Care UK Community Partnerships Ltd

Silversprings

Inspection report

Tenpenny Hill
Thorrington
Colchester
Essex
CO7 8JG

Tel: 01206251962
Website: www.careuk.com/care-homes/silversprings-thorrington

Date of inspection visit:
27 March 2018
29 March 2018

Date of publication:
17 May 2018

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 unannounced comprehensive inspection took place on 27 and 29 March 2018. At our previous inspection on 13 February 2017 the service was given an overall rating of requires improvement and we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe management of medicines and insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the overall rating of the service. At this inspection we found although the provider had taken action to improve the rating of some domains inspected, further improvements were still necessary in order to fully meet all regulatory requirements.

Silversprings 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.

The service provides residential and nursing care for up to 64 people, some of whom are living with dementia. At the time of our inspection 50 people were using the service.

There was a registered manager 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.

During the inspection, we observed there was sufficient staff to keep people safe and we found call bells were answered in a timely manner. However, we did still receive mixed feedback in relation to staffing particularly on Caroline

Medicines were now managed safely and the provider had procedures in place so they were stored securely, administered in line with recommended guidance and recorded.

Robust recruitment procedures were in place and all staff completed an induction when they started work. People told us they felt safe living at the service with the support from staff. There were safeguarding policies and procedures in place. Staff were knowledgeable about what action they should take if they suspected abuse. We saw there were risk assessments in place to identify specific areas of concern.

Mechanisms to provide staff with training and supervision, and appraisals were in place to support staff to be effective in their role. However, not all staff always felt supported by the registered manager and deputy manager, this meant for some staff morale was low.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. Most staff demonstrated an understanding of the MCA and worked within its principals, including gaining consent to care for people who lacked mental capacity. We have made a recommendation about supporting staff to gain a better understanding of this area.

People enjoyed a balanced healthy diet. Their healthcare needs were fully met and the service worked well in partnership with other health professionals to ensure people received good healthcare.

People were complimentary about the way staff interacted with them. Independence, privacy and dignity was promoted and respected. Staff took account of people's individual needs and preferences and people were encouraged to be involved in making decisions about their care.

Staff knew people well, could describe their routines and preferences and understood how to provide care and support that was tailored to each individual. People were provided with opportunities to engage in activities which reflected their interests and preferences both within the service and out in the community. We saw that the registered manager investigated and managed complaints thoroughly and in a timely manner.

The provider and the registered manager undertook regular quality assurances checks. The registered manager had responded to our feedback positively in relation to staff feedback and low morale of some staff and was planning some team building activities.

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.

Staffing levels had improved overall; however, there were times when staffing levels/deployment of staff needed further investigation.

There were systems in place to minimise risks to people and to keep them safe.

People told us they felt safe living at the service.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Consent was sought from people in line with best practice guidance. Staff gained verbal consent before providing people with assistance.

The service worked with external healthcare professionals to provide on-going support to people.

Is the service caring?

Good

The service was caring.

Staff were attentive and caring in their interactions with people.

People's independence, privacy and dignity was promoted and respected.

Staff took account of people's individual needs and preferences.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

Meaningful activities were organised that reflected peoples interests and people were able to access the wider community.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

People were supported when making decisions about their preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Staff did not always feel listened to or included in the running of the service, work was needed in respect of staff morale.

There was an effective quality assurance system in place. As a result the quality of the service was continually improving.

Silversprings

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 27 and 29 March 2018 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. An expert-by-experience is a person who has personal experience of caring for someone who uses health and social care services.

Before the inspection, 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 also reviewed other information that we held about the service such as safeguarding information and notifications. Notifications are the events happening in the service that the provider is required to tell us about. We also reviewed information received from relatives of people who used the service and information shared with us by the safeguarding and quality improvement teams of the local authority.

