Pine View Care Homes Ltd

Royal Manor Nursing Home

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 6 October 2016, and the visit was unannounced.

Royal Manor provides residential and nursing care to older people including people recovering from physical and mental health issues and some who are living with dementia. Royal Manor is registered to provide care for up to 25 people. At the time of our inspection there were 23 people living at the home.

Royal Manor had a registered manager in post. The registered manager was also the provider, and he was supported by a care manager at the home. 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 we asked the provider to record issues that affected people which were seen as informal complaints. Audits and checks of the service were carried out by the provider but issues forwarded through the quality assurance questionnaires had not been recorded. These audits also failed to recognise pattern with formal complaints. The absence of this analysis failed to ensure the service continuously improved.

There were appropriate arrangements for the recording and checking of medicines to ensure people's health and welfare was protected against the risks associated with the handling of medicines. However the accurate recording of people's hydration, when topical creams were applied and where injuries had occurred were not recorded consistently.

Though some staff had not been provided with safeguarding training they were still aware and had an understanding of their responsibilities to protect people from harm. The registered manager understood their responsibilities to manage any safeguarding concerns raised by staff. The provider ensured all notifications required by law had been sent to us in accordance with the legislation.

Staff worked as a team, however were not deployed to provide the appropriate level of observation to keep people safe. The noise levels in the home were noticeably raised, and at times people presented with behaviour that challenged staff. Poor staff deployment did not assist staff in being able to deflect this behaviour.
People were offered meal choices however some staff did not clearly explain what meals were on offer. Staff recorded the food and fluid people ate and drank. However governance of these records did not reveal that staff did not complete them consistently.

New staff received an induction which included working alongside more experienced staff. This helped them get to know people's needs and establish a relationship with them before working with people on a one to one basis.

Staff worked within the principles of the Mental Capacity Act 2005 and had a good understanding of their responsibilities in making sure people were supported in accordance with their preferences and wishes. Staff knew people's individual communication skills and abilities and showed concern for people's wellbeing in a caring and meaningful way. However they were observant of peoples dignity at all times.

Care records were personalised and each file contained information about the person's likes, dislikes, preferences and the people who were important to them. Plans around behaviours were written to reinforce positive behaviour rather than concentrating on the negative. Care plans also included information that enabled the staff to monitor the well-being of people. There were systems in place for staff to share information through detailed records for each person. Risk assessments and management plans covered aspects of people's needs and included health and daily routines.

The provider had recruitment procedures that ensured staff were of a suitable character to work with people and ensure they remained safe. Most staff had received training in the areas the provider considered essential for meeting the needs of people in a care environment safely and effectively. Planned training was in place for the remainder of the staff to ensure all staffs' knowledge was up to date.

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 consistently safe.

Medicines were ordered, administered and stored safely, but improvements were needed to medicines records. Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed or suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Most staff had completed essential training to meet people's needs safely and to a suitable standard, and the remaining staff had their training planned. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005 though did not always ask for people's consent before care was provided.

People received appropriate food choices that provided a balanced diet which met their nutritional needs. However meal choices offered to people were not clearly and consistently communicated by staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring and kind but did not always support people in a dignified manner. People were mostly encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People mostly received personalised care that met their needs and they and their families were involved in planning how they were cared for and supported. Staff deployment did not assist where staff could have deflected some behaviour that

challenged.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Provider audits did not recognise themes through complaints, or the lack of consistent recording in essential records.
The provider used some audits effectively to check people were being provided with good care and ensured records were in place to demonstrate this. People using the service, their relatives and visiting professionals had opportunities to share their views and influence the development of the service.

Royal Manor Nursing Home

Detailed findings

Background to this inspection

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

The inspection visit took place on 6 October 2016 and was carried out by one inspector, a specialist advisor and an expert by experience. The visit was unannounced. A specialist adviser is a qualified social or healthcare professional. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both our specialist advisor and our expert by experience's area of expertise was the care of people with mental health needs and dementia.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Royal Manor Nursing Home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We considered this information when planning our inspection of the service. We spoke with commissioning staff from the local authority who told us they had undertaken a quality monitoring visit, and found the provider was operating effectively.

