MACC Care Limited

Church Rose Nursing 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**

Overall summary

This inspection took place on 9 December 2015 and was unannounced.

Church Rose is a privately owned care home situated in a residential area of Birmingham. Nursing care is provided for up to 48 older people who live at the home. The home is a two storey building, with suitable access for people with restricted mobility. There were 47 people living in the home at the time of our visit.

There were two registered managers in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We last inspected the home in December 2014. After that inspection we asked the provider to take action to make improvements to ensure people's needs were met by sufficient numbers of appropriately skilled staff and medicines were managed safely. At this inspection we found improvements had been made, but further improvements were still required.

Summary of findings

Most people were happy with the staff, but told us that staff were busy and they sometimes had to wait for assistance with personal care. Staff we spoke with said there were enough staff to support people safely and ensure they received the care they needed. Further improvements were needed in the allocation of staff to ensure there was oversight of communal areas at critical times.

People told us staff were respectful and kind towards them. Staff protected people's privacy and dignity when they provided care and asked people for their consent before care was given. There was a programme of activities and entertainment to support people's social needs. Friends and family were welcomed into the home.

Assessments had been completed to determine people's capacity to make certain decisions. The provider was meeting their requirements set out in the Deprivation of Liberty Safeguards (DoLS).

People received care from staff who had the skills and experience to meet their needs effectively. People were referred to other healthcare professionals and received their medicines as prescribed.

Staff understood their responsibilities around keeping people safe**.** There were systems and processes in place to protect people from the risk of harm. These included a procedure to manage identified risks to people's care

Care plans contained information for staff to help them provide the individual care and treatment people required, however staff were not always able to respond to people's needs at a time people preferred.

There were systems in place to assess and monitor the quality of the service. This was through feedback from people who used the service, their relatives, staff meetings and a programme of checks and audits.

There was a lack of clarity around the roles and responsibilities of the management team. Changes in managers meant there was uncertainty about the future leadership of the home.

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?

Requires improvement

The service was mainly safe.

People's needs had been assessed and where risks had been identified, staff made sure people received support that kept them safe. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. Improvements were required in how staff were allocated in the home to ensure communal areas were always monitored. People received their prescribed medicines from staff as directed by health professionals.

Is the service effective?

Good

The service was effective.

People received support from staff who were competent and trained to meet their needs. Where people did not have mental capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards. People were offered choices of meals and drinks that met their dietary needs. People were referred to other healthcare professionals when a need was identified.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and promoted their dignity when providing support. Staff were kind, patient and reassuring in their interactions with people. They did not rush people and supported them at their preferred pace.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Staff had a handover between shifts which gave them information which enabled them to provide the care and support people required. Staff were not always able to respond to people's needs at a time people preferred. There was a programme of activities and entertainment to keep people busy and meet their social needs.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

There was a lack of clarity around the roles of the managers within the home and uncertainty as to the future leadership of the home. Some areas required better organisation to ensure everyone had consistently positive experiences in the home. People and staff were encouraged to provide feedback about the quality of care provision.

Church Rose Nursing 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.

This inspection took place on 9 December 2015. The inspection was unannounced and carried out by three inspectors, a pharmacy inspector and a specialist nurse advisor.

We reviewed the information we held about the service such as statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We also spoke with the local authority who provided us with information they held about this location. The local authority did not have any information to share with us that we were not already aware of.

As some people had complex nursing needs and limited communication, we spent time observing care in the lounge and communal areas throughout our visit. We spoke with 10 people who lived at Church Rose Nursing Home and two relatives to ask about their experiences of what it was like living there.

We spoke with one of the registered managers, the peripatetic manager and the area manager. We also spoke with two nursing staff, five care staff, three non-care staff and two visiting healthcare professionals. We looked at seven people's care records and other records including quality assurance checks, medicines, complaints and incident and accident records.

Requires improvement

Is the service safe?

