Four Seasons (DFK) Limited

Meadowbrook Care Home

Inspection report

Twmpath Lane
Gobowen
Oswestry
Shropshire
SY10 7HD

Tel: 01691653000
Website: www.fshc.co.uk

Date of inspection visit:
14 September 2016

Date of publication:
22 November 2016

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 was carried out on 14 September 2016 and was unannounced.

The home was last inspected on the 7 and 9 December 2015 where we gave it an overall rating of requires improvement. We had identified the provider was in breach of Regulations 9 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to not enough staff suitably deployed to meet people's needs and a lack of person centred care. We asked the provider to make improvements and send us an action plan. We found that improvements had not been made and that the provider remained in breach of the Regulations.

Meadowbrook Care Home is registered to provide accommodation with nursing care for up to a maximum of 79 people. There were 66 people living at the home on the day of our inspection. People were cared for in three units. These included the Garrett Anderson unit which provides supports to people living with dementia. The Mary Powell Unit which provides support to people with physical health needs and the Agnes Hunt unit which supports people living with neurological needs.

There was a manager in post who was present during our inspection. The manager was in the process of applying to become registered manager for the service. 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.

Although people felt safe there were not always enough staff to meet their health and social needs in a timely manner. There was a high turnover of staff and numerous staff vacancies. Staff felt fatigue and morale was low. Agency staff were used to cover staff vacancies but they were not always familiar with people's needs. This placed additional pressure on permanent staff who were overwhelmed with their workload.

People were not always provided with support that was tailored to their individual needs and preferences. Support provided was task focused and placed people's independence at risk. There was a lack of stimulating things to do to maintain people's emotional wellbeing and people were bored.

The provider had a clear complaints procedure however, this was not consistently followed. The provider had a range of routine checks in place to monitor the quality and safety of the service but these had been ineffective in identifying shortfalls in the service. The provider had committed resources to make the required improvements and to change the culture of the service.

There was a lack of formal supervision to allow staff to discuss their training and development needs. Staff lacked knowledge and understanding of people's complex illnesses as they had not received specific training on how best to support them.

People were protected from harm or abuse by staff who knew how to recognise and report concerns. The provider had safe recruitment procedures which ensured that prospective new staff were suitable to work with people living at the home.

People received support to take their medicines as prescribed. Only staff who had received training on the safe administration of medicines did so. Staff monitored people's health and arranged health care appointments when required. The provider employed their own physiotherapist to support people's physical wellbeing.

People were provided with a choice of meals and drinks. People enjoyed the food and were offered drinks at regular intervals. People were supported to eat their food in a patient and dignified manner.

People were supported by staff who were friendly and caring. Staff had formed positive working relationships with people. Staff talked with and about people with respect.

People knew the manager and both they and staff felt they were approachable. The manager was keen to develop the service and had introduced meetings to gain feedback to improve the service.

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 not always supported by enough staff to meet their physical and emotional needs. People were protected from harm as staff were able to recognise the sign of abuse and who to report concerns to. Staff were aware of the risks associated with people's care needs and how to minimise these. People received support to take their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff who were not supervised in their roles. Staff had not received specific training to meet people's individual complex needs. Where able people were supported to make their own decisions. People were provided with choice of what to eat and drink and enjoyed the food. People were supported to see health care professionals as needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with consideration or respect. Staff were friendly and caring. People had positive working relationships with staff. People were supported to maintain contact with friends and relatives who were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that was suited to their individual needs or ability. There was a lack of stimulating things to do to maintain people's emotional wellbeing and people were bored. The provider had a clear complaints procedure but this was not consistently followed.

Is the service well-led?

Requires Improvement

The provider was working towards improving the service however, this had not been sustained at the time of our inspection. Routine checks the provider had in place to monitor the quality and safety of the service were ineffective in identifying shortfalls. The manager had introduced daily meetings to share information to improve the quality of care provided.

Meadowbrook Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 September 2016 and was unannounced. The inspection was conducted by three 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 care service.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We had received information from the local authority regarding concerns raised with them which they were investigating. We used this information to plan the inspection.

