One contributing factor was that people now had moving and handling equipment allocated for their own use.

There was a daily cleaning checklist for clinical equipment such as blood glucose monitoring machines and a night time cleaning checklist for wheelchairs and other moving and handling equipment. Records confirmed that these checks had been completed.

Overall, we found that the provider had made sufficient improvements and was no longer in breach of the regulation.

People told us that they felt safe. One person said, "No people can get in from outside, I feel safe." We found that this person was making reference to the digital locks fitted to all external doors.

We saw that people had risks to their wellbeing assessed when they moved into the service and these risks were regularly reviewed and any changes to their needs recorded in their care plan. For example, we saw where a person was at risk of developing skin damage due to their inability to move independently that their care plan recorded that they needed assistance to change their position frequently. Furthermore, we found that staff had a re-positioning chart to record these changes and this had been completed regularly. Where a person was receiving oxygen therapy there was a sign on their bedroom door alerting others that oxygen was in use.

There were not always enough staff to meet people's needs. For example, we found that call bells rang for long periods of time before they were answered. People told us

Is the service safe?

this was a common occurrence. One person said, "At night time the call bells do go a lot, I have got used to it and I go off to sleep." Nursing and care staff said that they felt there were not always enough staff on duty to provide the care that people required. We found that when a member of staff was on sick leave or annual leave attempts were made to cover their duties by asking staff to work additional hours. However, staff told us this was often unsuccessful and staff from Woodview would cover Greenwood for a couple of hours and vice versa. One staff member said, "Last minute changes to staffing rotas happen with no explanations." They said this impacted on the rest of the team. Several people expressed concern about the number of staff on duty, their heavy workload and skill mix. One person told us, "Could do with more [staff] don't think there's enough."

A registered nurse on secondment from an agency told us that they felt the skill mix was an issue. They said this was because the home had recruited a lot of new staff and due to a high staff turnover; they were promoted very quickly whilst they were still relatively inexperienced. This meant they lacked confidence and were more liable to make mistakes and this was not taken into account when mistakes occurred. We found that 36 staff had left their post in the previous nine months. People were aware of this issue and one person said, "Losing good staff and I don't know why, it worries me."

Records showed that appropriate checks including two references and a disclosure and barring service check were completed before staff started work at the service. We found robust checks were also undertaken with agency staff and the registered manager liaised with the agency for confirmation that the staff member had the knowledge, skills and security clearance to undertake their role. Furthermore, agency staff were provided with the provider's staff induction pack.

People told us that they understood what their medicines were for. People had care plans with information about the medicines they were prescribed, why they took them and some had special advice to guide staff to administer them safely. For example, we saw where a person received medicine which slowed down their heart rate; there were instructions about monitoring their heart rate and the action to take if it dropped below a certain level. However, we found that when people were prescribed medicine through skin patches the manufacture's guidance on how often it was safe to use the same skin site was not being followed. This put some people at risk of developing sore or damaged skin on over used sites.

We looked at the safe storage of medicines and found they were stored in accordance with requirements. All medicines were stored in locked cupboards, medicines trolleys or fridges. Daily fridge temperature checks had been recorded and were found to be within acceptable limits. We saw there were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner.

We spoke with a registered nurse who told us that they had their competency assessed prior to administering medicines when they first started work at the service and was reassessed annually. They said they had completed a competency assessment within the previous six months. Furthermore, a registered nurse on secondment from an agency told us that they had undertaken a competency assessment for administering medicines at the service, but would undertake an additional assessment before they were able to order medicines.

We looked at the medicine administration records (MAR) charts for 18 people and found that most people were given their medicines as prescribed. We saw where a medicine was omitted that a standard code was used to give the reason for this, such as when the person was asleep. However, three people did not receive their medicines as prescribed as they were regularly asleep and no action had been taken to ensure that these people were able to have their medicines at a time that met their needs.

We observed two registered nurses undertake the medicines administration rounds and saw that they took steps to maintain the safety of medicines in locked medicines trolleys. We saw that MAR charts were referred to before they administered the medicines. However, we found that staff did not follow the correct procedure for administering medicines. We observed that one staff member signed multiple MAR charts after all of the medicines had been given and the other staff member signed MAR charts before giving people their medicines.

There was a risk that people who had been prescribed medicines on an as required basis may not have had these

Requires Improvement

Is the service safe?

medicines given in a consistent way by the registered nurses. We found that people's records had insufficient information to show the nursing staff how and when to administer these medicines.

Good

Is the service effective?

Our findings

People and their relatives told us that they thought that nursing and care staff knew what they were doing and were able to meet their needs. One person said, "I have everything I need."