Our findings

When we last inspected Church Rose Nursing Home we found there were not always enough suitably trained and skilled care staff on duty to meet people's needs. At this inspection we found some improvements had been made, but further improvements were still required.

Since our last inspection the home had been separated into two units with identified staff on each floor. During the morning, there were four care staff on the ground floor unit and five on the first floor unit. There was a trained nurse on each floor. The peripatetic manager told us this had improved the responsiveness of staff as they knew where they were working and it allowed a staff presence on each unit.

People we spoke with gave mixed responses about whether they felt there were enough staff in the home. One person told us, "Yes there is enough staff, I am shown the buzzer and there are no problems." Whilst another said, "No they don't always come quickly." Other people told us there were occasions when they had to wait for assistance from staff. One person explained, "When I need to go to the toilet they come and help me. Sometimes I do have to wait, sometimes I don't." Another said, "Enough staff? I would say 50/50. Sometime there is, sometimes there is not." A visiting healthcare professional told us there were times they had to wait to see people because staff were busy supporting others.

We asked the registered manager how staffing levels were identified. They told us staffing levels were based on the number of people in the home and their needs. They explained, "There might be more staff in the building if there is a need. If a person is poorly there might be an extra member of staff with them. When we have an admission, we may have someone as an extra carer. Last week we had somebody extra because someone was going to the surgery. We didn't want to take someone off the floor so we put an extra person on." However, there was no tool to demonstrate how the needs of people individually and living as a group had been assessed. As many people required the support of two staff, such a tool would provide assurance there were sufficient numbers of staff on the rota and staff were allocated where they could most effectively and safely meet people's needs.

On the day of our inspection, care staff were not rushed but were engaged in carrying out tasks throughout the day. We were not aware of call bells ringing for long periods or people calling for assistance and daily records confirmed people received the care set out in their care plans. However, we found some need for improvement in how staff were allocated. Care staff were busy providing care and support in people's bedrooms so there were times when there was no staff presence in the lounges. This meant staff were not always available to monitor people or respond to people when they preferred. One relative told us, "Generally, if I am in the lounge, there is rarely anybody (staff) in there. They are passing through though."

All staff we spoke with said there was sufficient staffing to carry out the personal care and support people required and to respond to peoples requests for assistance. One care worker told us, "Yes there is enough staff, there are usually four downstairs and five up when we are full and we have the nurses as well." Another said, "Mostly enough, if all the staff come in and don't phone in sick we are okay. We do have a lot of people who require two staff for personal care and hoisting so additional staff would always be welcome, but we manage." One care worker told us, "We are not short staffed, just busy, we don't hurry people, we treat them with respect. If we are seeing to someone we can't just leave them to go to the next person."

At our last inspection we found that medicines were not always managed safely in the home. At this inspection we found significant improvements had been made, but further improvements were still required.

There were clear, effective systems and processes for ordering and receiving medicines. When people received their medicines this was recorded clearly on Medicine Administration Record (MAR) charts provided by the pharmacy. There were no gaps in the MARs which indicated people had been given their medicines as prescribed. Any handwritten additions or changes to the MAR charts had been checked and signed by a second member of staff to confirm their accuracy. The balance of medicines in stock matched the administration records and were accurate. The provider maintained accurate and up to date records for the receipt and disposal of medicines.

Medicines were stored safely and securely and in accordance with manufacturer's advice. Oxygen cylinders were stored in the clinic room, however there was no warning sign displayed on the door.

Requires improvement

Is the service safe?

Nursing staff took care to ensure the correct medicine was administered to the right person. Any refusal of medicine was documented. People's allergies were clearly recorded. One person was supported to self-administer their own medicines.

Guidance for the administration of 'as required' medicines was available. This guidance provided information as to when it was appropriate to administer an 'as required' medicine and ensured that people received those medicines in a consistent manner. However, if there was a choice of how much medicine to give, the amount people had received or the time it had been given was not always documented on the MAR chart. This could result in people being given too much medicine.

