Bupa Care Homes Limited

Netherton Green 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 22 and 23 March 2017 and was unannounced. The service had been registered with us previously and was rated as requires improvement. There has been a change to the provider's legal entity and this was the first inspection since this service was re-registered in January 2017.

Netherton Green Care Home is registered to provide accommodation and nursing support for up to 120 older adults with a variety of health conditions including dementia. The home is a purpose built building and consists of four separate single storey buildings each accommodating up to 30 older people. The four units are called Saltwell, Darby House, Windmill House and Primrose. On Windmill House, nursing care was provided to people who lived with dementia and 27people
were in occupancy. Primrose provided care for people who lived with dementia and 29 people were in occupancy. On Darby House palliative nursing care was provided and 27 people were in occupancy. Saltwell provided intermediate/rehabilitation nursing care and 26 people were in occupancy. This is a step down support unit for people discharged from hospital who were not ready to return to their own home.

On the day of our inspection there were a total of 109 people living in the home. A acting manager had recently been appointed and was managing the home with the support from an area manager in the absence of the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

People felt safe in the service and staff knew how to ensure their safety as they had received the appropriate safeguarding training. Sufficient staff were not always available to support people appropriately. People were administered their medicines as prescribed as the gaps we had identified on the medicines administration record was due to recording errors.

While the provider was aware of the Mental Capacity Act 2005 they did not ensure people were supported in the least restrictive way. Staff had regular training to ensure their knowledge was up to date. Staff were able to get support in the way of regular supervision and the opportunity to attend regular staff meetings. People were able to decide what they had to eat and drink. People were able to access healthcare from external professionals where needed.

While people felt staff were mainly kind and caring we found some inconsistencies in the actions from staff where they did not demonstrate they were always kind and caring. However we found that people's privacy, dignity and independence was being respected. People were not always supported to make choices.

While staff had access to equality and diversity training, people's cultural needs were not being met in a consistent way. People were not able to access their care plan or assessment documentation consistently and where reviews took place people were not being involved on a regular basis. People's likes and dislikes

were not being considered as part of the activities being made available. The provider had a complaints process to enable people to make a complaint but complaints made were not being managed consistently.

The provider's care records were not consistently up to date or accurately reflected the support people received. The provider did not ensure they notified us where a Deprivation of Liberty Safeguards application had been approved by the supervisory body.

People were able to share their views on the service by way of completing a questionnaire. The provider ensured the appropriate spot checks and audits were taking place on the service, but the checks were not always effective.

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 were sufficiently happy with how they were administered their medicines.

There was not consistently sufficient staff to ensure people were supported timely.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

While the provider was aware of their responsibilities under the Mental Capacity Act (2005) they did not ensure that people were supported in the least restrictive way on a consistent basis.

Staff were able to get support from management when needed, but did not get sufficient training to understand how people should not be restricted.

People were able to get enough to eat and drink to keep them well and they were able to access healthcare as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

While staff were mostly kind and caring, staff did not always communicate with people.

People were able to express how they wanted to be supported. But where they were unable to express their views they did not have access to advocate services.

People's privacy, dignity and independence was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to their assessment and care plan documentation and were not involved in the reviewing process on a regular basis.

People's likes and dislikes were not being considered as part of the activities being made available to them consistently. Activities were not being made available on a regular basis to everyone.

People had access to the complaints process, but the provider did not ensure that complaints were handled appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not know who the acting manager was.

Records were not being kept on an accurate basis to ensure staff knew how to support people.

The provider did not ensure that CQC were notified where a Deprivation of Liberty Safeguards application had been approved.

People were able to complete a questionnaire about the quality of the service they received. The checks and monitoring of the service was not always effective in identifying areas for improvement.

Netherton Green 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our inspection took place over two days 22 and 23 March 2017 and was unannounced. The inspection was conducted by two inspectors and a specialist advisor with experience in nursing. Our inspection team also included four experts 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. The experts by experience had personal experience of supporting people who lived with dementia.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from the Local Authority who have responsibility for funding and monitoring the quality of the service. We received information from them which we used as part of the inspection of this service.

