Crossways Residential Home Limited

# Crossways Residential Home

## Inspection report

66 Highgate Road
Walsall
West Midlands
WS1 3JE

Tel: 01922646168

Date of inspection visit:
15 May 2018
16 May 2018

Date of publication:
25 June 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 15 and 16 May 2018 and was unannounced. The service was last inspection in October 2017 and was rated as 'Requires Improvement'.

Crossways Residential Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Crossways Residential Home accommodates 23 people in one adapted building.

The was a manager in post who had recently applied and been interviewed to become the registered manager of the home. 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 and were supported by a group of staff who were aware of their responsibilities to raise and act on any concerns they may have. Staff were aware of the risks to people and were kept up to date with any changes in people's care needs. Staffing levels were based on people's dependency levels and plans were in place to increase staffing at particular times of the day to ensure people's needs were met.

People were supported to take their prescribed medicines. Concerns regarding infection control issues had been responded to and actions had been taken, though more work was required in this area. Where accidents and incidents took place, the information was regularly reviewed and analysed for any trends and where appropriate, actions were taken.

People were supported by staff who had received an induction that prepared them for their role. Staff felt well trained and were offered additional training and support in order to improve their skills and knowledge.

People's dietary needs and preferences were catered for and people were supported to make choices at mealtimes. Drinks were readily available to ensure people remained adequately hydrated.

Health care plans were in place which identified people's particular healthcare needs and how to support them to maintain good health. People were supported to access a variety of healthcare services and where guidance was provided by healthcare professionals, it was followed.

The environment was well sign posted to assist people when walking around the service. The provider had plans in place to improve the environment for the people living at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People described staff as kind and caring and enjoyed warm and friendly relationships with those who supported them. Staff treated people with dignity and respect and were mindful to respect people's choices regarding how they wished to spend their day. For those who required the support of an advocate, arrangements were made to ensure people were able to access these services.

People were involved in the development of their care plans and were supported by staff who were aware of their likes and dislikes and how they wished to be supported. Some activities were available for people to participate in, but people had asked to be supported to access the community and staffing levels were not in place to support these additional requests.

People were supported to raise complaints which were investigated and responded to appropriately. People's end of life wishes were respected.

People considered the service to be well led and were complimentary of the manager and the changes they had introduced to the service. Staff felt supported by the manager and were on board with the changes they had introduced to the service.

A variety of audits were in place to assess the quality of the service and the manager actively sought advice and worked alongside other professionals in order to improve care delivery.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were supported by staff who were aware of the actions they should take if they suspected a person was at risk of harm. Safeguarding procedures were followed and acted upon appropriately. People were supported with their medicines. Infection control issues had been responded to and work continued in this area. Lessons were learnt and improvements made when things went wrong.

### Is the service effective?

Good

The service was effective.

Staff received an induction and training that prepared them for their role. People were supported to eat and drink a balanced diet and have access to a variety of healthcare services to help maintain good health. Staff obtained people's consent prior to supporting them.

### Is the service caring?

Good

The service was caring.

People enjoyed warm relationships with the staff who supported them and described them as kind and caring. People were supported to make decisions regarding their daily living and were treated with dignity and respect.

### Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some activities took place but people had repeatedly asked for more and for the opportunity to access the community. People were involved in the planning of their care and were supported by staff who knew them well. People were supported to raise complaints which were dealt with and responded to

appropriately. People's end of life wishes were respected.

## Is the service well-led?

Good

The service was well led.

People were complimentary of the manager and the improvements they had introduced to the service. Staff felt supported and were aware of their responsibilities. There were a variety of audits in place to assess the quality of the service provided.

# Crossways Residential Home

**Detailed findings**

## Background to this inspection

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

The inspection was prompted in part by a number of notifications received regarding allegations of abuse at the home. As part of the inspection, we looked at the risks to people that these allegations posed, and were assured that the provider had acted appropriately in response to the concerns raised.

The inspection took place on 15 and 16 May 2018 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed 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.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback.

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 to us.

We spoke with the manager, the deputy, the provider, the area manager, three members of care staff, the cook and a visiting healthcare professional. We also spoke with all nine people living at the service and a relative.

We reviewed a range of documents and records including the care records of three people using the service, five medication administration records, two staff files, training records, accidents and incidents, complaints systems, minutes of meetings, activity records, surveys and audits.