Some people received their medicines in a covert manner. Covert administration of medicines may take place when a person regularly refuses their medicine, but they lack the capacity to understand why they need to take it. One person had their tablets crushed and added to food or drink. No information had been obtained from a pharmacist to confirm that crushing the medicine and putting it into drinks would not affect the effectiveness of the medicine.

The registered manager regularly reviewed the daily monitoring sheets completed by staff and recorded any issues with medicine administration. The pharmacy audited the management of medicines on a six monthly basis, with the last audit in December 2015. No issues were identified at that visit. Any medicine incidents had been reported and actions taken after discussion with staff.

Staff knew and understood their responsibilities to keep people safe and protect them from harm. They were able to identify the different areas of abuse and the signs that might indicate a person was at risk. One member of care staff told us, "I would be suspicious if people's behaviour changed and they became withdrawn if they were usually chatty, or if I found bruising on a person's arms or thighs that couldn't be explained." Another said, "You need to remember how to talk to people and be gentle, don't shout or talk to people disrespectfully, that's something I wouldn't like." Staff knew what to do if they were concerned about a person's safety, "I would speak to the senior, a nurse or the manager. I wouldn't just leave it. I would make sure someone senior knew so they could take action." A senior member of staff told us, "If a care worker reported any concerns about abuse I would try to speak with the person and would refer it to the managers so they could alert social services." They also said, "I had an update in safeguarding training in June, it keeps you up to date. We also have a poster in the front office with the safeguarding numbers so we know who to refer concerns to." The registered manager had made appropriate referrals to the local safeguarding authority when concerns had been raised.

The provider's recruitment process ensured risks to people's safety were minimised. Records showed the registered manager checked staff's suitability before they started working at the home. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

The provider's policy for managing risks included assessments of people's individual risks to their health, physical and emotional wellbeing. Where risks were identified, people's care plans described how staff should minimise those risks and the equipment and actions staff should take to support people safely.

Staff we spoke with knew the risks associated with people's care, for example moving and handling needs and risks associated with eating and drinking. They had a good knowledge of how to manage identified risks. For example, using a hoist and slide sheet to move people unable to move independently and how people needed to have food and drink prepared if they were at risk of choking. Staff knew how to monitor people's skin to prevent it becoming sore and the action to take if they were concerned about anything. One member of care staff told us, "Any concerns I would report it to the nurse or [registered manager]."

Staff told us they checked equipment to make sure it was safe to use, including hoists, wheelchairs and pressure relieving equipment. One staff member told us how risk of falls was minimised, "We check people's environment to see if there are clear walkways, we encourage people to use their mobility aids and if they are at risk we use bedrails with bumpers when people are in bed."

Accidents and incidents were recorded and up to date. Records were analysed by the registered manager to

Requires improvement

Is the service safe?

identify any trends or patterns to prevent further possible reoccurrences. Staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency.

Good

Is the service effective?

Our findings

People were mainly positive about the care they received at the home. One person told us, "I am happy enough with the staff, the majority are quite good, you get the odd one or two but they get on with the work."

We spoke with three staff who had recently started working at Church Rose and they all told us they received an induction and training to support them to do their job. They told us they were completing an induction programme that included understanding policies and procedures, getting to know people's needs and preferences, and completing essential training. Comments included: "I have had a good induction. I know what I am doing. I shadowed seniors and experienced staff; they watch what you are doing and give you advice if you need it." "My induction helped me understand my job and how to do things properly." "My induction is going well. I am improving and learning. I have met all the residents, have completed three shadow shifts and can now work on my own."

The Care Certificate sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment**.** Senior staff had attended training to understand the requirements of the certificate which was being introduced into the home.

People received support from care staff who had the skills and knowledge to meet their needs effectively. Records showed care staff received training in the use of moving and handling equipment, food handling and infection control. Staff had also received training to meet the specific needs of people in the home, including supporting people living with dementia. One staff member told us, "I had dementia training it was really useful and helped how I worked with people." During our visit we observed staff putting their training into practice, for example when supporting people to move safely around the home. The registered manager told us they supported care staff to gain further qualifications to support their role in the home and their career development. They told us, "Quite a few carers have left to go into nursing."