We found that new staff were supported through a period of induction. One recently appointed staff member told us that they shadowed other staff for a few weeks until they felt confident to work independently and were familiar with the needs of the people they cared for. They also told us that they had a staff induction book and a training pack to work through.

Staff were supported to undertake mandatory training once a year in key areas such as moving and handling and fire safety. The registered manager told us that some care staff had undertaken an intensive training programme that provided them with advanced care skills to enable them to deliver specialised care to people with complex health care needs. For example, some staff had developed skills on the management of feeding tubes for people who were unable to swallow safely.

We looked at the supervision and appraisal timetable and saw that most staff had regular supervision once a month. In addition, staff could attend group supervision sessions on a range of subjects to support their role. The last session for care staff was about effective record keeping and was attended by eight staff. In addition, a group supervision session for registered nurses on effective pain management had resulted in nursing staff referring people to their GP to have their pain relief reviewed. However, feedback from staff on their experience of supervision was not always a positive one. One staff member said, "I don't know how she [the registered manager] can supervise me, she doesn't know me."

Several people had a care plan that focussed on their human rights and consent to care and treatment and gave an overview of the person's ability to make specific decisions and the ways in which their participation in decision making could be maximised.

We spoke with the registered manager and nursing and care staff about their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. We saw there was a policy to guide staff in the DoLS and MCA decision making processes. We saw that capacity assessments had been undertaken in a person's best interest for living at the service, receiving medicines and personal care. Staff told us that they had received training on MCA and DoLS.

We saw where one person lacked capacity to give their consent to care and treatment that their next of kin who was also their lasting power of attorney signed consent on their behalf. A lasting power of attorney is someone registered with the Court of Protection to make decisions on behalf of a person who is unable to do so themselves. We saw that staff sought consent from people for the safe use of bed rails and to have their photograph taken for identification purposes and this was kept in their care file.

We found that some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. Some people had a do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly. Most DNACPR orders indicated that the decision had been discussed with the person. However, we found that some people did not have capacity to make the decision themselves and there was no evidence that a mental capacity assessments and best interest decision meeting had been undertaken.

People told us that there was always enough to eat and drink and they were always given a choice. One person told us, "The food is nice, it is always hot and we have a choice of what we would like. I enjoy the food." Another person told us, "Pork chops today, the meals are good." We saw people were offered a choice of hot and cold drinks and snacks between meals. One person said, "I am not a big eater, but I can always have a snack when I want."

There was a notice in the main reception area informing visitors to the service that 'protected mealtimes' were practised. This meant that interruptions at mealtimes were kept to a minimum so as a person's dining experience was

Good

Is the service effective?

not disturbed inappropriately. However, we saw that where a person would benefit from their relative supporting them at mealtimes that they were encouraged to participate. One relative said, "We have been offered meals too."

We saw where a person with swallowing difficulties had their food pureed that their meal was well presented and they were offered gravy with their meal. We spoke with their relative who told us that the chef was very good. They said, "The chef gives alternatives, we've discussed her likes and dislikes."

People were offered a choice of condiments, sauces and gravy with their meal. Care staff enabled people to eat their lunch independently and we saw some people had their food cut into bite size pieces. We saw that other people who needed more support to eat their meal ate at their own pace and lunch was not rushed. However, we observed one member of care staff stand over a person to assist them to eat. Another staff member challenged their behaviour and the staff member sat down to assist the person. People were offered a choice of drink with their meal.

Several people had their food and fluid intake recorded on a special chart; this meant that staff could monitor their intake to ensure that they had enough to eat and did not lose weight or become malnourished. We saw where two people were unable to take food and drink orally they received all their nutrition and hydration needs and medication through a special tube inserted directly in to their stomach. Care staff told us that they were supported by a dietician and the person's GP to manage this process effectively.

People were supported to maintain good health and had access to healthcare services such as their GP, district nurse, dentist and optician. We saw that people and their relatives had access to a range of information leaflets on health related issues such dementia.

We observed that staff worked closely with external agencies. For example, we observed two wheelchair technicians fit a new seat pad to a person's wheelchair. They explained to a member of care staff how to use the wheelchair effectively so as the person gained maximum benefit from it. Another person had a visit from a dietician who reviewed their nutritional intake.

Good

Is the service caring?

Our findings

During our inspection in August 2014 we found that the registered person did not always make suitable arrangements to ensure the dignity, privacy and independence of service users and did not always treat service users with consideration and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had been made. For example, staff had undertaken dignity training, dignity matters were covered at staff meetings and the service had nominated dignity champions. Dignity champions are members of staff who have the knowledge to support colleagues to deliver dignified care. Throughout our inspection we observed staff treat people with dignity and respect. For example, when a member of staff spoke with a person who had difficulty speaking, they gave them time to reply. Furthermore, we saw that people who lived in Greenwood were encouraged and enabled to maximise their independence.