We spoke with 19 people, 17 relatives, 10 members of staff, three nurses, three unit managers, the recently appointed acting manager who was covering for the absence of the registered manager and two area managers. We looked at the care records for nine people, the recruitment and training records for four members of staff and records used for the management of the service; for example, medicines

management, accident records and records used for auditing and monitoring the quality of the service.

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

Requires Improvement

Is the service safe?

Our findings

We found that staff were not always available to ensure people were supported in a timely manner. People we spoke with told us, "We could do with more staff", "There is not enough staff as I sometimes have to wait to get support to go to the toilet", "I feel that the staff rota could be improved as at times staff are stretched" and "There is enough staff". Relatives we spoke with told us, "There is sometimes not enough staff", "[Person's name] is not got up until 11am for breakfast when she used to be got up at 9:30am. There is not enough staff" and "My mom regularly has to wait till midnight before she is assisted to go to bed". People told us they were not always supported on a timely basis when they needed to use the toilet. We found on one unit that a relative had to put a person on the commode as the call bell was pushed but staff did not respond timely.

Staff we spoke with gave us a mixed view as to whether there was enough staff. Some staff said, "There is enough staff" and other staff told us, "There is not enough staff to ensure people get supported on a timely basis". We saw staff on another unit standing in a group talking amongst themselves while people were just left in the lounge watching the television passively. While we found that the provider had a dependency tool to help them ensure they had enough staff to meet people's support needs, we found that people were not being supported in a timely manner. On another unit where most people needed two staff to support them at all times the staffing levels did not reflect this need to ensure people could be supported in accordance with their preferences. We discussed this with the acting manager and the area manager who told us that staffing levels were being monitored regularly to ensure there was sufficient staff. We however raised concerns to how effective the monitoring system was as we found deployment of staff did not ensure people's needs were met. The acting manager and area manager confirmed they were currently in the process of appointing more staff but would look at the concerns we had identified to ensure the deployment of staff related to where people had most need.

We found that risk assessments were taking place to ensure the support people received was carried out in a safe manner. Staff we spoke with confirmed they had access to people's risk assessments so they would know what the risks were and how to reduce any risks. We saw risk assessments on moving and handling people, medicines administration, the environment and where people had specific health risks like choking. Staff we spoke with told us that risks to people were discussed as part of the handover process between shifts. This ensured they would know the risks to how people were supported.

People we spoke with told us they were able to get their medicines how they wanted and had no concerns. A person said, "I am given my medication regularly and I cannot remember them forgetting to give them to me, they stand and make sure that I take them". Another person said, "I am happy with how I get my medicines". Relatives we spoke with all had positive comments to make about the management of medicines. A relative told us, "As far as I know he [person receiving the service] has it [medicines] when he should. There's never been a problem". Staff we spoke with told us they were not able to administer medicines unless they had received the appropriate training. We found that medicines were administered predominantly by nursing staff. These staff had their competencies checked to ensure the administering of medicines was being carried out as it was prescribed. A Medicines Administration Record (MAR) was being

used to show that staff had administered people's medicines appropriately. However we found on one unit that there were gaps on the MAR's. Staff we spoke with assured us that people's medicines had not been missed and the gaps were as a result of staff not signing the MAR after giving medicines. This was known because the provider used a blister pack system which would show the left tablets in the pack not given.

The provider had an appropriate medicines procedure in place to give staff the guidance they would need to administer medicines. Where people were administered medicines 'as and when required' the appropriate guidance was in place and staff knew when to give these medicines. We found that where patches were being used to administer medicines a body map was in place to identify to staff where the patch should go on the body. This ensured staff would apply the patch in a consistent manner.