Nursing staff received training to ensure their clinical skills were maintained and they followed best practice. Records showed that recent training undertaken included catheter care, tissue viability and safe handling of medicines.

The registered manager ensured staff were supported to be effective in their practice through regular supervision meetings. They explained, "Some are quite knowledgeable, but some need to improve. We continue to support them through one to one supervision or during meetings." All staff spoken with confirmed they had regular supervision. One staff member told us, "I have supervision with [senior care worker]. We discuss my work practice and personal development. She also checks my learning to make sure I understand what I have been trained to do."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

The registered manager understood their obligations under the legislation. They told us, "Everyone has capacity until they have been assessed as not having capacity. We assume everybody has capacity and we support them to make choices. Everybody is able to make choices if they can." Records showed that assessments were in place for those people who were not able to give consent to their care and support. Where people did not have capacity, decisions were made in their best interests. The registered manager explained, "We would work in their best interests. We would weigh up the pros and cons. For example, if they had swallowing difficulties and can't swallow bread, we would have to make a decision if it was in their best interests not to give them bread. We would involve the family and a multi-disciplinary team."

Care staff understood the requirements of the MCA meant people should be supported to make their own decisions. One care worker said, "You have to assume people have capacity until they have been assessed otherwise. Some people here have dementia but they can still make daily decisions about their lives." Staff explained how important it was to obtain people's consent before providing care and support. One member of staff explained, "You have to have people's consent before you can provide care. It sounds

Good

Is the service effective?

difficult but it's not, you just have to tell them what you are about to do and if they are okay with you doing this." Another told us, "It's about giving people choice and asking for their consent. If people refuse personal care you have to accept this, but you would try and persuade them, if they still refused I would ask another member of staff to try or go back a bit later."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The manager understood their responsibilities under the legislation. They had identified that some people needed restrictions to their liberty and had submitted the appropriate applications to the authorising authority.

Care workers knew about people's nutritional needs and preferences. They knew who had risks associated with eating and drinking and how they needed to have their food prepared, for example food pureed and drinks thickened to avoid risk of choking. They also knew which people required sugar free diets to manage their diabetes. Food for people not on special diets was fortified with cream, butter and full fat milk to increase people's calorie intake to maintain their weight. Care workers said they completed food and fluid charts if people were unwell or had lost weight to monitor how much they had to eat and drink to make sure they were having sufficient nourishment. We looked at three fluid balance charts and saw people were offered fluids on a regular basis and charts were kept up to date. Night staff were responsible for identifying any concerns around fluid intake so action could be taken to encourage people to drink more. People's weight was regularly monitored to identify if people required further support to maintain their weight.

People were offered a choice of lunch and tea and were generally happy with the quality of food provided. Comments included: "The food is okay, I've got no reason to criticise it." "The food is not too bad, I love eggs and bread and butter. I am sure they would get it for me." "It's good here, you get plenty to eat and drink." "The food is quite good. Sometimes there is too much. You get a choice of two items. I have soft food. There is enough to drink, too much." The menu took into account the cultural needs of people living in the home. Curry and rice was offered as an alternative most days and an African Caribbean option was offered twice a week. At lunch time staff supported people to eat independently and were friendly and enabling in their approach.

Records showed people received care and treatment from health care professionals such as dentists, opticians, tissue viability nurses, chiropodists and dieticians. The GP visited the home once a week and saw people who required treatment.

Good

Is the service caring?

Our findings

Most people told us staff were caring. Comments included: "Staff are caring, I think it's all about give and take and I get on with them." "They are caring, the way they talk to me." "Staff attitude is pretty good, it can be a bit up and down." A relative told us, "They have been really nice and welcoming to us." During our visit we found staff interacted well with people and were warm, engaging and reassuring. At lunch time there were relaxed conversations and lots of laughter. A visiting healthcare professional told us, "Staff are very caring and respectful and professional in the way they approach their job. They do seem to care about what they do."

