Care Quality Commission

Fellingate Care Centre Limited

Byker Hall Care Home

Inspection report

Allendale Road
Byker
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This was an unannounced inspection, we carried out on 22 January 2015.

This was the first inspection of Byker Hall since changed registered provider. It was registered on 27 February 2014.

Byker Hall provides nursing care and support for up to 48 older people, some of whom may be living with dementia. All bedrooms have an en-suite shower and toilet.

A registered manager is in place. '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 said they felt safe and they could speak to staff as they were approachable. Comments included; "I do feel safe living here." And; "I feel safe here, I'm a home bird." "A

Summary of findings

relative said; “My Mum is safe, we’ve never had any cause for concern.” We found there were enough staff on duty to provide individual care and support to people and to keep them safe.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People received their medicines in a safe and timely way.

The necessary checks were carried out to ensure the building was safe and fit for purpose.

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as falls, mobility, skin damage and nutrition.

Staff knew people’s care and support needs, but detailed care plans were not all in place to help staff provide care to people in the way they wanted. Information was available for people with regard to their individual preferences, likes and dislikes.

Communication was not always effective to ensure the well-being of people who used the service.

People said staff were kind and caring. Comments included; “The staff are very helpful, nothing is a trouble.” And; “Staff are very respectful, they talk to me and explain what they want to do, they will do anything for me.” Another person said; “I think the staff are lovely.”

Menus were varied and a choice was offered at each mealtime. Staff were sensitive when assisting people with their meals and the catering staff provided special diets which some people required.

Byker Hall was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training and had a good understanding of the Mental Capacity Act 2005 (MCA) and best interest decision making, when people were unable to make decisions themselves.

Staff were provided with training to give them some knowledge and insight into the specialist conditions of people in order to meet their care and support needs.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

Activities and entertainment were available for people.

People had the opportunity to give their views about the service. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided.

The registered manager was introducing changes to improve the quality of care and to ensure the service was well-led for the benefit of people who used the service.

We found one breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 in relation to records.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 told us they felt safe living at the service and family members also confirmed that their relative was safe.

People's medicines were managed appropriately.

There were enough staff to meet people's needs in a timely manner and there were systems to ensure that new staff were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Communication did not always ensure the necessary information was passed between staff to ensure people received appropriate health care.

Staff were supported to carry out their role and they received the training they needed.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

People told us that the food was good. People's nutritional needs were met and specialist diets were catered for.

Is the service caring?

Good

The service was caring. Relatives and people we spoke with were complimentary about the care and support provided by staff.

People's rights to privacy and dignity were respected and staff were patient as they provided support.

People were encouraged and supported to be involved in daily decision making.

People's preferences and choices were in place for their end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Regular staff were knowledgeable about people's needs and wishes. However, people did not always receive support in the way they needed because staff did not have detailed guidance about how to deliver their care.

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Summary of findings

Is the service well-led?

Good

The service was well-led. A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Byker Hall 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 22 January 2015 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received.

During the inspection we spoke with 17 people who lived at Byker Hall, seven relatives, the director of operations, the registered manager, the clinical lead nurse, six support workers, two visiting professionals, the activities organiser, a domestic and two members of catering staff. We observed care and support in communal areas and looked in the kitchen and four people's bedrooms.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for seven people, the recruitment, training and induction records for four staff, three people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We also contacted commissioners from the local authorities and health authorities who contracted people's care.

We spoke with the local safeguarding teams. We received information of concern from the health authority and saw the action that had been taken to address these concerns at the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "I do feel safe living here." And; "I feel safe here, I'm a home bird." "A relative said; "My Mum is safe, we've never had any cause for concern." Another person said; "I feel perfectly safe living here." And; "My room is nice and comfortable and I feel quite safe." And; "I feel safe, my call bell is answered quickly even by night staff who are always bringing me a cup of tea." Another person commented; "Staff are kind, they don't shout."

We found the provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found six concerns had been logged appropriately. Safeguarding informed us some of the alerts had been raised with regard to people receiving their care in a timely manner. These had been investigated and resolved.