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

Over the course of our inspection visits, we spoke with the registered manager, residential manager, regional director, 13 care staff, the maintenance worker, two lifestyle co-ordinators, 14 people living in the service and eight relatives. We reviewed various documents including 11 people's care records, seven staff files and other relevant documentation such as training records, quality audits and minutes of meetings

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2017, we found there were not always enough staff on duty to meet peoples care and support needs. At this inspection, we found that staffing levels had generally improved and throughout our inspection we observed staff carried out their duties in a relaxed manner and had sufficient time to provide social and emotional support to people. We did note that on the first day of our inspection one of the areas in the service named Caroline had four staff when we first started the inspection, we were told by the staff that one of the upstairs units had sent a member of staff down to help out. On the second day of inspection there were five staff on duty in Caroline. This meant that during our inspection on both days we observed Caroline with five staff on duty. However, some people and staff still raised concerns there were times when staffing levels felt stretched, in particular on Caroline when only four staff were on duty.

The registered manager told us staffing numbers had increased and the service recruited over the recommended staffing numbers as detailed within their dependency tool. When we reviewed the rotas, we did note that on Caroline unit, there were days when there were five staff available and on other days, there was four. The registered manager also had a member of night staff that worked later on some days. The registered manager told us that the dependency tool indicated that four staff should be sufficient to meet people's needs. Staff we spoke with told us that on days that there were only four staff available they felt that while they were meeting people's needs it felt more rushed, they also added if it occurred that within these numbers there were less experienced members of staff on shift then they found it more difficult to spend time with people. There were mixed views from both people that used the service, relatives and staff.

One person told us, "It is alright, I have not got any bad points to tell you, when I buzz I have not had to wait too long, the male and female staff get anything I want, there is always somebody there." Another person when asked about staff response to the call bell said, "Sometimes quick, not too bad at night, waiting is acceptable." Other people had different views in relation to staffing. One person told us, "Not enough staff, weekends are worst, no manager on, we don't to get to see the manager on their own, the deputy is always there." Another person said," If you buzz when they are changing people or making beds you wait. Some staff go the extra mile for you, I have not made a complaint but have spoken about continuity of staff." A third person said, "Lovely here, well looked after, wait a bit in the mornings and around 8pm, wait at weekends sometimes."

Staff we spoke to also had mixed views about staffing within the service particularly on Caroline unit. They told us the change from five staff to four staff was difficult and meant when they had four staff they felt under pressure. One staff member said, "When we have five staff on Caroline it makes such a difference, we have time to sit and have a chat, when we have four we do meet people's needs but it feels more rushed, sometimes I go without a break." Another staff member said, "When we have four it can depend who is on, if it is regular staff it can be okay but if we have newer staff that need more time then we are rushed. People on Caroline like things done in a particular way and at a particular time so we want to try to make sure that happens. We do work well together and help each other but with all the paperwork I do not stop." A third staff member said, "There are not enough staff on Caroline; should be five but not always here, staff have

been taken away, sometimes it's four."

When we spoke to staff in the other two units of the service their views were more positive about staffing levels. One staff member we spoke to believed that staffing levels were adequately covered in the unit they worked and that agency staff were not used much. They added, "We have enough staff for the residents we care for." However, they did comment that one of the units in the home was not staffed well at times. Another staff member told us, "They had no concerns", and that there "Was a good staff to resident ratio".

We discussed this with the registered manager who told us they used a dependency tool, which was reviewed monthly for each individual and adjusted staffing levels accordingly. The registered manager had recently increased the staffing levels at night because of reviewing the needs of people that used the service. We discussed the comments made about staffing levels on Caroline and they agreed to talk to staff and look at how staff were deployed throughout the service to establish where improvements could be made.

The service had a robust recruitment process, which ensured people were supported by suitable staff. The registered manager had obtained appropriate checks in line with regulatory requirements. There were Disclosure and Barring Service (DBS) checks, written references and evidence of staff's right to work in the country on all of the staff files viewed.

At our last inspection of the service in February 2017, we found the service did not have effective systems in place to ensure medicines were managed safely. At this inspection, we found the registered manager had implemented the changes required to improve this area.

Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Medicines were given to people from the container they were supplied in and people were given the support and time they needed to take their medicines. People were offered a drink of water and staff checked that all medicines were taken. People's preferred medicine support needs were recorded within their care records.