We asked the registered manager how they encouraged staff to maintain a caring approach. They responded, "If I see staff who are not caring, I will pull them up and speak to them. I ask nurses to do the same." A senior care worker who supervised and observed new staff said, "I would be looking that new staff offer choices to people, ask people what they wanted and if they agreed before they did anything. I would also be watching how they communicated with people, especially how they talked to people and if they took time to listen to what people said to them." One new member of staff confirmed, "I was told about talking to people when you see them or helping them to eat. They also showed me how to support someone to eat, you sit next to them don't stand over them, and go at their pace not to rush."

One person received all their foods and fluids via a percutaneous endoscopic gastrostomy (PEG). PEG feeding is used where people receive nutrition through a tube into their stomach because they cannot maintain adequate nutrition through oral intake. We saw the PEG feed being implemented by one of the nurses. They were caring and empathetic in their approach and took time to explain to the person what they were doing. Another person was taken to hospital for a regular appointment. It was cold outside and staff ensured the person was appropriately dressed for the weather. The person was also given a packed lunch in case they were at the hospital longer than anticipated.

People who required help with dressing, were supported to make decisions about what clothes they wanted to wear. Care workers told us that people were given the choice of a wash, shower or a bath every day. One care worker told us,"[Person] likes a bath every day, so we help them do this." A healthcare professional confirmed, "When we go in the patients seem well dressed, clean and tidy."

People we spoke with told us staff respected their choices. One person told us, "I prefer to keep my pyjama trousers on, this is my choice." During our visit we found people were listened to and staff understood people's preferences, for example what they liked to wear and where they preferred to sit. Staff offered people choices particularly what people preferred to drink and eat and how they liked to spend their time. One staff member explained, "Some people like to go out, some stay in their rooms, we ask them, it's their choice."

We asked staff how they maintained people's privacy and dignity. One staff member responded, "I always knock their door and wait if people are able to tell you to come in." We saw that when people were provided with personal care within their room, the door was closed to maintain privacy. Another staff member told us, "I make sure people have a blanket covering their legs when we hoist them. We also put a screen around the person while we hoist them so their dignity is maintained." We observed this put into practice twice during the afternoon when staff assisted people to transfer using the hoist. Staff explained to the person each stage of the process, offered reassurance and checked they were safe and feeling relaxed. One person told us, "I can lock my door and lay down and have a sleep if I want in private." A visiting healthcare professional told us that when they needed to see people, "They are seen in their room or taken to one of the side rooms."

Relatives and friends were welcomed into the home whenever they wished and supported to maintain a role in their family member's life. The registered manager told us, "We recently had a family who came in and spent the night with somebody until they passed away in the morning. If someone is dying and they have nobody with them, we send a member of staff to sit with them. They put soft music on and hold the person's hand."

Requires improvement

Is the service responsive?

Our findings

People had an assessment of their needs before they moved to the home to ensure the service could provide the care and support they required. Care plans were developed from those assessments and contained detailed information that enabled staff to respond to those needs. Staff told us people and families were encouraged to be involved in care planning decisions. One staff member explained, "We try to involve relatives in reviews if people are not able to understand the process."

Staff knew about people's needs, preferences and how they liked to spend their time. Care staff on the ground floor, who were all new to the home, said they had not read people's care plans, but understood people's needs because they had a detailed handover between shifts. One new member of staff told us, "I haven't read a care plan yet. I know we should read them, but I've not had time unless I come on early or stay later. It's something I know still needs doing. I know about people's care needs as we have a good handover and seniors and nurses tell you about any changes." Another member of staff told us, "Communication works well. We have a handover every day, good information is shared about people so you know what's happened and any changes since you were last here." A visiting healthcare professional confirmed, "Staff know people's needs."