The provider is required to send us a Provider Information Return (PIR). This allows the provider to provide some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made, so the provider did not have an opportunity to complete this.

During this inspection, we asked the provider to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the service they had made following our previous visit. We also asked the provider to forward more information following our visit, as some documents were not available on the day. These were sent the day following the inspection.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported due to their mental health needs. We used the short observational framework tool (SOFI) to help

assess whether people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

To learn about people's experiences of living at Royal Manor Nursing Home, we spoke with three people and three visiting relatives. We also spoke with the provider, care manager, three care staff and two visiting health professionals. We looked at four people's care records to see how they were cared for and supported. We looked at other records relating to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the service, and health and safety records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2015 we found that medicines records needed to be more accurate. At this inspection we found some improvements had been made.

People told us they received their medicines when the needed them. One person said, "They give me my tablets in a morning and at other times [during the day]."

We looked at the medication administration records (MARs) for six people. These had been transferred to an electronic system which prompted staff to sign records when medicines were administered. The MARs had people's photographs in place to reduce the risks of medicines being given to the wrong person. Information about identified allergies and people's preference on how their medicines were given was also included. This helped to ensure that people received their medicines safely.

However staff had not always signed when they had applied topical creams to people. This type of medicine relied on staff completing a paper 'cream application chart', as the new electronic MAR system was not designed to support that type of recording. We spoke with the provider who said this was a recording issue rather than the cream not having being applied. The provider agreed to address this issue.

In addition, staff had not regularly completed body maps which are used to show the extent of an injury or other damage to the person. That meant staff could not consistently identify if a person had more than one injury, or the progression of healing. The provider agreed to address this issue also.

People in receipt of 'as required' (known as PRN medicines) had instructions added to the MARs to detail the circumstances these should be given and included the maximum dose the person was to be given in any 24 hour period. We observed the lunch time medication round and heard people being offered pain relief which was prescribed on an 'as required' basis. That demonstrated that staff understood when and how these medicines should be offered.

We found that medicines were stored securely in a temperature-controlled room. A record of storage temperatures for the medicines room and medicines fridge had been kept by staff. Staff we spoke with knew the storage temperature limits and what to do if these exceeded or fell below the recommended maximum and minimum. This meant medicines were stored safely at the recommended temperatures.

People told us that they felt safe and staff cared for them safely. One person told us, "I feel very safe and comfortable here. I haven't got any worries at all."
A visiting relative said, "[My family member] is very safe." Another relative told us, "[My family member] is very safe and I have no concerns. Her room is nice and the place will be so much better with the extension." However another relative said, "I do worry about some of the residents having access to the stairs."

Parts of the building did not ensure peoples' safety. We observed the main staircase was not gated so was open to people to freely use the stair case which they might not be able to do safely. There was also a grab

rail at the top of the staircase which was not secured properly. We spoke with the provider about this and they said these areas would be made safe. The building work on the new extension was on-going, and this was safely cordoned off and did not pose a risk to people. The remaining premises were safe and well maintained, though some areas were due to be decorated and some flooring replaced following the completion of the building work.
Staff were able to tell us about people's individual needs, and the support they required to stay safe. People's care records included risk assessments, which were reviewed regularly and covered areas relating to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of minimising risk. People told us they were involved in discussions and decisions about how risks were managed to ensure their safety.

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse. Staff we spoke with had received training in protecting people from harm and had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them to ensure people remained safe in the home.

Staff were aware of the provider's whistle blowing policy and told us how they could use it if any concerns they had were not acted on. Staff were aware which other authorities outside the service to report any concerns to if required, which would support and protect people. The provider was aware of their responsibilities and ensured safeguarding incidents were reported to the Care Quality Commission if required.

