Clarendon Manor Limited

Clarendon Manor

Inspection report

37-41 Golf Lane
Whitnash
Leamington Spa
Warwickshire
CV31 2PZ

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25 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 25 January 2017 and was unannounced.

Clarendon Manor is registered to provide accommodation and personal care for a maximum of 35 older people. On the day of our visit there were 30 people living at the home.

Following our last comprehensive inspection of the service in February 2015, we found the provider was providing the standard of service we would expect in four key areas and we rated the service 'Good'.

A registered manager was 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 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the home. Staff had received training in safeguarding and protecting people from the risks of harm or abuse and understood their responsibilities to keep people safe. There were processes to minimise risks to people's safety, however records did not always reflect people's current care requirements.

Medicines were stored safely, but people were not always given their medicines in accordance with their prescriptions.

Overall, there were enough staff to support people. However, staff were not always available in communal areas and on the day of our visit staff did not have time to spend with people because they were so busy. Recruitment processes ensured staff were suitable to work with people who lived at the home.

Staff had a caring attitude and were keen to provide a relaxed and friendly atmosphere for the people who lived at Clarendon Manor. People told us staff were kind and respectful and had the right skills to provide the care and support they required. Staff treated people with dignity and respect.

Staff followed the principles of the Mental Capacity Act 2005 in their interactions with people. The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests.

People told us they enjoyed the food at the home and had a choice of meals. Where people had developed additional health needs, they were referred to the GP or other healthcare professionals.

Care records contained relevant information to help staff provide people with personalised care. Care plans contained a detailed description of peoples' individual needs so people received care and support in a way

that met their personal preferences. Care staff knew people well and communication between staff ensured information about any changes in people's needs was shared.

People spoke positively about the care they received and said how well the service was led and managed by the registered manager. People told us if they had any concerns they would speak to the registered manager.

Staff we spoke with said that staff morale was very good and that the registered manager was approachable and responsive to suggestions made to improve the quality of service. However, some checks to ensure the safety and consistency of the service were not always effective. Improvements were required in gathering the views of people and their relatives about the quality of care provided.

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 consistently safe.

Staff were confident in how to safeguard people from harm or abuse and knew what actions to take if they had concerns. Risk assessments did not always reflect the current risks to people's health and wellbeing, and how to minimise these. There were enough staff to keep people safe, but staff were not always available in communal areas to maintain people's safety. People were not always given their medicines in accordance with their prescriptions.

Is the service effective?

Good

The service was effective.

Staff received an induction into the service and completed regular training so they could meet people's needs effectively. Staff understood the principles of the Mental Capacity Act 2005 and supported people to make their own decisions where possible. Referrals were made to other healthcare professionals when required to support people's needs and maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff had a strong commitment to providing person centred care and support and this was demonstrated in their practice. Care was provided ensuring dignity and respect, and staff treated people with kindness and patience. The environment was welcoming and people were encouraged to maintain relationships with those who were important to them.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individual needs and preferences. Staff knew people well and understood how to respond to their individual needs and how to

support them at times of anxiety. Staff supported people to participate in some activities but were not always able to do this every day. People knew how to raise complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and staff were positive about the home and the leadership demonstrated by the registered manager. Staff told us managers were approachable, staff morale was good and issues raised were addressed quickly. However, some systems and processes were not in place or operated effectively to ensure quality was maintained or identify where improvements were needed.

Clarendon Manor

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 service was last inspected in February 2015 when we found the provider was meeting the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in four key areas. Improvement was required for the service to be Effective.

This inspection visit took place on 25 January 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Clarendon Manor. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their healthcare needs. However, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

To gain people's experiences of living at Clarendon Manor, we spoke with 11 people and three relatives. We also spoke with the registered manager, care manager, four care staff, the cook and a member of support staff. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed three people's care plans and two people's daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives were confident the care and support delivered at Clarendon Manor kept them safe. One person said, "I feel safe here. I've got my walking frame and I've not had any falls." A relative told us, "My mother had frequent falls getting up at night, that's why she came here. It's safer for her to have staff around her 24/7."

