Cedar Tree Care Home Ltd

# Cedar Tree Care Home Limited

## Inspection report

Rowley Lane
Littleover
Derby
Derbyshire
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Tel: 01332767485

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15 April 2016

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## Ratings

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

# Summary of findings

## Overall summary

The inspection took place on 15 April 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor who had experience in nursing, dementia care and end of life care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert had experience of dementia care.

The service, located on Rowley Lane, Derby is registered for 40 older people, including those living with dementia. 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.

At our last inspection on 29 July 2013, we found examples of poor management of medicines which meant the provider had not always protected people from unsafe administration of medicines. We also found that staff were not always supported by the manager, as supervisions were not always conducted at the frequency described in the provider's policy. These were in breach of Regulations 13 and 23 of the Health & Social Care Act (2008) Regulated Activities Regulations (2010) which following the legislative changes in April 2015, corresponds to regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider sent us an action plan, detailing how they would address these concerns. At this inspection we found that improvements had taken place to the management of medicines and the provider was now meeting the requirements of Regulation 12.

However, we still had concerns regarding supervisions at this inspection, and we have made a recommendation regarding the frequency and quality of supervisions in this report.

We found that risk assessments and care plans were not always updated following incidents. Therefore we could not be assured that people always received the most appropriate care to meet their needs. We also found that information about people was not always shared where there was a legal duty to do so, for instance safeguarding incidents. Therefore people were not always protected from the risk of harm or abuse. We have made a recommendation regarding the reporting of incidents and sharing information, in order to keep people safe.

We found a lack of understanding from some staff, regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). Particularly how this impacted on their ability to care for people lawfully; especially where people had their movements restricted. For example, there were some people receiving restrictive care to keep them safe, which had not yet been legally authorised. We have made a recommendation regarding how the MCA and DoLS are applied when caring for people.

Staff received an induction where they were supported by the senior staff team to complete all the

necessary training; and develop a thorough knowledge of the service and the people using it. This was supported by on-going training and supervision of staff. This meant staff were able to update their skills and knowledge to care for people effectively.

We observed positive caring relationships between staff and people using the service and their families. Staff clearly knew people's individual needs, preferences and interests and provided care, support and activities in response to these. For example in response to individual interests and requests, there was a model railway in the lounge for people to use. There were also pet guinea pigs and birds, an outdoor seating area and a varied programme of events and activities that included the local community. This meant people had access to a variety of activities to suit their individual interests and abilities and felt part of the wider community and neighbourhood.

People, families and staff spoke highly of the registered manager, who they said was always available and 'a great support to all'. Relatives were reassured that their family member was 'in safe hands' and staff felt supported and motivated The registered manager told us they understood their responsibilities to ensure that people received high quality care and had appropriate systems in place to monitor this. However, we found they had not always recognised their duty to share information, in order to protect people from the risk of abuse or harm.

## 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.

Staff did not always recognise abuse and incidents were not always reported.
However, there were sufficient staff available to meet people's needs and medicines were managed and stored safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not always understand or follow the principles of the Mental Capacity Act 2005 (MCA). However, people were supported to access community healthcare services and maintain good health.

### Is the service caring?

**Good**

The service was caring.

People were cared for by staff who were kind and compassionate and promoted their dignity and privacy. People's views and wishes were considered when developing care plans.

### Is the service responsive?

**Good**

The service was responsive.

Care plans were well written and personalised. Staff understood individual preferences and supported people to maintain their interests. The service had a complaints policy and sought feedback which was used to improve the quality of care.

### Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

The registered manager did not always recognise their responsibility to share information they held about people, where they had a legal duty to do so. However, people and staff

spoke highly of the registered manager who they said was friendly and supportive; and there were quality assurance systems in place which enabled on-going improvements to be made to the care of people using the service

# Cedar Tree Care Home Limited

**Detailed findings**

## Background to this inspection

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

This inspection took place on 15 April 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor who had experience in nursing, dementia care and end of life care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert had experience of dementia care.

Before the inspection, we reviewed information we held about the service. This included the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the most recent contract monitoring report conducted by local commissioners, feedback from other agencies who worked with Cedar Tree Care Home, and notifications the provider has sent us. Notifications are events or incidents that providers are required to notify us about under the terms of their registration.

