Fairview Care Home Ltd

Fairview House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 4 and 9 December 2015 and was unannounced. The home provides accommodation and personal care for up to 24 people, including people living with dementia. There were 17 people living at the home when we visited.

At our previous inspection, on 8 June 2015 we identified that records relating to decisions made on behalf of people were not recorded appropriately and records relating to people's care were not always up to date. At this inspection we found action had been taken and the provider was meeting the fundamental standards of care and safety.

The home had a registered manager in place. 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.

Summary of findings

Providers are required to display their performance rating on their public website and prominently within the home. The provider had not done this, although their rating was displayed in the home on the second day of the inspection.

Most medicines were managed appropriately, although there was a lack of information about when to administer 'as required' medicines and topical creams were not always managed safely. Suitable infection control processes were followed, other than the storage of clinical waste in the laundry which posed a risk of cross infection.

The risks of people falling or developing pressure injuries were managed effectively. However, one person's pressure relieving mattress was set at the wrong level and a door wedge was being used which would have prevented a fire door from closing in an emergency. Where accidents had occurred, appropriate action was taken to reduce the risks.

Legislation designed to protect the rights and freedom of people was followed. Staff sought consent from people before providing care and support. Staff were suitably trained and supported in their role, although supervision meetings were only held sporadically for some staff.

There was a system in place to regularly assess and monitor the quality of service. Changes were made when they were identified, but audits had not picked up the lack of information about 'as required' medicines or that the system to manage topical creams was not being followed.

Most people felt the home was run well. A high level of staff turnover had unsettled the staff team, although team work was improving. There was a clear management structure on place and staff understood their roles.

People told us they felt safe at Fairview House. Staff had received training in safeguarding adults. They knew how to identify, prevent and report abuse and responded appropriately to allegations of abuse.

There were enough staff to meet people's needs and appropriate recruitment practices were in place. People were complimentary about the food and were encouraged to eat and drink well. People were supported to maintain good health and had access to healthcare services.

People and their relatives described staff as "kind" and "caring". We observed positive interactions between people and staff. Staff knew people well and spoke about them fondly. They engaged in meaningful conversations and encouraged people to remain as independent as possible.

People's privacy and dignity were protected at all times. They, and their relatives when appropriate, were involved in planning the care and support their received. Care was delivered in a personalised way and people were supported to make choices.

Care plans included clear guidance about how people wished to receive care and support. They were updated regularly and staff were responsive to changes in people's needs. A range of activities was provided. Feedback from people about the service was sought and acted on.

People had agreed to the use of a CCTV system to monitor communal areas of the home. This was used to investigate complaints and allegations of abuse. The provider notified CQC of all significant events. The registered manager was aware of key strengths and areas for development for the service and there was a development plan in place.

We identified a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Medicines were not always managed safely. The storage of clinical waste posed a risk of infection. Individual risks to people were not always managed safely.

There were enough staff to meet people's needs. Recruitment practices were safe.

Requires improvement

Is the service effective?
The service was effective.

Staff were suitably trained and supported to perform their roles effectively.

People were offered a choice of suitably nutritious meals and received appropriate support to eat and drink. The nutritional intake of people at risk of malnutrition was monitored effectively.

Staff followed legislation designed to protect people's rights. People could access healthcare services when needed.

Good

Is the service caring?
The service was caring.

People were cared for with kindness and treated with consideration. Staff knew people well and spoke fondly about them.

People, and their relatives where appropriate, were involved in planning the care and support they received.

People's privacy and dignity were protected and confidential information was kept securely.

Good

Is the service responsive?
The service was responsive.

People received personalised care and their needs were met. Care plans were detailed and were reviewed regularly. People could take part in a range of suitable activities.

The provider sought and acted on feedback. There was an appropriate complaints policy in place.

Good

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

The provider had not displayed their previous inspection rating in their website or on the premises.

Requires improvement

Summary of findings

There had been significant turnover of staff which had unsettled the staff team and impacted on team working.

Quality assurance systems were in place but had not identified concerns relating to the management of medicines. Investigations of complaints or concerns were thorough. The provider notified CQC of significant events.

Fairview House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 4 and 9 December 2015 and was unannounced. The inspection was conducted by one inspector.

