Countrywide Care Homes (2) Limited

Dussindale Park

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**

Summary of findings

Overall summary

Dussindale Park is registered to provide nursing and residential care for up to 58 people. At the time of the inspection 46 people were living at the home. The home supports older people with a range of nursing and physical needs. Some people at the home were living with dementia. The accommodation is comprised over two floors and was built in the 1990's.

There was 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. For the purposes of this report the registered manager will be referred to as the manager. There was also a deputy manager who was also a registered nurse.

There was a new manager in place from when the home was last inspected. Whilst we recognised that the new manager had identified and taken action regarding several areas and made improvements. We also found other areas which required improvements to be made.

People's call bells and alarms in their rooms were not always working. The provider and manager were aware of this, but there were no plans in place to address this issue to ensure people's call bells and alarms worked. There were other systems to check people's safety when they were in their rooms. However, the call bells and alarms were not being checked regularly enough, considering they were faulty.

There had been some medication errors but the quality assurance system had not identified all of them. There were quality monitoring systems in place, but these did not identify the issues which we found during our inspection.

We made a recommendation about the service improving the systems and audits they use to monitor the quality of the service.

People had thorough risk assessments relating to their health and physical needs. There were also regular reviews taking place of people's needs and what action was needed when a person's health needs changed. The nursing staff monitored people's health needs closely if they were very unwell. Referrals to the GP and specialist health teams were taking place when required in a timely way.

Records gave guidance to staff about how to manage people's needs and what actions were needed to keep people safe. However, people's diabetic care plans were not effective, but we were told these were being reviewed and it was confirmed that this process had started.

The manager responded effectively to some accidents and incidents. However, they and the provider had

not taken appropriate action regarding the faulty call bells system at the home.

The manager and staff knew how to protect people from potential harm and abuse. There were systems for staff to report their concerns to the manager. The manager knew of external agencies they must report such concerns to. Staff knowledge about these agencies was variable, but the manager said they would address this issue.

People benefited from being supported by staff who were safely recruited. There was consistently enough staff to safely meet people's care and nursing needs, at the time of this inspection.

Care staff and the nursing staff felt their induction to their job prepared them for their work. The Care staff and the nursing staff also received regular training. The competency of the nursing staff was monitored and assessed. Additional training relevant to the care staff role was not taking place. However, we were told of plans to address this issue.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and reports on what we find. The service was working within the principles of the MCA. Staff had a good understanding about the need to seek consent from the people they were supporting.

People told us that staff treated them in a caring and kind way. People and staff had formed positive relationships with one another. People's dignity and privacy was promoted.

There was a range of activities and planned events which took place on a regular basis. There were also plans to increase this further with an additional activity co-ordinator.

We found there was a positive and open culture at the home. Staff found the manager and deputy manager approachable and had confidence in them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's call bells, alarms and pressure matts were not always working. This increased the risk of people experiencing falls or being unable to alert staff if they needed urgent assistance.

There were sufficient staffing levels to meet people's care needs.

Staff knew how to identify safeguarding concerns.

Is the service effective?

Good

The service was effective.

Staff received regular supervisions and competency checks were completed.

When necessary the service was compliant with the MCA when supporting people with best interest decisions.

People spoke positively about the food and drinks at the home.

Is the service caring?

Good

The service was caring.

People were treated in a kind and caring way.

People's dignity and privacy was promoted by staff.

People's confidential information was protected.

Is the service responsive?

Good

The service was responsive.

People had person centred care assessments.

People were involved in the planning and delivery of their care.

People received care in response to their needs.

There were regular activities and events.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not responded to issues regarding people's call bells and alarms.

The service did not have an effective system to monitor and respond to medication errors.

There was an open and positive culture at the home.

Dussindale Park

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 26 May 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor who was a nurse 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.

Before the inspection we viewed all of the information we had about the service. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team, the local authority safeguarding team, and the clinical patient safety team in the NHS, to ask for their views on the service.

During the inspection we spoke with ten people who used the service and seven relatives. We spoke with the registered manager, deputy manager, two nurses, four members of the care staff, and two chefs.