Overall, we found that the provider had made sufficient improvements and was no longer in breach of the regulation.

We found that recent changes to practice meant that within one week of a person moving into the service they were allocated a named nurse and a key worker. The named nurse and key worker were responsible for undertaking all risk assessments and care plans and getting to know the person's likes and dislikes. We found that they worked with people to identify and record their choices and preferences. Furthermore, we saw that risk assessments were reviewed once a month and any necessary changes were made to their plan of care.

People spoke highly of the service. One person said, "These people have kept me going." Another person said, "Fantastic, couldn't grumble at all." Relatives also spoke positively about the care their loved one received. One person's relative said, "Staff are wonderful, try very hard, work as a team." Another relative told us, "The home is very good, the staff are good and the staff nurses are excellent."

We saw that people were treated with kindness and compassion by staff. There was a good rapport between people and staff and people were treated with dignity and respect and made to feel that they mattered. For example, we observed care staff respond sensitively to a person who had become agitated and frustrated because they thought that another person was laughing at them. Care staff sat with the person and quietly calmed them. We saw recorded in one person's care file that they preferred to be called by a nickname rather than their given name. We observed staff acknowledge their preference and call them by their chosen name.

We found that people had care plans developed to meet their individual needs. People and their relatives told us that they had been involved in their care plans and staff had listened to what they felt their care needs were. One person said, "I feel listened to. Staff always react to my needs straight away." One member of care staff said the reason they liked working at the home was because, "Everybody cares so much."

Leaflets on the role of the local advocacy service were on display. These provided care staff and people with information on how to access an advocate to support a person through complex decision making, such as permanently moving into the care home.

People's bedrooms were personalised with items of furniture, pictures and ornaments and people told us that staff respected their space. One person said, "It helps me. It doesn't feel like a care home." Another person said, "Staff always knock before they come in."

The registered nurse said that they tried to serve the morning drinks when they were able to as it gave them the opportunity to speak with each person and take the time to talk with them. They said, "I know then that I have spoken to everybody."

We observed care staff attended to people's needs in one of the lounges. One person wanted to read their book and a staff member fetched their glasses for them. We watched staff interact with a person who had limited mobility to transfer from their armchair to their wheelchair using a special standing aid. We saw that care staff explained what they were going to do and constantly checked that the person felt supported.

Good

Is the service responsive?

Our findings

During our inspection in August 2014 we found that the registered person did not take appropriate steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe because they did not planning and delivery of care did not always meet individual service users' needs or ensure the welfare and safety of service users. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had been made. We found that people had their care needs assessed and personalised care plans were introduced to outline the care they received. For example, we saw where one person who was at risk of social isolation was supported to attend a keep fit class in the local community centre. We found another person was at risk of falling. Their care needs were reassessed and a standing hoist was introduced to help them transfer safely from their arm chair to their wheelchair. The person's care file recorded the revised risk assessment and action staff would take to support their care needs. In addition, people had a daily care record that recorded the care they had received that day.

Overall, we found that the provider had made sufficient improvements and was no longer in breach of the regulation.

Several people told us that they enjoyed being busy and doing the things the liked to do. For example one person said, "I get a bit lonely and welcome attending my ladies group once a month." Another person said, "It's nice to get a change of environment. It's nice when they take you out. I'm looking forward to the holiday that's coming up soon."

We found that people ordered their choice of meal the previous day and most people we spoke with could not remember what they had ordered for lunch. There were no written or pictorial menus on display in the dining rooms to help jog people's memory or to inform of the choices that were on offer.

We spoke with the chef who explained that there was a four week menu plan and food choices were discussed with people at residents and relatives meetings. Furthermore, they had introduced speciality evenings such as a 'pub' themed night and a meal in celebration of the Chinese New Year. The chef said, "These go down very well with the younger residents."

People took part in a range of group and individual activities and pastimes and were given a choice of how and where to spend their time. We saw that one person had a personal weekly activity programme on display in their bedroom that enabled them to plan for the week ahead. We were told that the following week's activity programme was handed out on a Friday and that people were involved in planning the programme.

We spoke with the activity coordinator who explained how activities were tailored to meet people's individual needs and preferences. They told us that they had an activity year book that helped them plan events that related to key dates such as making pancakes on Shrove Tuesday and paper lanterns for the Chinese New Year.