People we spoke with told us they felt safe. A person said, "I do feel safe in the home I have never felt uneasy about anything", another person said, "I do feel safe". A relative said, "I don't have any worries of him [person receiving the service] being safe, staff are aware of people wanting to get out". Another relative said, "I feel [person's name] is safe, I have no complaints". Staff we spoke with were able to explain what actions they would take where people were at risk of harm and understood the different sorts of harm people could be at risk of. A staff member said, "I would ensure anyone who was being harmed was safe by removing them from the situation and report the situation to my manager". Another staff member said I would report any harm to my manager or the local authority safeguarding team". We found that training in safeguarding people was available to staff and staff we spoke with confirmed this.

We found the provider had a recruitment process in place to ensure only the right staff were appointed. The staff we spoke with all told us they were required to complete a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. This check was carried out to ensure that staff were able to work with vulnerable people. The provider's recruitment process also included references being sought to ensure staff had the appropriate character. We found that staff were able to shadow more experienced staff as part of an induction process and their experiences, skills and knowledge were checked before an appointment was made. We found that where nursing staff were being employed the appropriate checks were taking place to ensure these staff were appropriately qualified and registered to practise as a nurse.

We found that where incidents and accidents had taken place that appropriate systems were in place to record these and take the appropriate action required. Staff we spoke with were able to explain the actions they would take in recording any accidents or incidents along with ensuring people were kept as safe as possible. We found that trends were being monitored to ensure improvements could be made to reduce accidents and incidents where possible.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that DoLS authorisations were in place for some people and applications had been made as required to the supervisory body. One person had conditions on their authorisation which we found were not being met. We discussed this with the unit manager who assured us that action would now be taken to ensure staff were recording information as required by the condition of the authorisation. Staff we spoke with had a limited understanding of the requirements of the MCA and the DoLS and were not sure which people had an authorisation in place and the reasons for this. Staff were unsure if there were any conditions on people's authorisations. This meant that staff were not aware of what actions they needed to take to reduce the impact of the deprivation so that people's care was delivered in the least restrictive way possible. We saw that some restrictions to people's movement were in place. For example some people had sensor mats in their bedrooms and some people used bed rails for their safety. We saw records were not always in place detailing the rationale for these and to confirm if best interest meetings had taken place. We also saw that some relatives had signed consent forms giving staff permission to provide care and support to people without having the legal authorisation to do so. We discussed these shortfalls with the acting manager and the area manager who informed us that improvement in this area had been identified and included as part of their improvement action plan.

A person said, "My consent is sought before staff support me". Relatives we spoke with told us that people's consent was sought and that staff did in the main ask before supporting people. Staff we spoke with told us that people's consent was sought. A staff member said, "I do get people's consent before I do anything". We saw staff asking people's permission before they supported them on numerous occasions throughout our inspection. We found that staff did not always know which people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place, and these were not being reviewed consistently. This meant that where a person did not want to be resuscitated that staff may not know this and people's wishes were not being updated to ensure they were still current and up to date.

People we spoke with said, "I would give 10 out of 10, there is always a choice on the menu and on a weekend I go for the full English breakfast. For snacks we get fruit or cake and drinks are always available during the day", "The meals are lovely. It's always very tasty" and "The food is very good". Relatives we spoke with told us that they were able to help their relatives during lunchtimes and the meals were good, with people being able to make choices as to the meals they had. One relative said, "I have no complaints the

meals are good". Our observations during meal times were that people were able to make choices as to what they had to eat. People had access to drinks during meal times, menus were displayed showing the various options available and where people did not want the choices available they were able to get an alternative meal. However the menu was only available in one format. The acting manager told us that they were currently looking to make the menu available in other formats and a show and tell type menu was being implemented. This would assist people living with dementia to make an informed choice. Staff were available to support people where they needed support to eat and drink and people were able to eat in their bedrooms or within the main dining areas as they preferred. We found on one unit that laundry was being taken through the dining area during lunch time. We raised this with the acting manager as this was not appropriate during meal times. They agreed and told us they would take the appropriate action however on our second day of the inspection the same situation happened again.

Some people had special dietary requirements, for example their meals needed to be pureed due to a risk of choking. We found that the appropriate guidance was available to staff by way of the Speech and Language Therapists (SALT) service. This ensured staff would know how the risk to people choking should be managed.