Before the inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also obtained feedback from the local authority safeguarding team.

We spoke with four people living at the home and three family members. We also spoke with the registered manager, the deputy manager, the head of care, two senior care staff, four care staff, the cook, the cleaner and the maintenance person. We looked at care plans and associated records for four people, staff duty records, four recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

We observed care and support being delivered in communal areas. 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. Following the inspection we received feedback from a doctor.

Requires improvement

Is the service safe?

Our findings

There were appropriate arrangements in place for obtaining, recording, administering and disposing of most medicines. Staff were suitably trained to administer medicines and knew how people liked to take them. A series of audits by staff, supervisors and the registered manager was in place and had helped make sure people received all their medicines as prescribed. One person received their medicines covertly by staff hiding the medicines in small amounts of food to make sure the person received them. This had been discussed with the person's family, the GP and the pharmacist to make sure it was done in a safe way. In line with best practice guidance, staff only used this method of administration when essential and always offered the medicines to the person openly first.

Information was available to help staff recognise when people needed to be given 'as required' (PRN) medicines, for example sedatives to relax them when they became anxious. However, this did not always include information about the dose to give or how long staff should wait after giving one dose before giving another. We saw sedatives were used rarely, as staff were skilled at using alternative strategies to support people when they became anxious. The system used to make sure topical creams and ointments were not used beyond their safe use-by date was not robust; it relied on staff writing the date on the container when it was opened, but this was not always done. We brought this to the attention of the registered manager and by the end of the inspection they had developed additional guidance for staff and introduced a new creams monitoring system.

Medication administration records (MAR) confirmed that people received their medicines as prescribed. Some people were living with dementia and were unable to communicate when they were in pain. For these people, information was available to help staff identify when people needed pain relief.

Suitable arrangements were in place to protect people and staff from the risk of infection. A family member told us "[My relative's] room always looks nice and I've noticed there is always someone cleaning the wheelchairs." New bedding had recently been provided throughout the home and the registered manager conducted daily checks of this, and people's rooms, to check they were clean. All staff had received training in infection control and had ready access to personal protective equipment (PPE), such as disposable gloves and aprons, which they used appropriately. Check sheets confirmed cleaning had been completed as planned. All areas of the home were clean and fresh. Most clinical waste was stored safely, although used continence pads were sometimes brought into the laundry for storage initially, before being transferred to outside clinical waste bins; this created an unnecessary risk of cross infection. We discussed this with the registered manager who told us they would make arrangements for clinical waste to be stored outside of the laundry.

We viewed the provider's policy on infection control. Although this had been reviewed recently, it referred to out of date guidance issued in 2003, so did not reflect current best practice. However, staff had access to this guidance in a separate document. Regular audits of infection control were conducted and we saw this had led to improvements. For example, pedal operated bins had been installed in the kitchen and a new procedure had been introduced for cleaning carpets.

People and their relatives told us that care was delivered in a safe manner and they felt safe and comfortable around staff. One person said, "It feels like a safe place and if I ask for help I always get it." A family member told us "[My relative] is absolutely safe; I've got no worries about that at all." Another family member said, "I've no concerns. I can walk out of here and feel I don't have to worry about [my relative]."

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. Records showed the registered manager and other staff responded appropriately to allegations of abuse. We viewed a sample of these, which showed they had been investigated thoroughly and in cooperation with the local safeguarding authority. A staff member told us "[The registered manager] takes [abuse] seriously. She just wouldn't accept it."

The provider had installed CCTV in communal areas so the safety of people and staff could be monitored from the registered manager's office. An appropriate policy was in place and its use had been discussed and agreed with

Requires improvement

Is the service safe?

people living at the home, or the person's relatives if they lacked the capacity to make the decision themselves. The registered manager told us the system had been useful when investigating incidents or allegations of abuse.