There were processes in place to protect people from abuse and keep them free from harm. Staff had received training in safeguarding and protecting people from the risks of harm or abuse and understood their responsibilities to keep people safe. They understood the type of concern they should report and how to report it. One staff member said, "Safeguarding training covers different types of abuse and what our responsibilities are to keep people safe. Abuse is neglect, being cruel or withholding personal possessions." Another explained, "I have a duty to keep people safe." Staff told us they were observant for signs that people with limited verbal communication could be suffering harm. One told us, "If I saw bruises on a person's skin, I would tell the manager straightaway."

Staff said they would have no hesitation raising any concerns they had about poor practice within the home. One staff member told us, "We have a whistle blowing policy, I am confident to speak out."

Staff told us they had confidence in the provider's whistleblowing and safeguarding policies and procedures because their concerns would be taken seriously and investigated. Staff told us they would escalate their concerns if they felt appropriate action had not been taken. One staff member told us, "I am confident the manager would take action, but if they didn't, I would phone social services myself."

The registered manager knew what action to take and had raised concerns with the local safeguarding team. The registered manager also knew their safeguarding responsibilities extended to the staff team. Where a need had been identified, they had taken action to keep staff safe.

People we spoke with did not raise any concerns about the availability of staff, but accepted they were sometimes busy. Comments included, "The nurses respond to the bell very quickly. When they are busy, they acknowledge and then ask if they can come back to you in 5 minutes" and, "I never need the call button, I can wait if I need something – I give way to the others. The only time I might use it is if I want to go to bed."

Staff felt there were enough staff to meet people's needs. One staff member told us, "There is enough staff now. Some new staff have been recruited which has improved things." However, on the day of our inspection visit staff told us they were working one member of care staff short. Staff assured us they could still provide safe, effective care, but told us they could not spend so much time with people because they were so busy. One staff member explained, "Normally there are five carers and a senior on. Today there are just four carers. We manage and it is safe, but we have less time to sit and chat with people. It was very busy this morning, but by working as a team, people's needs were met." Staff told us the registered manager provided support and assistance if required. One member of staff told us, "There is enough staff, but if we

are short the manager helps us to care for people."

The registered manager was confident there were enough staff on duty to meet people's needs safely. They told us if there was a change in people's needs, they would increase staff numbers to meet that need. They gave a recent example of when six new people had moved to the home after another home in the area closed. The registered manager told us, "I put more staff on then because it was needed. Emotionally those people needed more staff." They also told us that non-care staff such as domestic staff and kitchen staff had a visible presence in the home and were additional 'eyes and ears' to keep people safe.

Our observations on the day of our visit, showed care staff were busy, yet staff supported people and cared for people at the pace they required. However, we found some need for improvement in how staff were deployed within the home. We noticed there were periods of time when there was no staff presence in the communal lounges, particularly when two care staff took their break at the same time. We raised this with the registered manager who told us they would speak with senior staff to ensure breaks were organised to maintain effective staffing levels at all times within the home.

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. The registered manager had obtained written 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. A new member of staff confirmed, "My references were checked and I had to wait for my DBS before I could start work." These checks ensured staff were suitable to work with people who lived at Clarendon Manor.

The risks associated with each person's care and support had been assessed, recorded and plans developed to manage the risk. Risk assessments covered areas such as moving and handling people, nutrition and risk of skin damage. They were updated regularly to ensure any changes in risks were identified and minimised. For example, one person was at risk of skin damage and needed to be repositioned every two hours. Staff knew the risks to this person, and records showed they followed the care plan and supported the person to minimise the risks by making sure they regularly changed position.

However, we identified one person who had been prescribed a thickener in their drinks because they were at risk of choking. Although staff knew they had to add thickener to the person's drinks, this had not been recorded in their care plan which could lead to inconsistency in managing the risk. Another person was at risk of malnutrition. Their care plan stated this identified risk should be managed by the implementation of food and fluid charts if they started to lose weight. We saw the person had lost weight in the previous eight weeks, but charts had not been implemented. When we brought this to the care manager's attention, they took immediate action to ensure the person's food and fluid intake was accurately recorded.

Another person had a catheter in place, but there was no care plan to guide staff as to how the catheter should be managed to minimise the risks of an infection. The care manager told us the catheter bag was changed each Thursday, but records did not confirm this was always happening. The registered manager assured us they would immediately contact the district nurses to seek advice and prepare an appropriate care plan.