In order to assess the quality of care and support people received at Cedar Tree Care Home, we spent time talking to people who used the service, their relatives, visiting health professionals, staff and the registered manager. We spoke to nine staff including nursing and care staff, activity coordinator, cook and the registered manager. We looked at three care files, three staff records and assorted management records including audits, supervisions, training matrix, policies, meeting minutes and rotas. We also carried out a SOFI during the lunchtime period. SOFI is a short observational framework for use in inspection. We used SOFI because some people were living with dementia and had difficulty communicating their experience of care to us

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection on 29 July 2013, we found examples of poor management of medicines which meant the provider had not always protected people from unsafe administration of medicines. This was in breach of Regulation 13 of the Health & Social Care Act (2008) Regulated Activities Regulations (2010) which following the legislative changes in April 2015 corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Following that inspection the provider sent us an action plan, detailing how they would address these concerns. At this inspection we found that improvements had taken place. Medicines were now administered as prescribed, protocols were in place and records were fully completed and audited.

People told us they received their medicines on time. One person said, "Yes, I have them every morning", another said, "Yes, regularly". We observed a medicines round and noted that the nurse administering medicines followed standard protocols regarding storing, administering and recording of medicines. They told us they received mandatory and specialised training in respect of medicines. For example they received additional training to support people with diabetes management. Records we viewed confirmed that staff received appropriate medicines training. This meant that people were protected from the risks of harm due to medication errors and the provider was now meeting the regulation.

We looked at care records which confirmed that risk assessments had been completed and plans put in place to minimise the risk of harm to people. For example we saw risk assessments in respect of pressure care, falls and nutritional risks. These made sure staff were informed of the risks and how to suitably protect people. We also saw that people had signed their support plans and risk assessments which showed they had been involved in preparing them.

However, we noticed that some plans or risk assessments had not been updated following incidents. For example, we saw a report in the incident file which included details of an incident and measures put in place to reduce any further risk. However, when we cross referenced this with the persons care plan and risk assessment, it had not been mentioned. This meant that staff were not always aware of changing needs or increased risks to people, so may not always have provided the most appropriate care. We also found examples of incidents which should have been referred to the local safeguarding authority for assessment, but had not. On discussion with staff it was clear that not all staff recognised abuse from person to person as a safeguarding risk; therefore they were not making the appropriate referrals to protect people from harm.

When we discussed this with the registered manager they said staff were informed at handover of all incidents and what measures had been put in place to reduce further incidents; so staff were aware of any changing needs and how to respond to these. However, they agreed this should have been recorded in care plans, risk assessments should have been updated and safeguarding referrals made. They said they would ensure this information was shared with all staff, records were updated and processes reviewed, to ensure correct action was taken in the future.

We recommend that the provider reviews how they report incidents, review risks and share information with

other agencies, in order to keep people safe.

Staff told us they knew how to recognise abuse and would report any concerns to the manager or 'higher up' if necessary. They said there was a whistleblowing policy and they would not hesitate to use it if necessary. All staff we spoke to told us they understood their duty of care, to protect people from harm. However our inspection of records indicated that not all staff recognised all types of abuse, (for example person to person) and were therefore failing in their duty of care to some people. This meant that staff required further clarification and support to identify and report abusive incidents, in order to protect people from harm or abuse.

We asked people if they felt safe living at Cedar Tree Care Home. One person said, "Oh yes, I've never thought about it, I feel safe enough"; another said, "Yes I do"; and another said, "Yes, it's nice, the nurses are really nice." Relatives also felt that people were safe at the service. They told us, "Yes, they'd be out of here if it wasn't. It's the whole atmosphere and the people working here" another said, "I needed to know it was secure".

Staff told us people were safe because the building was 'safe and secure'. One carer told us that there was, "No bullying, it would not be tolerated by [the registered manager]". Another staff member said, "[the registered manager] is constantly on top of safety issues".

People said that there were enough staff on duty to meet their needs. When we asked them if staff responded quickly in response to call bells, one person said, "Yes, most of the time; but there are odd times when no one available, just the odd occasions". A relative said, "There seem to be plenty", and another said, "There's always someone available in a short time". This meant people felt there were enough staff to meet their needs.

The registered manager showed us the rota and said there were eight carers in the morning and seven in the afternoon, plus domiciliary staff and an activities coordinator. They explained how they used a dependency tool to assess the number of staff required to meet people's care needs and made sure that there was always a nurse on duty to administer medicines, along with senior carers to support new or less experienced carers. This meant that there was always the right skills mix of staff on duty to meet people's needs. The registered manager told us they used agency staff only if absolutely necessary, for example at night time. This was because staff preferred to cover if possible, to ensure continuity of care for people. We observed one member of staff in the lounge at all times when people were in there. They told us this was to reduce the risk of falls and so they could respond quickly if someone needed assistance.

