St Philips Care Limited

Pine Trees Care Centre

Inspection report

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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

We inspected Pine Trees on 29 and 30 January 2018. The inspection was unannounced. At the last inspection, in July 2017, the service was rated 'Inadequate.' This was because we had some concerns that risk assessment procedures were not appropriately implemented. For example, there was a failure to assess and take suitable action to minimise risks; suitable action was not taken to assist people at risk of malnutrition, dehydration and diabetes; procedures were not appropriately followed when there had been an allegation of abuse; and there was not an effective system of audit and quality assurance. We were also not confident that management of the service was effective. Subsequently we took enforcement action and issued three warning notices. We also issued three statutory requirements because care records, including care plans, were not appropriately maintained and reviewed; the complaints procedure was not effective, and CQC was not always notified appropriately of matters, such as safeguarding concerns, as is required by law.

At this inspection we found there had been some improvements. However talking to people, their relatives, staff and external professionals, outcomes for people were still mixed. As a consequence we have issued four statutory requirements about person centred care, staff recruitment; induction, training and staff supervision, and support for people at meal times. Overall the service has been rated as 'Requires Improvement' as a reflection that although there have been improvements at the service there is still further work the registered provider needs to do to ensure the service is managed to a satisfactory standard where regulatory requirements are met.

Pine Trees is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Pine trees accommodates 35 people.

The service provides ground floor accommodation. Some bedrooms have en suite toilets and wash hand basins. There is a large lounge, and a sun lounge leading to a patio area with tables and chairs. The building was well maintained and decorated, with good quality furnishings.

The service had a registered manager. A manager is a person who has with the Care Quality Commission to manage the service. Like providers, they are 'persons'. 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. The registered manager was on long term sick leave, at the time of the inspection, but the registered provider had arranged for a general manager, to manage the service.

We had concerns about recruitment records and checks which had taken place regarding staff who had been appointed since the last inspection. For example, some staff employed did not have satisfactory references from previous employers.

We were concerned whether staff induction processes were effective in terms of providing staff new to the

care sector with effective training to learn their roles. Records of induction were not always fully completed and there was insufficient evidence to show staff who were new to the care industry had started the Care Certificate, which is an industry wide standard for new care staff.

Support people received at the meal times we observed was not always satisfactory or consistent with good practice. People's experiences of receiving a satisfactory level of support were variable and not always appropriate. People said they liked the food they received and were provided with a choice.

We received some positive reports about care staff and care practice. For example people said, "The staff are a good lot," and "I am happy enough here." Relatives said "(My relative) is happy here. (They) like the staff. I am happy." "The staff are very good. You can always approach them and they will help you." However, we continued to receive mixed reports about whether the care people received was appropriate and timely. Some people said they experienced delays in receiving help to get up, delays in staff responding to call bells, and staff did not provide them with appropriate support to go to bed at a time they wanted. Similarly personal care was not always provided at a suitable time.

Safeguarding processes were to a satisfactory standard. For example, the staff we spoke with knew what action to take if they suspected abuse was occurring. The majority of staff had also received satisfactory training. The registered provider had taken appropriate action when they felt people had been at risk of abuse. The service had been subject to a service wide safeguarding enquiry. The registered persons had fully co-operated with this. The local authority has judged satisfactory progress has been made and the safeguarding enquiry has been closed. The service had suitable whistle blowing procedures.

The service had suitable risk assessment processes in place. People had suitable risk assessments on their files. These were regularly reviewed.

Record keeping had improved. Each person had a care plan, and regular records were kept about their care. However we found some gaps in care records which the registered persons needed to address.

Suitable health and safety systems were in place. The service also had suitable equipment (for example to assist moving and handling). Suitable checks were completed and documented.

There were some concerns raised by people who use the service, their representatives and staff about staffing levels and staff responsiveness. We have recommended staffing levels need to be reviewed.

There were improvements about the operation of the medicines system. People received their medicines on time, suitable records were kept, and medicines were appropriately stored. There were still some concerns about the recording of the administration of creams, and the registered persons' needed to make further improvement in this area. Staff administering medicines had received suitable training.

The service was clean, and suitable infection control procedures were in place. People said the laundry system was effective and reliable.

People received appropriate support from medical professionals. Links with other agencies and professionals such as the district nurse team had improved.

The building was designed, decorated, furnished and maintained to a good standard. People said they were always warm enough.

The service had taken suitable steps to ensure people's legal rights were protected in line with the Mental Capacity Act 2005. Staff received training about this, but it was not clear whether this was effective in enabling staff to understand people's rights and staff responsibilities.

People were involved in making decisions about their day to day lives, and to some extent about care planning. Most of the time, we observed most staff working in a manner which was caring and kind.

Visiting hours at the service were flexible, and visitors said they always felt welcome.