Staff recorded accidents and incidents electronically and these were transferred to the registered manager to review. The registered manager reviewed each incident and, where necessary, took action to reduce the likelihood of reoccurrence. For example, where people had fallen in their room, a sensor mat had been provided to alert staff when the person got up so staff could respond promptly.

People told us they received their medicines when they needed them. One person told us, "The carers bring the medicines and they make sure I take it." Another told us, "I get my regular medications from the care staff and they give me medicines to take with me if I go to visit home."

Medicines were stored safely in a locked medicines trolley within the medication room. The trolley was tidy, well organised and medicines were stored at the recommended temperature to ensure they remained effective. Everyone had an individual medicines administration record (MAR) with their photo, to minimise the risk of errors. Records showed staff signed when people's medicines were given and recorded when people declined to take their medicines. Where people received their medicines through a patch placed directly on their skin, body maps were used to ensure the site of the patch was rotated to prevent their skin becoming sore. Care staff sought advice from other health professionals when people were at risk of not taking their medicines regularly.

We observed a senior member of staff giving people their medicines. They gave people the opportunity to agree or decline their medicines and waited beside the person to make sure they had swallowed the medicine, before they moved away to update their MAR sheet.

However, we found improvements were required to ensure medicines were given in accordance with people's prescriptions. For example, some people were prescribed medicines that needed to be given 30 to 60 minutes before food. The care manager confirmed that people were given those medicines with their breakfast. One person was prescribed a medicine that needed to be given 30 to 60 minutes before any other medicines. The care manager confirmed this person received all their medicines at the same time.

Some medicines require extra checks because of the risk of abuse, such as a second staff signature to confirm the medicine has been given. We found four occasions when a second staff member had not signed to confirm a controlled medicine had been given.

One person kept their own pain relieving cream and on occasions applied it themselves. A staff member told us the person would tell them if they had applied the cream and they would then sign the MAR chart. This did not meet best practice guidelines.

The provider employed a maintenance co-ordinator who maintained the building and ensured checks were carried out on fire, electric and water systems to ensure the safety of the environment. On the day of our visit, the home was clean, well maintained and tidy.

The provider had systems in place to manage emergencies. Each person had a personal emergency evacuation plan (PEEP) which informed the emergency services of what their needs were to support them with safe evacuation. Staff we spoke with knew how to evacuate the building and the procedures for evacuation.

Good

Is the service effective?

Our findings

People told us staff provided good, effective care. Comments included: "All the staff are good from the cleaners to the carers" and, "The carers are particularly good with mobilising people."

A new member of care staff told us they felt effective in their role and knew what to do, because they had an induction into the home which included shadowing an experienced staff member before they worked independently with people. This gave them the opportunity to get to know people's needs. They explained, "I was assigned a buddy who showed me the ropes. I shadowed my buddy for about two weeks before I worked on my own." After 12 weeks of commencing work, new staff started to work towards the nationally recognised Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff working in a care environment.

Staff said they received regular training to refresh their knowledge and keep their skills up to date. Comments from staff included, "Training is plentiful" and "Training is excellent; I can do my job well." One staff member told us how training in supporting people living with dementia had made them think about their everyday practice. They gave an example of one person who often became anxious because they were looking for someone from their past. They told us they responded to this person positively and explained, "I learnt in dementia training that using negative words or telling people they are wrong increases anxieties."

Staff said they were well supported by the management team so they could effectively carry out their role and responsibilities. Staff had regular supervision meetings to review their practice and personal development which ensured they maintained their skills and knowledge. One member of staff told us, "I have frequent supervisions with the manager. We talk about me, how I am feeling and if I need any training." A new member of staff said, "I feel supported and feel confident to ask questions."

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible.

Staff understood the principles of the Act and assumed people had capacity to make everyday decisions. One staff member told us, "People have capacity until proven otherwise. I cannot assume people don't have capacity." Staff told us they supported people to make as many of their own decisions as possible. One member of staff told us of a person whose health had deteriorated over the last 12 months. The person sometimes became frustrated as they could no longer tell staff verbally what they wanted. The staff member explained, "I show [person] things so they can make choices like the salt and pepper at mealtimes. I show [person] outfits and they nod their head to choose the one they want." One person confirmed, "I have a free choice when to get up and whether to have breakfast downstairs or in my room. I don't usually go to bed until around 10 o'clock".

