Yardley Great Trust

Greswold House

Inspection report

76 Middle Leaford
Shard End
Birmingham
West Midlands
B34 6HA

Tel: 01217831816
Website: www.ygtrust.org.uk

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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**

Summary of findings

Overall summary

This inspection took place on 29 June 2017 and was an unannounced visit. We returned to the location on 13 July 2017 for an announced visit to meet with the registered manager as they were unavailable on 29 June 2017 and we needed some information that only they had access to. Following these inspection site visits, we received some information of concern. Therefore we returned to the home for a third time on 28 July 2017.

Greswold House is registered to provide accommodation and personal care for up to 29 older people, some of whom were living with dementia. At the time of our inspection, there were 28 people living at the home.

At the time of our last inspection in December 2014, we found the provider was meeting all of the requirements of their registration and the service was rated as 'Good' in all of the five areas that we looked at, namely whether the service was safe, effective, caring, responsive and well led.

At this inspection, we found that the some improvements were required to the safety and leadership within the home. People were not always protected against products that could be harmful to their health because the staff had not always maintained a safe environment. Some staff members did not always feel supported or listened to in their role and the providers quality monitoring systems had not always identified shortfalls that we found during the inspection.

At the time of our inspection there was a 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.

People and their relatives told us that people felt safe with the staff that supported them. Staff were knowledgeable about the actions they needed to take to protect people from the risk of abuse. Risks associated with people's health needs were managed safely. There were sufficient numbers of suitably recruited staff to meet people's needs. People received appropriate support to ensure they received their medicines as prescribed.

People received support from staff that were trained and supported to provide appropriate care. People were supported to maintain choice and control over their lives as far as possible so that their human rights to consent to care were maintained. People received support to have food and drinks that met their nutritional needs and personal preferences. Support was available to people to ensure their health needs were met in a timely way.

People and their relatives were complimentary about the staff that supported them. Staff cared for people in a caring and sensitive manner and people were supported to remain as independent as possible.

People and their relatives knew how to raise any concerns they had and there were systems in place to gather the views of people to ensure they were happy with the service they received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected against avoidable harm because the staff had not ensured that they maintained a safe environment.

People were protected from the risk of abuse because staff knew how to recognise when a person may be at risk and were aware of what the reporting procedures were.

People were happy with the support they received with their medicines.

People were supported by staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

People felt staff had the skills to support them appropriately with their needs and to ensure their rights were upheld.

People were involved in making choices about their care where possible.

People were confident staff would ensure that they were supported to access health professionals if needed.

Is the service caring?

Good

The service was caring.

People were supported by staff they had developed a good relationship with and who were caring and kind.

People's privacy, dignity and independence were promoted by staff.

Is the service responsive?

Good

The service was responsive.

People felt involved in the planning and review of their care.

People were happy with the care provided by staff.

People felt any concerns raised were taken seriously and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the safety and quality of the service were not always used effectively

Staff did not always feel supported or listened to by the management team and felt that communication systems within the home could be improved

People felt the management and staffing teams were accessible, approachable and responsive to their needs and/or concerns.

Greswold House

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 29 June 2017 and was unannounced. We returned to the location on 13 July 2017 to meet with the registered manager as they were unavailable during our visit on 29 June 2017 and they had access to information we required as part of the inspection process. This second visit was an announced visit because we needed to ensure the registered manager would be available. Following these two site visits, we received some information of concern about the care being provided to people. Therefore, we returned to the home for a third time on 28 July 2017; this time we visited during the early hours of the morning so we could speak with night staff. This third visit was unannounced and conducted by one inspector. The first inspection visit on 29 June 2017 was conducted by one inspector and an Expert by Experience. An expert by experience is someone who is deployed by CQC to support the inspection process. They are someone who has had experience of using or caring for someone who uses adult social care services, similar to the one being inspected.

Before our inspection we had asked the registered provider to complete and send us their Provider Information Return (PIR). A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the provider does well and any improvements they plan to make. However, due to some technical faults, we had not received this information ahead of our inspection.