Individual risks to people were managed effectively. These included the risk of people falling or developing pressure injuries. Fall saving equipment, such as walking aids, were in people's reach at all times and staff encouraged people to use them correctly. Where people had fallen, additional measures were put in place to protect them, such as reviewing their medicines or changing the layout of their rooms to remove hazards. For two people, for whom bed rails were not appropriate, new beds had been provided which could be lowered to the floor, so they would not hurt themselves if they fell out of bed. Pressure relieving cushions and mattresses were in place for people at risk of developing injuries. However, one mattress was not at the correct setting for the person's weight, so may not have been effective in preventing injury. We brought this to the attention of the registered manager who sought advice from the community nursing team and adjusted the setting.

Staff encouraged people to maintain their independence by supporting them to take risks when mobilising around the home. For example, whilst it might have been safer for one person to use a wheelchair, they were clear that they preferred to walk slowly using a frame and they accepted the risks surrounding this.

We observed equipment, such as hoists and pressure relieving devices, being used safely and in accordance with people's risk assessments. Hoist slings were allocated individually to ensure they were the right size and type to support the person safely. Relatives confirmed that hoists were always operated correctly by two members of staff. Staff had sought advice from an occupational therapist in relation to the use of a hoist for a person whose skin was very fragile. Following advice and discussions with the person and their family, it was decided that the person would be cared for in bed and turned regularly using a slide sheet. This had been implemented, which had protected the person's skin from damage.

There were enough staff to meet people's needs at all times and we observed people were attended to promptly.

Staffing levels were determined by the registered manager who assessed people's needs and took account of feedback from people, relatives and staff. The provider had made arrangements with an agency to supply staff to cover any gaps in the roster. Agency staff were not used often, but provided resilience in an emergency. A staff member told us "we're not stressed for time and have time to talk to people which is good."

Recruitment checks were in place to help ensure staff were suitable to work at the service. These included references from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home.

There were plans in place to deal with foreseeable emergencies. The provider had a sister home in a neighbouring town, and arrangements had been made to share resources if the need arose. An emergency bag had been prepared containing contact details for staff, management and contractors available out of hours, together with personal evacuation plans for people. These included details of the support they would need if they had to be evacuated. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. However, we found one person's door was held open with a door wedge, which put the person at risk in the event of a fire as it would have prevented the automatic closure device from working effectively. The registered manager removed the wedge and instructed staff to use the automatic closure device to keep the door open in future.

Accidents and incidents were recorded in people's care records. The registered manager analysed these and took steps to reduce the likelihood of them occurring again. Following a recent incident where staff had difficulty lifting a person who had fallen on the floor, staff training now included recovery using a hoist. A universal hoist sling had also been purchased for people who did not have their own. New head injury monitoring procedures had also been introduced which records showed were followed when needed.

Good

Is the service effective?

Our findings

At our previous inspection, on 8 June 2015 we identified that decisions made on behalf of people were not recorded appropriately. At this inspection we found improvements had been made.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by seeking consent from people before providing care or support. They consulted with relatives and professionals when needed and documenting decisions taken, including why each decision was in the person's best interests. These included decisions about the provision of personal care, the use of bed rails and the administration of medicines. Care plans identified the support people needed to help them make some decisions and staff were clear about how they did this. For example, a staff member told us "[The person] struggles to choose what to wear, so I get two or three of their favourites out and talk through which they'd like to wear today."

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). 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 the provider was following the necessary requirements. No DoLS authorisations were in place, but applications had been made to the supervisory body for five people. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

People and their families told us staff were knowledgeable and provided effective support. One person said, "I get all the help I need." A family member said of the staff, "Their training is intense and they do the job well. They know exactly how to care for [my relative]." Another family member told us "The general care is very good; I can't criticise it."

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, and safeguarding vulnerable adults. New staff received induction training and spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. Arrangements were in place for staff who had not worked in care before to undertake the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, most staff had obtained, or were working towards, vocational qualifications in health and social care. Staff told us the training was "good" and had equipped them to do their jobs well; we found staff were knowledgeable about how people's needs should be met effectively.

People were cared for by staff who were supported in their role by the provider's representative and the registered manager. They received yearly appraisals from the provider's representative; these provided opportunities for them to discuss their performance and set objectives for the year ahead, which the provider monitored effectively. Some staff had also received supervisions with the registered manager. Supervisions provide an opportunity for managers to meet with staff, identify any concerns, offer support, and discuss training needs. One staff member told us "I have had supervisions and appraisals. We talked about goals and what training I needed." However, records showed supervision sessions were not held regularly with all staff. One staff member told us "I have tried to speak with [the registered manager] but my supervision was changed as she was busy." The registered manager told us staff should receive supervisions every eight weeks but this had not always happened, due to "a high turnover of staff"; they said plans were in place to improve the frequency of supervisions in the future.