Staff understood the importance of gaining people's consent before providing care or support. During our

visit we saw that staff checked with people whether they wanted assistance before supporting them. For example, we saw one staff member say to a person, "Would you like to go to the conservatory, we have an entertainer there." When the person said they would, the staff member supported them to move to the other room.

Some people had a lasting power of attorney to allow other people to make decisions on their behalf. The registered manager had recorded when relatives had the right to make decisions on people's behalf, but had not always seen the relevant documentation. The registered manager told us they would ask relatives to show them the court documents that gave them the decision-making power, to make sure decisions were made by a person who had the legal right to do so.

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 registered manager had identified 19 people whose care plans contained some restrictions to their liberty and submitted the appropriate applications to the authorising authority. The majority of the applications were still awaiting assessment by the authorising authority at the time of our inspection visit. The registered manager had submitted further applications for two people whose approved DoLS had recently expired.

People and relatives we spoke with were happy with the range and choice of meals provided. Comments included: "The porridge is well made in the morning. I don't eat chips but they make me mash instead" "The food suits me – there's a good variety" and "The food is good, battered fish and chips is my favourite. I eat well for lunch, not much for tea but I don't need much then." People knew who the chef was and the chef knew people's likes and preferences. On the morning of our visit the chef went round asking people what they would like for lunch the following day. One person responded, "I'll have the cheese omelette, not chips of course and you know me well, what do I have for supper?" The chef replied, "Let me guess, ham sandwiches on brown, your banana, satsuma and some of your strawberries from the fridge."

The cook told us they received information about people's dietary needs so they made sure people received their foods in a way that did not put them at risk. They told us they prepared two meal choices and if people wanted an alternative, they did what they could to prepare alternative choices. On the day of our inspection people could choose between pork or liver. The cook told us they had offered liver because it had been requested, but it had actually not been very popular.

The lunchtime meal was served in the dining room which was a pleasant environment to eat in, with tables laid with tablecloths, napkins, cutlery, condiments, and drinking glasses. However, people were served their meals at the tables already 'plated up' and were not given a choice of what vegetables they wanted or whether they wanted gravy.

People and their relatives were confident their healthcare needs were met. Where people had developed additional health needs the registered manager made referrals to the GP or utilised the services of visiting health practitioners to check out people's health needs.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care staff. One person told us, "It's quite good care – the girls are all nice. They are patient with me." Another said, "It's like home from home."

During our visit we found staff had a caring attitude and were keen to provide a relaxed and friendly atmosphere for the people who lived at Clarendon Manor. One member of staff explained, "Care is being a friend and showing people respect." Another described good care as, "Being patient, being kind and being respectful."

All staff were helpful to people and spoke to them in a positive way. For example, we saw one member of staff encouraging a person to stand up and walk around. They said to the person, "You can do it, stretch your legs, get the blood flowing." The person smiled in response and said, "Ok, I'll give it a go."

Staff demonstrated patience and understanding and did not rush people. They were knowledgeable about the people who lived in the home. One staff member told us, "I know people well; I talk to them to find out all of the small details so I can provide personalised care."

Staff recognised people's anxieties and provided support to reduce that anxiety. One staff member told us about a person who had been reluctant to have a bath or shower when they first moved to the home. This was because they had previously been unable to get out of the bath and this had upset and scared them. Over a period of months the staff member had worked with the person who was now having a bath every week. The staff member explained, "I have gained their trust and they know there is nothing to be scared of. We took small steps and they are now confident to get in and out of the bath."

We observed how staff supported a person who displayed signs of anxiety as they walked along the corridor. The person was shouting for staff to help them. A member of staff responded quickly, walked alongside the person and engaged them in conversation, which reduced their level of anxiety.

Staff respected people as individuals and demonstrated that respect in their interactions with them. One staff member told us, "Everyone is a bit different, I respect people's differences." Staff understood an important aspect of respecting people was to support them to maintain as much independence as possible in their everyday lives. One staff member told us, "I encourage people to be independent." They explained they did this by cutting up people's food so they could eat without assistance and giving them half cups of tea so they could drink without fear of spilling it.