Staff worked on designated floors so got to know people they worked with well. One staff member told us, "We are allocated specific corridors when we come on shift so you know who you are working with. I've learnt a lot about the people I support. I know how they like their care, each person is different and likes things done in different ways. I follow what they want, it's their home not ours." One person told us, "They have swapped the staff over on the floors, I had to get to know the new staff. They are much younger, but I am quite happy."

People were mainly happy with the care they received. However, they told us staff were not consistently responsive because they were not always able to provide them with care and support at times they preferred. One person told us, "The main issue is the lack of time keeping. They get me up between 10.30am and 12.00pm and I prefer to get up early." Another person told us, "The night staff have helped me to wash and dress but this is at 6am, so a bit early. It is either too early or too late." Another person said, "Once about 4 or 5 weeks ago on a Sunday I was still in bed at 12.20pm. The manager helped me to get up." We also found that not all people had call bells within easy reach to summon assistance. One person told us, "They don't always leave me with the buzzer, I forget to ask them for it."

Some people had limited verbal communication but care staff understood people's specific communication needs. One care worker told us about a person whose communication skills fluctuated when they were unwell. They explained, "Sometimes [person] can speak to you and tell you what they want, but other times they can't, but if you watch their eyes closely they communicate with them." There was a culturally diverse group of people living within the home speaking a variety of languages. The registered manager explained, "We have got staff who can speak Punjabi and we have staff who can speak Portuguese. We have one person who is Chinese and the family have done a list of the main phrases we need to use with them." The registered manager told us that if there were any communication difficulties they would seek an interpreter to support staff in responding to the person's needs.

There were things for people to do during the day. On the morning of our visit we saw some people participating in a daily exercise class. There was then an activity using picture cards to create discussion. Five people were involved and appeared to enjoy the interaction with each other and the activities co-ordinator who was leading it. In the afternoon there was a game of bingo. We were told about entertainers who visited the home regularly such as singers and choirs. The activities co-ordinator explained, "I do ask them what they would like. I do an evaluation afterwards and ask what they think." Some activities were linked to people's previous hobbies and interests. For example, one person had a particular interest in knitting and crochet. The activities co-ordinator told us, "I have a church group and one of them came in and did crochet with her."

We asked how the social needs of people who were looked after in bed were met so they could also maintain hobbies and interests. The activities co-ordinator explained, "I will read an article out of the newspaper, have a chat with them because I have to spend time with them." They had also made a connection with a national charity who sent representatives to "befriend" people who were bedridden and "who might just want a chat".

Requires improvement

Is the service responsive?

Representatives from different religions visited the home each month to provide guidance and meet people's individual spiritual needs.

There was information displayed in the home explaining how people could make a complaint. However, most people told us they discussed any concerns directly with staff. One person told us, "There have been 3 or 4 instances when I have talked with staff directly about something. I will leave it until the next day, I would rather we all work together. We get on okay."

We looked at the record of complaints. We saw there had been six formal complaints received in 2015. We saw these had been responded to in full and checks had been made to ensure people were happy with the outcome of their concerns. Complaints were analysed monthly to establish any trends and whether further action was required. Any issues around poor practice were shared and discussed with staff.

Requires improvement

Is the service well-led?

Our findings

People were mainly happy with the quality of care provided. One person told us, "I don't know that much about the management. It has to be well run, the staff are trained. The managers have to take the credit." A member of staff told us, "I think its well managed. I like the way they don't change things all the time, you have time to get to know people as you work in the same area."

Following our last inspection action had been taken to strengthen the management of the home. There were two registered managers at the service. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. One manager had been registered for three years and the other since September 2015. There was a lack of clarity around the roles and responsibilities of the registered managers. The registered manager who had been in post for three years told us, "I make the day to day decisions about the management of the home. Staff are quite aware I am the registered manager and [other registered manager] is the deputy manager." We were told the deputy manager worked in the home three to four days a week. On two or three days they were one of the named nurses on the rota. One day a week they were supernumerary to the rota to allow time for their managerial responsibilities. However, this meant they were not involved in making key decisions about the day to day running of the service for which they could be held legally responsible.