Good

# Is the service safe?

## Our findings

People told us they felt safe. One person told us, "I'm not worried about anything. I can go to bed, put my head on the pillow and go to sleep. I've no qualms at all. I'm alright". Another person said, "I see how they are with the other residents. They are so kind. They are always in and out to the lady that can't come out" [of her bedroom]. Relatives spoken with told us they considered their loved ones to be safe at the home and a visiting healthcare professional said, "I've not seen anything [of concern], I would raise it if I did". Prior to the inspection, we saw that a number of safeguarding concerns had been raised by the service. We found that each concern was reported and recorded appropriately and actions were taken in response to each incident. A member of staff provided us with an example of a safeguarding concern they had raised and we saw evidence of this. Where a particular safeguarding concern arose, a healthcare professional recorded, "We are entirely satisfied with how the incident was reported, managed and investigated". The provider told us in their Provider Information Return [PIR] that they had introduced a new safeguarding process which they were confident that staff were following and we saw evidence of this. We saw information was on display to alert staff to the different types of abuse people were at risk of and the relevant agencies to contact if staff suspected a person was at risk of harm.

People were supported by staff who were aware of the risks to them on a daily basis. We noted that where possible, people were involved in the assessment and management of the risks to them. For example, we saw one person had been assessed as needing additional support when moving around the home. The person had been involved in the process and it was agreed that when required, the person would receive more assistance. The person had written in their care plan, "I have decided that it is best for me on a good day for two carers to support me". This meant staff responded appropriately to the person's needs on a daily basis and were mindful that two days were not the same. We saw risk assessments were in place that provided staff with the information required to support people safely. A member of staff told us, "Information is passed through the communication books including updates in risk assessments and handovers as well". We saw this information was regularly reviewed and updated and staff told us they were kept informed of any changes in peoples care needs. We saw where accidents or incidents occurred, they were recorded and acted on appropriately and staff were aware of the actions they should take in the event of such incidents. For example, a member of staff said, "If someone had a fall, I'd ask if they were in pain, ring 999. I wouldn't move them and would complete the accident record and contact the family".

A person said, "There's plenty of staff and they look after you". We saw that people were responded to in a timely manner. The manager confirmed, and we saw that there was a dependency tool in place to assess staffing levels which was regularly reviewed. However, staff raised concerns regarding staffing levels in the morning and evening and told us they felt there should be more staff available on shift at particular times of the day. We saw that these concerns had also been raised in staff meetings and the provider had responded to this and was actively looking at how hours could be added to shifts to increase staffing at particular times of day.

People were supported by staff who had been recruited safely. Staff told us that prior to commencing in post, the appropriate checks had been put in place, including references and DBS [Disclosure and Barring

Service] checks. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed.

We saw there were systems in place to ensure people received their medicines as prescribed by their doctor. We observed a member of staff administering medication. This was done patiently and respectfully. The member of staff explained to each person they had to take their medication and supported them to take it, without rushing them. We also saw the member of staff approach a person and ask, "[Person's name], can I ask you, are you in any pain? Would you like any paracetamol?" We looked at the Medication Administration Records [MARs] for four people and found what had been signed for and administered tallied with what was in stock. We saw daily audits took place which meant any errors that may take place, would be picked up and acted on quickly. We saw protocols in place for medication that was to be administered 'as required'. The protocols provided staff with the information required to ensure the medication was given in the appropriate circumstances. Where medication was to be administered covertly (where a decision is made in a person's best interests, to disguise their medication by putting it in food or drink), we saw the appropriate authority had been received from the person's GP and records of meetings taking place to ensure this practice was in the person's best interests.

Prior to the inspection, some concerns were raised in respect of infection control at the home. We saw that as this had been highlighted, it had been responded to and disciplinary processes had been followed. We saw an action plan was in place to address the issues raised which included cleaning rotas being put in place for each individual room. There remained some areas which still required action, for example, replacement flooring. We spoke with the provider regarding this and they confirmed plans were in place to carry out this work and replace the flooring in particular areas.