Staff maintained people's privacy and dignity. Staff told us they respected people's personal space with one staff member telling us, "I always knock peoples' doors out of respect before I enter." One member of staff told us about a person who experienced tremors due to their health condition. They told us, "Their tremors make them spill their food. We bought aprons to protect their clothing as it's not very dignified to have dinner on your jumper." Another member of staff told us that some ladies did not like bare legs if they wore a skirt. They explained, "I always ask ladies if they want tights on if they're wearing a skirt."

The registered manager ensured the home was clean, well decorated and welcoming for people and their visitors. One staff member told us, "It is a lovely environment, very clean and nicely decorated." People's rooms had been personalised and displayed items that were of sentimental value or of interest to them.

People were encouraged to maintain relationships with those who were important to them. We observed family and friends could visit when they wished and we saw staff welcoming them when they arrived and chatting to them about their family member's day. A member of non-care staff told us, "Visitors are invited to stay for lunch, many people enjoy this. At Christmas two relatives stayed for lunch, it was a lovely day."

Good

Is the service responsive?

Our findings

People we spoke with had positive views about how their care and support needs were met because they were supported by a consistent staff team. One person told us, "They are quite an established care team – not too many bank staff."

Written care plans were comprehensive and clearly explained how people should be supported. For example, each person had a detailed care plan to ensure they were assisted safely to move around the home and where people needed assistance, this was clearly described. One person's care plan stated, "Encourage [person] to use their [walking] frame as she can be unsteady on her feet. Encouraging her to walk will strengthen her leg muscles.' During our visit we observed staff encouraging and reminding the person to use their walking frame as set out in their care plan.

Care plans contained a personalised description of peoples' personal care needs which included details about how people preferred to be assisted, for example with washing, dressing and other personal care needs. For example, one person's care plan stated 'Likes to use a roll on deodorant as aerosols are too cold for her.' This person's care plan also said the person never wore trousers and preferred to wear a blouse and a skirt. We saw they were wearing this on the day of our inspection visit. This information ensured people received care and support in a way that met their individual preferences.

One person could demonstrate signs of distress or anxiety. The person's care plan clearly described how staff should respond to provide reassurance to distract them from their anxieties. Staff we spoke with had a good understanding of how to provide support to this person and were consistent in their responses. One staff member explained, "We use distraction techniques if [person] is upset. For example, I talk about their holidays. I speak gently to them, sometimes it works. If it doesn't, another member of staff might be able to reassure them."

The provider had recently introduced electronic care planning into the home. The registered manager assured us that the written care plans would be transferred in full to the electronic system. This would ensure none of this important information was lost and staff could continue to provide person centred care that was responsive to people's individual needs and preferences.

Staff told us communication was good in the home and staff worked well together as a team. They told us this benefited the people who lived in the home because they were able to effectively respond to changes in their needs. One staff member told us, "We always have handover. It's really useful as I know what I need to do during my shift." They told us the handover included information about how people were feeling, any appointments and medicine changes.

The registered manager told us there was no member of staff specifically employed to provide activities, but that all staff engaged in activities with people. They explained, "The staff will do whatever people want. A lot just want a bit of one to one time."

On the afternoon of our visit an entertainer visited the home which people clearly enjoyed. However, during the morning we saw people spent long periods of time sitting in the two lounges without stimulation. Some people were able to chat with each other, but others appeared quite isolated. We asked one member of staff about activities. They told us, "Some days I have time to sit and talk with people, today I haven't had time. We can't always offer activities, but we do try. If we had an activities person it would take pressure off the care staff." Another member of staff told us, "I think some people get a bit bored."

The registered manager told us they would like to have a person to specifically support people with activities and had started to put an extra member of staff on the rota once a week to carry out that role. However, more work needed to be done to regularly encourage a sense of purpose and achievement for all the people who lived at the home. The registered manager told us they would discuss this with the provider with a view to providing more hours for activities.