We saw staff files that contained all the relevant pre-employment checks, including references and Disclosure and Barring Service (DBS) checks. This showed the provider followed safe recruitment guidance and people employed at the service were considered to be suitable to care for people.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection on 29 July 2013, we found that staff did not always receive sufficient support from the manager, as supervisions were not always conducted at the frequency described in the provider's policy. This was in breach of Regulation 23 of the Health & Social Care Act (2008) Regulated Activities Regulations (2010) which following the legislative changes in April 2015, corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had taken place and a new supervision policy was now in place. However, staff were still not receiving regular supervisions in line with their own policy or with current best practice in the health and social care sector, and the policy was in need of further review.

Staff we spoke to confirmed they had supervision meetings with the registered manager but the frequency varied between staff. The provider's policy states that staff will receive 'one-to-one supervisions twice each year, completed by a more senior member of staff', as well as an observation and three team meetings. This policy does not match current best practice in the health and social care sector, of one-to-one supervisions at least every 6-8 weeks. We also found there was little information recorded in supervision minutes and the structure of the meeting did not provide opportunity for reflective practice or performance management in respect of quality of care, goal setting and reviews. We noticed that supervision had also been highlighted for attention by the local authority at their last contract management review in May 2014. Even though the supervision policy had been reviewed since then, no changes had been made; which meant that staff were still not receiving adequate one-to-one supervision. This meant that staff performance and development was not being formally managed which may lead to poor practice going unnoticed and people experiencing poor quality care.

We recommend that the service considers current best practice regarding the supervision of staff and amend their policy to include any changes made. This would enable the manager to monitor and manage staff performance and lead to improvements in the quality of care people received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and they are appropriately supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that although all care and nursing staff had received training on MCA their understanding of the practical implications for the way that they cared for people, varied. We found examples in care plans where decisions had been made on behalf of

people who lacked capacity but there was no evidence of a 'best interest' meeting or decision recorded.

For example one person who lacked capacity had received a 'flu jab', another had a bed rail and sensor mat in place but there was no evidence of any 'best interest' discussions and decisions recorded prior to the injection or the rail and mat being installed. Staff told us, "Families make those types of decisions if their relative can't". However, staff did not know if relatives had a legal right to do so with a 'Welfare Power of Attorney'. Therefore staff were not always sure that people's individual rights had been considered and promoted and that staff were acting lawfully.

Some people who lacked capacity were prevented from leaving the building by the locks on the external doors and staff diverting their attention elsewhere if they tried to leave the building. Other people had bed rails and sensor mats in place to alert staff if someone was out of bed. When we checked the care plans of these three people we noted that although capacity assessments were in place in all three; there had been no consideration given to if people were being deprived of their liberty in any way. This meant that some people could have received restrictive care without the correct authorisations in place.

In response, the registered manager told us they would 'revisit' MCA and DOLS training with staff to improve their understanding and ensure they were aware of their legal responsibilities when caring for people.

We recommend that the provider seeks advice and guidance from a responsible body and reviews its policy and practice regarding how they support people who lack capacity and make decisions in their best interests. This review should consider the impact of the MCA and DoLS when safeguarding adults.

However, in respect of routine decisions regarding care and daily activities, people told us that staff asked for their consent and explained their care to them. One person said, "Yes they do", another said, "I'm sure they would". Staff told us they always checked with people before offering care, and were led by what the person wanted. We saw examples of this when we observed the interaction between people and staff in the lounge and during lunchtime.

We found people were cared for by staff who had the knowledge and skills to meet their needs effectively. People told us staff understood their healthcare needs and relatives were happy with the way staff understood their family member's individual needs and ways of communicating. One relative said, "[my relative] can't speak, we read their eyes. Staff go through this routine with [my relative] and it seems to be working". Another relative said, "They [staff] know the signs of infection by [my relative's] behaviour; because of the dementia, they know what to do".

Staff told us they received training and support to carry out their roles and responsibilities. They said they had access to mandatory and specialised training which helped them feel more confident in their role. On the day of our inspection some staff attended training on moving and handling using particular hoists. Staff told us this was, "Really good, really useful. We hoisted each other, so got to know how it feels for people". They said they had a better understanding of how it felt for people being moved in a hoist and knew when to reassure people. This showed that staff received training relevant to meet the particular needs of people using the service.