The medicine administration records (MAR) were clearly written stating which tablet should be given and when. This also reflected which member of staff gave the medication. There was evidence of a system in place to denote if medication had been refused, omitted or withheld. Any as required (PRN) medication was clearly labelled. There was evidence of a PRN protocol, which was available to all staff via the intranet. Instructions were clear on the PRN medication label. There was a section on the reason the PRN medication was being given which is recorded in the people's care plans. One person told us, "Medicines always on time and they stay till I have taken them."

Staff had received training in safeguarding so knew how to protect people from the risk of abuse and were aware of the reporting process. Staff told us they would feel confident to report any concerns and to whistle blow if needed. One staff member said, "I would report to my line manager but if I did not think it was being dealt with I would go higher." Another staff member said, "I can assure you I would report anything I saw, the residents come first."

People had risk assessments in place, which were tailored to each individual. Associated management plans were in place to provide guidance to staff on how to manage risks. Staff we spoke with demonstrated a good awareness of the risks to people. For example, one staff member told us, "[Named person] needs to be positioned in a comfy chair with their legs raised to help their circulation." People had repositioning charts in place and we saw these had been consistently filled in evidencing that people had been regularly

supported to change position to minimise the risk of developing a pressure ulcer.

People had care plans relating to specific health conditions, for example, diabetes. These included guidance for staff on the signs and symptoms associated with this condition. Staff we spoke with could explain the signs and symptoms and knew what to do in practice to keep people safe.

Where people had behavioural issues, management plans were in place to support staff to manage people's behaviours. There was a good level of detail, including information about potential triggers for behaviours and strategies staff could use to diffuse situations. Staff we spoke with were able to explain ways to respond to behaviour that might be difficult. One staff member said they would approach the person in a calm and re-assuring manner and then use distraction techniques. They gave an example of knowing one particular person by saying. "When this resident gets upset I take them to their room and sit with them and look through family photos. This always seems to have a calming effect when they see their children."

Accidents and incidents were recorded and analysed to identify any trends or re-occurrences. All were recorded using an electronic system that would identify the details of the accident/incident, the location, date and time. The system would send the registered manager emails of any accidents or incidents recorded and any action taken was recorded. Where people were at risk of falls, measures were in place to minimise the risk, for example, low rise beds, crash mats and bed rails if appropriate. CQC statutory notifications related to any accidents or incidents reported to CQC as required. We saw that all incidents, accidents or safeguarding examples were discussed with staff during meetings in lessons learned sessions.This helped the team to explore what happened and discuss any changes to practice that might be needed to prevent a reoccurrence.

The environment was regularly audited and risks assessed to ensure that it was safe for people to use. Water temperatures, call bells and fire safety equipment were checked and personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order. Suction machines were now stored in treatment rooms and checked daily by senior staff. Infection control was well managed and staff had a good understanding of how to keep people safe by limiting the risk and spread of infection. We saw that staff used protective clothing when required and regularly washed their hands. There were supplies of liquid soap, paper hand towels, and hot water and protective gloves accessible throughout the building for staff use. The registered manager carried out infection control audits regularly to assess the standards.

Good

Is the service effective?

Our findings

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

At our last inspection we found that there was some confusion about MCA and DoLS and staff were not sure who had an authorised DoLS in place. Records did not always clarify this and some added to the confusion. At this inspection, we found that improvements had been made to the records around both mental capacity assessments and DoLS information. The registered manager kept copies of mental capacity assessments for specific decision making around any restrictive practices in place and we found care plans did emphasise the importance of supporting people to make their own decisions and obtaining consent. One person's care plan stated, "[Named person] is able to decide what they want to wear, encourage [named person] to be involved in all care choices and maintain their independence."

We also found that whilst senior staff had a good understanding of the MCA and the DoLS application process, we found care staff had less understanding.

We recommend that the service further explore how they can support all staff to understand and demonstrate a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005.

