Bupa Care Homes (AKW) Limited

Erskine Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	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 unannounced inspection took place on 2, 3 and 15 November 2016. We visited the service on 2 and 3 November 2016, and completed the inspection on 15 November 2016 when we received feedback from a professional we had contacted.

The service provides care and treatment to older people with chronic health conditions, physical disabilities, and those who require palliative or end of life care. At the time of the inspection, 62 people were being supported by the service.

When we inspected the service in October 2015, we found staff training was not up to date, food and fluid charts were not always completed fully to evidence that people were eating and drinking enough. Also, wound care was not always evidenced in people's care records. Although we found improvements had been made to staff training during this inspection, staff were still not always keeping up to date records of what support they had provided to people. However, we saw that the manager had put processes in place to improve this.

There was no registered manager in post, but a manager who had been in post since June 2016 had started the process to register with the Care Quality Commission. 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.

The provider had effective systems in place to safeguard people and staff had received safeguarding training. There were individual risk assessments that gave guidance to staff on how risks to people could be minimised. People's medicines had not always been managed safely, but improvements had been made in the medicine management systems to ensure that people received effective treatment.

The provider had effective recruitment processes in place, but people did not feel that there was always sufficient staff to support them safely. More staff had been recruited so that a consistent group provided continuity of care. The manager and staff understood their roles and responsibilities in ensuring that people's care was provided in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Staff training was now up to date. Staff were supported in the form of supervision and team meetings that enabled them to provide appropriate care to people who used the service.

Although people's needs had been assessed and they had care plans that took account of their individual needs, preferences and choices, people had not always been supported quickly when they rang their call bells. However, the manager has put processes in place to improve this. People were supported to have sufficient food and drinks, and had access to health services when required in order to maintain their health and wellbeing.

Staff were kind and caring towards people they supported. They treated people with respect and supported them to maintain their independence as much as possible. A variety of activities had been provided to occupy people within the home and people had been given opportunities to pursue their hobbies and interests outside of the home.

The provider had a formal process for handling complaints and they responded quickly to people's concerns. They encouraged feedback from people and their relatives, and acted on the comments received to improve the quality of the service.

Although the manager and other senior staff provided support to staff, some staff did not feel that they worked well together as a cohesive team. The manager regularly assessed and monitored the quality of the service provided, but more work was required to ensure that they provided consistently safe and effective care that met people's needs and expectations.

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 medicines had not always been managed safely, although recent improvements had been made.

People felt safe and there were effective systems in place to safeguard them. However, they did not feel that there was always sufficient staff to support them safely.

The provider had robust recruitment procedures in place.

Is the service effective?

Good

The service was effective.

Staff received adequate training and support in order to develop and maintain their skills and knowledge.

Staff understood people's individual needs and provided the support they needed.

People had enough nutritious food and drink to maintain their health and wellbeing. They were referred to other health services when required.

Is the service caring?

Good

The service was caring.

Staff were kind and caring towards people they supported.

People were supported in a way that protected their privacy and dignity. Where possible, they were also supported in a way that maintained their independence.

People's choices had been taken into account when planning their care and they had been given information about the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans took into account their individual needs, preferences and choices. However, people were not always supported quickly when they rang their call bells.

A variety of activities were provided, and people had been supported to pursue their hobbies and interests.

The provider had an effective complaints system.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People's care records were not always up to date to evidence what support had been given.

Although the manager and other senior staff provided support to staff, some staff did not feel that they worked well together as a cohesive team.

People and their relatives were enabled to routinely share their experiences of the service and the provided acted on their comments to improve the service.

The provider had quality monitoring processes in place, but more work was required to ensure that they provided consistently safe and effective care that met people's needs and expectations.

Erskine Hall Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 2 and 3 November 2016, and it was unannounced. The inspection was completed on 15 November 2016 when we received feedback from a professional we contacted. It was carried out by an inspector, a pharmacy inspector, a specialist advisor with experience of managing services that provide palliative and end of life care, and an expert by experience on 2 November 2016. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Only the inspector visited the service on 3 November 2016.

Prior to the inspection, we reviewed information we held about the service, including the previous inspection report, concerns we had received from the local authority about how people's medicines were being managed, and notifications the provider had sent us. A notification is information about important events which the provider is required to send to us.

During the two days of the inspection, we spoke with 11 people who used the service, five relatives or friends of people who used the service, a visiting exercise trainer, four care staff, five nurses, the deputy manager, the manager and a visiting GP who has worked closely with the service for a number of years.