We reviewed the information we held about the service and looked at the notifications the provider had sent us. A notification is information we receive about important events, such as accidents/incidents, deaths and safeguarding concerns, which the provider is required to send us by law. We also contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

As part of the inspection we spoke with eight people who lived at the home and one relative. We also spoke with 14 members of staff including the registered manager, deputy manager, three senior carers, six care assistants, a member of the catering team, a member of the laundry staff and a representative from an external learning and development agency deployed by the provider to support with staff training. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of five people to check that they received care as planned and also looked at medicine management processes and associated records. We looked at training records for staff and at three staff files to review recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety records, medication administration audits, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

During the inspection process, we received some information of concern which related to the safety of the people living at the home. We were told that people's safety was at risk because they had access to substances that were potentially harmful to their health, including cleaning products and medicines. The informant told us that there had been a 'near miss' incident at the home whereby one of the people living there had allegedly tried to eat a dishwasher tablet that had been left out in a communal area and due to this person's health condition, they would be unable to protect themselves from these risks and relied upon the staff and the provider to support them in maintaining a safe living environment.

When we visited the home on 28 July 2017, we found dishwasher tablets and a bottle of disinfectant stored in unlocked draws and cupboards on one out of the three units. This unit was described by the registered manager as the unit where people who had the most complex care needs including people living with dementia, and therefore were most at risk of environmental hazards. Staff we spoke with told us that this was a regular occurrence and the registered manager also confirmed that this had been raised as an issue in the past, but they thought it had been addressed. We also found medicines had been left in unlocked draws on the same unit. This meant that people had access to medicines that had not been prescribed for them and that could be harmful to their health. Some of the staff we spoke with told us that they had not noticed these medicines in the draw before but that they 'weren't surprised'. The registered manager told us that they believed these medicines had been 'planted' by a disgruntled member of staff. Immediate action was taken by the registered manager to ensure that these risks were addressed and an action plan was implemented and shared with us that aimed to prevent such risks reoccurring in the future.

A number of safeguarding concerns had also been raised with us about the safety of some of the people living at the home, which had been passed on to the local authority who were in the process of investigating the concerns raised. We have been told by the local authority, that the provider was working with them to assist them in their enquiries.

People and relatives we spoke with told us that they thought people were well looked after and were safe living at the home. One person we spoke with said, "There is nothing here to make me feel unsafe". Another person we spoke with told us, "If I didn't feel safe I would tell my daughter". A third person said, "I feel safe when the staff care for me". A relative we spoke with told us, "We trust the staff implicitly". Throughout the inspection we saw that people looked relaxed and comfortable in the presence of staff.

Staff spoken with were able to give examples of different types of abuse, the actions they would take if they suspected abuse and informed us that they had undertaken safeguarding training to protect people from the risk of abuse and avoidable harm. One member of staff said, "If we [staff] see anything like bruises or see or hear someone shouting at anyone like verbal abuse, or if someone seemed withdrawn or different, I would always report it to a senior member of staff or my manager. If a person told me anything of concern I would listen and explain to them that I have to tell someone in order to protect them and write everything down; I have never had any concerns here". Another member of staff also told us that they too would report any concerns that they had to the management team and that they were confident that these would be

escalated appropriately in keeping with the relevant safeguarding procedures. Training records we looked at confirmed that staff had received training in safeguarding people. We also saw that the provider had worked with the local authority when safeguarding concerns had been raised in the past.

Risks associated with people's health and care needs were being managed safely because staff knew people well enough to know what people needed and how to care for them. People spoken with told us that they felt they were assisted safely by the staff. One person said, "The staff are always there and know how to look after me". A relative told us, "[person] has many complex health issues which is a worry for me but the staff are always vigilant, contacting health professionals when needed; they are very observant and understand her [person] medical conditions. We [relatives] have peace of mind knowing she is well cared for, for which we are eternally grateful". The registered manager told us and we saw that risk assessments were in place to keep people and staff safe; however some of these required up dating. Nevertheless, staff spoken with told us that they developed an understanding with people over time and got to know people well enough to know exactly what they needed in order to keep people safe.

