Care Quality Commission

Christchurch Fairmile Village LLP

Fairmile Grange

Inspection report

Royal Close
Christchurch
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Tel: 01202476960

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30 January 2018

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

Summary of findings

Overall summary

This inspection took place on the 23 January 2018 and was unannounced. It continued on the 24 and 30 January 2018 and was announced. This was the services first inspection since registration on 5 January 2017.

The home had a manager who had been in post four months at the time of our inspection. During our inspection they became the registered manager. 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.

Fairmile Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide care for up to 80 people. At the time of our inspection there were 50 people in the home some of whom were living with a dementia. The home provides accommodation over four floors. Rooms have en suite shower facilities. Communal facilities include specialist bathrooms, lounge, kitchenette and dining rooms, quiet social areas and an accessible garden.

People had not always been protected from avoidable harm as actions in place to minimise risks to people had not always been followed. One person had a high risk of falls and needed to have their walking aid in reach and an alert pad on their chair. We found this had not happened. We observed another person have a fall and they were lifted off the floor by care staff instead of using moving and transferring equipment. This meant people were at risk of avoidable injuries.

Medicines had not always been stored, administered or recorded safely. We observed a medicine trolley left unlocked and unattended potentially providing access to vulnerable people. Topical cream administration was not consistently happening in line with prescriptions meaning people were at risk of deteriorating skin conditions. Protocols for administering medicine as required for mood management had not been followed which meant that people could be having unnecessary medicines.

People had person centred care and support plans that had been developed in line with current good practice guidance and were stored securely on a computer database. Care workers and agency care staff had limited access to information held on the computer which meant people were at risk of not receiving consistent person centred care

People had the opportunity to develop end of life care wishes. Reviews took place regularly and at times included people, families and social and health care professionals.

People at risk of malnutrition had their weight, food and fluid intake monitored. Measures to reduce risks

such as fortified foods, high calorie drinks and referrals to a GP were in place. People had their eating and drinking needs met including special diets and allergies. Meals were well balanced and appetising with plenty of choice. Some people were at risk of skin damage. Pressure relieving equipment was in place and being used correctly. People were protected from avoidable risks of infection as staff had been trained in infection control and food hygiene. Staff understood how to recognise abuse and the actions needed if abuse was suspected. Interactions between people and staff was respectful and respected people's individuality.

People were supported by enough staff to provide safe care. Processes were in place to manage high sickness and absence levels, staff retention and more clarity and efficiency with the staffing rota and staff deployment. Staff had been recruited safely including checks that they were suitable to work with vulnerable adults. Staff had completed an induction and on-going training which provided them with the skills to carry out their roles and continue with their professional development.

People were supported to access both planned and emergency health care when needed. Working relationships with other professional agencies meant that people were receiving positive experiences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their families described the staff as caring, kind and courteous. If people were anxious staff spent time offering emotional support. Staff had a good understanding of people's interests and this meant that staff could talk with people about things that interested them. Activities took place in groups and also individually reflecting a person's interests or hobbies. People had their communication needs understood which meant they could express themselves and be supported to make choices about their day to day life's. People's privacy, dignity and independence was respected which enabled people to express their individuality. A complaints policy was in place which people and their families were aware of and felt able to use if needed.

Staff had not always felt involved in decisions that impacted on their roles and responsibilities. Systems had been introduced to improve communication such as general staff meetings, daily heads of department meetings and a newsletter. Resident, relative and staff meetings had been held to share information, receive feedback and discuss changes in the service.

When the registered manager took up their post they made us aware that they found statutory notifications had not always been sent to CQC and then sent us the missing information. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had not received information to support their monitoring of the service in a timely manner.

Quality assurance processes were in place and actions plans were in place and completed in a timely manner when areas for improvement had been identified. Information gathered from feedback from external monitoring visits, audits and accident and incident reports had been shared with staff as a learning opportunity to reflect on practice.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people had been assessed but actions to minimise the risk of avoidable harm and not always been followed.

Medicines were not always stored, administered and recorded safely.

Processes had been introduced to enable lessons to be learnt from accidents and incidents.

People were supported by enough staff that had been recruited safely.

Staff understood how to recognise abuse and the actions needed if abuse was suspected.

People were protected from avoidable risks of infection.

Is the service effective?

Good

The service was effective.

Assessments of peoples care and support needs were carried out in line with current legislation and best practice guidance.

People were supported by staff who had completed an induction and ongoing training that enabled them to carry out their roles effectively.

People had their eating and drinking needs met.

People had access to planned and emergency healthcare when needed.

Working with other professionals enabled effective outcomes for people.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring and provided emotional support appropriately.