During the inspection we spoke with 15 people who lived at the home, five visitors and three relatives by telephone. We spoke with 16 staff which included the regional, home and deputy managers, three nurses, seven care staff, two kitchen staff and one domestic staff member. We also spoke with a visiting health care professional. We viewed five records which related to the assessment of needs and risk. We also viewed other records which related to the management of the service such as medicine records, accident reports and complaint records.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that there were not enough staff suitably deployed to meet people's health and social needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how these would be achieved. At this inspection we found some improvement had been made.

Both the regional and home manager acknowledged there had been staffing difficulties at the home. They were actively recruiting staff and those who had been offered jobs were awaiting safe recruitment checks before they could start work at the home. In the meantime they were having to use agency staff to cover both nursing and care staff vacancies. To promote consistency they tried to use the same agency staff. They said agency staff were provided with information about people's individual needs during staff handover and worked alongside permanent staff members. The Regional Manager told us they continued to use the Care Home Equation for Safe Staffing (CHESS) to determine staffing levels at the home. As well as using the CHESS tool the manager completed walk rounds of the home several times a day to ensure staff were effectively deployed. They also took a daily print off of the response to call bell times and these were analysed to ensure that calls were responded to promptly. Where there delays in staff response to call bells, these were discussed with staff to establish the reason and action required to prevent reoccurrence. The regional manager told us when the home was fully staffed the staffing levels provided were above what the dependency tool recommended.

People and relatives we spoke with recognised that there were staffing problems at the home. For example, one person told us they felt that more staff were needed as sometimes they would have to wait for 20 to 30 minutes for staff to answer their call bell. Another person told us they did not think there were enough staff to meet their needs and they often had to wait for help when they asked for it. Staff said people and their relatives often commented on staffing levels to them. For example, they would say, "Short staffed again."

Staff told us that there were not always enough staff and they had become task focused in order to ensure people's basic care needs were met. One staff member told us, "I would change the staffing if I could. I feel like I'm running on empty. Very rushed and just focused on the care." They explained that they struggled to provide anything above basic care due to staffing levels. Another staff member said, "I know all the basic care is given. We now need the opportunity to do the extras." They went on to say, "There is light at the end of the tunnel and we recognise management need to make the right recruitment decision." They explained that the manager was under pressure to get the right staff. They said agency staff always work with a regular staff member to provide consistent support. While staff welcomed the support of agency staff two staff members found that this added extra pressure on their busy workload as they had to explain everything to them. However, another member of staff felt that they often had the same agency workers who had got to know people and their needs.

Staff and management told us there were safe recruitment processes in place to ensure that staff were suitable to work with people living at the home. These included references from previous employers and disclosure and barring service checks (DBS). The DBS helps employers make safe recruitment decisions and

prevent unsuitable prospective employees working with people.

People told us they felt safe living at the home. One person told us, "They [Staff] are organised and it takes the stress away from me, always someone there at all times." Another person said they felt safe in every sense.

A relative we spoke with told us that the manager took prompt action to protect their family member when concerns of abuse were raised. They felt the manager was open and honest about the incident and kept them informed about actions taken to address the situation. The manager had notified the local authority safeguarding team, the police and us of the concerns and a full investigation was undertaken. Staff we spoke with were knowledgeable about the different forms of abuse and how to recognise signs of abuse. They were clear about the action they would take if they became aware of or witnessed any form of abuse. One staff member said, "I would report to the manager straight away."

Risks to people's health and safety had been assessed and staff were aware of the support and equipment people required to maintain their safety. One person told us they were at risk of skin breakdown and therefore needed to change position regularly. They used a bed that turned them every quarter of an hour and therefore allowed them to have a good night's sleep. One person's risks assessment deemed that they were at high risk of falls. We saw that staff followed the guidance provided to assist them to move safely. Some people required the use of a hoist and two staff to move them. Staff explained the process to them to ensure their understanding and safety.