Whilst some people we spoke with told us that staff were always available to support them when required, other people told us that there was not always enough members of staff to meet their needs, particularly of an afternoon. We were told that the provider deployed four care assistants plus a senior carer in the mornings, which was then reduced to three care assistants and a senior carer during the afternoons. This meant that in the afternoons, people living on each of the three floors were supported by one care assistant and the senior carer assisted where required. Some of the people we spoke with told us that at times, for example, during a medical emergency within the home, they felt that there was not always enough staff available to meet their needs. One person said, "If there is an emergency on another floor; the staff leave us and go to help; this leaves us without staff". During our inspection we saw that there were periods of time, particularly in the afternoons, when staff were absent from one of the floors, leaving people unsupported. We also saw that staff found it difficult, particularly during the afternoons, to support people's varying needs, single-handidly. We discussed this with the provider at the time of our inspection and they told us that they would review the way in which staff were deployed to assist people in these situations and at these times. We will assess the effectiveness of this change at our next inspection. Other people we spoke with told us that staff were always available to support them when required. One person said, "When I press my buzzer [care alarm], they [staff] come straight away". Another person said, "Staff are there immediately when I need them".

Staff we spoke with and records we looked at showed us that the provider had completed pre-employment checks before staff started working at the home. The staff employment files we looked at showed that a Disclosure and Barring Service (DBS) check had been completed before staff were able to work unsupervised. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who require care. This showed that staff employed had been checked for their suitability to provide care to people.

People we spoke with told us that staff supported them to take their medicines as prescribed. One person said, "They [staff] never forget to give me my medication". We observed staff administering medicines to people safely and effectively. We saw that medicine administration records were completed reliably and monitored for accuracy. However, we found that protocols were not in place for people who received their medicines on an 'as required basis'. Nevertheless, the staff we spoke with were able to tell us how they administered these medicines in keeping with best practice guidelines. We discussed this with the provider and they assured us that protocols would be implemented to safeguard the medicine management processes.

Good

Is the service effective?

Our findings

People and their relatives told us they had been involved in planning their care and were happy with the support they received from staff. One person told us, "I am involved in decisions regarding my care, I do question what they [staff] do sometimes and they always explain it to me." Another person said, "I do have a care plan but I'm not sure what's in it; I could ask though". A relative we spoke with told us, "I am involved in making decisions about mum's care". Another relative said, "They [staff] are excellent at communicating and involving us; it's person centred care at its best".

People and relatives we spoke with expressed the opinion that they thought the staff were trained well and had the knowledge and the skills they required to care for them safely and effectively. One relative said, "The staff are skilled and they give you confidence when they are looking after your family". New staff were supported into their roles through an induction process where they worked alongside experienced staff to get to know how people liked to be supported. We saw that the provider kept a record of staff training which detailed the dates when staff had completed various training courses and when updates were due. We saw that staff were scheduled to complete any outstanding training in a timely manner and the registered manager facilitated regular supervision with staff to ensure that the training was implemented in practice.

Staff we spoke with including the registered manager had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA 2005 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 we spoke with and records we looked at confirmed they had received training on the MCA (2005). They were able to share examples of how they worked within these legal parameters and how they protected people's rights and the need for consent whilst providing care. One member of staff told us, "I always talk to residents [people] about what they want or need and give them options in different ways to allow them to make choices, for example, we will show them different options so they can point, or one person can't see very well, so I give things to them to feel, to make a choice that way". Another member of staff said, "Some residents are able to tell us what they want and what they need and give us consent in that way, others don't have the capacity to do that so we get a lot of information from people's family and social services; but even people who can't necessarily consent as such, you still gradually get to know their ways, their likes and dislikes and we care for them within their best interests based on the information we have and their care needs".

Records we looked at showed that staff were encouraged to continue offering day to day choices to people despite their mental capacity to consent. We also saw that people's relatives were involved in making decisions regarding their care or significant life events within their best interests, where appropriate. We saw that the proper processes had been followed in making best interests' decisions on behalf of people who lacked the capacity to consent to the care and treatment they received.