Systems were in place to ensure lessons were learnt and improvements made where things went wrong. Accidents, incidents, safeguarding concerns and complaints were analysed on a monthly basis to identify any trends. For example, it was recognised that more falls were happening early morning before more day staff came onto shift. This, coupled with staff raising the issue in staff meetings had prompted the provider to look at starting the morning shift an hour earlier. The provider told us they were currently looking at how they could arrange shifts to support this.

Good

# Is the service effective?

## Our findings

Prior to moving into the home, people's needs had been assessed. These assessments gathered information regarding people's personal care needs, their medical history and their social needs. People had been asked about their dietary preferences, their family, whether they needed any particular equipment to support them and also their needs in relation to any protected characteristics under the Equality Act, such as sexuality and religious needs. People told us they felt well supported by staff and were happy with the care they received. One person had provided written feedback on the service. They wrote; "The carers are wonderful and so are management. I am lucky to be here".

People were supported by staff who received an induction that prepared them for their role. A member of staff told us, "The induction included shadowing staff and meeting residents". Another member of staff said, "The manager spoke with me and checked I was ready to go on shift [after the induction] and I wasn't allowed to use the hoist until I'd been trained". Staff told us they felt well trained and received the support they needed from the manager. One member of staff told us, "I wasn't comfortable at first with manual handling and I asked a senior member of staff to help me and watch me". Another member of staff described how their training regarding people's mental capacity had informed how they supported a particular person. There was a training matrix in place which kept the manager up to date with staffs training needs and alerted them to when training was due to expire. Additional training had also been sourced with regard to dementia care, in order to improve staffs learning in this area. We saw systems were in place to assess staff competencies and the manager had recently completed a number of unannounced spot checks on staff at night in response to some concerns raised. Staff competency checks had also recently taken place to ensure staff were following the correct hand hygiene guidelines in response to the infection control concerns that had been raised. We saw that staff received regular supervision and an annual appraisal.

People told us they liked the food on offer and enjoyed their meals. At lunchtime we observed people sat in the dining room around a large table. People were sat for over 15 minutes before their food was served and one person commented, "We've been waiting about 20 minutes" and appeared to be frustrated. We raised this with the manager who told us they would look into this. We saw that other people chose to eat in the main lounge. There were three choices available for both the main course and dessert and staff were on hand to offer and provide support where needed. Where people required special diets to meet their healthcare needs, these were accommodated. People were asked if they preferred to help themselves or have their food served to them and they were offered a choice of cold drinks. We observed staff to be polite and courteous and responded appropriately to requests from people. We spoke with the manager regarding the way food was presented on the main table. They told us they had tried a variety of ways of serving lunch in order to encourage people to eat more and that this was the most effective way to date. We noted this meant people were able to plate up their own meals with a variety of items which suited their preferences and which they enjoyed. The manager showed us there had been an increase in weight gain for some people following this decision and people spoken with told us they were happy with the arrangement. We saw one person say, "This is horrible" when they were presented with their meal and they were immediately offered an alternative, which they accepted. Another person said, "Yes, I enjoy all my meals".

We saw that people were supported to maintain good health by being supported to attend appointments with healthcare professionals. Health care plans were in place which identified people's particular healthcare needs and any follow appointments. We observed a member of staff talking to a person about a hospital appointment. The staff member explained what the appointment was for, when it was and where it was and offered to accompany the person to the appointment. They reassured the person, told them not to worry and offered to go to one of the restaurants at the hospital for lunch if they wanted to whilst they were there. We spoke with a visiting healthcare professional who told us that staff were always prepared for their visits and ensured they were provided with the information they needed at every visit. They confirmed that staff followed guidance given to ensure people's health care needs were effectively met. They added, "Staff are pro-active and they will ask if they think I need to see another person, they don't leave it until the next day". The provider told us in their Provider Information Return [PIR] that they had implemented daily pressure area checks following guidance from a healthcare professional and we saw evidence of this.

We noted signage in place to assist people when navigating their way around the home. There was maintenance support available if work needed to be completed in a timely manner and we saw evidence of this. For example, we observed a person having problems moving their walking frame on part of the patio areas. Another person told us one of the slabs were loose. We immediately raised this with the manager who arranged for the maintenance man to rectify the problem. We noted the area was cordoned off, and the work was immediately carried out and people were made aware of what was happening. We saw that people's bedrooms were decorated to reflect their personal tastes. The provider told us they had a number of plans in place to improve the living environment, including a heated conservatory.