A person said, "The staff are good they do know how to support me". Another person said, "The staff do have the skills and understanding to support me". A relative told us, "The staff do have the right skills I have no concerns". Other relatives we spoke with told us that staff knew what they were doing whilst looking after their relatives.

Staff we spoke with told us they felt supported since the acting manager started. A staff member said, "Yes I am able to get support when needed". Another member of staff told us that since the acting manager started they did feel able to approach him when they needed support. We found that staff received regular supervision, and had access to staff meetings where they were able to share their views. Annual appraisals were taking place so staff were able to access appropriate training and development. We found that the training provided to staff covered mandatory areas that all staff had to complete for example, health and safety, behaviour that challenged, moving and handling and fire safety. We found that staff were also able to access training where people had specific support needs for example, where people were at risk of malnutrition or had dementia. We were unable to identify from the evidence we saw whether other training was available where people were at risk of choking or had epilepsy. However the acting manager told us that this type of training was provided as and when it was needed.

We found that the provider had an induction process in place so newly appointed staff were able to shadow more experienced staff and receive an appropriate induction into the service. A staff member said, "I am shadowing today as part of my induction and I have started the care certificate". The care certificate sets out fundamental standards for the induction of staff in the care sector.

A person said, "I have seen the optician and I can see the doctor if I need to". Another person said, "I can see the doctor if I am not well". Relatives told us that people were able to access health care whenever they needed to and they saw the chiropodist every few weeks. A relative said, "If mom is unwell the staff will ring me and tell me and get the doctor. They see the doctor every few months just as routine but they always call the doctor if they are at all concerned. The staff are brilliant like that". Staff we spoke with told us that the doctor visited on a daily basis and that people were also able to access other health care professionals. We saw the doctor visiting on one of the units.

Requires Improvement

Is the service caring?

Our findings

We found from our observations that staff were good natured, kind, compassionate and warm toward people living at the home. They acknowledged people by their first name and we saw a lot of general chit chat between staff and people which was good humoured. This indicated that staff knew people well and people were relaxed among the staff. On one occasion we saw a staff member stop what they were doing to welcome a person back into the lounge who had been poorly for a number of weeks and was unable to leave their bedroom. However we found that this was not consistent within every unit. A number of relatives told us that staff did not always sit and talk to people. A relative said, "Since my mom came to the home it has been a constant battle with management and staff to get things done". We observed that staff communicated with people inconsistently across the units when supporting them with equipment. On one unit staff supported someone and spoke to them throughout the process while on another unit we observed staff supporting someone to move using a hoist and they did not speak to the person once throughout the process. This we found would not be in accordance with the guidance staff would have been given in their moving and handling training. This showed that staff were not consistent in how they communicated with people when assisting them to move around the home.

We observed people deciding how they were supported by staff. This was done by staff clarifying with people how they wanted to be supported. However people told us this was not always done on a consistent basis across all four units. Where people were unable to share their views staff would approach relatives but this was not always done consistently. A relative said, "I am kept informed as to how my mom is supported". While another relative told us, "I am not always kept informed as to the changes to my relatives care". We found that relatives meetings were taking place, however the evidence we saw from these meetings did not show that people were involved in the discussions about how the home was managed and run. A person said, "We are not asked our opinions and I don't remember us having any meetings".

People were unaware of an advocacy service and didn't feel supported to share their views. The acting manager told us that an advocacy service was available to people on each of the four units to enable them where needed to share their views. We did not see anything displayed on the units and people, relatives and staff were unaware of the service. We saw that people who were unable to share their views would benefit from advocates supporting them to share their views.