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). Providers are required to submit an application to a 'supervisory body' for the authority to deprive a person of their liberty within their best interests in order to keep them safe. The registered manager was able to articulate their understanding of DoLS and was aware of their responsibilities. Staff we spoke with also had an understanding of what DoLs meant for people living at the home and were able to tell us about how they cared for people in the least restrictive ways possible. For example, one member of staff told us, "We have an open door policy here; people can come and go as they please. Some people may need staff support to go out but we would never deny anyone the opportunity to access the community". We were told about how some residents enjoyed going to the communal room in the neighbouring supported living complex to play bingo or to have a meal with friends that they had made there. The registered manager said, "We try to support people to be as independent as possible and encourage people to go out and enjoy life as they would if they still lived at home, as this is now their home. We have bought some mobility scooters for people to use to get out and about if their mobility isn't as good as it used to be".

We received mixed reviews about the food prepared for people at the home. One person said, "The food is more than enough to eat and most of the food is good". Another person said, "The food is ok, but it can be boring at tea times, it's mostly sandwiches". A third person said, "We get a choice; we don't always like the puddings but we can ask for ice cream". We discussed this feedback with the management team. The registered manager and the deputy manager explained that they had held lengthily meetings with the residents about the food options available and the menu had been altered on many occasions. Records we looked at confirmed this. We saw that people had asked for the main meal to be changed from evening to lunch time, which had been accommodated and that the catering staff had produced a four weekly menu rota which also had additional options available in case people did not want any of the options on the set menu. For example, on the day of our inspection, most people had opted for egg and chips. This was not on the menu, but rather an alternative choice available to them. This showed that the provider had been responsive to people's feedback and had made menu planning more flexible. However, it was difficult to see how people were supported to make meal choices because a menu was not readily available. We were told that people were asked verbally but the staff acknowledged that a daily or weekly menu with pictures may be more inclusive within a dementia friendly environment.

We saw meal times were a relaxed and social event; the tables were laid, condiments were available and people ate whilst chatting to staff and with each other. The food looked and smelt appetising and people appeared to enjoy their meals. We saw that people had a choice about what they had to eat, drink and where they wanted to sit. We saw staff provided the appropriate level of supervision and assistance to people to ensure they received the support they required in order to eat their meals safely. People that required assistance to eat, were supported by staff in a way that was kind and encouraging. Staff we spoke with were aware of people's specific dietary requirements and support needs, however these were not always clear or consistently recorded in people's care records. For example, we saw that one person had been assessed by the speech and language therapist as requiring a fork mashable diet which had not been consistently recorded in their eating and drinking care plan or recent risk assessment. Food monitoring forms had also been introduced for this person because they had been observed to be losing weight but these had not been completed reliably and there was no evidence of what action staff were taking to meet this person's changing needs. However, staff we spoke with were all aware that this person required a soft diet and fortified foods (high calorie) and also needed assistance to eat, therefor no impact was found. Nevertheless, the importance of accurate and timely record keeping was discussed at the time of the inspection with the provider and the management team, in order to promote safe and effective care.

People had access to GP's and other health and social care professionals. People we spoke with and records

we looked at confirmed this. For example, we found that some people had nutritional assessments and care plans in place that had been informed by the assessment and guidance of Speech and Language Therapists and/or Dieticians. We also saw that other people were regularly reviewed by a Psychiatrist or received input from the local Community Mental Health Team for their mental health needs, such as dementia. We found that GP visits were sought as required and people were supported to attend hospital appointments. One person we spoke with said, "There are professionals available like doctors, chiropodists, dentists and opticians which they arrange for us". A relative we spoke with told us, "If mum needs a doctor they come straight away; I've also seen the doctor visiting others too". Records we looked at showed that people had access to opticians, dentists, and chiropodists. This meant that people were supported to maintain good health any health care concerns were followed up in a timely manner with referrals to the relevant services.

Good

Is the service caring?

Our findings

People and relatives we spoke with were positive about the care provided to people and the staff that supported them. One person told us, "It's very nice here, staff are lovely; I can't fault it." Another person said, "They [staff] look after us well." A third person told us, "The staff are very kind and very caring". Feedback we received from a relative told us that the atmosphere of the home was always 'warm and welcoming' and the staff at Greswold House were 'amazing'. The feedback stated, "10 years on and it is still a lovely atmosphere; the staff have an excellent rapport with residents and their families". A social worker we spoke with also shared some feedback with us that they had received from a relative, stating that they were very happy with the care being provided to their loved one and that they couldn't praise the staff enough reporting it to be the best home they have been to.