We spoke with the staff about what they would do if they suspected someone was being abused at the service. One member of staff said, "I would tell the nurse, or care manager, if they didn't do anything, I would go to the provider." They followed up by saying they would then raise their concerns with the local authority if they had not been dealt with at the service.

We looked at the people's personal evacuation plans (PEEPs). These tell staff how to safely assist people to leave the premises in an emergency. Copies of the PEEPs were also kept in each person's care file and reviewed periodically. Staff told us they took part in regular fire drills so they knew what action to take in the event of an emergency, and were aware of the location of the PEEPs and emergency equipment.

We found there were sufficient numbers of staff available but due to their deployment could not always ensure people's safety. Staff told us they believed staff were employed in sufficient numbers to ensure people were cared for safely. However we found the deployment of staff did not always support a safe environment.
We found that there were instances people were unobserved by staff in the lounges. An example of this was where two people seated in the lounge having a verbal disagreement, there were no staff available to ensure their safety. We saw further examples where other lounges were left unobserved when people were eating their lunch time meal. This supported our observations that staff deployment did not provide a consistently safe environment for people and care was strongly task led. Task led meant staff concentrated their efforts to ensuring tasks were undertaken and did not ensure people were safe and observed at all times when required.
People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service. This helped to ensure that only suitable staff were employed to work at the service.

From our observations the home was mostly clean, though a small number of areas required attention. Infection control risks were identified and monitored to keep people safe. Infection control audits were undertaken, and the outcomes of those were seen by the provider. A cleaning schedule ensured that rooms were cleaned regularly. However the storage of mops did not ensure infection control principles were upheld and this placed people at risk from potential cross infection or cross contamination issues. We spoke with the provider who said he would look at alternative storage facilities and staff training to address this issue.

Requires Improvement

Is the service effective?

Our findings

People told us the service was effective and staff said there was enough training and they did not feel they had any gaps in their knowledge. There was evidence staff had received induction training after they commenced their employment. This was followed by training in safeguarding, moving and handling, food and hygiene, fire safety, the mental capacity act, Deprivation of Liberty Safeguards (DoLS) and health and safety. The nursing and senior care staff had training in the administration of medicines.

Relatives told us they were happy with the staff that supported their relations and felt staff understood their needs and how they preferred to be cared for. A visiting relative said, "There seem to be enough staff and they appear to be trained for the job. Their communication is good and the same (staff) faces have been here for a long time."

One member of staff said, "We have enough training, but I would prefer more face to face training as I don't like the computer training."

We saw from the training matrix that some staff had not had some essential training. The provider said the training dates had been arranged and all staff training would then be updated. This was confirmed by information made available following the inspection.

Staff felt support and communication within the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they felt the regular staff meetings with the provider and care manager also provided support. Staff supervision was used to advance staff knowledge, training and development by regular meetings between the management and staff group. Clinical supervision for the nursing staff was undertaken by a qualified nurse. Supervision benefited the people using the service as it helped to ensure staff were more knowledgeable and able to care and support people effectively.

The care manager, nursing and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

When people lack the capacity to give their informed consent, the law requires registered persons to ensure that important decisions are taken in their best interests. A part of this process involves consulting closely with relatives and with health and social care professionals who knew the person and had an interest in their wellbeing. Records showed that all the people's files we viewed had mental capacity assessments in place with regard to making certain choices and decisions. Where people were unable we saw their relatives

were involved in decisions about their care.

One person had a DoLS authorisation in place with another six awaiting approval. This meant there were restrictions of their liberty and the provider had applied for the necessary authorisation from the relevant local authority.

People told us their health and medical needs were met, and they were happy for the staff to arrange GP and health appointments for them. People's care records showed that people received health care support from a range of health care professionals and when necessary were accompanied to external medical appointments by relatives and staff. The records we viewed confirmed people were subject to regular health checks by their GPs, specialist health professionals, and hospital consultants.

People told us they were happy with the meals provided. One person said, "The food is very nice. There is a menu."

A visiting relative said, "From what I have seen the food seems good, it always smells nice." Another said, "The staff are good and the food is nice. [My family member] eats everything and always asks for more which they do give her."