Staff told us they felt supported by the "open-door" management style of the registered manager. Staff said, "[The registered manager] is always around and will offer support or advice if we ask". Staff told us they attended team meetings where they discussed people's care needs, shared information and made suggestions on how to improve care or meet individual needs. They also said that daily handovers were an important part of the information sharing process, in respect of people's changing needs. Records we saw

confirmed that information was shared at handovers and team meetings.

Staff told us they worked well together as a team and supported each other to provide the best care possible for people. One staff member said, "We support new staff, we explain how people like things to be done and show them how to do it". Another said, "The team know each other, we support each other with work, training etc". Staff confirmed they had an induction period when they first started which involved mandatory training, observations and time with senior staff and the registered manager. Records we viewed in staff files confirmed there was a structured induction and training and support takes place. This helped ensure new staff developed the skills to care for people effectively.

Staff told us they had access to on-going training which they said gave them opportunity to update their skills or learn new ones. We saw notices advising staff of dates of upcoming training, along with records in staff files when training had been completed or requested. We also saw the training matrix which provided an overall picture of training, what it covered, when it was scheduled, completed and due for renewal. This meant the registered manager was able to monitor attendance and plan relevant training for all staff, which ensured they had up-to-date knowledge and skills to care for people effectively.

People were supported to maintain a healthy, balanced diet. They were given choice and assisted to eat where necessary. People told us, "Yes, they're quite good meals, I sometimes ask for lemonade". Another said, "Yes, I eat most things". One relative told us, "[my family member] has never complained" another said, "[my relative] enjoys their food, relishes it, they always bring a trifle to top it off". The cook told us they were aware of individual dietary needs, personal food preferences and offered a varied menu which gave people choice and variety.

We saw people were offered culturally sensitive meals for example vegetable curry with chapatti, samosas and dahl and those with specific dietary needs were offered appropriate choices. For example low sugar meals for diabetics, mashed or liquidised for people who required it. We saw evidence of people's nutrition and hydration being recorded and monitored where necessary; along with staff encouraging or assisting people to eat where there were concerns. Staff demonstrated good food hygiene practice and wore disposable aprons and gloves if necessary, during meal times. People were also offered clothing protectors where required, which most people accepted.

People told us they were supported to access community health services when they needed it, to maintain their health. One person told us, "The optician will come in, I'm due another test". Another person said their optician and chiropodist came to see them. Relatives confirmed that people were supported to attend healthcare appointments or healthcare professionals came to the service to see people there, if that was more convenient for them. Care staff told us they had a good relationship with the nurses and could always ask for advice when needed. This showed that the service supported people to maintain their health by supporting access to other services.

Good

# Is the service caring?

## Our findings

People were cared for by staff who were caring, compassionate and enjoyed their work. People told us staff take time to talk to them and get to know them. One person said, "You can have a chat with them and everything, so that's nice". Another person said, "I couldn't do without these girls, I wouldn't hear a bad word said against them". When we asked relatives how staff treated people, one relative told us, "They're all very good, they respect the wishes of [people]". Another relative said, "They are very welcoming. I like to see that they interact with people, they sit alongside someone and spend time with them". Staff told us they really enjoyed their work and caring for people. One staff member said, "I like it here, I've always enjoyed it, I love the residents" another said, "This is a really nice nursing home, we work as a team and the (registered) manager is lovely, so nice".

We observed staff had friendly positive, interactions with people and clearly knew their individual characters and preferences. Staff asked people about their day and people were happy to chat with staff and share their news with them. People were seen laughing and joking with staff. We saw examples of non-verbal support from staff including hand holding, good eye contact, and hands placed on people as they spoke. This showed that there were positive caring relationships developed with people who used the service and staff spent time with people, not just focusing on the task in hand.

People told us staff supported them to be as independent as possible. We observed staff carefully watching people who were getting in and out of chairs independently, making sure they were OK but staying close enough to offer assistance if required. Staff gave clear explanations if they were assisting people and took time to move people at their own pace. Staff were heard to say to a person being moved in a hoist, "Going up menswear", the person was singing and laughing which indicated that they felt secure. This showed that staff respected people as individuals, supported their independence but stayed close by in order to reduce the risk of falls and harm to people.

We saw from care files that people had been involved in their care plans and their views had been considered. Visitors were welcomed and links with the wider community were encouraged and developed. People told us that where possible they made their own choices for example, meals, drinks, clothing, bed time and activities. One person said, "The staff know what I like, they're very good". A relative told us, "The staff do everything they can to make things nice". Staff explained how people liked to dress and how they liked their hair and make-up, which demonstrated that they knew people as individuals and cared about how people looked and presented themselves, as they knew this was important to people.