We looked at the care records of seven people who used the service and the medicines administration records of eight people. We also viewed records relating to the management of the service. These included risk assessments, reviews, three staff recruitment files, training records, audits, and various safety records.

Requires Improvement

Is the service safe?

Our findings

When we visited Dussindale Park we found that the service was safe in many respects, however we found some areas which required improvement.

During our visit we discovered an issue with people's alarm bells. We noted that two people's alarm bells were not working. This also meant that the pressure sensor matts placed next to them were also not working. In both cases this had been identified by us. We told a member of staff and swift action was taken by the maintenance person. We spoke with the manager about this who said they had identified to the provider that the alarm bell system needed replacing. We saw records that confirmed the call bells were being tested monthly. We asked if a more frequent check was appropriate, the manager said that the maintenance person did not have time to do this, alongside their other duties. The manager said they would speak with the provider again about this call bell issue. We could see that people who were unable to access the call bells had hourly checks, to ensure they were safe. However, despite knowing the call bells were faulty at times; people's call bells were not being checked on a more regular basis. People had also been provided with pressure matts because it was identified that they were at a high risk of falls. These people remained at a higher risk of falls all the time the pressure matts were not working. We concluded that improvements needed to be made in this area to ensure people were safe.

We looked at the medication administration records (MAR) of eight people. We looked at their corresponding medicines and found that one person had not had two doses of one of their medicines as the prescriber had intended. We spoke to the nurse in the medication room at that time, who agreed that an error had taken place. This nurse then added the error to a document of potential medication errors. No further action was taken or considered at this time to see if this person was well. We spoke with the registered manager about this who later confirmed to us that this error had been addressed with all the nursing staff. The manager did not confirm if additional steps were taken to ensure this person was safe not to have this medicine.

We concluded that the service's systems to manage this and respond to errors required some improvement.

We found that medicines were being stored securely and within the recommended temperatures. There was clear guidance for medicines prescribed for occasional use (PRN).

We asked some people if they felt safe. One person told us, "Yes I do [feel safe] they've got the code locks on the door, carers and a nurse at night." Another person said, "First class, I feel well looked after, they're [staff] are ideal." A relative told us, "Yes, very much [I feel my relative is safe], I'm generally well pleased."

Staff knew how to protect people from the risk of potential harm and abuse. Staff told us what potential abuse could look like. They were clear about the need to report it to the deputy manager or to the manager. One member of staff said, "I wouldn't hesitate to report it, otherwise that would make me no better than them." However, not all staff were clear about outside agencies they could also report their concerns to,

such as the local authority safeguarding team and how they would do this. We spoke with the manager about this, who told us they would address this issue.

People who lived at the home had detailed and thorough risk assessments. We looked at a sample of people's care assessments and reviews and found these had identified the risks which people faced. People also had care plans which identified what action staff needed to take to keep individuals safe. For example, one person had complex moving and handling needs. This person's care plan gave detailed step by step guidance for staff, about how to transfer this person from one position to another, safely. Some people were at risk of developing a break down to their skin. In these situations, plans were put in place to manage people's needs in a safe way.

In some cases this involved staff needing to take certain action to manage individual risks. For example checking people on a regular basis and in some cases, in order to prevent a possible deterioration in a person's skin, repositioning people, and checking pressure relieving equipment was working. We looked at a sample of people's daily records and found these records were up to date. This told us, that according to these records staff were following these people's care plans, in order to manage these risks.

However, we looked at the plans in place to manage the needs of people who had diabetes. We found that, with the exception of one person's care plan, that there was insufficient guidance for staff about how to manage people's diabetic needs. We spoke with the manager about this. They told us that these plans were under review, and were in the process of being rewritten.

Some people had experienced a breakdown in their skin. We looked at these people's records and spoke with the deputy manager about this. We were shown records that had demonstrated to the nursing staff that the sores were decreasing in size. We could also see from people's records and we were told by the deputy manager, that the GP had reviewed these pressure areas and was satisfied with how these were being managed.

There was a contingency plan in place about what action was needed if there was an emergency with the premises. The manager and deputy manager took it in turns to provide an on call service for the night nurse and night care staff.