Staff demonstrated they would take action in the event of an accident or incident. They told us they first ensured the person's safety and wellbeing before reporting to the nurse in charge. They subsequently completed incidents forms which were reviewed by the manager. Records we looked at confirmed this, for example, one person had sustained a skin tear injury. We saw that staff took appropriate action to prevent infection and sought advice from the doctor. The manager told us they analysed the accidents forms. If they saw that a person had suffered an increased number of falls they would ensure their health needs were reviewed to establish the cause. They would also refer to them to the falls clinic. Similarly if a person was becoming increasingly anxious they would complete behavioural charts and refer them to the mental health team. This was confirmed by a health care professional who was visiting a person who was experiencing high levels of anxiety.

People told us they received their medicine as prescribed and when they needed it. One person said, "I always have a choice. If I refuse they [Staff] always tell me what could happen. If I want paracetamols or gel for my arm I can just ask they always help me out." We saw that people were supported to take their medicine in a safe and patient manner. Staff explained what the medicines were for and ensured that people had a drink to take them with. Only staff who had received training to administer medicine did so. Staff received competency assessments to ensure they continued to administer medicines safely. We saw that medicines were stored securely and accurate records were kept.

Requires Improvement

Is the service effective?

Our findings

People and relatives had different views about staff's abilities. When asked about staff knowledge of their illness one person told us staff did not always know about the complexity of their needs and they had to explain it to them. They said they were normally supported by the same staff and this consistency of support helped a 'lot'. A relative we spoke with felt staff did not have the time or understanding of their family member's needs and the support required to meet them.

Staff had mixed opinions about the quality of training provided. Some staff liked the on line learning experience. However, other staff felt that this did not provide the opportunity to ask questions about how to apply the training to practice. The provider had systems in place to ensure staff received essential training to maintain people's safety. However, two staff expressed concerns that they did not receive training on specific illnesses that people lived with at the home. These included Huntington's disease and multiple sclerosis. They felt they lacked the knowledge and understanding on how best to support the individuals concerned. When we spoke with the manager they told us they used to gain support from specialist nurses but they were no longer able to access this. The manager agreed to source other training opportunities for staff to support in these specific illnesses.

One new staff member explained that they underwent a 'resident experience' during their induction. They said this gave them first-hand knowledge of what it was like to experience poor care. They explained they were given glasses to wear that had been smudged with Vaseline which simulated poor vision. Other staff members did role play where they talked over them instead of to them. They said this had learnt them how important it was to explain to people what they wanted them to do so they understood and were prepared to be helped. They told us they also worked with experienced staff for two weeks until they felt confident to support people on their own.

Staff felt that they could approach the manager or senior staff for support when required. One staff member told us, "[Nurse's name] is lovely, very nice and friendly. If I have any worries I can go to them." The manager told us that one to one meetings had not been happening as regular as they should have been. They were working through both appraisals and one to one meetings to identify staff support and development needs. They had targets in place to ensure that all staff received regular one to one meetings and the progress was being monitored by the provider. The manager told us they had delegated meetings to senior staff who were meeting the set targets. However, we were unable to establish the effectiveness of this process during the inspection as it had only recently began.

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. Staff demonstrated sound knowledge of the MCA and their responsibility to ensure people's rights were protected. Staff told us that people were supported to make their own decisions where able. They provided information in a way they could understand to facilitate this. For example, they would show people

different items of clothing to choose from or simplify the question. Where people were unable to make their own decisions staff understood that these needed to be made in their best interest. The nurses were responsible for completing mental capacity assessment and best interest meetings. Records we looked at confirmed people, their relatives and where appropriate other professionals were involved in this process.

People told us that staff made sure they were happy to be helped before they went ahead and provided support. Staff we spoke with told us they always asked people's permission before helping them and should they decline support they would return at a later time. We saw that staff explained to people what they wanted them to do and sought their consent before proceeding.