People's privacy and dignity was promoted by staff who supported independent decision making and respected their views. We saw examples of people being given choice regarding meals and drinks and people being supported to change clothes if needed. Assistance at meal times was discreet and people sat in friendship groups at tables so they could talk to other people. Staff gave us examples of how they promoted people's dignity whilst providing personal care and encouraged independence where possible. Some people spent time in their room rather than the communal lounges and this was respected by staff who also kept a discreet check on people by occasional visits to their rooms.

Staff told us they were encouraged to attend funerals of people who had lived at Cedar Tree if they wished, which was another indicator of the caring and compassionate relationships between people, families and staff.

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to their needs. When we asked people if staff understood their needs and knew their personal preferences, one person replied, "Oh yes they know me". Another person said, "Yes, I suppose so". We asked relatives if people received personalised care and one relative told us, "Yes, as far as I can see". Another relative said, "They pace it and try and find staff [my relative] will respond to". We observed staff at lunchtime providing personalised care to people, one person was asked how much parsley sauce they would like and where (directly on the food or next to it on the plate); other people were asked if they would like assistance with cutting up food and everyone was offered a choice of drinks. We saw one person was provided with a culturally specific meal that was different from what other people were eating. We observed staff offering discreet and prompt attention to people where required and heard meaningful conversations with people during the lunch period.

Staff told us that they had introduced new seating arrangements that week at mealtimes and grouped tables together to make it more sociable for people. This was in response to a staff member's suggestion after they had observed little interaction between people at lunchtime and new people had said they had no one to talk to. The staff were hopeful that the new seating arrangements would enable people to talk to each other and develop or maintain friendships. Tables were set with table cloths, flowers and name cards; this made it look inviting and made it more of an occasion, rather than just a task that needed to be completed. The introduction of new seating arrangements showed staff were responding to people's needs and using different ways to enable people to mix with others and develop new friendships or social groups. We saw and heard people chatting to each other and the staff, which demonstrated that the new arrangements had a positive impact on people.

The service had caged birds and guinea pigs at the request of people and a safe landscaped garden with bird feeders, seating areas and flowers. These were examples of how the provider had responded to individual likes and interests. We saw people smiling and talking to the birds and the guinea pigs which showed that the animals had a positive impact on people's wellbeing. A local rail preservation group had donated a model railway that they installed in one of the communal lounges, for people to use. Staff told us about one person's previous employment in the rail industry and their love of trains and how they had 'hours of fun' using the model railway, along with friends and visitors. This provided a meaningful activity for people and provided opportunities for reminiscence and socialising with family, friends and staff.

We saw activities taking place throughout the day of our inspection, these included group bingo, bean bag game, singing and one-to-one time, when staff spent time with individuals reading, talking or colouring. We saw and heard people laughing and joking with staff during these activities or smiling and taking an interest in one-to-one activities. This showed us that people's individual needs were catered for which also provided opportunity to take part in stimulating activities, meaningful conversations and socialising. This provided variety for people throughout the day and had a positive impact on their wellbeing.

We spoke to the activities coordinator who showed us the varied resources they had and spoke about individual people's personal interests and how they supported them to maintain or access these. For

example one person was supported to attend the temple every week, another was accompanied to the theatre and football matches. A small group went to the local pub; and church groups visited regularly to attend to the spiritual needs of people. The activity coordinator showed us the daily activity records they had developed for people, which included photographs, comments and suggestions from people. We also saw examples of art and craft work around the rooms that people had created, this made it a homely environment and provided 'talking points' for people and visitors. There was a regular programme of entertainers for people and their guests. This demonstrated that the service responded to the interests and diversity of people using the service, enabled participation where possible and developed links with the wider community.

The registered manager was keen to ensure that the service was part of the community. They encouraged groups from the community to come to them, for example the Salvation Army regularly came to meet people and groups from local schools also visited. They also supported people to attend events and services in the community, for example a group of people regularly visited the social club next door. This helped people retain their sense of personhood and develop or maintain external relationships which were important to them.

Our inspections of care files showed us that people and families contributed to care plans, risk assessments and reviews. People and families had provided information about individual histories, family relationships, pets, interests and significant events in people's files and this information was used in care plans where relevant.