We reviewed the care records for 11 people who used the service. We looked at 15 medicine administration records (MAR) to check how medicines were being managed and we followed up on recent concerns about people's medicines not being managed well. We looked at six staff files to review the provider's staff recruitment and supervision processes, and we also looked at the training records for all staff employed by the service. We looked at information on how complaints were being managed, and how the quality of the service was being assessed and monitored. We observed how care was being provided in communal areas of the home. We contacted the local authority officer who inspected the service in June 2016 and we received feedback from them.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection, we received information of concern from the local authority notifying us that some people's medicines had not been managed safely in order to provide effective treatment. Recent safeguarding investigations conducted by the local authority showed that for a number of days during September 2016, four people did not receive the medicines they required to maintain their health and wellbeing or to provide pain relief. Additionally over a two day period in October 2016, one person was given more medicines than they had been prescribed, but they did not suffer any significant harm from this. The nurse involved was stopped from administering medicines until they had undergone further training and had been assessed as competent to do so safely. During the inspection, we found medicines were administered safely by competent nurses and three senior care staff who had been trained.

The manager told us that the missed medicines were due to the failure in their systems to check stock levels and re-order medicines before they ran out. There were also unnecessary delays as a result of miscommunication by all the professionals involved. However, the manager was able to demonstrate the processes they had put in place to ensure that this risk had been minimised and that they had learnt from the incidents. This included more stringent daily checks of medicine stock levels and the deputy manager had now been allocated as a single point of contact for the GP surgery and pharmacy to ensure that there was no miscommunication when requesting prescriptions. The manager said that they were now happy with the arrangements made with the supplying community pharmacy and the GP, and this was confirmed by the GP we spoke with. However, further improvements were required as a person told us that the service had recently run out of paracetamol. They added, "I was told by the nurse they hadn't got any and nothing was done."

People we spoke with reported that they received their medicines in a timely and correct manner. We checked how medicines were stored and the stock levels of the medicines kept at the service. All prescribed medicines were available at the service and were stored securely in locked medicines trolleys, within locked rooms. A record was kept of balances of medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more in a timely manner. We looked at 15 medicine administration records (MAR) and found one gap in the recording of medicines administered which was due to a nurse not signing for the medicine after administering it. We found that appropriate authorisation and input from professionals were in place for a person whose medicines were administered covertly. For example, there was evidence of a mental capacity assessment and a medicines form which was signed by the GP and the pharmacist to authorise the medicines being given this way. This assured us that overall, people received their medicines safely, consistently and as prescribed.

Some people said that there was not always enough staff. One person said, "There is not enough staff on and I am constantly waiting for assistance to the toilet." Another person said, "I often get told they haven't got time, some carers make you feel you are a nuisance at times." A third person said, "Weekends are more of a problem I think for everyone." A member of staff also said, "We don't have enough staff on and the pressure is high on this floor." However, we noted that staffing numbers had been increased since June 2016

and most staff we spoke with said that this had made a huge difference to how quickly they supported people. One member of staff said, "I feel much better about my work since staffing levels went up in June." Another member of staff said, "We have enough staff, but some days can be really busy with the same number of staff and residents." The duty rotas showed that on each of the three floors, people were now mainly supported by one nurse and five care staff during the morning, one nurse and four care staff in the afternoon, and one nurse and two care staff at night. The manager told us that they had recruited more nurses and care staff, and that they had only vacancies for one nurse and two care staff. They had used agency staff a lot during the summer due to vacancies, sickness and planned leave, but this had now greatly reduced and has led to greater continuity of care.

The provider had robust recruitment procedures in place. Staff records we looked at showed that thorough pre-employment checks had been completed before staff worked at the service. These included obtaining appropriate references for each employee and completing Disclosure and Barring Service (DBS) checks. DBS helps employers to make safer recruitment decisions and prevents unsuitable people from being employed. They also made checks to ensure that the nurses they employed were registered with the Nursing and Midwifery Council (NMC), including checking whether they had renewed this annually.