We saw that support was given to people with complex health needs to take part in activities. For example, one person received one to one support from an artist several times a week. Other people were supported to maintain contact with the local community and one person travelled by taxi to their monthly fellowship meeting and others attended social events in the village hall.

The local football club visited once a week and providing a variety of activities to help promote people's physical fitness such as curling. The activity coordinator said, "The group that come are very good at getting the residents involved and they are very enthusiastic, and they get to know the residents names and who likes which games."

We saw where a person was unable to take part in group activities that staff supported them to feel involved. For example, during a group activity in the afternoon one person was wearing a special apron that had different objects sewn into it such as buttons, buckles and zips. A member of staff explained that this was specially developed with different tactile items for the person to touch to help them feel occupied and relaxed.

Staff told us that if a person raised a concern or complaint with them, they would try to deal with it themselves, but if it was complicated then they would escalate the concern to the registered manager. We saw that staff received feedback at team meetings on complaints that had been received and investigated and lessons were learnt.

Good

Is the service responsive?

We saw that there was a complaints policy and that complaints were responded to in a timely manner. For example we saw that one complaint has been investigated and responded to within 48 hours. There was a flow chart that recorded the complaint and action taken to resolve.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in August 2014 we found that the registered person did not protect service users, and others who may be at risk, against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of service provided in the carrying on of the regulated activity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had been made. The emergency contingency plan had been updated to reflect the action to be taken in an emergency situation. We saw that a programme of regular audit had been introduced for medicines, infection control and care plans. In addition, a quality improvement action plan had been introduced in January 2015 to address key topics such as staffing, consent to care and treatment and dignity.

Overall, we found that the provider had made sufficient improvements and was no longer in breach of the regulation.

One person told us that they were involved in staff interviews and attended staff meetings. They said the benefit of this was that the perspective of people who lived at the service was taken into consideration. They told us that they had seen improvements in the service since our last inspection, but did not provide any details.

The provider's mission statement, with aims and objectives was clearly visible in several areas of the service. However, the provider was aware that there were discrepancies with the quality of service provided and a self-imposed embargo on new referrals to the service was put in place two weeks before our inspection. We were informed that this was to enable the management team to assess shortfalls in the service for themselves.

We found that staff were not always happy in their work and did not have confidence in the way the service was managed. For example, some staff expressed significant concerns about the culture in the service and the impact on their own health and well-being. One member of care staff said, "This place is unbearable. It needs a reset button, someone needs to come in and press it so we can start again. I don't sleep before I come to work." However, some staff did report that they had a good relationship with the registered manager but were aware that others did not.

Several staff members asked to speak with us 'off the record' and said it was because they were frightened they would be identified as they felt scared and bullied by the registered manager. One senior member of care staff explained to us that poor staff morale and leadership was having an impact on the standards of care and people were aware. They told us, "This is not a good place to work the manager is not approachable. There is short notice rota changes, lots of staff have left, training is cancelled, residents meetings have lapsed or she doesn't turn up. And we only have time for the basics. Residents have complained that they are not getting the care they want."

A visiting healthcare professional had concerns about leadership in the home and told us that there was a gap between staff and management. We were informed that the post for deputy manager for Greenwood had been vacant for several weeks and the registered manager was overseeing this vacancy.

We found that leadership was reactive rather than proactive. For example, over thirty staff had left their post in the previous 12 months. We raised the high staff turnover in with the registered manager who told us that a lot of staff had to be performance managed and had been dismissed or voluntarily left there post.

The whistleblowing policy was accessible to all staff and was on display in staff rooms and in the main reception area. Staff told us that they were aware of the policy and new where it was kept. However, there had been no whistleblowing concerns raised in the previous 12 months despite several staff sharing their concerns about leadership in the home with the inspection team.

Staff said they were kept up to date through a range of meetings. They said there was a staff meeting every two months, monthly carers meetings, registered nurses meetings and weekly heads of departments meetings.

We saw infection prevention and control audits had been carried out on a weekly basis over the previous few months. These indicated compliance with most elements

Requires Improvement

Is the service well-led?

of the audits but where actions were identified it was not always clear whether or not these had been actioned. There were also signed sheets indicating that clinical equipment had been cleaned regularly.

We saw evidence of regular medicine management audits by the registered manager. Where areas of concerns had been identified, action plans were put in place to address these. Staff had access to detailed and comprehensive medicines handling policies that reflect the National Institute for Clinical Excellence (NICE) guidance, although we found that these policies were not always adhered to.

We saw that the registered manager held meetings for people and their relatives that were referred to as 'surgeries'. A surgery was held in Greenwood on the afternoon of our inspection.