People told us they knew how and who to complaint to, if required. One person said, "Yes, I've only had one argument in eight years". Another person told us, "I'd just call one of the nurses or the (registered) manager". There was also a copy of the complaints procedure in reception which relatives told us they had seen and would not hesitate to use if they had any concerns. There were no complaints received by the registered manager but we did see the policy and how they would respond if they did receive a complaint.

The service listened and responded to people's experience of care and to feedback and comments from relatives. Relatives told us they were invited to meetings to discuss plans with the registered manager and there was a monthly news sheet to keep people and relatives informed. We saw questionnaires available in the reception area for people to give feedback and we saw completed questionnaires which were read by the registered manager and used to plan improvements.

The registered manager gave examples of how they had changed things in response to feedback. For example changing the dining arrangements as a response to staff suggestions; offering a glass of sherry to a person's visitors, as this is what they used to do at their own home. They told us they had held a cheese and wine event the day before our inspection, which we heard people talking about and they had a BBQ the week before when the weather was nice. They said that even though they had a plan for activities, this was flexible and was changed depending on individual needs, abilities and the weather. This indicated that the provider responded positively and used feedback and comments to improve the service and the experience for people living there.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager adopted an open and inclusive style of management where staff felt supported, motivated and empowered to develop themselves and provide the best care possible.

People told us they felt the service was well managed. One person told us, "It's nice, there's someone you can go to" another said, "The [registered] manager is a lovely person, nothing is too much trouble". Relatives told us they felt the service was well managed and the registered manager was available and approachable. One relative said, "Yes, especially when you hear about other places. Another relative told us, "[the registered manager] cares for the relatives as much as the residents, but in a different way". This demonstrated that people and families were confident in the management of the service and the registered manager was accessible to people and families. This reassured families that their relatives were 'in the right hands'.

There was visible management and leadership of the service. Staff were supervised by the registered manager and supported to be creative in how they supported people. A staff member told us, "[The registered manager] is always available and is lovely, will try and solve anything if we have a problem". Another staff member said, "[The registered manager] is by far the best and listens to us, looks after us to the best of their ability". Staff told us they attended team meetings where they discussed people's care needs, shared information and made suggestions on how to improve care or meet individual needs. Records we saw confirmed that information was shared in team meetings.

Even though staff said they felt supported by the registered manager, we were concerned that the existing supervision policy was out-dated and the supervision that staff received was of poor quality. We found the registered manager had not followed advice from previous inspections, conducted by the local authority and ourselves, and had not improved the frequency or quality of supervisions. We were concerned that without a robust supervision policy and more frequent supervision of staff, the registered manager may find it difficult to monitor and manage the performance of staff. This meant people could experience poor quality care as a result of this.

The registered manager said they were supported by the directors who also made sure resources were available, to improve the facilities for people using the service. The registered manager told us they understood their responsibilities in respect of their CQC registration and notified us of events and incidents as required. We checked our records and confirmed that notifications had been received regarding expected and unexpected deaths. However we noticed that they had not always reported safeguarding incidents to us or the local authorities when they had a duty to do so, nor had they always notified us when a DOLS was in place for people using the service. This demonstrated that the registered manager did not always recognise their responsibility to inform other authorities of concerns or information they had about people; where they had a duty to do so. This could mean people were not always protected from unsafe situations.

Staff told us they were motivated and empowered by the registered manager to do the best they could. One senior staff member said, "[The registered manager] knows I'll do what's best for people, so leaves me to it".

Staff understood their roles and responsibilities and supported each other to improve. A relative said to us, "Staff know what they are doing, 100% good here." Staff spoke highly of the senior team and of their colleagues which demonstrated a supportive and empowering working environment. This had a positive impact on people using the service as they were cared for by staff who enjoyed their work and were encouraged to develop positive relationships with people.

The registered manager was responsible for maintaining and improving the quality of care for people using the service. They explained how they attended local forums to meet with other care managers to share ideas, best practice and discuss new guidance. This showed how they were able to keep up-to-date with new practice and learn from others. They showed us their audit processes and examples of how things had changed in response to findings from audits. For example there was now a staff member in the lounge at all times in response to an increase in falls. This had led to a reduction in the number of falls in this area which meant that people were safer and had a reduced risk of injury.

We saw records of team meetings where achievements were shared with the staff team and ideas were discussed for changes and improvements to care and activities. This demonstrated staff were actively involved in developing the service, which was empowering and motivating for them. We saw thank you cards and letters on display from family and visitors who commented on the high quality of care their relatives had received. These examples demonstrated that the registered manager had a positive approach to improvement which benefited people who used the service, as they received higher quality care from staff who wanted to do better.