People had their individual communication skills understood which enabled them to be involved in day to day decisions about their care.

People had their dignity, privacy and independence respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support plans were person centred and regularly reviewed but not fully accessible by care workers or agency care staff which meant people were at risk of not receiving consistent person centred care.

A complaints process was in place and followed when complaints had been received.

People had their end of life wishes respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Processes had been introduced but not embedded to support staff involvement in changes to the service, promote teamwork and staff understanding of roles and responsibilities.

Information had not always been shared with other agencies in a timely manner.

People, their families and staff had opportunities to be engaged with the service through meetings and quality assurance surveys.

A programme of scheduled audits is effective in highlighting areas of improvement and used to improve service delivery.

Care Quality Commission

Fairmile Grange

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.

The inspection began on the 23 January 2017, was unannounced and the inspection team consisted of an inspection manager, two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued with one inspector on the 24 and 30 January 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider was not asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with six people who used the service and nine relatives. We spoke with the quality and learning manager, head of people, learning and development manager, registered manager, two deputy managers, five nurses, two senior care worker, five care workers, two agency care workers, an administrator, chef, dining room supervisor, hostess and two activities organisers. We also spoke with a visiting health care worker from a local hospital and community mental health nurse to gather feedback on their experience of the service. We reviewed eight peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing

the safety and suitability of the environment and observing staff practice.

Following the inspection the provider sent us additional information on staffing levels which we considered alongside evidence gathered during the inspection.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm. Assessments had been completed which identified risks to people. Actions had been put in place to minimise identified risks but had not always been followed.

One person had a high risk of falls. They needed to have their walking aid with them at all times and an alert pad on their chair to alert staff when they stood up. We observed the person sitting next to the nursing desk without their walking frame or alert pad. The previous night they had fallen and required hospital treatment for an injury. We spoke with a nurse who had been on duty when the fall happened and they confirmed the alarm pad had not been in place at the time of the fall. The accident report read that the person had not had their frame with them when they fell. We later observed the person lying on top of their bed with their alarm pad in place. However, a senior care worker told us their walking aid had been left in the lounge area. We observed three staff supporting another person who had fallen. Their care and support plan stated 'If found on the floor two staff to use hoist to support up'. We observed them physically helping the person from the floor into a chair. Following the inspection the registered manager told us staff are trained to assess each moving and transferring situations at the time to determine the best and safest method. Staff supporting the person who had fallen had felt the best way to stand them had been enabling the person to stand without the aid of a hoist. However the practice we observed had not reflected the persons care and support plan. We discussed our findings with the registered manager during our inspection who immediately carried out a review of risk assessments and care and support plans for both people and shared this with the senior staff team. The moving and handling trainer met with staff to review their practice and understanding.

People did not always have their medicines stored, administered or recorded safely. Some people had been prescribed topical creams. A care worker told us "(Name) doesn't have cream in their room as they eat it". The person mobilised independently and due to confusion linked to their dementia was known to enter other people's rooms. We queried their access to other people's stored creams. The care worker explained that creams were kept in cupboards with safety catches. We checked the room opposite and found the catches not working. A Medicine Administration Record (MAR) was in place to record when creams had been applied. One person had a cream that needed applying daily but had been recorded as only given 11 times in 30 days. Another person had a cream prescribed twice daily. It had only been recorded as applied 20 times over 30 days. Creams had not always been dated when opened to ensure they were within safe dates to be effective. Information for administering creams did not always provide detailed information such as where the cream needed to be applied or how often.

Some people had medicines prescribed for as and when required (PRN). Protocols were in place that described what the medicine was used for and which circumstances it could be administered. One person had a medicine to manage their mood. The protocol included looking at other methods first such as ensuring known triggers that could cause the behaviour were not present. The protocol stated that before administering the medicine there had to have been two incidents of aggression within half an hour. The MAR showed the person had been given the medicine on two separate occasions in January. We checked

their behaviour records and on both dates there had been no recorded incidents of challenging behaviour. After the inspection the registered manager told us that staff also gave this medicine as part of a de-escalation plan prior to any distressed reaction manifesting. This practice differed to the actions set out in their medicine protocol and may have put them at risk of receiving inconsistent support to meet their needs.

We observed one nurse leave a medicine trolley open and accessible to people living with a dementia whilst they went to dispense medicine. We discussed this with the registered manager who told us they would review the medicine audit tool in order that it would be more effective in capturing the issues raised at this inspection.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was at risk of malnutrition. They had been prescribed a high calorie fortified drink. Staff explained that the person only tolerated hot drinks so they warmed it up first for them. Another person had been referred to their GP and their weight was being monitored weekly with records kept of their food and drink intake. The kitchen staff were preparing them food fortified with additional calories and records showed us their weight had been slowly increasing.