A person said, "Staff are caring and kind". Relatives we spoke with also told us that staff were kind and caring. A relative said, "The staff are so very kind all of the time. They're so good to my mum. She [person receiving the service] loves them and is very happy here. Even the domestic staff chat with her. The unit manager and one of the receptionist pop to chat with us most days. I couldn't find a bad thing to say, at all". Another relative said, "They are wonderful. They always listen to what my husband wants and his choices. The girls [staff] are really kind and will spend a lot of time sitting with him. Especially now he is quite poorly. They listen to him and accept his decision. If he doesn't want a wash or he just doesn't fancy his food then they don't make him, you know. They're not like that. They just chat and sometimes then before you know it he's changed his mind because he's forgotten he said no. At the end of the day they treat him as if he's just ordinary and well. They are so kind". We saw on one unit someone had been left sitting at the dining table

sometime after they had finished their meal and staff had not responded and supported them to leave the area and go back to the lounge or their bedroom. We had to intervene to let staff know this person had been left and then they supported the person to a comfortable chair.

People commented as follows: "My privacy is respected and they [staff] cover me up when I have a bath", "I am totally independent and I am waiting to go home" and "Staff do respect my privacy and dignity. They always cover me up". Relatives we spoke with told us that people's privacy, dignity and independence was being respected by staff". Staff we spoke with told us that they always respected people's privacy and dignity and gave examples as to how they did this. They told us they closed curtains and covered people over during personal care tasks. A staff member said, "I always knock on people's bedroom door before I enter and people are encouraged to do as much as they can for themselves to promote their independence". We observed staff supporting people in a way that promoted their privacy and dignity. Information about people was managed in a way that ensured only people who needed to know the information had access to it to ensure people's confidentiality and privacy was maintained and respected.

Requires Improvement

Is the service responsive?

Our findings

We found that staff had access to equality and diversity training, but staff were unable to identify how the equality and diversity training supported their knowledge and skills to meet people's support needs. We found that where people had particular cultural requirements that had been identified through the assessment process these were not being met. We found that a person had noted on their care records that they liked to eat their own cultural meals but this was not being provided and staff we spoke with were unaware.

People told us the following, "They [staff] promised us a copy of the care plan three weeks ago but never came up with one", "I have seen my care plan" and "I have never seen my care plan".
A relative said, "The support my mom gets is not reflective of her care plan". We found that assessments and care plans were in place to show how people should be supported but this information was not always available or always reflective of the support people should receive. Staff we spoke with did not consistently know across all four units the assessed needs of people or how they should be supported from the information in their care plan. For example on one person's care records information about how they wanted the care to be delivered staff were unaware of until we told them.

A person said, "I have not had a review". Another person said, "We have had a proper review now". Relatives we spoke with told us that they were not consistently invited to reviews. We found that while there was documentation to show a review system was in place. There was no evidence that reviews involved people and or their relatives and happened on a consistent basis. We discussed this with the acting manager and area manager who told us this would be an area to add to the current improvement plan that was already in place which we were given a copy of.

We found that people's likes and dislikes were not always being identified as part of the assessment and care planning process. A person said, "We sit like zombies. Occasionally we play bingo and other games when the girls [staff] have the time". Another person said, "No one comes in my room to speak with me or anything". We found that the activities being made available were not linked to what people's likes and dislikes were. We found that the provider had recently introduced a 'My life story'. This was a document to be used by the activity coordinators to gather people's views on their lives, what they like to do and what they disliked along with their preferences as part of planning the activities people would like to do in the future. We found from some of the activities that had previously taken place that people were able to go out of the home on trips where they were able and also had regular visitors to the home to perform to them. While we saw that activities did take place it was not necessarily the activities people wanted to do. A person said, "We've had singers sometimes and bingo in the lounge, but this is boring".

We found from speaking to staff that an activity plan was available for each unit showing the activities available, but this was not displayed in a way that ensured people could know what was available. We had to ask to see the plan as it was not displayed. People we spoke with were not aware of the activity plan. We found that an activity coordinator was available for each unit but there seemed to be no coordination or consistency as to how they worked or what they provided to people by way of activities. We saw on one unit

an activity taking place that people were taking part in and enjoyed from our observations. Staff were observed actively supporting and encouraging people to take part in the activity and two activity coordinators were also present. While on another unit people were just sitting doing nothing while staff walked past them and there was no activity coordinator available to direct or involve people in the activity that had been planned for that time of the day. We found that while activities were taking place they were not consistent across the four units and people were not involved in deciding the activities that took place. The area manager who was present told us that they had already identified concerns with the lack of activities available to people and this had been identified on their improvement plan which we saw.