There were various safety tests carried out to ensure that the equipment used was safe to use. This included equipment which supported people to transfer from one position to another. There were regular checks that people's 'pressure relieving' equipment, for those who were at risk of a breakdown in their skin, was working correctly. Weekly fire tests took place and there had been a recent fire drill which had tested some people's evacuation plans, were effective. There was a maintenance person at the home five days a week, who completed these tests and responded to equipment failure.

When we visited the home we requested to see records of 'accidents and incidents' which people had experienced. We could see from these documents that individual accidents and incidents were responded to appropriately. There was a clear analysis of what had happened and action was taken to try and prevent it from happening again.

People told us that there was enough staff to meet their needs in a timely way. We asked people about the staff response to when they pressed their bells in their rooms. One person said, "[The call bell is answered] Quite quickly, not over much, occasionally have to wait….yes they [staff] stay." Another person told us, "[Staff response to call bells] It varies, sometimes they're [staff] are here in seconds, mostly quite quick."

The staff we spoke with said they felt there was enough staff to meet people's care and nursing needs.

We observed staff responding to people's needs in a timely way. Sometimes staff in the morning would respond to a person, who had requested support by saying, "I will be a few minutes," while they helped someone else. We saw that people were not distressed by this and that care staff returned to these people quickly. We spoke with the manager about how they assessed they had enough staff. They told us they used a dependency tool which also took into account the lay out of the building. Staff told us that the manager responded to the staff's views about staffing levels. We could also see that people were asked about staffing levels at the 'residents and relatives' meetings.

During our visit we looked at three staff recruitment files. The manager showed us that the Disclosure and Barring Service (DBS) checks had been carried out. A DBS check enables employers to carry out safer recruitment decisions and prevents unsuitable staff from working with vulnerable people.

Good

Is the service effective?

Our findings

People were supported by staff who were effective in their work.

The staff we spoke with spoke positively about their induction to their new role. Staff said they spent a period of time shadowing experienced staff and they spoke with the deputy manager if they had questions or needed support. The manager and staff told us that staff who had transferred from a different home, owned by the same provider, also had an induction, like new staff. Staff told us that they had a discussion with the manager or deputy manager before they started working more independently. This was to check they were confident and felt competent to work without close supervision. Staff also told us about the training they completed before they started work. This was a combination of different learning styles which included some face to face training.

Care staff told us that they received supervision on a regular basis. The records we looked at confirmed staff had received regular supervisions. Care staff competencies were checked during these conversations. The registered manager told us that they, and the deputy manager, completed general competency observational checks on all care staff, when they were carrying out their work. However, these observations and the subsequent actions were not recorded. The manager told us that a record of these types of competency checks for care staff will now be introduced.

All the care staff and nursing staff all completed a programme of training which was refreshed yearly. Staff received training in fire safety, moving and handling, safeguarding, mental capacity, and infection control. The staff we spoke with spoke positively about this training. All the care staff we spoke with said they would welcome training in pressure care, diabetes, and supporting people who required prescribed thickeners, to prevent them from choking. The nurses had training and knowledge in these areas. The care staff we spoke with said they spoke with the nursing staff if they had concerns regarding people's needs, in these areas. We spoke with the registered manager about this. They told us about the plans they had made to introduce training regarding pressure care and supporting people who required prescribed thickeners. The manager also told us about the plans they had made to strengthen the 'dementia awareness' training, staff had already received.

The training records for nursing staff confirmed they had received specialist training. Training courses were provided from the Norfolk and Norwich University Hospital in order for the nursing staff to support people with particular complex nursing needs. We noted that these training courses were within date. Training included supporting people with diabetes, nutrition and hydration, and 'tissue viability.' The manager told us about plans for further specialist nursing training. They also told us about a situation when they were unable to accept the admission of one person, because the nursing staff had yet to receive the particular specialist training, required to meet this person's individual health need.

We were shown records of the competency checks which the deputy manager carried out relating to the nursing staff at the home. These were detailed records checking that the nursing staff were competent to carry out their nursing role. This included the administration of medicines, which was completed yearly or

more frequently than this, if issues were identified. Nurses completed a reflective practice document at the beginning of the year, which the deputy manager went through with the individual nursing staff at their supervisions. We were told the aim of this was to promote learning and development of the nursing staff.