A visiting relative said, "They always make us feel welcome when we visit and offer us a cup of tea. It has always been good but seems to be getting better."
However we found the support people had to eat and drink enough and maintain a balanced diet was not always effective. People had the choice of eating in the dining room, lounge or their bedroom. Staff did not serve people table by table, and we observed where one person sat for ten minutes after others had been served. During that time the person had started to sleep. The person was served their meal only after we prompted staff.

People were given a choice regarding meals, however it was not always clear people understood the choices on offer. Staff did not use photo or other prompts to assist them to choose their lunch time meal to suit their taste so people with communication needs may not have understood what the choices were. Staff told us people they knew people's preferences and offered meals based on this information. We later observed a staff member asking people what they would like for their teatime meal. The interaction with each person was good, with the staff member retaining good eye contact. Each question was adapted to ensure the person understood the choices being offered. That demonstrated the different levels of understanding staff had in providing effective communication with people living with dementia.

Drinks such as water and cordial were served after people had been served their main meal. Staff appeared to know what drinks people preferred. However we saw one person stopped the member of staff and said, "I don't want that, I want orange." The member of staff supplied a fresh glass and served the person their chosen drink.
There were three people who dined in the lounge next to the dining room. Staff told us this was because they did not enjoy the dining experience with others on the same table. We saw one person complained about not being offered a meal. Staff explained that this person was given their choice of meal and then attempted to throw it on the floor. They offered a pudding which they enjoyed. We later confirmed this person had health input to ensure they received a balanced food intake. This showed that staff were effective in ensuring and adequate and balanced diet for people.

We saw people's dietary needs had been assessed and where a risk had been identified, people were referred to their GP, speech and language therapist (SALT) or dietician. This ensured people's dietary needs

were managed in line with professional guidelines. One person was recorded as having a poor appetite. Records showed how much the person should eat and drink as a minimum and staff monitored their food and fluid intake to ensure they had sufficient to maintain their health.

However when we looked at the records for two people who were cared for in bed we saw that staff had not consistently recorded the fluid people had drank. One person's fluid intake records had not been totalled regularly for seven days in September 2016, which meant staff did not know what fluids the person had taken. Another six records were not completed for large parts of the day, and recorded the person drank between 350 mls to 600 mls per day. This person had a medical device fitted and staff recorded their urine output which was much higher. We spoke with provider, who concluded the staff had not recorded all the fluids the person had drank.

We looked at the service's meal provision and how staff ensured that people received a nutritious diet and maintained a healthy weight. Menu preferences were discussed at meetings between people using the service and staff. Information on people's likes and dislikes were recorded in their care plans, and distributed to staff. There was information in the kitchen and staff were aware of peoples preferences and any food allergies.

We saw that some people had been provided with adapted cutlery and crockery to enable them to eat their meals independently. Others required prompting and some required one-to-one assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact to provide effective support.

We asked a staff member, what actions they would take if they found a person had lost weight. They stated, "I would inform the nurse or (care) manager." Staff told us they monitored people's weight loss or gain to ensure people received dietary advice and support if needed. A visiting relative told us their relation had to have fortified drinks due to their weight loss and these were supplied.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring and approachable. One person said, "The people (staff) are very caring. They can't do enough for you. They are all very nice and considerate."

A visiting relative said, "The staff are very good and they seem happy in their work. They take our worry away as we know mum is being cared for." Another visiting relative said, "The staff are ever so good, sometimes (my family member) won't go to bed so they let her sleep in the chair or walk around if she wants to. They are very caring, especially the more mature ones. One of the night staff in particular, is very dedicated. They always treat her with respect and are calm and patient with her." We spoke with staff who confirmed the person slept in their chair infrequently, and were able to explain how they ensured the person was kept comfortable. However details of this was not entered in their care plan or risk assessment.