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

People told us that staff obtained their consent prior to supporting them and we observed this. A member of staff described how they would approach a person to obtain their consent prior to offering support. They told us, "I would come down to the person's level first and ask them 'would you mind if I helped you with …'" and we saw evidence of this. There was a culture amongst staff of ensuring they respected people's choices and supported people to make choices regarding their daily lives. People's care records reflected this, we noted one person's care record stated, "I can look after myself, but I don't mind the ladies helping me".

We saw that a number of people living at the home had DoLS authorisations in place and records seen showed that these applications had been made appropriately. Where best interest's decisions were required, they were recorded appropriately and where conditions were in place with regarding to DoLS authorisations, they were adhered to.

Good

# Is the service caring?

## Our findings

We observed a number of kind and thoughtful interactions between people and staff living at the home. For example, we saw one person become upset whilst sitting with other people outside and asked them to stop talking. A member of staff who was eating their meal close by, immediately went over to the person to check they were ok and followed this up after the person moved to another communal area in the home. A person told us, "[Staff member] really comforts me when I get upset about missing my dog" and another said, "I don't know what I would do without them. I have had some nice times here. It's not posh, it's a bit tatty, but who lives in palaces? The best thing about living here is the staff. They are always cheerful. We have some laughs". Another person told us, "They [staff] are wonderful, they are the best thing about this place. I couldn't pick one out to say they were better than any other. Even between shifts. They are all as nice as each other". They went on to say that they liked to have banter with the staff and added, "It's camaraderie really".

We observed there was a pleasant atmosphere, people greeted each other and staff as they entered the rooms, asked after each other and passed the time of day. A number of people welcomed staff with open arms, enjoyed receiving hugs and kisses, and staff reciprocated these demonstrations of affection. We observed a number of acts of kindness. We saw one person become upset and a member of staff noticed this immediately and went over to the person and tried to comfort and console them. The member of staff spoke to a colleague who went away and came back with the phone and asked the person if they would like to speak to a relative. This was arranged and the person appeared calmer afterwards. We observed all staff, including the housekeeper and kitchen staff, engaging in casual and humorous conversations with people throughout the day. Two people referred to this as "banter" which they enjoyed.

People told us they were able to make choices when it came to how they spent their day, what time they rose and went to bed. On the day of the inspection, we noted people presented well, in the afternoon we saw that three people had been supported to change their tops and they told us this was because it was a warm day. One person told us, "The girls [staff] are ever so good. If you want anything they get it for you". Relatives told us they felt welcome when they visited the home and one told us, "You don't feel like a visitor, you feel like you're going to your Nan's house" adding, "They've [staff] all got empathy, I was worried when [person] first came in but they are settled".

People told us they were treated with dignity and respect and we noted this. Staff were able to describe how they maintained people's dignity whilst supporting them with their person care, for example, by ensuring curtains and doors were closed. The provider told us in their Provider Information Return [PIR] that people were encouraged to become involved in their care planning, to ensure their care plans reflected their preferences and we saw evidence of this. We saw that where possible, people were supported to maintain their independence. For example, a relative described how their loved one had lost their confidence and ability to walk following a long stay in hospital, but that staff at the home at worked with them to improve this. They told us, "[Person] walked from their bedroom to the dining room and the garden; to do that is massive; they have encouraged them to walk".

For those people who required the support of an advocate, this was arranged. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Requires Improvement

# Is the service responsive?

## Our findings

One person told us, "The thing is I'm bored" and another said, "I don't go out and I don't have visitors". During the inspection, we observed many 'empty laps'; people sitting in areas with little or nothing to do. We noticed the television was on, but people's chairs closest to it were in such a position that it would be difficult to see the screen. On one occasion an American DIY programme was on which involved a lot of shouting. No-one in the room was watching the programme. We asked the manager who usually chose which channel was on and they told us, "We usually have GMTV on".

We asked people how they spent their days, they told us, "One of the girls does our nails" and proudly showed us their varnished nails. Another person said, "I like the quiet, I pop into the other room. I like looking at the flowers. I love crochet but I haven't got it with me". They told us they would love to crochet and also that they would like to go out but they didn't have anyone to go out with. Another person said, "They do my makeup. They give me a makeover". They went on to explain that they really missed their dog, but that the service had had visits from miniature ponies and an entertainer who sings with people. They also showed us round the garden and pointed out bird feeders and a bird bath which they looked after, "I feed the birds outside my window and the squirrels come".