Information displayed within the home informed people and their visitors about the process for making a complaint. There were forms available at the front desk for people to complete if they had any formal complaints, or a book where they could record any minor concerns. People and their relatives told us they would speak to the registered manager if they had a complaint however, no-one we spoke with could remember making a complaint. Comments included: "There is a complaints board and leaflets at the entrance" "I'd see the manager if I had a complaint" and "I'm not sure about making a formal complaint, I would choose to go to [registered manager]."

Staff told us they would support people to make a complaint. A member of staff said, "If a person complained to me, I would tell the manager." The registered manager told us they had not received any complaints in the last 12 months but assured us that any received would be dealt with in accordance with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

People's experiences of using the service were positive. One person told us, "I get first class care – no problems with the staff." People spoke about how well the service was led and managed by the registered manager. One person said, "I have a good relationship with the manager. She keeps a good house." A relative told us, "The registered manager has been brilliant (at settling their family member into the home)."

Staff were clear about the leadership structure within the home and spoke positively about the approachable nature of the registered manager and care manager. Comments included: "The managers are brilliant, so approachable. They are so down to earth and good listeners" "The managers are lovely; I think the home is very well run" and "I have full support from my managers."

Staff spoke of the open culture promoted by the registered manager who made themselves accessible to them and listened to their views. Staff told us they enjoyed working in the home and felt well supported. One staff member explained, "I feel supported, if I had any problems the managers help straight away." Another told us, "The manager walks around to see how we are doing things. They tell us if we need to do things in a different way. Management style is good, hands on." Staff told us staff worked well together as a team. "Staff morale is high, teamwork is good."

Staff said they had opportunities to share their views and opinions at regular staff meetings and managers listened to what they had to say. One staff member told us, "My suggestions are welcomed." We looked at the minutes for a meeting in August 2016. Staff had raised a concern that they were 'stretched' as they were short staffed. Staff we spoke with confirmed new staff had now been recruited. At a meeting on 1 November 2016, staff had requested that four people be assessed by the continence nurse. Records demonstrated the registered manager had taken action and the assessments had been completed on 22 November 2016.

The registered manager told us the provider visited the home regularly and carried out checks in areas such as care planning and quality assurance. We were shown emails where the provider had shared issues and requested that they were addressed. However, the checks were not formally recorded to provide an audit trail of actions taken to address issues. Medication checks carried out by the provider had not identified the issues we identified around giving people their medicines. Checks of care plans had not identified the issues around risk management. This demonstrated that the governance of the home was not always effective and needed improvement.

We found improvements were required in gathering the views of people and their relatives about the service. People had been invited to attend a 'residents meeting' in November 2016 to discuss what activities they would like over the Christmas period. Prior to that, the last meeting had been held in January 2016 and there were no meetings for relatives. One person told us, "There isn't a residents committee as far as I am aware." Staff told us, "The manager has an open door policy," and walked around the home most days talking with people, however there was no formal process for recording people's feedback. Care records did not demonstrate that people or their relatives had been involved in planning how their care should be provided or been invited to reviews of their care needs. One relative had responded to a questionnaire in June 2016, 'I

would like to participate in care planning meetings'. The registered manager was unaware of this comment and no action had been taken to facilitate the involvement the relative wanted.

We found improvements were needed in record keeping within the home. The provider had recently introduced an electronic care planning system and staff recorded on 'i-phones' what care they had provided for each person, what food and drinks the person had taken and their moods and behaviours. However, we found staff needed more support and training to ensure they completed the records accurately as some important information had been omitted from daily records. For example, we looked at the daily records for one person who was at risk of malnutrition and who had recently lost weight. Their daily records indicated they had only eaten breakfast on the two days prior to our visit. No further food intake was recorded. We raised this with the care manager who told us, "It is the recording that is wrong [person] is eating and drinking." Staff confirmed they encouraged the person to drink throughout the day but sometimes forgot to record it. Typical comments were, "As the recording system is new we struggle with it. We have only been doing it eight weeks" and "I struggle with the electronic system. It is very easy to make mistakes." The registered manager was confident the system would support the delivery of safe, effective care in the future, but acknowledged improvements were needed to ensure vital information was not lost.

When we arrived for our inspection, we saw the provider was not displaying their CQC rating from our January 2016 inspection. It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. We discussed this with the registered manager who immediately took action to ensure a poster was displayed to show the rating of the home.