Staff had an understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They told us, and records confirmed they had completed safeguarding training. Up-dated safeguarding training was to be carried out by the local authority in April 2015. This would inform staff of the multi-agency safeguarding procedures and the role of each agency when an alert was raised. Staff were able to tell us how they would respond to any allegations or incidents of abuse and were aware of the lines of reporting within the organisation. They told us they were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future.

People received their medicines in a safe way. People had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. We observed a medicines round and saw the worker remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Up-to-date policies and procedures were in place to support staff and to ensure medicines were managed in accordance with current guidance. General guidance was available with regard to "as required" medicines, however there was no specific written information for each person, who required such medicine. The nurse had a good understanding of when to offer "as required medicine." For example, they discreetly asked the care workers to inform them about a person's bowel movements, to check if the person required the prescribed "as required" laxative.

Risks to people's safety had been assessed by staff and records of these assessments had been made to minimise the risks. These assessments were for falls, swallowing, nutrition and the use of bedrails to keep people safe.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this as any trends and patterns that were identified, action was taken to reduce the likelihood of them recurring.

The director of operations told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of our inspection there were two nurses and six care workers on duty to care for 44 people. We were told this increased to seven care workers on some days. We had concerns staffing levels were not maintained consistently each day to meet the current level of need. The director of operations and registered manager confirmed they would review this.

We checked after the inspection to see the action that had been taken. We found seven care workers were on duty each day and this increased to eight on some days to assist with the running of the home whilst the occupancy level remained at 44 people. We were told staffing levels were altered depending upon occupancy levels and people's needs. The director of operations told us night care worker staffing levels had also been increased from three to four care workers. An additional three care workers had also been recruited to cover holiday and sickness in the home.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references, one of which was from the person's last employer, and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms

Good

Is the service safe?

included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

The registered provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Records we looked at included; maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety checks. Regular checks were carried out and contracts were in place to make sure the building was well maintained and equipment was safe and fit for purpose.

Requires Improvement

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included; "The opportunities for training are improving." A person who lived at the home commented; "The staff are good at what they do and know what they are doing." Some health professionals had commented, "There are some issues with the competencies of staff to carry out nursing tasks, for example; catheterisation and the use of syringe drivers." They did say the registered manager was "very receptive to any offers of training and the upskilling of staff." Other comments included; "Staff are very willing to learn and are keen to attend training." We checked the staff training matrix. We saw training with regard to these nursing tasks had taken place and more was planned for other staff members with regard to, catheterisation, venepuncture, which is the collection of blood from a vein, syringe driver and Percutaneous Endoscopic Gastrostomy (PEG) training. PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.

The staff training record showed staff were kept up-to-date with safe working practices. One staff member said; "It is important to me to make work safe and to keep my nursing status safe." The director of operations told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that gave them some knowledge and insight into people's needs and this included a range of courses such as; dementia care, palliative care, nutrition, distressed behaviour and equality and diversity. They had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Staff told us they were supported to carry out their caring role. One staff member said; "I feel well supported." Another said; "The manager is fine." Care workers said they had regular supervision every two months with the senior support worker and nurses received supervision every two months from the registered manager. Staff said they could approach the management team at any time to discuss any issues. They also said they received an annual appraisal to review their work performance. They said they felt well supported by colleagues and senior staff.

CQC monitors the operation of DoLS. DoLS are part of the MCA. These are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that a number of applications were being considered and three people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. For example, a best interest decision was in place, as required by the MCA, because a person no longer had the mental capacity to understand their health care needs.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. One person commented; "Staff ask my permission before doing anything with me." Other people confirmed they were asked for permission before receiving any care.

People were positive about the food saying they received good sized portions and nice food. One person commented; "I like the food, there's plenty to eat." And; "I can have something else if I don't like the meal." A relative said; "(Name) loves the food, I've never known her to tuck in so heartily." We saw the midday meal was well presented and hot. Everyone said they enjoyed the meal which was braised steak with vegetables or leek and potato pie, followed by rhubarb crumble and cream or ice cream. Drinks were available during the day with biscuits provided in the morning and cakes in the afternoon. One person commented; "When staff are passing my room they always ask if I need anything such as a coffee."