People told us that they felt safe living at the home and they had been supported well by staff. One person said, "I feel safe here definitely, I have no worries for my safety." Another person said, "Yes, I feel safe here." A relative told us, "Yes, my [relative] is very safe here. [Relative] has only been here [a few] weeks, but I know [relative] is safe." Another relative said, "I believe [relative] is safe here, but I have concerns about other things." On further discussion with the relative, we found out that they had concerns about their relative being given less nutrition via Percutaneous Endoscopic Gastrostomy (PEG) than they had been given in hospital. This is a procedure where a tube passed into a person's stomach through the abdominal wall when oral intake is not possible. We discussed this with the deputy manager and they assured us that they had followed the instructions on the hospital discharge letter. In order to assure the person's relatives that they were getting the right treatment, they were also going to check with the hospital to ensure that there were no errors in the information sent to them.

The provider had processes in place to safeguard people, including safeguarding and whistleblowing policies. Whistleblowing is a way in which staff can report concerns within their workplace without fear of consequences of doing so. Information about how to safeguard people was displayed around the home to give people who used the service, staff and visitors guidance on what to do if they suspected that a person was at risk of harm. This also contained relevant contact details of organisations where concerns could be reported to. We saw that staff had been trained on how to safeguard people and those we spoke with showed good understanding of the actions they needed to take to keep people safe, including reporting of any concerns to the manager, the local authority safeguarding team or the Care Quality Commission. One member of staff said, "I have had training in safety and safeguarding." Staff told us that people were safe at the home. One member of staff said, "Residents are safe here and if I had concerns, I know who to call." Another member of staff said, "Residents are definitely safe. I have never been concerned about anything."

The care records we looked at showed that potential risks to people's health and wellbeing had been assessed and detailed risk assessments were in place to manage the identified risks. For example, there were assessments for risks associated with people being supported to move, pressure area damage to the skin, falling, not eating or drinking enough, medicines, and use of bedrails and bumpers. These had been reviewed regularly or when people's needs had changed. We observed safe practices when staff used equipment to support people to move, and staff told us that they had the equipment they needed to support people safely. However, a member of staff told us that they were not confident that all staff knew how to use the equipment safely. They said, "I don't feel confident with some staff when I am hoisting as I

know they can be sloppy." However, staff training records showed that they had all been trained on how to use equipment. We also advised the member of staff to discuss with the manager if they are concerned about some of the members of staff's competence to use the equipment safely.

The provider had systems in place to ensure that the environment where care was provided was safe. For example, fire safety checks had been undertaken regularly, including the testing of fire alarms, fire-fighting equipment and emergency lighting. Maintenance and repair work had been carried out when needed by staff employed to carry out this role. Gas and electrical appliances had been tested to ensure that they were safe for use. Additionally, all the equipment used within the service including hoists and slings, was regularly inspected to ensure that it remained safe for use by people. The service also kept records of incidents and accidents, with evidence that these had been reviewed and actions taken to reduce the risk of recurrence.

Good

Is the service effective?

Our findings

When we inspected the service in October 2015, we found staff training was not up to date. During this inspection, we found staff training had improved. The majority of staff were up to date with their training, with only a few who had not been able to do their training as soon as it was due because they had been on leave. Staff we spoke with confirmed that they had training and that it had helped them to develop their skills and knowledge. One member of staff said, "I have had all my training and it's up to date." Another member of staff said, "We get enough training and we therefore have skills to support residents." A third member of staff told us, "Training is really good. If you need specific training, they will provide this." We saw that some members of staff had also been able to gain nationally recognised qualifications in health and social care, including National Vocational Qualifications (NVQ) and Qualifications and Credit Framework (QCF). The nurses we spoke with also told us that there were opportunities for them to develop their skills and knowledge, and support for them to meet the 'revalidation' requirements of the Nursing and Midwifery Council (NMC). One nurse said, "We get enough training and support towards NMC revalidation."

Prior to the inspection, we had received concerns that some of the people receiving palliative or end of life care were not always supported appropriately. We discussed this with the manager who told us that they had recently decided that they would only provide limited palliative care at the service to no more than three people at a time as not all the staff had the skills required to provide effective care and treatment. They also told us that they had asked the training manager to develop a basic training version of the palliative care and end of life course that the clinical services manager and the deputy manager were currently doing so that all staff could be trained.

The majority of people said that staff had the right skills to provide the support they required. One person told us, "I believe staff are trained well and they try their best." Another person said, "Most carers and good. I suppose I get good care." Staff told us that they tried their best to provide good care to people who used the service. One member of staff said, "We really try to provide good care to all residents." Another member of staff said, "Residents get good care. I know they do when I am on duty." A third member of staff said, "The residents are looked after much better here than other services I have worked for before."