People and their relatives were complimentary about the quality of the food. One person told us "The food is excellent; I like it all." A family member described the meals as "second to none". People were offered varied and

Good

Is the service effective?

nutritious meals including a choice of fresh food and drink. Bowls of fresh fruit were also available for people to help themselves. Kitchen staff were aware of people who needed their meals prepared in a certain way or fortified to increase their intake of calories. Drinks were available to people and within reach, together with a variety of cups and beakers to suit people's needs and coloured plates and dishes. These are known to help people living with dementia to eat well as the colour contrast can make the food easier to see and recognise.

People were encouraged to eat well and staff provided one to one support where needed. At lunchtime, two people who needed full support to eat received this effectively, in quiet areas where staff could engage with them individually. However, on the first day of the inspection arrangements in the dining room were rather chaotic and we saw three staff members supported a person to eat at varying times during their meal. The person ate very slowly and their meal was almost cold by the time they had finished it. On the second day of the inspection, the dining room was more organised and continuous support was provided to this person by one staff member.

One person did not eat their main meal and we saw staff tempted them with alternatives, such as sandwiches or fresh fruit. They engaged in friendly banter with the person about the type of sandwiches they would like and whether they preferred "crusts on or crusts off?" and "triangle shapes or squares?" This promoted the person's interest in food and we saw they ate most of the sandwiches when they arrived. Snacks were also provided throughout the day. Staff closely monitored how much people ate and drank, through the use of food and fluid charts, which were kept up to date. They took appropriate action when required to protect people from the risk of malnutrition or dehydration, for example by referring them to doctors or specialists.

People were supported to maintain good health and had access to appropriate healthcare services. Relatives told us their family members always saw a doctor when needed and were admitted to hospital promptly if investigations or treatment were required. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified. All appointments with health professionals, and the outcomes, were recorded in detail. A family member told us "[My relative] needed antibiotics a couple of weeks ago for a chest infection and got them straight away." People had also been offered, and most had accepted, winter flu vaccinations. A visiting doctor told us "I'm happy with the way [the home] operates. Referrals are made appropriately; staff know what they are doing and follow advice."

Good

Is the service caring?

Our findings

People and their relatives described staff as "kind" and "caring". One person said of the staff, "They're absolutely marvellous." Another person said, "I'm very happy here; all the staff are very kind." A family member said, "I love the staff here; I think they're brilliant. Their kindness is second to none and they always make a fuss of people on their birthdays."

We observed positive interactions between people and staff. Staff recognised when people became confused or anxious and stopped what they were doing to provide support and reassurance. They made people feel listened to by smiling, bending down to make eye contact and using touch appropriately. A family member told us "Everyone from the manager down will come and kneel next to [my relative] and talk to her; they're so nice to her."

Staff knew people well and used their knowledge of people's lives, backgrounds and interests to strike up meaningful conversations and build relationships. The provider had purchase a number of dolls which three people in particular enjoyed interacting with, and we heard many conversations with people about these. Staff entered people's reality when discussing them and it was clear the dolls gave people a lot of comfort. When snacks were being taken round to people, a staff member remembered that one person liked a particular type of biscuit. They made a point of going to the kitchen to get some of these for the person and said, "Look, I got these specially; they're your favourites aren't they." The person smiled and ate them with great enjoyment.

People were supported to be as independent as possible within the limit of their abilities. One person said of the staff, "They'll do as much as you need them to do for you. They take you to the shower, but then let you get on with it if you can. Another person confirmed this and said, "They're there in case I need any help [in the shower], but I like to try and manage myself."

Staff spoke fondly of the people they cared for and treated them with consideration. A staff member told us "The residents become like your family members and that's how we treat them." Another staff member said, "I genuinely care for them and get sad when I can't say goodbye, like when they go into hospital and then don't come back. I think they know they are loved and cared for." One person was reluctant to go to the dining room for lunch and was supported with warmth and patience. The staff member held the person's hands as they guided them towards the table. They then took time to make the person comfortable.