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. However records showed these were not actioned at the required intervals for all people. For example, a person who had problems with nutrition and had been referred to the speech and language assessment team, their nutritional assessment had advised a weekly weight check, however the weight checks had not

Is the service effective?

taken place within the required frequency for monitoring the person's weight. Another person's records also indicated they should be weighed weekly and this was not always happening. The registered manager confirmed they would check this with staff. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. Records showed milk shake snacks had been introduced for all people where there was weight loss and possible poor nutrition. Referrals were also made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause.

Information was given to the catering staff to ensure they were aware of people's specific dietary needs. We saw this information corresponded with people's nutritional care plans that identified requirements such as the need for a modified diet. One relative needed reassurance as their relative was receiving a pureed diet and they didn't know the nutritional content of the meal. We intervened and the chef spoke to the person and explained what they did to the meal and the relative was appreciative and reassured.

People were supported to maintain their healthcare needs. A visiting community nurse commented; "Communication is good. Staff will do what's needed for the patients, they're good at letting us know." People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as; physiotherapists, speech and language teams, tissue viability staff and occupational therapists. An end of life care plan for one person showed the involvement of the McMillan Nurse specialist team. People had regular access to the GP or district nurse when appropriate. A person commented; "I get painkillers as my legs get sore as I've arthritis." Records were kept of visits and any changes and advice was reflected in people's care plans.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so staff were aware of the current state of health and well-being of people. The nurses told us a handover of verbal and written information took place between the nurses for each shift.

We had concerns however with regard to the communication amongst staff as it was not always effective to help ensure people's care was not compromised.

We recommend that the service seek support and training, for the staff, about communication and team work.

It was difficult to see the continuity of care from day to night staff. For example, a relative we spoke with was very upset when she arrived. The information she had passed onto a member of night staff, the previous evening, had not been acted upon. We were told it had not been communicated, we saw the information had not been recorded in the communication book or person's care records, there was no evidence that the information and feedback from the hospital appointment had been logged for the information of staff. The director of operations and nurse liaised with the relative. We saw immediate action was taken with regard to the person's care. We were told an investigation would be carried out and changes made to ensure communication was more effective.

Care workers had also commented communication should be improved so they were kept up-to-date with the daily care and support requirements of people. For example, if people had hospital appointments, the care workers to be informed in reasonable time so they could make sure the person was ready for their appointment and transport. Some health care professionals also thought there may be issues with staff communication. For example, if a health professional asked for a follow up task to be completed staff communication may not have effectively communicated this to ensure the follow up task was carried out to ensure the person's health needs were effectively met. It was commented; "If there are any issues, once staff are informed by visiting professionals they are pro-active in ensuring it is done, but, they are often unaware that a particular task has to be completed." Therefore the advice and instructions left by health care professionals was not always communicated for staff to follow up, to ensure people's health care needs were met effectively.

The GP told us about the specialist care home support team which held a clinic one afternoon each week in the home. The team comprised of a GP, nurse consultant continence care, specialist nurses and pharmacist and a nurse from the home. Areas discussed included; emergency health care plans, do not attempt resuscitation decisions (DNAR) and laxative medicines. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. The registered

Requires Improvement

Is the service effective?

manager said this was a good service as people's health care was co-ordinated and any change in their medical condition could be reviewed swiftly. The service had also arranged for the GP linked to the home to attend a relative's meeting to discuss the aims of the project and the benefits to people who used the service.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were very positive about the care provided by staff. Comments included; "The staff are extremely pleasant." And; "The staff are very helpful, nothing is a trouble." A relative said; "We are perfectly happy with the care that is given." And; "Staff are very respectful, they talk to me and explain what they want to do, they will do anything for me." Another person said; "I think the staff are lovely and the care they give is good."

During the inspection there was a relaxed and calm atmosphere in the home. Staff interacted well with people, joking with them and spending time with them. One person commented; "I spend quite a bit of time in bed and the staff are great. They pop in to see me or say hello as they pass. I think they're lovely."

Staff engaged with people in a calm and quiet way. They were enthusiastic and made time to sit and talk to them. Staff were quick to respond when a person asked for assistance to go to the lavatory and this was done quietly and discreetly. Staff bent down as they talked to people so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. We saw as the nurse administered people's medicine, she explained and told them what the medicine was for.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. People who used the service were pleased with the care they received. They thought staff seemed knowledgeable about their care needs and family circumstances and knew how to look after them.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People's privacy and dignity was respected. Staff knocked on people's bedroom doors before they entered and could give us examples of how they respected people's dignity. One person said; "I love it here, I have my privacy, staff will knock on my door before they come in."