Some people were at risk of skin damage. Equipment such as pressure relieving mattresses and chair pads were being used correctly. Some people needed staff to regularly help them change position in bed and records showed us this happened.

Some people had medicine that was time critical. A relative told us "I've checked as it's so important for managing their (health condition) and it's happening". Some people living with dementia were unable to tell staff if they were experiencing pain, staff used a recognised tool to assess if people were in pain. This meant people received pain relief when they needed it.

Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. We saw information on notice boards providing information about external agencies that could be contacted if people, their relatives or staff had concerns. One person told us "I always feel safe when the staff help me". People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers and moisturisers available at points throughout the building. Staff understood actions to take if someone is suspected of infectious disease and required barrier nursing. All areas of the home were clean and odour free.

People were supported by enough staff to provide safe care. Staff sickness, absence, retention and changes to staff working patterns had left some staff concerned about staffing levels. We checked staffing rotas from 23 November 2017 to 19 January 2018 and found staffing levels for shifts were variable. Examples included am shifts varying from 14 to 20 staff, pm shifts varying from 12 – 19 staff and nights from six to ten staff.

We spoke with the registered manager and looked at records which demonstrated that management processes had been introduced to reduce staff absence and provide more parity on the rota which would

mean more consistent staffing. Agency care workers and staff from other homes in the organisation provided additional staffing when needed. A care worker told us "People's care needs are met regardless of the staffing such as re-positioning and toileting". A nurse told us "Some days there are enough some days not. It's more about skill set, sometimes confidence as well". A night nurse told us "There are enough staff at night. The twilight shift support the staff. Night carers can get on (with helping people. After midnight it's usually quiet". Nursing staff completed a dependency tool which calculated the hours needed to support people's assessed needs. The registered manager told us that staffing each day was approximately 50 hours over the dependency tool recommendation. A hostess role had been introduced to provide additional support at mealtimes enabling care workers to have more time supporting people with their meals. We observed activity staff providing social engagement throughout our inspection. People told us and we observed staff responding to call bells and people needing assistance in a timely manner.

People were supported by staff who had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults.

Accidents and incidents were recorded and shared with staff at shift handovers and a daily heads of department meeting and included any changes to how risks to people needed to be managed. Where concerns had been bought to the registered manager's attention they had co-operated fully with relevant authorities to ensure people were protected.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care plans had been developed in line with current legislation, standards and good practice guidance.

Staff had completed an induction and received on-going training that provided them with the skills to carry out their roles effectively. One person told us "The staff know their job". A care worker told us "I've completed the care certificate, had a week long induction and completed additional training such as first aid. I've been given the opportunity to complete a health and social care diploma". The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Nurses had received clinical training updates. One nurse told us "The training is very good. I have recently completed catheter and venepuncture (taking of bloods). Now I just need to have 10 observations before qualified to take bloods on my own".

The learning manager explained that staff had asked for more training on dementia as part of their monthly supervisions. They said "At the moment staff get a half day face to face workshop then an on-line module. We now have a new dementia programme starting next week. There are four one day sessions for every member of staff. The modules included communication, living life well, reality of dementia where people's families will be involved and challenging behaviour".

Job chats formed supervision for staff and were recorded. They included opportunities for discussing concerns, goals and personal development. We read that one nurse had requested wound care training. Records showed us they had completed this with an external trainer.

People had their eating and drinking needs met. One person told us "The food is good. You put in an order and you get it. I enjoy a bacon buttie". A relative explained "The food is very good. They will always do something else if (name) doesn't like it." We observed people being served well balanced, appetising meals. Menus included hot and cold choices for each mealtime. People were able to choose where they had their meals around the home and invite family and friends to join them. People living with dementia or people who had a visual impairment had modified crockery to support them remain independent at meal times. Care staff, meal hostesses and the catering team knew peoples dietary requirements, likes and dislikes. The chef told us "When we talk about likes and dislikes with food we also like to ask about their hobbies so that we can decorate their birthday cake. One man liked fishing and we made a cake the shape of a fish". Each floor had a kitchen and the fridge was filled daily with snacks including soft textured foods for people with special dietary needs. Soft drinks were also available throughout the day.

Working relationships with other professional agencies supported positive outcomes for people when receiving care. A visiting health professional told us "Staff follow professional advice and care plans are mutually agreed". A community mental health nurse told us "They (staff) are quick to raise any alerts to our team. It all seems to work well".