Staff ensured people's privacy was protected by closing doors when personal care was being delivered. They described practical steps they took to maintain people's dignity, such as partially covering them with towels when delivering personal care. A care staff member told us "If someone has had an accident in bed I get them up as normal and don't say anything so as not to embarrass them. But one person is aware when they've had an accident and likes to see me change it in front of them, which is fine. Then they know they'll have a nice clean bed." This showed consideration and understanding for people's feelings.

When a person's dress rode up as they sat down in a chair, we noticed a staff member placed a blanket over the person's legs to protect their modesty. When people used the bathroom, staff offered to wait outside and put the engaged sign up so the person would not be disturbed. People had been asked whether they had a preference for male or female care staff; their preferences were recorded, known to staff and respected. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it.

When people moved to the home, they, and their families where appropriate, were involved in assessing and planning the care and support they needed. Comments in care plans showed this process was on-going and family members were kept up to date with any changes in their relative's needs. One family member told us "I've been through [my relative's care plan] with the staff. If there's ever a problem, they get it out and go through it again."

Good

Is the service responsive?

Our findings

At our previous inspection, on 8 June 2015 we found records relating to people's care were not always up to date. At this inspection we found improvements had been made.

People received personalised care from staff who supported people to make choices and were responsive to their needs. One person said, "I can choose to do whatever I want and [the staff] help me." A family member told us "[Staff] know exactly how to approach [my relative] and have built up a good relationship with her."

Care plans provided comprehensive information about how people's needs were to be met, together with clear guidance about how they wished to receive care and support and how they liked to spend their day. For example, the care plan for one person said, "I don't like to spend too much time in the bath and when I come out I like to be wrapped in warm towels." Care plans were reviewed regularly and updated as people's needs changed. Records of daily care confirmed people had received care in a personalised way in accordance with their individual needs and wishes.

The needs of a person had changed and they were being cared for in bed. Family members told us staff had responded to these changes appropriately. They recognised that being in bed all day might affect the person's internal body clock and they could further lose their awareness of day and night. To overcome this, they had agreed morning and evening routines with the person and their family to help them maintain a sense of time. They had also been moved to a room where staff and visitors could interact with them more readily; and their television had been mounted on the wall to allow them to view it more easily. The registered manager told us "We have a routine, but it's based on [the person's] needs and is flexible on a day to day basis." Other staff confirmed this; for example, one said "We go with what [people] want. It's their home, not ours."

Improvements had been made to the way staff supported people with their continence. Clear information was available about the type and frequency of support each person needed, together with details of continence products they used. These were kept in people's rooms and arrangements were in place to help make sure there was always a supply in stock. A care staff member told us "It's all sorted out now and we've learned when to change people and how [people's needs] can vary."

A range of methods was used to pass information about people's needs between staff and from shift to shift. In addition to all updates being recorded in people's care records, a communications book and 'handover notes' were used to inform staff about any changes. Staff told us the system "works well" and we found staff were well informed about the current needs of each person.

A mixed range of activities was provided in the home by staff and external entertainers. These included music, reminiscence and pet therapy, pictures of which were displayed; these showed people engaging and enjoying the activity. We observed people singing along to familiar songs, which they clearly enjoyed; some played simple musical instruments or tapped their feet in time to the music. The activities were advertised on the home's notice board and reviewed regularly to help make sure they met people's needs. People told us the activities were "very good".

The provider sought and acted on feedback from people, relatives and staff to help improve the service. For example, one person told staff they did not like their room. An alternative room was offered to the person and they were involved in selecting the colour scheme and layout of the room before moving into it. We saw that the finished result included all the features the person had requested. The provider conducted yearly surveys of people and their families and we saw that the 2015 survey was in progress. The results of the previous survey had been analysed and the provider had responded to the findings by increasing the activity provision in the home. A member of staff had also been recruited to operate the laundry, following feedback from people about clothing going missing.