The culture was a caring one and people's needs were catered for by staff, but there were at times a lack of compassionate and caring communication. People were communicated with and asked if they had completed their meal prior to plates being removed. We observed two members of staff who assisted people to eat their lunch. Both staff ensured the people's clothes were protected from food spillages, however the tabards used were stained and faded and required to be replaced.

However we also saw where at times, following lunch where some people's dignity was not recognised. We saw drinks being removed from tables, without people being consulted. We also saw people's faces being wiped, again there was no communication prior to this. We witnessed one person physically pushed a carer's hand away and wiped their own face.

We observed staff moving and handling which was not done in a dignified way. This was mostly done safely, however we saw one person had to be assisted by two staff when they were unable place them self safely in a seat. This was very undignified and staff had to verbally prompt the person and steady their arms to guide them into the seat. That could have placed the person and staff in danger of injury.

When asked staff told us they used privacy blankets when hoisting people though we did not see this on the day. We discussed this with the provider who stated they would look at re-training staff.

Staff understood the importance of caring for people in a dignified way, but did not always demonstrate this. They described to us the caring qualities needed to provide good quality care. They said there was a good staff team who knew people's needs and the nurses and care staff worked as team.
Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name.

Care records were signed by the individual or a family member, and staff told us care plans were read to people and their comments recorded. The provider said care plans reflected people's needs and were reviewed monthly or sooner if required.

Staff said people were asked to take part in care plan reviews but only a few of them chose to do so. Staff added relatives were informed when people's health or wellbeing changed.

A visiting relative confirmed this, and said, "We live quite far away and [staff member's name] is very good and will keep me informed of any issues. I always come unannounced and she is always happy."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found there was no system in place to record minor complaints, and following this we were told by the provider he was developing a system that would record these. At this inspection we were told there was still no system in place. We noted from the 2015 /16 relatives' survey that one person had made a comment about two 'minor issues' regarding the availability of their relation's personal clothing and glasses. There was no record of this being resolved or any outcome. We have again asked the provider to address these type of complaints and ensure that the service is responsive and improves outcomes for people.

The provider had systems in place to record complaints. One visiting relative said "I have never had to complain, and I am not sure if my views have been asked, I may have done a survey once perhaps." Another said, "I have never had to complain, and I haven't had a survey or anything."

People we spoke with said they knew how to make a complaint, and indicated they could rely on the care manager and staff to deal with any issues. Records showed the service had received two written complaints in the last 12 months. An outcome had been provided, and changes were made to the service. Analysis by the provider had not acknowledged that three complaints had similar themes, which resulted in similar complaints being made by different people over a period of time. This did not demonstrate a responsive approach to concerns and complaint's.

A visiting relative told us, "The activities they do are good." Another relative told us, "I do think the TV is on a bit too much." We observed the television was on the majority of time we visited. The programme was not being viewed by the people in the lounge, and was not responsive to people's needs.

We observed people who presented with behaviour that challenged, and when available staff did not seem to attempt to distract or divert them to more appropriate activities. There were many occasions when people were unsupervised in the lounges, and were agitated, arguing or unoccupied. The level of agitation displayed by residents did not appear to be managed well, and appeared to be accepted as normal. This unmanaged behaviour left those people at risk.

People told us they were not sure if they were involved in the planning and review process for their care. However visiting relatives confirmed their involvement in the process on the person's behalf.

We saw that some people received personalised care that was responsive to their needs. We looked at four care plans which included pre-admission assessments. The provider explained that pre-admission assessments were undertaken by nursing staff prior to people moving into the home.

Care planning was linked to people's individual needs which ensured care plans were specific to each person. We saw evidence of information on allergies, likes, dislikes, and peoples' life and family histories. We also saw detailed information on personal care, mobility and dexterity, pressure area care, continence, nutrition and hydration, communication, dental and foot care, night-time care, religious observances, falls,

mental health, medical history, pain relief. People's capacity and DoLS status was also recorded. Staff were able to explain, and demonstrated through the care we observed, the specific support that people required.