We saw the lunchtime meal was calm and relaxed. Some people came to the dining rooms for their meal and some people remained in their bedroom. Care workers were helpful and assisted people to eat or provided prompts of encouragement in a quiet and unhurried way. Staff chatted with people as they helped them and the atmosphere was calm and relaxed. People ate well and appeared to enjoy their food

Family members told us they were kept informed about any changes in their relative's condition. One relative commented; "They're good at letting me know if my Mother's not well."

A community nurse commented; "Staff will do what's needed for the patients. They're very good at letting us know." A visiting GP said; "The carers are brilliant, they really know the residents and relatives."

Records showed the relevant people were involved in decisions about a person's end of life care choices. For example, a person had an end of life care plan in place that showed it had been discussed with the person, his family and the GP. The care plan detailed the "do not attempt resuscitation" (DNAR) that was in place. The care plan was reviewed monthly and referred to the need to involve the specialist palliative care team if required.

Requires Improvement

Is the service responsive?

Our findings

People commented there were activities and entertainment. One person said; "I mostly opt out of activities as I prefer to watch my DVD's or television, but I do get my nails and hair done." Another said; "I go to church and staff take me." And; "I find this a lovely home."

We found records did not all accurately reflect people's care and support needs with guidance for staff to deliver care and support in the way the person wanted. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Records confirmed that pre-admission assessments were carried out before people moved into the home. Assessments were carried out to identify people's support needs and from these care plans were developed that outlined how these needs were to be met.

Up-to-date written information was not always available for staff to respond to people's changing needs. Records we looked at showed care plans were in place but they did not always reflect the current care and support needs of people. For example, a person's mobility care plan recorded the person was unable to walk due to a fractured femur and used a wheelchair. However, we saw the person walking, and found the care plan had not been updated to show the change in the person's need. A detailed care plan was not available that provided instructions for staff to help maintain the safety of the person when they went out independently, other than to make sure they had a mobile telephone. For example, information was not available to ensure the person was not restricted and instructions what to do if they did not return. The registered manager said this would be addressed.

Care plans were in place and provided some detail for staff to give care and support to people. For example, for personal hygiene, "(Name) can wash her hands and face herself but needs assistance with her back as she has arthritis." However, not all the care plans reviewed provided enough detail about the care and support needs and actions needed to ensure people received individual care and support tailored to their needs. This was discussed with the registered manager and we were told it would be addressed. Care workers were to be involved and contribute to all care plans, as they delivered the direct care to people and knew how people liked their care to be delivered.

Staff told us some people displayed distressed behaviour. For example, when they were being assisted with personal care. Records were not all in place for the management of this behaviour which could be challenging. Care plans did not give staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. As staff did not have a care plan that gave information about the interventions required they did not have written information to ensure they all worked in a consistent way with the person, to help reduce the anxiety and distressed behaviour.

Staff made daily notes about each person, however the daily notes were brief and information referred to the basic care delivered. Information was not always available with regard to interactions with people and their behaviour and mood in order to monitor their health and well-being. Therefore for people who may display distressed behaviour it wasn't always clear if the person was appropriately cared for and supported. People were referred to a behavioural support team if required for specialist advice and guidance. A nurse said she had discussed with a GP about the care of a person with distressed behaviour. Advice was given that staff were to monitor the behaviour with a view to referring the person to the behaviour team.

Relatives we spoke with said they had not been involved in review meetings to discuss their relative's care needs, they did say their relative's care was discussed on an on-going basis. People's care records did not show that regular reviews or meetings took place for people and their relatives to discuss people's care and to ensure their care and support needs were still being met. Relative's meeting minutes however, showed that the registered manager had informed people that review meetings would be taking place to discuss their relative's care and support.