Staff had the skills, knowledge and experience to deliver effective care and support. They told us, and the records confirmed they had received a thorough induction and training met the needs of the people that used the service, such as for catheter care and dementia. Staff told us they completed the Care Certificate as part of their induction. The care certificate represents best practice when inducting staff into the health and social care sector. One member of staff described their induction experience. They told us, "I was shown around and buddied up for support. I did my safeguarding, manual handling, fire safety, infection control, MCA and dementia training before I started. Most is e-learning but manual handling and first aid is face to face. The training is very good." Another staff member said, "If you want particular training you just have to ask". They added, "This was offered in my recent supervision".

Staff also said they had received in-house training in diabetes and knew the signs to look for that might tell them a person was becoming unwell. We asked staff how they got to know people so they knew how to meet their needs effectively. Staff told us they shadowed existing staff and received a verbal hand-over and spent time reading people's care plans. Staff told us they were assigned as keyworkers,, which made them the point of contact for people or their relatives.

Staff confirmed when they first joined the service, they were observed by senior staff to ensure they had the knowledge and skills to care for people effectively. One staff member told us, "I have had three observations of my practice, looking at how I use the hoist and slings."

Most staff confirmed they had received supervision. One staff member told us, "It is helpful as we learn from each other." Another staff member said, "Supervision was given and useful." Staff told us this enabled discussion to take place about any difficulties or problems they may be having.

On Caroline unit, feedback in relation to supervision was not so positive; Comments included; "I have had two supervisions and an annual appraisal, we don't get told if we are doing well." Another staff member said, "Supervision has just started but I had to push for it and I am now getting it every month. [Named senior] is good at feedback." Staff said whilst they found support from seniors positive they told us they felt less able to approach the registered manager and the deputy manager as they did not always feel listened to. The registered manager told us they would ne making more time available to talk to staff.

Most people told us the food at the service was satisfactory, Comments included, "Food is very good, more a less two or three things to choose from, fresh fruit in the dining room all the time and if I have not got any in my room from my family they would bring me some", "Get a jacket potato or sandwiches if you don't like what's on, there is fair choice, you can ask for more, plenty of water, machines with fizzy drinks, jugs full of juices, trolley comes around with tea and coffee, hot drinks before bed – plenty to drink", "Food wise it's very good, breakfast I can have what I like, lunch a couple of choices plus vegetarian one or a salad, they don't run out" and, "Get enough food and drink, enough choice, fresh fruit and veg, there are always apples oranges bananas and grapes in the dining room and crisps for you to take", "I have had egg, bacon and tomatoes this morning, they encourage me to eat more."

People were able to choose when they ate their main meal of the day and the menu was put up the same day and this meant people told us sometimes one of the meal choices could run out. One person said, "They ran out of fish one day and roast lamb on a Sunday – they are trying to cut down on the food wastage." We did note that the choices on the first day of our visit were both pasta based. We did discuss this and the concerns about one of the choices running out with the registered manager who told us they were aware of this and it had only happened on these two occasions and ordering was being monitored.

We observed the lunch service in both the upstairs and downstairs dining rooms. People had a choice of drinks, and some were able to choose where they wanted to sit as they came in independently, people were looking at menus and choosing what they wanted to eat. Staff were going around and gently encouraging people with comments like, "Do you want me to cut it up for you", "Do you want some more milk" and, "What do you fancy".

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their health and wellbeing. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk or malnutrition. Where a risk was identified, a risk assessment and management plan was implemented to support staff to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. People identified at risk also had food and fluid charts in place to monitor their intake. We saw that food and fluid was recorded consistently and monitored by senior members of staff. Where a change in need was identified, we saw that people were supported to receive the appropriate treatment, for example, thickened fluids or food supplements. We saw an example where a person had been identified as losing a significant amount of weight. The risks to this person had been re-evaluated and advice and treatment had been obtained. The person's eating and drinking care plan had been updated and the person was now

receiving fortified meals.