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 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.

The staff we spoke with, and the manager, had a clear understanding of the importance of offering people choice and enabling people to make their own decisions. The care records we reviewed reflected whether people could make specific, informed decisions about their care. For example one person was at risk of choking when they ate and drank, they had received specialist advice, but this person wanted to eat certain foods, which were contrary to this advice. This person had been assessed as having capacity to make this decision so staff supported this person to eat the foods they enjoyed. We looked at this person's daily notes and we could see they were being supported and assisted to eat these foods.

Some people were deemed as lacking capacity to make specific decisions. In these situations the manager had arranged 'best interest meetings' which included people's relatives and in some cases the GP. The purpose of these was to arrive at a decision that was in the person's best interest and something they were likely to have agreed to, if they had capacity to make that particular decision.

The manager had made appropriate applications for DoLS authorisations to the local authority. We concluded that the service was compliant with both the MCA and DoLS.

People spoke positively about the food and drinks provided at the home. One person told us, "They give us nice food and I'm fine." A further person said, "Yes, a certain amount of choice, it's good, tasty." A relative told us that, "[Relative's name] always eats all of their dinner with them [staff]. I came in today before lunch was cleared and the plate was clean."

We observed people being supported by staff to eat their food; there were gentle interactions with staff checking the person was okay and were eating at their own pace. Meals were appropriately spaced and people had access to drinks and some snacks during the day.

We saw one of the chefs going around and asking people what they wanted for lunch and for their evening supper. One of the chefs told us that they also went around again in the afternoon to check what people wanted for their evening supper. One chef said, "Well, they [people] might have changed their mind."

Some people were at risk of choking when they ate and drank. They needed their food and drink prepared in a particular way so they could eat and drink more easily. In these situations referrals were made to a speech and language therapy team who gave guidance about how some people's foods and drinks should be prepared. For example, some people had a soft diet and one person had a pureed diet. During lunch we saw

this advice being put into practice. We spoke with the chefs who told us how they prepared food for those people who were at risk of choking, and they told us how they ensured this food looked appetising. We spoke to one of the chefs about this, who showed us they did have records about people's dietary needs.

People's weights were also being monitored on a regular basis. Some people were being weighed more regularly than others in order to monitor potential weight loss and for staff to take action to manage this weight loss.

People told us that their day-to-day health needs were met by the nursing staff at the home. One person said, "The doctors call occasionally to see I'm alright, about once a month. The doctor came quickly when I had breathing problems." A relative told us that, "[Relative's name] got to have a new set of dentures, and they [managers] sort it out, they send the dentist round. They also have someone who comes in and tests people's eyes. They have a chiropodist man comes every six weeks."

When we looked at people's care records we could see that referrals had been made to specialist health teams. We could also see that nursing staff had consulted with the GP regarding a change in people's health needs. The GP was also involved to review and monitor some people's health needs, who had complex health needs.

Good

Is the service caring?

Our findings

People were treated in a kind and caring way by staff at Dussindale Park.

People told us that care staff and nursing staff were kind to them. One person said, "The staff are very happy, if we're happy they're happy. The night staff are good too." Another person said, "I can't fault the care that I'm getting." A further person said staff were, "Good and kind." A relative told us, "The staff are very understanding and caring."

People told us and from the interactions we observed, people had formed positive relationships with the staff that supported them. During our two day visit we saw that people were familiar and friendly towards the staff working on those days. One person told us, "I feel comfortable with them [staff]." Another person said, "They are a good lot of girls, I torment them, they laugh." A relative also told us, "When they [staff] come in and out (of room) they're [staff] perfectly relaxed with [relative]."

The staff we spoke with were able to tell us about the care needs of the people they were supporting. We spoke about one person, with a member of care staff, who sometimes expressed behaviour which challenged other people. This member of staff said, "It's just the way you approach, tone of voice, being interested in what [person] is saying." A visitor told us how staff wanted to get to know their relative. They said, "The staff ask me about the picture on the wall, they're keen to know all about [relative]."

People told us that staff listened to them, and they were involved in the planning of their care. People said that they were asked about what time they wanted to get up and go to bed and the care they wanted to receive. One person said, "They [staff] treat me as an individual." Another person said, "They [staff] do ask me (about providing personal care)."