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. A relative told us that the provider had applied for a DoLS for their family member as they were unable to maintain their own safety. The manager had trained and prepared staff in the knowledge of MCA and DoLS. They had delegated the responsibility of completing DoLS applications to the nurses one each unit. The manager maintained an overview of DoLS in place and when these required reviews. Staff we spoke with had a good understanding of DoLS and used the least restrictive measures to support people. For example, one person had an alarm fitted to their bedroom door to alert staff when they were leaving their room so they could provide support to maintain their safety.

People told us and we saw that they were provided with a choice at all mealtimes. One person told us they were also regularly offered drinks and snacks between meals. There was a set menu and care staff recorded people's preferences to the choices available. We saw that one person had changed their mind about what they had chosen for lunch. They were promptly provided an alternative.

People and their relatives were positive about the quality and quantity of meals provided. At lunch time we heard one person say, "I enjoyed that, it was lovely." A relative we spoke with said, "[Person's name] has nice meals and eats well." Where required we saw that staff supported people to eat their meals in a patient and dignified way. Other people were given gentle encouragement to eat and some used adapted cutlery to eat independently. We heard one staff member say, "All you have to do is try. Just eat what you can." People's nutritional needs were routinely assessed and monitored. Where there were concerns about what people ate and drank we saw food and fluid charts were put in place to monitor their intake. Both kitchen and care staff demonstrated they were aware of people's dietary needs and the required consistency of their meals. The kitchen staff said they also catered for special events such as barbeques and menus themed on different countries such as Spain and India.

People we spoke with told us staff arranged health care appointments when required. One person said, "I can see a doctor whenever I want. The nurses seem to know what they are doing. I can ask them anything." Another person told us staff called the doctor if they asked them and that they were due to see the doctor later that day. The provider employed their own physiotherapist. One person explained they had been suffering cramps and as a result was receiving physiotherapy. Staff had also arranged for bloods to be taken to see if there was a physical cause for the pain. A staff member told us that the physiotherapist got to see people as much as they needed.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with consideration or respect. For example, we saw that ten staff passed through the Mary Powell unit during the 30 minutes we were in there completing a SOFI and not one of them interacted with or acknowledged the people sat in there. A relative told us their family member required reminding and reassurance to manage their continence needs. They felt this was not always provided in a timely manner as often when they visited they found their family member had been inadvertently incontinent.

One person told us staff always treated them with respect especially when providing personal care. A relative said that staff ensured their family member was always clean and well presented. Staff told us they protected people's dignity by ensuring they kept them covered when providing personal care and by waiting to be called in when they knocked on their door. One staff member said, "We work in their home, they do not live in our workplace." They explained that it was important to respect people and their property. We saw that staff supported people in a discreet manner. For example, when staff used the hoist to move people they put a screen up so that they were not exposed in front of other people.

People and their relatives told us staff were kind and caring. When asked their opinion on living at the home one person told us, "Yes I like it here." They explained that staff were always attentive to their needs. Another person said, "They [Staff] are good as gold here." A relative told us, "They [Staff] look after them the best they can." They went on to tell us that their family member disliked water and staff would go with them to the hairdresser to reassure them when they had their hair washed. Staff told us some people could become anxious and shout out. They explained they would try and reassure or give them space to calm down.

Staff had formed positive relationships with people. One person said, "Staff are lovely and always want to have a chat about something." Another person told us, "Very nice staff, they are lovely. We have a chat and a bit of a joke." Relatives we spoke with found staff warm and welcoming. One relative said, "[Staff member's name] is a darling. As soon as we come in they ask us if we want a drink." Another relative told us they liked how staff spoke about their family member in a positive manner. Staff were positive about their caring role and the people they supported. One staff member told us they enjoyed their job and liked getting to know people.