The manager told us they were working with another professional with a view to providing additional training for staff in respect of activities. They told us, "I am trying to get a change in staffs' mindset around activities". We saw at the last two meetings for people living at the home, people had complained regarding the lack of activities that were taking place. In response to this, board games and a DVD player had been purchased. We observed a small group of people playing a board game with a member of staff, which they enjoyed and a group of other people were involved in baking some cakes.

We saw there was a garden area for people to access and people enjoyed sitting in the sunshine. One person told us, "I go out in the garden every day. I have a walk round in the sun" and another said, "I love going outside, I have a smoke, I pretty much do what I like".

Overwhelmingly, people told us they wanted to take part in activities outside the home and be supported to access the community. One person told us, "My son can come whenever he likes and if he wants to take me out he just asks the supervisor. I'm lucky, my family come and see me". A member of staff told us, "Activities are planned for a few things, but the problem is staff availability. As only four staff on shift we can't leave the shift short to take others out. Some people would like to go the pub, but you need your full team of staff to protect people and keep them safe". This meant that people were not always supported to following their interests or take part in social activities outside of the home. We discussed activities and people being supported to access the community, with the provider. They told us they hoped to introduce an activities co-ordinator in future to address some of the areas raised.

We saw where possible, people were involved in the development of their care plans. Discussions with people were documented regarding different areas of their care and people were supported to sign to say they agreed with the content of their care record. Information in people's care records included not just

their care and healthcare needs, but their likes and dislikes, daily routine and what was important to them, for example, any special anniversaries or family birthdays they wished to be reminded of.

We were told that since the last inspection, work had taken place to improve the content of people's care records to ensure they reflected people's particular care needs and preferences and were less generic. We saw this had resulted in people being involved in their care records, and they reflected people's choices. For example, one care record stated with regard to the person's dental care needs, 'I only wear my top set of dentures if I go out to eat somewhere posh as I don't like to wear them!' We saw that some people responded well to 'doll therapy' and staff were mindful of this and responded to this appropriately. For example, we observed a person sitting on their own at lunchtime. Staff told us the person responded well to 'doll therapy' and this was used when encouraging the person to eat their meal and we observed this. A member of staff told us, "[Person] thinks the doll is her baby, and they will hold it and it makes them happy". We observed staff acknowledge the doll when speaking to the person and commented positively about it, which the person was pleased about.

We saw that people were supported by staff who knew them well. Staff provided us with a good account of the people living at the home, how to respond to their needs and what was important to them. For example, a member of staff described how a person became upset and the best way to help them calm down and reassure them was to 'talk about old times or music they liked'. They went on to add that the person sometimes became agitated with some members of staff so changes were made to allocations to ensure they were supported by other staff members. We saw how some people were bored and then became irritable with themselves and others, but as soon as a member of staff engaged in conversation with the person, their demeanour changed and they became calm.

There was a system in place to record and respond to complaints received. Pictorial complaints information was on display to assist people to assist people who may have difficulty reading the written word. Where complaints were received, they were logged, investigated and responded to appropriately. For example, we saw where one person had verbally raised a complaint, they were encouraged and supported to put the complaint in writing. This was then investigated, acted on and responded to appropriately, to the person's satisfaction. We saw a number of compliments regarding the service were also received. A relative had written to the manager following the death of their loved one. They said, "Thank you [manager's name] for your kind words about Dad and his life at Crossways. I don't think he could have been in a better place to be looked after and we will always be grateful to you".

A healthcare professional described to us how they had witnessed the love and care provided to a person at the end of their life. They had been called in to support staff and witnessed the manager and another member of staff stay with the person until they passed away. They told us staff read the Bible to the person [as per the person's wishes], combed their hair, said prayers, held their hand and provided comfort and reassurance until the person passed away. They told us, "I wanted [person] to have the most dignified passing". We saw that one member of staff had made the arrangements for the person's funeral in line with their wishes and had written the person's obituary based on the little information they had. They had also agreed to take responsibility for the care and attention to the person's grave in the future.