People felt they had been able to build up good relationships with staff because they had been involved in planning their care through the assessment and care review process, were consulted on a daily basis by staff and because they had gotten to know the staff that supported them on a regular basis. One person told us, "I would be very disappointed if I had to leave here; I think I would be very lonely". Another person said, "Everything is fine with my care, they [staff] always discuss how I am to be cared for". Staff spoken with spoke about people in a caring way, acknowledging their individual personalities. It was clear to us that staff had taken the time to get to know people, including their likes, dislikes, and personal histories. For example, the registered manager told us that one person loved to sing and that they used to sing professionally. They showed us a YouTube video that was a slide show of the person's life history with their voice singing in the background. The registered manager became emotional and told us that the person loved to watch the video and they were looking in to a way that they could download the photographs for the person to have in their room. We saw that the care staff also used their knowledge and understanding of people to offer personalised care and to provide reassurance when required. For example, we saw that one person became upset and staff reassured them with conversation about their family and reminded them that their son was due to visit at any time. It was evident that this provided comfort and reassurance to this person at that time.

People told us that they felt the staff treated them with respect and maintained their privacy and dignity. One person told us, "The staff are caring and they do not invade my privacy". A relative said, "The staff have always treated her [person] with dignity and respect". We saw that staff always knocked on people's doors before entering and always greeted people by their preferred name. Staff we spoke with were able to describe other ways in which they respected people's privacy and dignity. For example, one member of staff said, "It's important to make people feel at ease when providing personal care by talking to them as a distraction and to respect their wishes by giving them choices and just treating people in a way that you would want to be treated; with respect".

During our conversations with people and staff we were given examples of how people were supported to maintain their independence. For example, one person told us, "The staff help me to stay independent using my wheelchair". Another person told us that they helped out in the home by running the 'tuck shop' which kept them busy and they also continued with their roles outside of the home, to maintain a sense of self and

independence. A relative told us, "Mum is encouraged to be as independent as possible; the staff know how to get the best out of her". We saw that people were encouraged to maintain their independence and autonomy in various aspects of their care because staff encouraged them to make choices and offered the right level of support at the right time. For example, during a medicine administration round we saw staff asked people if they wanted to take their medicines, how they preferred to take their medicines (e.g. out of a pot or off of a spoon) and if they required support from staff to do this.

Good

Is the service responsive?

Our findings

People and their relatives told us that they were involved in the planning and review of their care and that they felt listened to by the provider. One person said, "I am asked for my opinion and they [staff] do listen to me". Another person told us, "I am involved in my care reviews". Feedback we received from a relative informed us that the staff had been 'excellent' at communicating any issues with the family and that they felt the care provided people at Greswold House was 'person centred care at its best'. Records we looked at confirmed that people and/or their relatives had been consulted in care planning and reviews. However, we found that where changes or updates were required, these were not always recorded accurately or consistently throughout peoples care files. Nevertheless, staff we spoke with were familiar with peoples current care needs and therefore no impact was identified on the care that people received. We fed this back to the registered manager at the time of our inspection. They advised us that new care planning systems were being implemented within the home and that care staff will be more involved in writing and reviewing peoples care, alongside senior carers. They felt that this would enhance the timeliness and accuracy of people's care records. We will check the effectiveness of this system at our next inspection.

People and relatives we spoke with were confident that the staff would respond to any changes in the support people required. We saw that the provider was responsive to the changing needs and requests of individuals. For example, we found that one person was at high risks of falls. The registered manager explained to us that this person had a falls detector mat (used to alert staff when they got out of bed so that staff could assist them and reduce the risk of falls) in place but this was found to be a greater risk to the person because they would try to step over it (due to visual perceptual difficulties associated with their health condition). Therefore the management team had explored alternative options including a bed sensor mat and an infra-red detector. We saw that both of these items had been ordered and delivered to the home. However, they were faulty on arrival and therefore were not able to be installed. The registered manager had contacted the agent to get a replacement. This showed that the provider had been responsive in thinking of alternative ways in which they could meet peoples changing care needs.