People told us they were involved in decisions about their care. One person told us, "When I first moved in they [Staff] went through everything. What I liked and disliked. They have a book which has all about me written down." Another person told us, "Staff know how I want my support and when." Relatives we spoke with told us they were involved in decisions and kept informed of any changes as required. One staff member told us when people first moved in they spoke to them, their family and friends about things that were important to them. They found this made it easier to work with them as everyone was individual and had their different ways. We saw that people were offered choice and were listened to. For example, when staff asked one person if they wanted to go to the dining able for lunch and they said they wanted lunch in their armchair. Their decision was respected and lunch was served to them in their armchair. Another person said, "When I get up they [Staff] talk to me and we chat about how I want a shave, electric or blade."

People were supported to maintain important relationships. One person told us, "Sometimes my [Spouse] comes down and they [Staff] set a table for us and we have lunch together." A relative told us they often took their family member out for the day. Staff would ensure they were ready when they arrived to collect them. Another person told us had recently had a family bereavement and told us that the staff were very good to them during this difficult time. The manager had also spoken with them and offered their support. A relative we spoke with told us that their family member was frightened to come out of their room when they first moved in. Staff had provided encouragement and reassurance and they now spent time in the lounge with other people. A health care professional we spoke with told us that relatives said to them they found staff supportive and caring not just to the person but to them also.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that people's preferences were not always known or respected. This was a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how these would be achieved. We found that some improvement had been made.

The provider told us they would ensure that people's preferences were known and acted upon. Work had been undertaken to establish people's preferences and interests. However, we found that people did not always receive care that was tailored to their needs. A relative we spoke with told us they had made staff aware of their family member's preferences but these were not always respected. They said, "They [Staff] don't seem to remember what we have said to them". When asked if they had raised their concerns they said, "All the time, but there aren't enough staff, I know that, and they do the best they can." They went on to tell us they felt senior staff did not take notice of their concerns. Another relative told us they felt that there was only enough staff to manage people's basic care needs. They found that time for staff to do activities with people or spend time with them was "sorely lacking."

People and their relatives felt that staff worked hard but found the service was not always responsive to their needs. One person recognised that there had been staffing difficulties and felt the manager was trying to make improvements. A staff member told us they had little time or opportunity to work in a person centred way with people. They said, "I love my job and what I do but it has been hard. This was echoed by another staff member. They told us due to staff shortages they tended to do things for people rather than encouraging them to do things for themselves as this saved timed. Such practice would place people at risk of losing their existing skills and their independence. We saw that there was positive interaction between people and staff. However, we found that this was centred on supporting people with tasks such as meals, drinks and helping people move around safely.

People we spoke with said there was a lack of stimulating things to do. One person told us, "There's not anything really to do. I get a little bored." Another person told us there was not enough to do and there was no one to help with activities. They went on to say all there was to do was to read the newspaper and watch TV or listen to music. A relative we spoke with said, "Activities is the major thing that is lacking." They went on to tell us that they kept telling the staff, yet nothing had been 'sorted'. Staff told us they had limited time to spend with people apart from when providing personal care or support with meals. One staff member said, "Our daily goals are to complete the basics. People are missing out on the on- to-one stimulation". Another staff member said, "Activities are just not working with the expectations of the carers doing it. I would love to be more involved in the activities. One of the rare occasions we were able to do bingo it was fantastic, but rare." We saw that there was a lack of stimulating things for people to do. Staff had very limited time to spend with people. Some people spent long periods of time watching the television while many others fell asleep in their chairs.

This is breach of Regulation 9 HSCA 2008(Regulated Activities) Regulations 2014.

The registered and regional manager explained that all three activity worker posts had been vacant. One new activity worker had started work on the day of our inspection. They were waiting for recruitment checks for a second activity worker and aimed to recruit a third. In the meantime there was an expectation that care staff completed activities with people. However, no arrangements had been made to cover their care roles to allow them enough time to do this. The 'quality of life' checks the provider had in place to monitor people's experience of the service had failed to identify this as a deficit.

In the afternoon in the Garrett Anderson Unit we saw a person enjoyed a game of dominoes with a staff member and there was friendly chat and laughter. When activities took place these were enjoyed. For example one person said, "We had someone come in and they did bingo. I really enjoyed it. I couldn't hear so they moved me closer and included me. I didn't know the rules and I got a prize."