Staff told us that they had received regular supervision and they were appropriately supported by the senior staff. One member of staff said, "Supervision is good. I am a supervisor for some staff too." Another member of staff said, "I get enough support, definitely." A third member of staff told us, "Most of the time we get support, but this can be improved so that we can get help to do our job well." They further told us that as the only nurse on each unit, they sometimes found there were a lot of things for them to do and this put pressure on them. However they added, "I sometimes ask the deputy manager or the clinical services manager and they help." The supervision records we looked at showed that this had been provided more regularly in recent months and there were schedules in place to show when staff will have their subsequent supervision meetings.

We saw that where possible, people had given written consent to their care and support. Staff told us that they asked for people's consent prior to support being provided and they respected people's views and

choices. Where people did not have capacity to give consent or make decisions about some aspects of their care, mental capacity assessments and best interest decisions had been made to ensure that their care had been provided in accordance with the requirements of 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 made on their behalf must be in their best interests and as least restrictive as possible.

We also saw that when required to safeguard people, referrals had been made to the relevant local authorities so that any restrictive care met the legal requirements of the MCA. Some authorisations had been received, but others were outstanding. 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).

Although one person told us that the food was bland and they were not always given salt and pepper if they ate in their room, others told us that they enjoyed the food and they always had enough to eat. One person told us, "The food is good and I enjoy it. We get plenty of drinks." Another person said, "The food is cooked well and I do enjoy it." A third person said, "I like the food here. I have absolutely nothing to complain about that." A member of staff said, "The food is really nice and meets residents' needs." At lunchtime on both days, we observed that the dining room had been set-up nicely with tablecloths, flowers and condiments in order for people to have a pleasant dining experience. The food served to people appeared well-cooked and appetising. Some of the people were having either white or red wine with their lunch.

We saw that people with specific dietary requirements had also been supported to eat well. A variety of options were available for people who required soft food, high calorie food or food low in sugar content for those living with diabetes. Staff regularly monitored people's weight to ensure that this remained within healthy ranges. We saw that Malnutrition Universal Screening Tool (MUST) forms were completed monthly to assess the risk of people not eating enough and appropriate action had been taken when the risk was assessed as being high. For example, we saw that advice had been sought from a dietitian when a person was noted to have lost weight in June 2016 and staff followed the nutritional plan prescribed by the dietitian.

There was evidence that people had access to health services, such as GPs, dentists, dietitians, opticians and chiropodists so that they received the care and treatments necessary for them to maintain their health and wellbeing. The GP visited the service on the first day of our inspection to see people who needed medical assessments and treatments. None of the people we spoke with had concerns about how their health needs were being managed.

Good

Is the service caring?

Our findings

Although there were mixed views about whether staff were caring, the majority of people we spoke with said that they were. One person said, "Some of the carers are really trying to be helpful, but some carers don't give a tosh. It depends who you get really, they are kind to me and I don't complain as they are busy." Another person said, "One carer on the night shift is good. Some carers understand my needs and some don't. I think the young ones are embarrassed to help (with personal care)." A third person told us, "Some carers are good and they show respect, but I have no real concerns here." A relative said, "I get on really well with the carers here and I am in four times a week visiting [relative]. Staff do try and help [relative], yes they are caring." Another relative said, "I think the staff are caring, most of them anyway. I attend the residents and relatives' meetings and last time they had a carer there to represent them, as they get the flack when really it's not always their fault."

We found the concerns raised by people were mainly not about whether staff were caring and compassionate, they were about staff not always having the time to interact with people during periods when they had not been enough staff on duty. This had been addressed by the service recruiting more staff and some people told us that they had already seen improvements in the quality of staff following a reduction in the number of agency staff required to make up the staff numbers. We observed positive and respectful interactions between staff and people who used the service. There was a lot of humour and staff always spoke with people whenever they came into the communal areas.

Staff told us that they really cared about people they supported, but staffing issues sometimes made it difficult for them to spend as much time as they would like with each person. One member of staff said, "I thoroughly enjoy what I do. I like caring for people, that's why I am a nurse." Another member of staff said, "The carers all love what they are doing for residents. Everyone is lovely here."

People told us that their views were listened to and they were able to make choices about how they lived their lives, including their daily routines. They also said that staff supported them in a way that protected their privacy and dignity. One person said, "They are always respectful." People had been supported to maintain their independence as much as possible. For example, we saw that people with limited mobility had been provided with equipment necessary to help them move around the home safely. A member of staff told us that they always ensured that they supported people to remain independent as much as possible. They told us that where possible, they encouraged people to do more for themselves and they provided support where people were unable to do things for themselves. An example they gave us was how they encouraged people to walk around the home frequently so that they did not spend most of their day sitting down.