We saw people being asked about day to day decisions about their care. At a resident's meetings people were asked about their views on the care and support they received. We observed that a planned activity had been cancelled, we saw the activity co-ordinator asking a group of people what they wanted to do instead, and a consensus was reached.

When we looked at people's records we could see that people had 'end of life' plans. These detailed what people wanted to happen at the end part of their life. In some cases when the person was not able to fully contribute, family members were asked to contribute to these plans. These were detailed and respectful plans which had involved the individual as much as possible.

During our visit we noted that people's confidential information was stored securely. People's records were stored in a locked room. People's daily notes were also placed in a discreet place in their rooms.

People told us that they were treated with dignity and respect. Staff told us how they promoted people's dignity when they were supporting people with their personal care. During our visit we saw staff knocking on people's doors and saying hello before they entered. We heard staff speaking with people in a polite and

friendly tone throughout our visit. We saw staff engaging with people at meal times, in friendly, but also respectful conversations. Staff referred to people by their names and staff spoke at their level when asking them a question.

People's relatives and friends said they could visit when they wanted to. One relative said, "I'm here when the cook asks (relative what they would like) for their lunch, I have a meal as well. Yes they make me welcome." Another person's relative told us that, "I know everybody [staff] here and get on fine with them all."

Good

Is the service responsive?

Our findings

People living at Dussindale Park received care which was responsive to their needs.

People received care which was focused on their individual needs and preferences. One person said, "They've [staff] got certain rounds (choice of when to get up and go to bed), if you want anything extra it's all available." Another person said, "I ask them for what I want and they [staff] provide it". A further person said, "I would say they're [staff] fine, they treat me as an individual."

We looked at a sample of people's care plans and assessments, from these we could see that people or their relatives had been involved in the planning of their care. These records, where possible, contained personal information relevant to individual people, about how they wanted their day to day care needs met by staff. This included the type of clothes they wanted to wear and the foods they liked, also the types of activities they enjoyed and their interests. People were asked what they liked to be called, with a list included, and what was important to them in how they wanted to be treated by staff. One person had some pets in their room; there was a plan in place about how to ensure these pets' needs were also met.

When we were looking at people's care assessments we could see that reviews were taking place to check if a person's needs had changed and their care documents were up to date. We could see from the sample we looked at that this was happening on a regular basis.

Staff did not feel they had enough time with people to sit and have a chat if they wanted to do this. Three of the staff we spoke with said they tried to "fit this into" their day, either at the end of a shift or during tasks, when they were supporting people. We spoke with people about this issue. Some people chose to spend all their time in their rooms; other people had complex health needs and were unable to leave their rooms. The people we spoke with did not raise this as an issue, but these members of staff felt those who spent all of their time in their rooms would benefit from more time, with staff in some form of a social activity. We spoke with the manager about this and concluded that once the additional activity person starts, there would be more social opportunities for people who spend a lot of time in their rooms.

Dussindale Park had an activities co-ordinator who worked five days a week. The manager told us about an additional activity co-ordinator who would be starting soon in this role. We saw this member of staff during our visit and saw them assisting with meals and drinks, we saw them chatting and engaging with people at these times. We were shown a document which had listed the weekly social events which had taken place over the last five months. There were accompanying photos with the events. People looked happy and were engaging with a range of activities, from a pre-school visit, Elvis, arts and crafts, Burns night, and a meditation session for mental health week. We were told about plans for a 'therapy dog' to be visiting the home to spend time with people. This was also mentioned in the recent newsletter.

There were also activities taking place, on one of the days we visited we saw one of these events taking place; this was a keep fit class. When we visited three people were sitting outside under parasols with drinks looking at magazines with the activity co-ordinator. They were chatting about the plants which had been

recently planted. Later that day, some people went outside and sat under a parasol while the gardener was planting up some tall plant containers. We saw them chatting with the gardener. We spoke with a member of the domestic team who told us, "I always have a chat with people when I clean their rooms, well it's all part of it." After breakfast we saw the activity co-ordinator sparking a political debate with people, which people engaged with.