A peripatetic manager had been appointed to support the registered managers. On the morning of our inspection the registered manager in post for three years told us they were stepping down in January 2016 with a view to the peripatetic manager being appointed as the registered manager. We were then told the deputy manager would remain as the sole registered manager. Through discussions with the management team, it was clear decisions still needed to be made by the provider about the future leadership of the home to ensure improvements were maintained.

We found the organisation of staff and key events during the day needed to be improved to ensure people received a consistent quality of care. For example, we joined people in the dining rooms at lunch time. Whilst the mealtime was unhurried, we found it was a mixed experience for people. People who could eat independently were served first, as well as people who were in their rooms. This meant people at the dining table who required assistance from staff had a fractured meal time. One person who required assistance from staff to eat was brought to the table at 12.30pm. However, they were not served their meal until 1.35pm when all the other people had finished their dinners. The management team had not identified this as an issue, but agreed that better organisation and deployment of staff could lead to more positive experiences for everyone in the home.

The retiring registered manager told us they liked to be visible within the home and explained, "I walk around the home on a daily basis and document it. I speak to any family in the building. I don't go out at the same time every day." We looked at the records of one of their recent "walk-arounds". We saw that the registered manager had identified a maintenance issue. We checked and this had been addressed. One person confirmed, "The management will ask me 'how are you getting on?" A visiting healthcare professional told us, "I have seen [registered manager] when they are short staffed, helping the staff and advising them how to do things."

The retiring registered manager told us they were open to suggestions from people and staff about how the service was run. They told us, "We are caring and we do listen to people if they bring any concerns. We have a suggestion box so people can suggest how to improve the service." One member of staff told us, "I haven't got any complaints. If I'm not happy with something I won't take it home with me. She [registered manager] will help me."

Meetings were held with staff to focus on consistency and quality issues and discussion included reminders about good practice. We looked at the minutes of a recent meeting with nurses and saw there had been discussions around better team work and medicines management in the home. Nurses had also been encouraged to reflect on their work to see if what they were doing was best practice and whether they could identify ways of improving. Staff told us they felt able to raise issues in the meetings. One told us, "We have staff meetings where we can share our views and raise any concerns. We don't have to wait for staff meetings I can go to [registered manager] at any time."

Requires improvement

Is the service well-led?

Another said, “We have staff meetings and we are encouraged to share our views. I was told ‘speak up for yourself that’s how things get improved’. If you don’t say they won’t know.”

Staff were positive about working at the home. One staff member told us, “I love my job, I put my all into it. We do the best we can here.” Another said, “At the moment this is my ideal job, I eventually want to go to university to study nursing.” We asked what the management could improve. They responded, “Nothing really. Well in an ideal world I wish we could have more staff, but I suppose no matter how many there are, it’s never enough.”

People and relatives were asked their views of the service through meetings and quality assurance surveys. We looked at the results of the last survey in March 2015.There had been positive responses to questions relating to staff promoting privacy and dignity and the availability of the registered manager to respond to problems. There had been negative responses to whether people felt involved in planning their care and whether they knew who their key worker was. The retiring registered manager told us they had revisited the role of keyworker with staff and they felt confident that scores in these areas would improve at the next survey.

The provider had additional systems in place to monitor the quality of service people received. The organisation completed checks and audits on care plans, infection control and medicines. The provider also completed regular checks and where these identified improvements, actions had been taken to ensure the home made the required improvements.

The service had links to the local community. The Prince’s Trust had supplied some volunteers at the home with a view to “improving their ability to communicate with the elderly.” The volunteers had assisted in providing activities such as bingo and quizzes. The home also provided placements for students undertaking courses in health and social care at a local college. People and their relatives were kept up to date with all these links through a regular Church Rose newsletter.