A person said, "I would know who to complain to, but I have not had to complain". Another person said, "I would report any complaint to the matron". Relatives told us they would complain to the unit manager. A relative told us they had made a complaint but the registered manager did not deal with their complaint. We were unable to follow this up as the registered manager was not present at the time of the inspection however a senior staff member of the provider advised that the complaint would be addressed. Staff we spoke with were aware of the complaints policy and told us they would pass all complaints onto the acting manager. We found that a complaints policy and a system for logging complaints was in place. We saw that a system for monitoring complaints through the provider's head office was also in place however the system was not effective as the registered manager had not been dealing with all complaints as required within the provider's complaints process.

Requires Improvement

Is the service well-led?

Our findings

People told us they did not know who the acting manager was. A person said, "I have no idea who the manager is". Another person said, "Never seen the manager". Relatives we spoke with did not all know who the acting manager was. People told us the home was not well led. A person said, "The service is not well led as there is not enough staff". Another person said, "'I wouldn't say it's well managed. The carers do their best". Staff we spoke with told us the service had not been well led. One person said, "The acting manager is much better and approachable". The acting manager was appointed in January 2017 to cover for the absence of the registered manager.

The acting manager understood the notification system and their role in ensuring we were notified of all deaths, incidents and safeguarding alerts as is required within the law. However we found that where a Deprivation of Liberty Safeguard application had been authorised we were not being notified as required within the law. We raised this with the acting manager and area manager. Since our inspection we have had a notification sent in to us as required.

We found that records were not being completed on a consistent basis. Care records did not consistently show the support people should receive so staff knew how people should be supported. Where people had behaviour that challenged this was not clearly identified in care records and staff we spoke with were not always clear as to how to support people in these situations. Where people had fluid charts that needed to be completed to show how regularly they received fluids, we found that these charts were not being completed consistently. This meant that records did not demonstrate that people were being provided with regular fluids to prevent dehydration.

We found that where people's weights should be monitored on a regular basis this was also not being recorded. We found where incidents or accidents had taken place that the appropriate forms were not being completed on a consistent basis. We discussed our findings with the acting and area manager. They told us that the concerns identified would be added to their improvement plan that the manager would be actioning.

We found on one unit that checks on the medicines administration and storage system were being recorded and completed before the date the check was due. This meant that the record systems could not be considered reliable or accurate. Gaps we found on the Medicines Administration Record where staff had not signed to show they had given people their medicines had not been picked up by the medicines checks. This meant the medicines checks were not effective in identifying areas of concern.

We found that spot checks and monitoring of the service was being carried out by the registered manager and the provider before the registered manager went on a period of absence. However these checks were not always effective as they had not picked up all the concerns we had identified. The actions identified in the improvement plan were as a result of concerns raised by a recent visit from the local authority and the checks carried out by the area manager. We found that most of the concerns we had identified had already been picked up by the improvement plan but were not identified by the systems in place for carrying out

checks within the home.

We found that the provider used resident surveys to gather people's views on the service. A relative said, "I have filled in a questionnaire". Another relative we spoke with told us they had completed a questionnaire. People we spoke with were unable to tell us if they had completed a questionnaire. We found from the most recent survey carried out in December 2016 that one of the areas identified that needed improvement was activities. The provider has since employed more activities coordinators.

We found that the provider had a whistle blowing policy in place. Staff we spoke with were aware of the policy and its purpose. A staff member said, "I am aware of the policy, it's called speak up. But I have never had to use it".

We found the environment of the home to be warm and welcoming. People were relaxed and able to move around freely. The home was clean, tidy and well maintained. We saw that there was a process in place for ensuring people's bedrooms and the communal areas were kept clean.

We found that the acting manager had support in place from the area manager in order to ensure the areas identified in the improvement plan are actioned to improve the quality of the service.