People's physical, mental health and social needs were assessed and reviewed monthly. When people's health needs had changed, this was recorded in their notes and their care plans were amended to reflect their changing needs. People's diary entries showed that people were supported to access healthcare services and received on-going healthcare support. Records confirmed they were able to see a doctor, district nurse or other healthcare professional, when needed. Where advice or treatment was provided this information was added to people's care records, which were updated to reflect people's current needs. For example in one care plan, we saw the person had regular input by the occupational therapist, the speech and language therapists (SALT) and the dietician. After the SALT visit, we saw that the eating and drinking care plan had been updated to reflect the new guidance. One person said, "Saw doctor yesterday – my leg was painful and the nurse put a dressing on and I have seen the optician. "We observed a handover, which was very detailed. The handover went through each person and provided information on their current health including when the person was last repositioned, if their catheter was draining well and other information required.

People's individual needs were met by the adaptions, design and decoration of the premises. There was an information boards indicating the activities available for people to participate in and these were up to date. There were pictures and items of interest on corridor walls. A well maintained garden was available for people to look out on or use, including a slide in the grounds for people's younger visitors to use. A new sensory room had just been completed and a man cave in the grounds enabled people with a history of working with their hands or outside the opportunity to continue this. This area (shed) had a variety of games and darts inside along with seating area and music. The hairdresser salon on the day of our visit was busy and had a nice sociable atmosphere.

Good

Is the service caring?

Our findings

Staff had positive relationships with people. They showed kindness and compassion when speaking with them. Throughout the inspection, we saw people were living in a calm and relaxed environment. One person said, "Staff are lovely and very helpful. I have hurt my arm and they help." Another person said, "The staff are pretty good." A relative told us, "Staff are friendly, kind and considerate to us, make us feel welcome, even the young girl who comes to paint [family members] nails, [family member] calls them friends."

We saw positive interactions between staff and people that used the service throughout our visit. One staff member was observed asking if a person would like their cardigan put on as it was falling off. The person replied, "Not now" and the staff member said, "Okay I'll come back later". Staff were seen chatting to people while they were waiting for lunch, one staff member held a person's hand, the atmosphere was social and friendly.

Information on people's sensory needs were included in their care records. This information helped staff ensure people could be included in decisions about their care and support. People had communication care plans. For example one care plan recorded, "Speak to [named person] at eye level, clean their glasses, speak slowly and clearly." Staff described how they supported people with sensory loss to be involved in decisions about their care and support. One staff member told us, "[Named person] is blind although can see shapes; so we will always describe what we are doing, they recognise us by our voices." And, "[Named person] lip reads, we speak slowly and use hand gestures and will write things down." During the inspection we observed staff communicating with people using their preferred method of communication.

Staff were able to demonstrate a commitment to communicating with people in ways that met their needs and preferences. There was a person living at the service whose first language was not English. Staff had learned phrases in the person's own language to support good communication practices.

Staff were aware of the importance of maintaining people's dignity and privacy when supporting with personal care. They told us they made sure curtains were drawn and doors were shut and covered people with towels and always asked permission. People were not always clear about whether their preferences around personal care were met and care files did not always record when people had refused a bath or shower. One person said, "Not having bath or shower – they said something was wrong in the bathroom so I have strip washes for the last couple of months – I would like a shower." Another person told us, "I have a shower once a week my choice." A third person told us, "They watch me have a shower, it makes me feel safer, they wash my back and ask me if I am willing for them to do it, they let me do what I can within reason." The registered manager showed us a new personal care preference form that made it clearer if people were offered baths or showers in relation to their preferences.

Staff understood the importance of encouraging independence. One staff member told us, "If people can do things for themselves then we let them to do it; we will just prompt and encourage so they don't lose their abilities." A person told us, "The girls in particular to me are lovely they are always respectful and ask, "Do you want to wash yourself? and they let you do what you can for yourself."

As far as they were able, people were actively involved in making decisions about their care. Care plans were signed by the person or their representative. Relatives told us they were kept involved about all aspects of their relative's care. They said that they were able to visit the home at any time and always felt welcome. Regular resident's meetings had been held and consultation about food and activities took place to ensure that people received the care they wanted. Where people had difficulty communicating their needs or had no family members to represent them, advocacy services were in use. An advocate supports a person to have an independent voice and enables them to express their views.