People were supported to maintain their health and had timely access to healthcare when needed. Records showed us that people had access to a range of health practitioners including a GP, opticians, dentists, chiropodists and audiologists.

The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible outside space. Lighted shelving outside people's rooms contained personal items of interest to help people orientate themselves to their room. Toilets and bathrooms had pictorial signage on doors and contrasting colours to aid people to orientate themselves independently. A beach sensory area had been created and included sand and sea shells. We discussed with the registered manager displaying details about activities, the day, month and other general information in a simple clear way to aid people's orientation.

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 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.

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 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.

Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. A Health and Welfare Lasting Power of Attorney (LPA) gives one or more trusted persons the legal power to make decisions about people's health and welfare if they lose capacity. Where people were not able to make decisions this had been clearly assessed and decisions made on their behalf reflected the principles of the MCA. For example, one person had a capacity assessment around the possible need for their medicines to be given covertly. There was a decision made in the person's best interest which had included their GP and family when considering whether this was the least restrictive option for the person.

Good

Is the service caring?

Our findings

People and their families described the staff as caring. One relative told us "We have nothing but praise for the home, facilities and care". Another said "I've never been treated with such kindness and courtesy. It's paradise here. The staff are all wonderful". We observed one person shouting out and quite distressed. A care worker went and spoke quietly to them, offering reassurance. They offered the person coffee and they stayed with them until they calmed down. We saw another person having a hug with a care worker. They told us "(Name) gets frightened. She just needs reassurance, a little more than others". We read their care plan which stated the person approached staff for a hug when frightened.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them.

Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level, using hand gestures and facial expressions and using visual props to aid understanding

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A care worker explained "(Name) is (foreign national) and I can speak a few works so we have a chat. I bought (name) some (foreign language) word books. We have a biography and it's a great starting point for a conversation when (name) becomes agitated". We observed staff talking with people about their families and topics such as pets that brought a smile to faces. .

People were involved in decisions about their day to day care. A relative told us "I find they (care workers) ask (name) rather than tell, for example for having a bath. (Name) can be difficult and choose not to have a bath. At home I would just say 'you're having one' but here they ask and give choice". We observed staff involving people in decisions. Examples included finding out how a person would like to spend their time or where they would like to sit.

People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. Staff also knew the informal names people had chosen to be addressed by and used these appropriately. People's clothes and personal space were clean and reflected a person's individuality. Confidential information was stored in secure cupboards or on password protected computers.

Requires Improvement

Is the service responsive?

Our findings

Detailed care plans had been written and were stored electronically. They were comprehensive and included information about a persons assessed care and support needs. The computer was accessed by nurses and senior staff. Care workers and agency carers did not have access to the computer. They accessed a written paper summary about each person but they did not contain enough information to ensure people received person centred care. A nurse told us "Agency staff don't access the computer for care plans. We have folders and the front sheet 'Who Am I' provides a summary of care. An agency care worker told us "Information about people is in care plans but we can't access it. The senior sends us to help somebody and they tell us about their mobility". They went on to say "We're not told about residents risk such as swallowing. You have to ask. It would be helpful to have a list in the kitchen. For example residents may say they take sugar and they don't because they are diabetic. They would not perhaps be able to tell you this". Following the inspection the registered manager told us that dietary information was recorded on the 'Who Am I' sheets which agency and care staff are able to access. They also advised us after the inspection that agency and care staff do not assist with serving meals from the catering trolleys.

Not all care workers had read people's care and support plans. We spoke with a care worker and an agency carer. Both had changed which floor they were working on half way through their shift. They both told us they had received information about people at the start of their shift but not been given information about people when they moved to work in another part of the home. We observed staff on two occasions not following people's moving and transferring care and support plans. On another occasion we saw a person who was struggling to walk whilst being supported by two staff although their care and support plan described them as independent with their mobility. Records showed us the person had been visited by their GP and been diagnosed with a health condition that impacted their mobility. This had not been reflected in the care and support plan or paper records. We spoke with the registered manager who reviewed and amended the care and support plan. This meant people were at risk of not receiving care that met their needs.

Handovers took place at the beginning of a shift and included an update on any changes with a person. We observed a night nurse handing information over to a morning shift and actions such as contacting a GP were completed by the next shift. The deputy manager told us they were introducing a new handover sheet which would include key details about each person such as whether they had a 'Do not attempt resuscitation' in place or a 'Deprivation of Liberty Safeguard.
Care and support plans were reviewed monthly. Records showed us that reviews had included people, their families and other health and social care professionals.