Staff we spoke with demonstrated that they understood the importance of maintaining confidentiality in order to protect people's privacy and rights. They told us that they would not discuss about people's care outside of work or with people not directly involved in people's care. They valued the contribution of people's relatives in helping them to better understand people's needs. One member of staff said, "We work together, staff, residents and relatives for the betterment of residents." We noted that relatives visited the

service regularly and where required, they acted as their relatives' advocates and were quite involved in supporting them to express their views and wishes. They also ensured that people understood the information they had been given by the service to enable them to make informed choices and decisions. If required, people could also contact independent advocacy services for support.

Requires Improvement

Is the service responsive?

Our findings

People told us that their individual needs were not always being met by the service because there were delays in supporting them when they used their call bells. Others said that prompt action had not always been taken when their needs had changed, resulting in delays in providing the care and treatment they required. A person who said that call bells were not always answered promptly added, "In fact, one day I had to wait over an hour to get help." Another person said, "I have had to wait for help to the toilet and have had accidents whilst waiting on staff, and I hated that. Night staff are worse I think." A relative of another person was not happy about delays in getting bigger catheter bags for the night so that their relative's sleep was not constantly disrupted by night staff emptying the smaller bags. They also said that the catheter had come out and it took a few days before it could be replaced. They added, "It's not good enough really." Another relative said, "We have had a few teething problems about (supporting relative to use the toilet). Hopefully it will get better. The carers are good I think." A member of staff told us, "Generally, we are trying our level best, but there could be times when everything does not go well. Otherwise, we aim to provide good care."

We noted that there had been delays in staff responding to call bells, with particularly late response times during July and early August 2016. We saw that during that period, some people had to wait for as long as 45 minutes to be supported. The manager took action to improve this by purchasing pagers for the service so that each member of staff could quickly see which call bell had been activated. This was introduced six weeks prior to our inspection and staff we spoke with told us that it had saved them the time they had to go and check the information boards located by the nurses' station on each floor. They also said that this meant that they could support people a lot quicker. Additionally, the manager took disciplinary action against members of staff who did not respond quickly to call bells and this was also being addressed during staff supervision. The manager also discussed this with people who had complained and their relatives and relayed the provider's guidance that no one should wait to be supported for longer than 10 minutes. Call bells were being monitored and the daily logs were audited to check if any call bells had not been answered within 10 minutes. We saw that a lot of improvements had been made and they had been no call bells not responded to within 10 minutes during our two days at the service.

Care records showed that people's needs had been assessed prior to them moving to the service and care plans had been developed so that they received appropriate care and support. The care plans we looked at showed that people's preferences, wishes and choices had been taken into account. We noted that each person had an allocated keyworker who reviewed their care plans regularly or when their needs had changed. Although some people could not recall if they had been involved in planning and reviewing their care plans, there was evidence that this had been done where possible. One person said, "Yes, I talk about my care plan with staff." A relative told us, "We are very much involved in [relative]'s care."

People had been supported to pursue their hobbies and interests. There was evidence that a range of activities took place within the home, and outings were arranged to places of interest for people. A weekly activities schedule was displayed on noticeboards on each floor and planned activities included an exercise class; crosswords; Holy Communion; dominos; horseracing dice game; movement with music; pianist; quiz; singalong; films on Saturdays and Sundays. Planned outings for November 2016 included a trip to Harefield

Dogs Trust on 8 November 2016 and to a local garden centre on 22 November 2016. We also noted that the service took part in the National Care Homes Open Day in June 2016 and this included celebrating the Queen's 90th birthday with a garden party and traditional afternoon tea. People told us that they enjoyed the activities provided by the service and none of them said that they were bored. The service had one activities coordinator, but the manager told us that they were in the process of employing another one to particularly arrange activities for people to do during weekends.