People who had developed pressure areas were referred onto tissue viability specialists who ensured the appropriate treatment for their condition. We saw other people had been referred to health specialists in a timely fashion that ensured treatment was appropriate. Visiting relatives confirmed this and said, "They arrange for a doctor if [my family member] needs one, and let me know." Another visiting relative said, "The staff always arrange a doctor or chiropody (treatment)."

Staff had access to people's plans of care and received updates about their care needs through daily handover meetings. The care files we viewed were comprehensive, and revealed regular reviews.

The environment itself was not calming. There was a lot of background noise and televisions were on constantly, doorbells, phones ringing and staff speaking loudly to one another. We discussed this with the provider who stated he would assess the levels of background noise and the affect that had on people. People were offered activities that met their needs. We saw people took part in and enjoyed the activity that was arranged on the morning of our inspection. We saw staff playing board games with some people and others signing along with musical instruments. There was an activities board which displayed the daily activities and a photo board which evidenced the activities people had taken part in. One person had access to a supply of personal books and papers and told us they preferred reading those rather than taking part in the activity programme.

There were lots of items available in the communal areas, such as books and newspapers, films and music. There was a chalkboard with date details which was clear and visible. In the corridors there were displays of art work which people had produced and a board showing memorabilia.

We spoke with the registered manager about how activities were decided in the home. They said the care manager asked people on an individual basis what they liked to do when their life histories were recorded. People were also asked about the activities they preferred through the regular 'residents and relatives' meetings and through regular quality questionnaires.

We looked at the minutes of the meetings which included discussions around the menu, activities and staffing suggestions. We spoke with staff about what activities people preferred to do. They told us that some people enjoyed painting and playing games. They added that though an activities plan was in place, if people didn't want to do the allocated activity, then staff would provide alternatives.

Requires Improvement

Is the service well-led?

Our findings

The provider's procedures for monitoring and assessing the quality of the service were not always effective.

Following the last inspection the provider had failed to introduce and record issues that affected people which were not made as formal complaints. At this inspection they failed to recognise the pattern that developed between formal and informal complaints and was therefore unable to positively affect outcomes for people.

The provider had also failed to detect the poor recording of care records of people whose hydration was monitored, and the effective use of body mapping. We also recognised staff deployment could be improved to positively affect the monitoring of people and where staff needed to fully recognise peoples' dignity.

Staff undertook some quality checks and discussed any changes to ensure that people who lived at the service were safe and well cared for. They also spoke with people and staff whilst at the service. Staff confirmed the assistant operations director spent time in the home, observing the care manager and staff.

We saw a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. There was an in-house maintenance person who undertook repairs on a regular basis. This helped to ensure the premises were well-maintained.

Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Other information included instructions as to where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

Relatives told us they had good relationships with the provider, managers and staff. They told us they regularly see the provider in the home and felt they could approach them if they had any concerns. One person said, "I don't know who the manager is but I think they [staff] are all helpful."

A visiting relative told us, "I do think [the service] is well run, caring and professional. I even have the provider's personal mobile number. They helped a lot with our funding and took the stress away from us." Another said, "I know the provider, he is here most days and they always speak to us. I feel I could talk to them anytime."
We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary they or their relatives assisted them in completing questionnaires. We saw some of the feedback had been adopted by the provider. Changes had been made to the menu, and the variety and availability of hot and cold drinks.

People who used the service and their relatives were also invited to meetings with the provider and care manager. We looked at the minutes of these meetings, and saw people requested to be able to have dancing, additional food added to the menus and additional choices for hot and cold drinks.
The provider ensured that we were notified of events that affected the people, staff and the building.

The provider had an understanding of what they wanted to achieve for the service and they were supported by the care manager nurses and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff had detailed job descriptions and had regular staff and supervision meetings. These were used to support staff to maintain and improve their performance. Staff confirmed they had access to copies of the provider's policies and procedures. They understood their roles, however failed to use this information to provide a consistent level of care throughout the home. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required.

One staff member told us, "It is a really good team, mostly long term staff who work here. I have no worries at work and it is good in all areas. I enjoy my job."