Information had been gathered about people past interests and hobbies. We spoke with an activity organiser who explained how this information has been used to create person centred activity opportunities. They told us about one person who following a health condition was unable to continue with their hobby. They had found innovative ways to support the person in getting involved in their hobby again. We observed another person who enjoyed helping with chores washing up cups with a care worker. A memory café had been set up. The activities organiser explained "People from outside (community) come

as well. We have tea and coffee. Last week was pets and animals; it sparks conversation". We observed people joining in with armchair exercises, pet therapy, manicures and music and singing. A monthly activity planner was on display and included a range of organised activities.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman.   A relative told us "I would feel able to make a complaint; I wouldn't feel threatened". Another said "I would complain on (relative's) behalf if not happy; think they would listen". We looked at the complaints log which recorded verbal complaints as well as written formal complaints. There had been three complaints in 2017 which had all been investigated and appropriate actions taken to resolve the issues included a referral to the local authority safeguarding team.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. We read feedback from one family which said ' Thank you to all at Fairmile Grange for making the last few weeks of my mums life as good as it could have been'.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post for four months and was registered with CQC during the inspection. Changes in management had left some staff feeling disempowered whilst other staff described changes as "positive and needed". The provider told us time and investment had been put into listening to staff. Heads of people explained "We asked 'what would you like to change'? The main things were sickness levels, weekend work not fairly covered on the rota and staff having weird start times". Management processes had been followed to address these issues. A care worker explained that they had been involved in meetings about their sickness levels and felt it had been dealt with sensitively. Over four months approximately 30 percent of the staff team had left the service. This had impacted on people and their families who told us they missed their favourite carers and were having to get used to new staff and an increased number of agency care workers. The registered manager explained the values of the service. "It's all about teamwork. We are a new management team with embedded principles and we need to move the whole team forward".

Staff did not always feel involved in changes that impacted on their roles and responsibilities. A care worker explained "A new hostess role has been introduced and we weren't involved. The hostess role impacts on my care role. We would have liked some reflection on the role, health and safety aspects, making it work for residents". After our inspection the registered manager sent us text from a senior care staff meeting held on 20 November 2017. It read 'MMO (registered manager) said there are to be two dining room assistants to ease the role of the carer and ensure safety in the dining room'. They also advised this information was then cascaded. Another told us "We changed from the on line to paper records without any explanation and are concerned completing paper documentation takes up more time than anything else". Another care worker told us "Teamwork varies; senior staff need to sing from the same song sheet". Systems had been introduced to improve communication but had not been fully embedded. During our inspection a planned general staff meeting was held. A nurse told us "It's the first positive meeting we have had. (Registered manager) has also set up a Head of Department meeting which is good. It's good we can communicate with each other and know what other departments are doing; it helps with communication between departments. We also have 11-11 meetings (daily). It's good you can share concerns and perhaps somebody's birthday. Normally I take my senior with me and we can give information to staff".

We read minutes of the first governance meeting with nurses and senior staff held in January 2017. Topics had included accountability and clinical governance. All senior staff and nurses had been enrolled on a leadership course that commenced during our inspection. The course involved face to face workshops and included topics such as managing through communication and management through governance. A nurse told us "Things are put in place now that were missed. You sometimes need fresh eyes. Things are being more delegated appropriately".

The registered manager when they took up their post found that statutory notifications had not always been made to CQC. They made us aware of this and provided us with the missing information. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had not received information to support their monitoring of the service in a timely way.

We read minutes for resident meetings, relative meetings and staff meetings that had been held in January 2018. The meetings had been used to share information about changes to the service and provide opportunities for concerns and ideas to be raised. At the residents meeting feedback had included call bells being answered more quickly and good nursing care with problems dealt with quickly. A quarterly newsletter had been introduced and the December 2017 issue included information on activities, new and leaving staff and an invite for families to join in for lunch or supper on Christmas day.

Quality assurance systems were in place to and used to gather information about service delivery. Where areas of improvement were identified actions had been put in place. An example had been staff not receiving post incident support. In response a policy had been written and shared with staff. During our inspection the registered manager identified post incidents were staff had been injured and met with them to provide support and reflective learning. We read minutes of staff meetings were findings of external monitoring visits had been shared and enabled lessons to be learnt. Staff had feedback they hadn't felt appreciated or valued. The operations manager told us two pamper days had taken place for all staff. An independent counselling service had been introduced for staff to access if they needed external support.

The staff team worked with other organisations and professionals to ensure people received good care. Records and feedback from professionals indicated that the staff followed guidance and shared information appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had been assessed but actions to minimise the risk of avoidable harm and not always been followed. Medicines were not always stored, administered and recorded safely.