The provider had a complaints policy and a system to manage complaints. The provider had a complaints policy and a system to manage complaints. The 'Customer feedback – Concerns, complaints, compliments and suggestions' leaflet was available by the main entrance to the service. There were also complaints forms available for use by people or visitors to the service and these also explained how their complaints would be managed. We checked the complaints records and noted that appropriate actions had been taken to investigate and resolve any complaints raised by people or relatives. Although one person said that staff were not always responsive to their concerns, some people said that their complaints had been mainly dealt with well.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in October 2015, we found food and fluid charts were not always completed fully to evidence that people were eating and drinking enough. Furthermore, wound care was not always evidenced in people's care records. During this inspection, we found staff were still not always keeping up to date records of what support they had provided to people. For, example, staff were not always recording in charts each time they supported a person to reposition in bed, to eat or during checks for people who required to be checked every two to four hours. While looking at care records at the nurses' station on one floor, we had observed staff checking and supporting a person a few times, but none of those interventions had been recorded on their charts.

Also, people's care plans for wound care did not always state how often the dressing needed to be changed. Although the daily notes showed that this was done every one to three days for one person, the nurse we spoke with said that the dressing was changed daily or when required. This had potential to cause confusion which could result in omissions in the care provided to the person. We spoke with a relative who said that they at times, thought that care had not been provided to their relative because the charts had not been completed. Additionally, we noted that daily notes were task focused and not always written in a person centred way. We discussed these issues with the manager and they showed us evidence that they had been discussing this with staff during individual supervision meetings and they also held group meetings. However, they were aware that this did not consistently happen and they said that they would continue to remind staff of the importance of keeping accurate records.

The manager had been in post since June 2016 and they had started the process to register with the Care Quality Commission. They were supported by a deputy manager and a clinical services manager. Some of the people told us that they did not know who the manager was. One person said, "Never seen the manager and he didn't introduce himself either." A relative said, "It would have been nice in his first two weeks to introduce himself and get to know people." Although most staff said that the manager and other senior staff were supportive, others said that there was lack of leadership during the weekends. One member of staff said, "At weekend we have no management in place at all and that is not good. We need to have someone more senior than a senior carer or nurse, it's a 24 hour service so management should work shifts." The manager and deputy manager told us that there was managerial cover at weekends as they operated an on-call system. The deputy manager told us that they normally visited the home when they were on-call at weekends to provide support to staff. A professional we spoke with told us that recent problems with people's medicines had prompted the manager to be more clinically involved than in the past, when they had left care management responsibilities to the deputy manager and the clinical services manager. This was supported by staff who told us that the manager was more visible and took interest in staff and how they provided people's care.

We saw that regular staff meetings had been held for them to discuss issues relevant to their work. However, some staff did not feel that they always worked well together as a cohesive team, so that they provided good care to people who used the service. One member of staff said, "Some staff are lazy and when you do point it out nothing happens. I look at my shift and see who is working and groan as I know it's going to be harder

on me." Another member of staff said, "Communication is poor and could be better." A third member of staff said, "You feel you have to work harder to support residents when you are working with some staff." Other staff were particularly critical of the managers not taking enough action to control the amount of time staff spent going outside to smoke. They felt that this put added pressure on those staff who did not take these additional breaks. We fed this back to the manager.

The provider had processes to enable people who used the service and their relatives to provide feedback. We saw that a number of compliments had been received by the service. Also on the second day of the inspection, relatives of one person had brought four bottles of wine and two cakes to thank everyone for the care and support they had provided to their relative. This had been offered to people during lunch and one person told us that they had enjoyed the cakes and wine. Some people chose to attend the 'Residents and Relatives' meetings and they were also able to give feedback about the quality of the service at any time by speaking with the manager. There was also a 'Residents Committee' and we saw the minutes of the most recent meeting held in September 2016.

The provider also sent out annual surveys to people and their relatives. The results from the survey completed in 2015 showed that improvements were needed in some areas including how quickly staff responded to call bells; staffing numbers; staff to know people and their needs. We noted that a response to these concerns had been displayed on the notice boards so that people and their relatives knew what action had been taken to make the required improvements. In May 2016, people had raised concerns about visiting dogs going in the dining and a notice had been displayed to encourage cooperation by the dog owners. Also, some refurbishment work was being undertaken during our inspection as a result of comments from people. This showed that the provider acted on people's comments in order to improve the quality of the service.

The manager and other senior staff completed a range of quality audits to assess the quality of the service provided. These included checking people's care records, health and safety of the environment, medicines management processes and staff records to ensure that they were accurate and contained up to date information. The manager produced a monthly report which was sent to the provider's quality team for monitoring. They developed an action plan if they identified any areas that required improving and on the whole, these issues were followed up and rectified in a timely manner. However, further worker was necessary to ensure that they provided safe and effective care that met people's needs and expectations.