People told us they were encouraged to make choices about their day to day lives. They said they were asked each day what they wanted to order for their meals and we saw at the lunch time meal they had the opportunity to change their mind. People also said they were able to decide for example; when to get up and go to bed, what to wear and what they might like to do. One person said; "I

Requires Improvement

Is the service responsive?

like a long lie, I get up at 11:00am and I'll have a cup of tea and a Weetabix." At lunchtime we saw the registered nurse offer a person the opportunity to be assisted to the dining room but the person chose to have their meal in their room.

We observed some staff were sitting talking to people asking what interests they had previously had during their lives. A lot of the people were able to talk about their life and were enjoying the discussion.

People confirmed they had a choice about getting involved in activities and a weekly activities plan advertised what was available. The activities person told us outings took place in the warmer weather and events and regular entertainment took place in the home. We saw a games session being held downstairs and quite a few people who occupied that floor took part. Each time there was a winner a verse of the person's favourite song was sung to the enjoyment of all. Other activities included; art and crafts, pampers sessions, church service, armchair exercises, reminiscence, bingo and a "ladies" club and "men's" club.

People said they knew how to complain. They commented; "It's fine here, I would not want to complain about anything." A relative commented; "In our view this is a good home, we visit twice a week, and we've never needed to complain." Another person said; "I've never needed to complain about anything." "We have never had any cause for concern." One relative said; "We attend resident/ relative's meetings and little things can be discussed there and sorted." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained. Two complaints had been received and investigated appropriately.

Good

Is the service well-led?

Our findings

A manager was in place who registered with the Care Quality Commission in February 2015. The registered provider had been pro-active in submitting statutory notifications to the Care Quality Commission, such as safeguarding applications, applications for Deprivation of Liberty Safeguards and serious injuries.

Staff said they felt well-supported. One person said, "I feel listened to most of the time." Another said; "The registered manager is approachable." And, "(Name) the manager is fine." And, "Communication is good we're kept informed." And, "The manager does listen to us. We have regular staff meetings." Another staff member said, "I love it here, if there's anything I don't know, I just ask."

The registered manager said she had introduced changes to the home to help its smooth running and to help ensure it was well-led for the benefit of people who used the service. She responded quickly to address any concerns and readily accepted any advice and guidance. Relatives and people who used the service said the registered manager was approachable. A person commented, "Manager is doing a fantastic job." Another said, "The manager is trying to build a team." A visiting professional commented, "They have difficulties with the staffing. The staffing is getting better. (Name) the operational manager and (name) the registered manager are a good support."

People told us there was a calm, friendly atmosphere in the home and this was reflected in the good interaction between people and staff.

Staff told us regular meetings took place and these included, weekly head of department meetings and general staff and nurses meetings. They were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed communication within the home, staff performance, accidents and incidents, people's care and record keeping. The registered manager said she included team building exercises in the general staff meetings in order to create a staff team as new staff were being appointed.

People told us that they felt their opinions mattered. Monthly meetings were held with residents and relatives. The registered manager, who had had been appointed in August 2014, used the meetings as a forum to re-assure people who used the service about her ideas for the running of the home and to inform about any changes to improve the well-being of people who lived there. She told us the meetings were well attended and she had introduced an educational element into the meetings. For example; end of life care, care planning and other issues were discussed and material was available for relatives to read. The registered manager said relatives' meetings also provided feedback from people who used the service and their relatives about the running of the home. They were also an opportunity to involve them. Meeting minutes showed comments from people included; "We're happy the way Dad has settled. He used to be in a wheelchair, now he is walking again." We saw suggestions that had been made by people had been listened to and acted upon. For example, food, menus, choice and presentation. Written menus were now available in dining rooms.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. Surveys had been completed by people who used the service in May 2014, there had been a 53% response from the 38 surveys distributed. Findings from the survey were positive and over 88% of the questions asked were rated as good or excellent. In areas where results had not been so positive action was taken to try and address the issues and we saw the topics were discussed at staff meetings. For example; communication, food and laundry.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on; documentation, medicines, staff training, medicines management, nutrition, skin integrity and falls and mobility. Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. The registered manager told us two monthly audits were carried out by the director of operations to check on the quality of care provided and to gather feedback from staff and people who used the service. Follow up records showed any identified action had been acted upon. A financial audit was carried out by a representative from head office. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

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 did not take formal enforcement action at this stage. 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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records did not all accurately reflect people's care and support needs.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.