Good

Is the service responsive?

Our findings

When people joined the service, their strengths and abilities were assessed and a care plan was designed to reflect their needs. People's care plans provided personalised information to support staff to provide person-centred care including information about family and the person's personality. For example, one care plan said, "[Named person] is fun loving." There was information about the person's social history and likes and preferences. People had sleep care plans in place, which detailed people's routines and preferences for sleep for example, what time people liked to go to bed and get up in the morning. This provided sufficient information to support person-centred care. For example, another person's care plan stated, "Likes room dark, door ajar, curtains closed, prefers to drink tea before retiring." People's preferences for male or female care staff were also recorded.

Staff were keen to provide people with person-centred care. One staff member said, "The residents come first, that is what I would like for me and my mum." Staff were able to give examples of taking a person-centred approach. One staff member said, "[Named person] likes a shower every day and their hair blow dried with a round brush." Another staff member said, "[Named person] likes their lipstick on and earrings in every day, and [named person] likes hospital corners on their bed, we do that with them."

The service employed a small team of staff that delivered activities and events to people.This included a lifestyle lead and two life style co-ordinators and meant they were able to provide a detailed activity programme for people covering the whole week. During our visit one of the lifestyle co-ordinators was based upstairs and another downstairs, this gave people a choice of various things to do throughout the day. Craft activities were being held downstairs while a variety of games were happening upstairs. Other activities in the programme included a visiting dance class, an under five pre-school had visited and animal therapy workshops. There were several trips out in the community, which included pub lunches, cafes, supermarket shopping, garden centres and farm visits. Other activities planned in the coming months include a re-enactment for WW2 where a garden tea party, an actual Spitfire plane and a Jeep would be shown. Church services were also held regularly at the service to support people with their religious observance.

People told us there was plenty to do at the service. One person said," The entertainers are very nice, there is enough to do, been to garden centre and Manningtree water front. I am very fortunate to have visitors and last week my daughter ordered the mini bus and the two of us went to a garden centre had lunch and wine together – it was nice." Another person told us, "We have singers, choirs, bands, entertainment is quite good, and we are making Easter bonnets. They are always going around with manicures. There are outings to garden centres and the seaside." We found that people using the service were very happy with the activity programme.

People also told us the service was responsive to their individual requests and people and their relatives were encouraged to decorate their own bedrooms with their own personal items. The bedrooms we looked at clearly reflected that these choices were being made. One person said, "Got my own crystal glasses, shelves, ornaments, cushions and lamp stand – the room is my own." Another person told us, "I am having my own table and chairs from outside brought but the man put a table and chairs outside my room so that I

could sit outside in the sunshine." A relative told us, "They moved the entertainers from a Tuesday to a Thursday as many of them go to the hairdressers on Tuesday and were missing out on the entertainer." Another relative said, "It is brilliant; we came for a visit with [family member]. They chose a room, but liked the furniture from another room, we met staff and chatted and had lunch and came back to look at the room and the furniture from the other room had been moved and [family member] chose to stay then – they have settled and [family member] loves it and calls it home." They added, "They told us bring whatever you like, brought the recliner from home, they put [family members] shelves up and their pictures on the walls"

The registered manager showed how the service was trying to expand its response to the variety of people that lived in the service. For example, they showed us the quiet room, which had recently been set up with tranquil music, sofa, soft lighting and decoration on the walls.

There was a clear complaints policy and procedure informing people how to complain. Any concerns raised were logged and investigated and the registered manager took appropriate action such as meeting with people and their families. We also noted that the service had also received compliments about the service.

People were supported when making decisions about their preferences for end of life care and their wishes were documented. Where appropriate a DNACPR was in place. A DNACPR is a way of recording the decision that a person will not be resuscitated in the event of a cardiac arrest. Records showed that when people's health needs changed and they became palliative the service worked with the local hospice to support people to be comfortable and pain free. Notes of one person who was end of life showed that the service had liaised with the GP and hospice and had obtained pressure relieving equipment and medication. The registered manager told us that they encouraged relatives to spend as much time as they wanted to with family members at end of life. They said, "One relative wanted to be with their [family member] and ended up staying for four weeks and used a vacant room, we will try to accommodate people wherever possible."