The provider had a complaints procedure in place. Relatives told us they had not had reason to complain but knew how to if necessary. One said, "If I had any complaints I'd go straight to [the registered manager] and she would deal with any concerns." Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy.

Requires improvement

Is the service well-led?

Our findings

At a previous inspection on 19 and 20 January 2015 we awarded an overall performance rating to the provider of Fairview House. Providers are required to display their performance rating on their public website, together with details of the website of the Care Quality Commission (CQC) where the latest report could be viewed. We checked the provider's website and found this information was not available as required.

Providers are also required to conspicuously display their performance rating on the premises. On the first day of our inspection, we found the rating was not displayed anywhere within the home. We raised this with the registered manager and on the second day of the inspection we saw the rating was displayed prominently in the reception area.

The failure by the provider to display the required information on their website and on the premises was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives felt the home was well-led. One person said, "Things are always organised when arranging [respite] stays." A family member told us "Things have improved and staff attitudes are nicer. On the whole, I'm satisfied." However, another family member said, "You can tell from the [staff] turnover that things are not happy here."

The registered manager confirmed that the staff team had undergone a lot of changes since the last inspection. A new deputy manager had been recruited and there had been significant turnover of care staff which had unsettled the staff team. They said, "It was horrendous. Some staff were doing their own thing. We had to make a lot of changes, but we now have a lovely, willing team who are here for the residents." The registered manager had taken action to restrict the number of people admitted to the home during this period, and had only recently started accepting additional people.

Staff were organised, understood their roles and told us management were "approachable" and "supportive". Effective arrangements were in place for information to be passed from shift to shift so they were always aware of people's current needs. A manager was always available out of hours to provider support and guidance to staff if needed.

Most staff told us the changes had led to better team working. Comments included: "I'm happy with how [the home] operates. There were problems, but they have been sorted out"; "Generally, the atmosphere has improved and the home is fairly well organised"; and "Now the managers are working better together, the staff are too." However, some staff felt further work was needed. Comments included: "There is good team working, but there are some clashes [of personality] and that makes some shifts harder"; "We've had a lot of new staff. We should be working as a team, but it doesn't always happen"; and "There is still some friction [between staff members], but it's not as bad".

There was a clear management structure in place. This consisted of the registered manager, a deputy manager and a head of care. The registered manager and the deputy manager worked on shift, at times, to keep in touch with care staff, understand the challenges they faced and make sure people were cared for effectively. Staff told us they appreciated this. One staff member said, "[The registered manager] has been on the floor more. It's nice to see her on the floor; she has the right approach and attitude." Another staff member told us "[The registered manager] spends time on the floor and spells out 'this is the way we should do it'; It's good to hear it first-hand rather than through the chain of command."

The provider and registered manager sought feedback from staff, including through occasional staff meetings. Staff were encouraged to make suggestions about how the service could be improved. A staff member told us "We can discuss concerns and come up with ideas. The way we were recording food and fluids [that people consumed] wasn't working, so we suggested a new way of doing it and it's working."

The provider had a system in place to regularly assess and monitor the quality of service people received. This included audits of key aspects of the service such as medicines, infection control, the environment, people's care plans and staff training. Where audits had identified concerns, action plans were developed to ensure improvements were made. For example, a new process was introduced after errors were found in the recording of

Requires improvement

Is the service well-led?

medicines administered to people; and a written procedure was introduced for carpet cleaning following an infection control audit. However, the audits had not identified that information about the use of PRN medicines was not sufficient or that the process used to manage topical creams was not working effectively.

The provider notified CQC of all significant events and relatives could visit at any time. A family member told us "I'm always made welcome and always offered a cup of tea." There was a whistle-blowing policy in place which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of this and told us they could approach the local authority or CQC if they felt it was necessary.

The registered manager kept up to date with current best practice by attending managers' training events, by liaising with managers of other homes through a care home association and by reading relevant circulars and updates provided by trade and regulatory bodies.

The registered manager was aware of key strengths and areas for development for the service and there was a development plan in place. This included improvements to the environment to make it more suitable for people living with dementia; and the construction of a storage store for wheelchairs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider had not displayed the relevant information about their performance rating on their website or conspicuously on the premises.** Regulation 20A (1), (2), (3) & (7)