People and their relatives were aware that they could speak with the registered manager, deputy manager or any of the care staff if they had any concerns and they felt assured that they would be listened to. One person told us, "I have no concerns and have never had to complain but I would speak to a member of staff if I was unhappy". A relative told us, "In the 10 years that my [relative] has lived here, I have never had to make a complaint". Records we looked at showed that where complaints had been raised, the provider had investigated the concerns and had responded to people with openness and transparency; acknowledging shortfalls and providing solutions.

People and their relatives told us that they were asked to comment on the quality of the service they received. People told us that this was done at care reviews, through residents and relatives meetings and through questionnaires that were sent to them. We also saw that there was an interactive feedback computer system in the entrance to the home which people were encouraged to use as well as a comments book. One person we spoke with said, "We have residents meetings, we put ideas forward". Another person said, "We discuss things like the food and activities". A third person told us, "We made a suggestion

regarding a smoking shelter, we finally got it!". Records we looked at showed that the provider sought feedback from people and relatives who used the service and that this was used to drive improvements. For example, where people had complained about the food, a meeting was held to discuss the menu options. We also saw that where there had been some conflict within the dynamics of the home between the people living there, the staff had facilitated a mediation meeting to address the concerns.

People and relatives we spoke with told us that occasionally they engaged in activities of interest, but that sometimes they were 'bored'. We saw that an activities programme was available but that this was not always delivered on a day to day basis and people were sat for much of the day unoccupied, unless they were able to engage in activities independently. Staff we spoke with told us that activities were an area that they had recognised required improvements. One person we spoke with said, "We have been planning with staff the activities we need". We saw that developments to the social calendar within the home had begun. For example, we saw that the staff had organised a summer fete and often arranged for singers or musicians to visit the home for entertainment. One person told us that when the weather was nice the staff would support them to go in to the garden. We saw that the garden was a nice open, landscaped space which had recently benefitted from a new summer house which both people and staff were proud of.

We found that people were supported to maintain their interests and hobbies and that rooms were personalised to reflect this. For example, we saw that one person was fond of trains and that when they moved in to the home; they had brought a large collection of their train collection with them which was on display in their room. A staff member we spoke with told us, "He loves trains and cuddly toys; you can't miss his room! You will see pictures of trains in the corridor outside his room too; we also have a lot in storage which we are helping him to sort out". We also found that cultural and religious needs were also met and that people's individual differences were respected. For example, we saw that religious services were arranged for people and those who weren't particularly religious were welcomed to join in for the singing. Care plans we looked at made reference to discussions held with people about their sexual orientation and staff we spoke with told us that they were a very open staff group who would support and respect people from the lesbian, gay, bisexual and transgender community. One member of staff said, "I am not aware of anyone who is openly gay here, although we have had people where we have suspected it and tried to support them as much as possible to feel comfortable enough to speak with us about it; but you also have to respect that for some people it can be a very private and sensitive issue". The registered manager told us that they were open to suggestions about how they could better promote the home as an open and accepting environment for people from all walks of life and that this is something that they would look in to developing further.

People and relatives we spoke with told us that they were supported to maintain relationships with people that were important to them. One person said, "I have my personal phone and keep in touch with family and friends, and many of us [people] go out with our families". Another person told us, "I like to go next door [supportive living complex] to play bingo and have fish and chips there sometimes". A third person said, "We celebrate all birthdays here". A fourth person told us, "I truly love living here; I am on a floor where we all support each other".

Requires Improvement

Is the service well-led?

Our findings

The provider is required to employ a registered manager as part of the conditions of their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations. We found there was a clear leadership structure within the home including a registered manager, a deputy manager and senior carers, all of whom played a role in the day to day running of the service.

However, whilst each of these persons had a delegated role to monitor and facilitate the safety and efficiency of the service, the systems and processes in place had not always been used effectively to identify areas for improvement. For example, we saw that the provider had a call monitoring system in place which meant that they could identify where any delays may have occurred in call bell alarms being answered, or when people had repeatedly requested assistance and may need additional support, or if there was a particular time of day or unit where additional staff may be required. Given some of the concerns reported to us about the staffing levels, we asked the registered manager to show us how they used this system to monitor the efficiency of the staffing levels. However, we found that the monitoring system had not been used in this way. The management team did not know how to access a data report from the system which would allow them to identify any areas of concern. We spoke to the technical support team who showed us how the system could be used and we found that for significant periods of time, the call monitoring system had not been switched on. The management team were not aware that the system had not been active, demonstrating its lack of use. The deputy manager told us, "There must be a fault in the system if it keeps turning itself off". They told us that they would request for an engineer to come and look at it.