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found the provider and new registered manager had made improvements to address most of the concerns we had at previous inspections. They had taken action in relation to medicines management and increased staff provision at the service. However, not all staff felt listened to by the registered manager or deputy manager particularly around staffing. Staff understood that staffing was worked out by the provider's dependency levels but felt in one area, which was Caroline unit staffing on some days, did not seem enough.

When we asked staff if they had discussed their concerns about staffing with the provider or registered manager they told us they did not feel listened to or supported by the registered manager or deputy manager. Staff told us they were not always included by the management team as to how the service was run. One staff member told us, "The registered manager is not very approachable and other staff feel the same." Another staff member said, "We get lots of support from seniors or each other but the registered manager or deputy do not really help when we are pushed. Morale is quite low, they walk around but are more likely to tell you when you have done something wrong rather than what you might have done right." A third staff member said, "I would go to a senior but not to management; they're too busy; I feel moaned at so I won't go."

We found in other areas staff were more positive about the support they received and told us that team work was good. One staff member said, "We all help out each other if there is lots of work to do." Another staff member told us, "I have enjoyed every minute; staff work well as a team, we are a good team." A third staff member told us, "If I have any problems I can go to the manager; I feel listened to and supported; we have staff meetings and unit meetings; it's a nice atmosphere."

The registered manager and provider were clear about their roles and responsibilities and we saw evidence of robust oversight of the service at management and provider level. There were a range of audits and checks in place to monitor safety and quality of care. The registered manager explained an electronic system they used assisted them to have oversight of the operation of the service. This was also shared with the regional management team who provided an additional level of audit and quality assurance in order to identify shortfalls and ensure action was being taken to make improvements where needed. The provider's quality team included themed topics such as medicines, documentation, health and safety and activities that would form part of the registered manager's monthly audit with themes changing month by month. Quality and safety monitoring information collected over the month about people was reviewed by the registered manager and provider to analyse trends in areas like falls, infection rates and pressure areas. By identifying trends the management team planned action they would take to reduce the amount of incidents occurring and promote safer care and support.

The provider used managers from other services to work with and supervise the clinical staff. Additional training and updates were provided to ensure they were following best practice. We saw that wound care, venepuncture, catheterisation and syringe driver training was provided to qualified staff

People, relatives, staff and other stakeholders feedback was requested via an annual satisfaction survey. The provider had acknowledged within their PIR , that in the relative's survey the results in relation to the registered manager still required work in terms of visibility and communication. The registered manager had tried to respond to this by holding relatives surgeries more regularly. We did find people and relative feedback was mixed in terms of the management of the service and comments included, "Senior (ground) will stick up for you and they listen, we have good dialogue – it falls down on the top management"," [Registered managers] relationship with staff is not good, [registered manager] is quite stern and staff don't get a lot of thanks, [registered manager] has a lot to learn." Other comments about the management of the service were much more positive and included, "Manager and deputy are very approachable, they are terrific, staff are excellent", "[Named registered manager] is the 18 or 19 manager here, but they have improved the generation of information from the office to relatives."

As well as annual surveys, regular meetings were organised where people, relatives and staff were invited to give their opinions on the service. Minutes were taken at each meeting and an action plan generated. The action plan clearly identified who was responsible for the action and when it should be completed. One relative said, "I would recommend it – staff are friendly, kind and considerate to us, that activity staff member showed us pictures of mum dancing."

The policies and procedures we looked at were regularly reviewed and accessible for staff. This meant that guidance for staff was up to date and easy for them to use. The registered manager knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriate notifications from the service.

We discussed the concerns related to staff feedback with the registered manager who told us she had worked hard on improving systems and processes at the service, which meant time talking to staff out on the floor was limited. Following the feedback to the registered manager they told us they had thought about what staff had said and had ideas to spend more time with staff informally at the service and introduce some team building events and training to improve morale.