Good

# Is the service well-led?

## Our findings

At our last inspection, we saw a number of actions had been put in place to improve the quality of the service provided to people at the home. At this inspection, we found improvements had continued but were told that both the manager, who had recently applied to become registered manager of the service, and the deputy, had handed in their notice. Both had provided a long period of notice to enable the provider to recruit to their posts.

We spoke with the provider regarding the manager and deputy leaving and the impact this could have on the service. They told us it was "A bit of a shock", but they were working with the area manager and hoped to recruit into both posts before the manager and deputy left so that a period of handover could take place. They told us they had also authorised the deputy to spend more time in the office prior to leaving, to ensure everything that needed to be done was in place before they left.

People were complimentary when they spoke about the manager and it clear that she was very well thought of by people living at the service, staff and relatives alike. A person told us, "The manager is lovely" and a relative said, "The manager is open and transparent, when there were problems with CQC she told people". We saw a notice in place in the staff room for staff advising them that the manager had an open-door policy and were flexible about the times they would see staff.

We observed the manager was visible throughout the day and knew people well. People referred to her by her name and as she greeted people, many held out their arms and indicated that they wanted to be hugged and the manager was happy to oblige. It was clear that she had warm relationships with the people at the home and they felt confident in approaching her and knew who she was.

A member of staff said, "Things have changed dramatically here and for the better. We have a wonderful manager. [Manager's name] has a passion for the home and wants what's best for residents. She's not a taskmaster. She's very supportive and so is [deputy's name] as well. I was disappointed they are leaving". Another member of staff told us, "I can see the improvements. Since being a manager, [manager's name] has made a difference, she works from the heart and treats residents as family. I was very upset when I heard she was leaving, I'm not happy she is going".

Staff told us they felt supported by their manager, but were frustrated that the staffing situation prevented them from being able to take people out into the community. They told us some staff came in when they were off shift to take people out in their own time. The manager confirmed this and told us this was something staff wanted to do, to improve people's quality of life, but added, "I can't expect my staff to do this unpaid".

The manager was aware of her responsibilities to the people living at the service and the staff group. They told us of the challenges they faced trying to obtain professional assistance when another person living at the service became ill. In response to this and the additional support that person required, the manager took the decision not to admit any other people to the home at that time. They told us, "We couldn't give

someone else a nice home, the staff were stressed, it was just awful, it really was".

The manager promoted a culture of supporting her staff group and praising them where appropriate. When describing one particular member of staff they told us, "I am so proud of [staff's name]. They have amazing potential. They are a star. They have something in them that is different". We saw in recent staff meeting minutes, it was noted staff were thanked for supporting the service at a time when there was a flu epidemic at the home.

We saw efforts were made to obtain feedback on the service through surveys and residents meetings. The comments from surveys were mainly positive, though they had not been dated. One relative had written, "Every time I go to Crossways, which has been for many years now, there is a lot of love and attention to the service user". We saw one person had commented in a survey that their meals weren't as hot as they would like. This was responded to and actions taken to ensure food that left the kitchen were kept hot. Residents meetings took place regularly. In minutes seen, there was a theme of people asking to take part in more activities and being supported to access the community. Although some of these requests had been met [in the form of the purchase of board games] people were still waiting for the opportunity to access the community.

We saw there were a number of audits in place to assess the quality of the service provided. This included reviewing any safeguarding concerns, care plans and complaints. Information regarding accidents and incidents was analysed for any trends, actions to be taken and lessons to be learnt. The area manager told us, "The monthly report identifies trends and patterns, for example, if there were falls at night and also identifies who was on shift at the time. This goes to the manager and the provider". We saw in response to this the manager produced an overview of actions taken, for example, referrals to the falls prevention team or a review of medication. We saw the provider had obtained the services of a consultant to work with them. They told us, "The consultant did a two-day audit of the home and is now working with [manager's name]. It's peace of mind having an independent pair of eyes. They will be visiting on a quarterly basis for the next year and then we'll review".

We saw that the manager was involved in a pilot with other healthcare professionals to reduce the number of avoidable admissions to hospital. They had also worked with commissioners to obtain CPN (Community Psychiatric Nurse) to work with them to provide additional support for a particular person living at the home. We also noted the manager worked with a number of other agencies, including, palliative care, continence care, dieticians, dementia support and advocacy matters and we saw evidence of this.

The provider had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.