The service had not had any formal complaints, although we did speak with one relative who told us they had raised certain issues about the care their relative had received, with the manager. They told us that the issue had been addressed. We were also shown a variety of compliments from relatives addressed to the manager and all staff thanking them for looking after their relatives, when they lived at the home.

Requires Improvement

Is the service well-led?

Our findings

When we visited Dussindale Park we found many examples of the home being well led by the manager and the provider. However, we found some areas which required improvement.

People's call bells in their rooms were not always working. The manager and the provider were aware of this. There was no plan in place to replace the call system. Call bells were being tested monthly but given the potential risk, these bells were not being tested on a more regular basis. We tested two people's call bells and these were not working. This area of managing people's safety required improvement.

There were monthly medication audits taking place by the deputy manager. We looked at a sample of these, these included checks to see if people had had their medicines as the prescriber had intended. One medication audit document, which we were told the service was trialling, listed what looked like several medication errors. When we looked at this document in detail, it was unclear. It also did not state what happened next, whether the medicine issues or errors had been investigated and what the outcome was. The registered manager later told us as a result of our visit they were no longer using this document. Medication errors or issues with the administration of medicines were happening at times, and there was not a strong system in place, to identify the error, analyse the error, and look at ways to prevent the error from happening again.

We therefore made a recommendation for the service to improve the systems and audits they use to monitor the quality of the service.

The provider's quality assurance officer completed a quality monitoring audit visit on a monthly basis. The manager told us that they had to share any serious events, safeguarding issues, a significant deterioration in a person's health or a serious breakdown in a person's skin with the provider. The quality officer would then audit these situations, if there had been any, to check appropriate action had been taken. The quality officer would also look at a range of other areas during their visit. We looked at these quality audit records and found they were detailed audits. These audits involved looking at peoples care records, safety checks, and speaking with people. However, the issue we found with the call bells had not been identified. The issue with the governance systems in place to monitor medication errors had not been identified. The robustness of care staff competency checks and the quality of care plans to manage people needs who had diabetes, were also not identified at these audits.

Dussindale Park has had a new registered manager since our last inspection. There was a positive culture at the home and clear leadership. People told us that they considered the staff to be happy in their work. The staff we spoke with told us that they enjoyed the work which they did and felt there was a positive team culture of working together.

Staff felt they could approach the manager and deputy manager and they had confidence in them. Staff told us about an issue late last year, when they felt staffing levels were too low. Staff told us that the manager responded to the issue, heard their views, and took action to resolve this issue.

We were shown a copy of the recent questionnaire produced by the provider. People had responded positively when they were asked about the quality of the care and support they had received. The questionnaire also showed that they had asked people and their relatives about their views of the care and services at the home. We also saw a recent newsletter liberally distributed about the home.

We saw copies of minutes from the residents' meetings. At these meetings ideas about possible improvements to the service were discussed. People were asked about the activities, the changes in the menu, and the care provided. We saw that when people raised issues these were responded to and action taken to address and resolve these issues. People told us that they felt they could approach the manager and they knew who the manager was. One relative told us, "I know the manager's door is open and they've been helpful at sorting things out."

Staff told us that for a time there was a lack of understanding of the different responsibilities and roles of the day and evening staff. This was affecting how staff worked together at the home. Staff told us and we saw this recorded, that the manager gave day staff evening shifts when they normally completed day shifts and vice versa. This was to enable staff to gain a better understanding of the roles and challenges of these different shifts. The staff we spoke with said this was a positive experience and this had enabled staff to work better as a team.

The care and nursing staff had regular supervisions and team meetings to discuss issues and raise concerns, the staff we spoke with said they found these meetings useful. Care staff told us that when they identified particular training needs, they were placed on the appropriate course. These members of staff said they felt listened to when they requested additional support to do their job. Care staff told us about the plans being made to support them to complete additional vocational courses in health and social care.

There were plans to engage with the local community. A summer fair had been arranged for later this season. We could see plans were underway which had involved the people living at the home. There was a fair last year, a local preschool had visited the home before and plans had been made for this to happen again.

The manager had a clear understanding of their responsibilities in managing the home. The manager was able to tell us what events they must inform us of by law. Our records we hold about the service confirmed they had told us about events in a timely way.