We saw that the registered manager monitored falls within the home and whilst some trends and the actions taken for some people had been recorded on a monthly basis, there was no evidence that this was a consistent approach or that the information had been used comparatively from one month to another. For example it was not always clear how this information had been used to minimise future risks to people, identify trends or to demonstrate how actions taken previously had or had not been effective and potential ways forward. We found that the provider had facilitated a well-being survey with people who lived at the home which had produced largely positive results. However, there was no evidence to show that this information had been analysed or used to identify any trends, themes or actions arising to drive improvements or sustain good practice.

We saw that information in peoples care records were not always up to date or correct, despite having recently undergone an audit. We found that protocols for medicines that were administered to people on an 'as required' basis were not in place, despite being recognised as a requirement by an external auditor last year. We found that the provider's 'room check monitoring forms' had not always been completed as part of the auditing process; this may account for the environmental safety concerns identified in relation to harmful substances being accessible to people.

We discussed these shortfalls with the registered manager and they advised us that they were currently

working with an external training agent who was supporting them to develop their quality monitoring processes and the ways in which they analyse and use the data to drive improvements. We also found that the provider was implementing a new record keeping system. We will monitor the effectiveness of these changes at our next inspection.

We received mixed reviews from the staff about the support they received and the efficiency of the management team within the home. Whilst some staff we spoke with told us they felt very supported by the registered manager, deputy managers and senior staff, others told us that they did not always feel listened to and that communication within the home was poor. One member of staff we spoke with told us that whenever they brought concerns to the attention of the registered manager, they never felt listened to and rarely saw any changes. Another staff member said, "We don't get told anything". A third member of staff, "I feel like things are brushed under the carpet a lot here; you don't feel compelled to say anything because nothing changes which is very frustrating". Records we looked at and discussions held with the registered manager showed us that some of the concerns that staff had raised had been investigated and addressed but that, where necessary this was done discretely. Other issues that could have been shared had not always been communicated with staff. For example, staff raised their concerns with us about one person who was at high risk of falls and who had a falls detector mat in place which was faulty. They told us that this equipment had not worked for a while and that despite informing the registered manager, nothing had been done about it. We found that the registered manager had re-assessed the persons falls risk, identified that the falls mat was no longer suitable for the person and had order two different types as an alternative intervention to reflect their changing needs; this had not been shared with staff. The registered manager acknowledged that improvements could be made with the communication systems within the home and they planned to discuss the concerns with staff to identify solutions collaboratively.

Throughout the inspection, we found that the registered manager was open and transparent in their communication with us and identified some areas that required improvement independently. They told us that over the past 12 months, there had been lots of changes and some instability to the staffing and management structures within the home which meant that at times, some of the managerial roles and responsibilities had taken a back step whilst supporting the day to day care of people. We found that the registered manager was responsive of our feedback and accepted this with integrity. Since our inspection, we have received an action plan from the registered manager to inform us of their immediate plans to address some of the issues identified. These included full environmental checks across the home with daily checks added to the daily walk arounds as well as urgent staff meetings with a solution focussed approach to identify ways forward to the communication systems, leadership styles and team dynamics.

People and relatives we spoke with were positive about the management of the home and knew who the registered manager and deputy manager were. One person said, "The manager and the deputy manager make a good team". Another person told us, "If it wasn't well managed I would not be here". A relative told us, "The staff and the management are approachable".

Information we held about the service showed us that the registered manager had ensured that most of the information that they were legally obliged to tell us, and other external organisations, such as the local authority, was passed on. This was with the exception of some statutory notifications to inform us that a person who lived at the home had died in hospital. The registered manager told us that they had been told previously by CQC that if a death occurred elsewhere (i.e. in hospital) they did not have to notify us. We clarified this misunderstanding and they assured us that all future notifications will be sent. We found that the provider had worked collaboratively with other external agencies such as the local safeguarding authority, Social Services and community mental health teams to ensure people's needs were met.