People and relatives had different views on how effectively complaints were dealt with. One person told us they had recently raised a complaint and they were very satisfied with the action taken by the manager. However, three relatives who we spoke with told us they had raised complaints but felt that these had not been properly addressed. We saw that the provider had a clear complaints procedure. The complainant would be spoken to clarify the nature of the complaint and to agree the action to be taken to prevent reoccurrence. When we spoke with the manager we could not be confident that the complaints procedure was consistently followed. This was because they were unable to provide us with information they had taken in relation to all the complaints in question.

People's needs were assessed prior to moving in and reviewed on a monthly basis thereafter. Relatives told us that staff kept them informed of any changes. One relative told us staff always alerted them of any changes or about important things. They explained that their family member could show increased anxiety. They said staff knew how to manage this well and they never remained anxious for long. Staff told us they were informed about and reported any changes in people's needs at staff handover. The nurses told us they were responsible for reviewing people's care plans and risk assessments on a monthly basis. Records we looked at confirmed this.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that the provider was in breach of Regulation 9 and 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. The provider sent us an action plan telling us how they were going to address the concerns raised. During this inspection we found some improvements had been made but that there were still concerns in some areas of practice. There were staffing difficulties at the home due to a number of vacant posts. Staff practice had become task focussed and morale was low. This was confirmed by a visiting health professional who stated the home had "lost its heart." They explained that they had spoken with staff and found their morale was low.

There was not a registered manager in post. There had been a number of changes to the management structure since the previous inspection. There had been staff changes at both regional and home manager level. Interim managers had been brought in to run the home until the current manager started in April 2016. The manager told us they wanted to provide good care and to ensure people were safe. When they first took up their post they had needed to concentrate on the management of the service, in particular allegations of abuse that had been raised. The manager told us there were also a number of staff vacancies they needed to recruit to in order to provide consistent support to people and ease the pressure on permanent staff. The manager told us they had identified a number of concerns about care practices and disciplinary procedures had been undertaken with some staff.

The regional and home managers recognised that a change in culture that addressed the practice issues was needed. They acknowledged that work needed to be done to ensure that staff received appropriate training and support to enable them to meet the needs of people living at the home. They were liaising with the local authority and clinical commissioning group in regards to accessing training they had offered. The manager intended to work alongside staff to assist and monitor the quality of the care provided. We were able to see that the provider and manager were working towards the required improvements. However, these had were not all in place at the time of inspection and will be reviewed when we next inspect the service.

The manager was committed to make the required improvements and to get the service back on its feet. They had implemented daily meetings with staff in order to share information and decide a way forward. Staff found these beneficial as they felt involved and were kept up to date about any changes. All the staff we spoke to apart from one told us they found the manager was approachable and supportive. One staff member told us, "[Manager's name] is always there. Always able to have a chat. If they are busy they will say give me five and will come back and find me." Another staff member said, "[Manager's name] is good and always says you do a brilliant job." They went on to tell us their feedback was appreciated. They also felt that they could speak to the deputy manager at any time. Staff told us they were given opportunities to put their views forward for improvement and felt listened to. For example, one staff member said they suggested having prize bingo and this had been arranged. Another staff member told us the manager was busy trying to put new things in place to improve the service. "I think [Manager's name] is doing really well".

There was a clear management structure in the home which provided clear lines of responsibility and

accountability. A manager was in post who had overall responsibility for the home. They were supported by a deputy manager, nurses and senior care staff. The manager told us the provider was supportive of them in their role and they could approach them at any time. The manager also had a mentor in the form of a manager from another home. They had weekly conference calls and attended monthly managers meetings which they used for their learning and development of the service.

People knew the manager and found them easy to talk with. One person acknowledged that there were concerns about staffing at the home but felt it was unfair to ignore the good things that went on. They went on to tell us the management needed a chance to make the required improvements. We saw that people recognised the manager and that the manager engaged with people and visitors as they walked around the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The Provider had not ensured that people received person centred care.