All people had a care plan and these were regularly reviewed. Some staff still had not had time to read care plans and required training to use the electronic system. Care record keeping had improved since the last inspection although we highlighted gaps in recording of important information to enable staff to effectively deliver good care.

The service had a comprehensive activities programme. People enjoyed the activities available. The activities included entertainers visiting. External trips were organised. An activities co-ordinator was employed.

Improvements had been made to the operation of the complaints system. Complaints received had been recorded, and there was an outline of action taken. People and their relatives had more confidence in the operation of the system.

The service had a suitable approach to end of life care. Suitable records were kept. Some staff had received training about end of life care.

The registered provider had ensured the service received extensive support from national and regional management since the last inspection to bring about improvement to the service. This has resulted in noticeable improvements to some aspects of the service since the last inspection. However, this report has resulted in the service not meeting regulatory standards regarding staff recruitment, and staff induction, training and supervision. We also had significant concerns about the support people received, from staff, at mealtimes. We have also repeated ongoing concerns about the adequacy of staffing levels, care planning, staff responsiveness, recording of the administration of some medicines, and communication, at times between staff, and also between staff and external professionals. These matters were not detected, and/ or appropriate action taken, by the registered provider since the last inspection.

The registered manager has been on long term sick leave, but suitable interim management arrangements have been in place since that time. Staff recognised the general manager had a difficult job to make improvements at the service, but the staff and people's relatives, respected her and supported the changes she was making.

The manager and registered provider demonstrated a clear ethos, and have introduced new systems and procedures which have resulted in improvements, in some significant areas, to outcomes for the people who used 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 entirely safe.

Recruitment procedures were not robust. We were not assured all staff employed were safe and suitable to work with vulnerable adults

Concerns were expressed about staffing levels and staff responsiveness. This meant some people did not receive effective care on time.

The medicines system generally operated well, and people received their medicines on time. There were ongoing concerns about the recording of prescribed creams

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always receive suitable induction, training and supervision so they had the right skills and knowledge to do their jobs.

People did not always receive suitable support to eat and drink at mealtimes.

The building was designed, decorated, furnished and maintained to a good standard.

Is the service caring?

Requires Improvement

The service was not always caring.

People viewed care staff as mostly caring and supportive.

Care received was not always at a time when people wanted, and there were concerns about staff being able to respond, in a timely manner, to call bells.

Relatives said they could visit at any time and they always felt welcome.

Is the service responsive?

Requires Improvement

The service was not always caring.

People viewed care staff as mostly caring and supportive.

Care received was not always at a time when people wanted, and there were concerns about staff being able to respond, in a timely manner, to call bells.

Relatives said they could visit at any time and they always felt welcome.

Is the service well-led?

Requires Improvement

The service was not entirely well led.

There were suitable management arrangements in place. Managers and senior staff understood their roles and responsibilities.

Although there was a comprehensive system of quality assurance and audit, the systems in place had failed to detect and bring about improvement to the issues of concern raised in this report.

Management had a clear ethos, and new systems and procedures introduced showed some indication of bringing about improvement of outcomes for people who used the service.

Pine Trees Care Centre

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 checked 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 29 and 30 January 2018 and was unannounced. The inspection team consisted of three inspectors (two inspectors present on each day.) On the first day of the inspection, there was an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience of caring for a relative with dementia. A specialist advisor, who was a nurse, also attended the inspection on the second day of the inspection. The specialist nurse had experience of working with people with dementia. On the second day of the inspection there was also a pharmacist inspector to check the medicines at the service.

Before the inspection we reviewed information we kept about the service and previous inspection reports. This included notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we used a range of methods to help us make our judgements. This included talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking (reading people's care plans, and other records kept about them), carrying out a formal observation of care, and reviewed other records about how the service was managed.

We looked at a range of records including five care plans, records about the operation of the medicines system, 13 personnel files, and other records about the management of the service.

Before, during and after the inspection we communicated with three relatives of people who used the service. We also communicated with two external professionals including GP's and social workers. We also spoke with eight staff.

Some of the people at the service could only answer simple questions or were unable to speak with us due to their disabilities. However, we were able to speak, at length, with six people who used the service. We also completed several observations, including using the Short Observational Framework Inspection (SOFI) on the first day of the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

The manager said the service had a suitable recruitment procedure. The manager said she was more concerned about potential recruits values and did not think previous experience in care was essential.

We spoke to a staff member about the process of their recruitment. Staff told us they had been interviewed by the general manager, and were, "Asked a lot of questions," and, "They asked lots of really in depth questions." There were notes of people's interviews on staff files.

However records showed there was concern about recruitment practice. All staff files we inspected included a Disclosure and Barring Service (DBS) check. However, we were concerned about the recruitment of six of the staff who had been recruited since November 2017. Three of these staff had only one written reference, although one of these staff also had a verbal reference. One person had two references although records showed concerns about the person's previous employment, and there was not evidence the registered person had risk assessed the situation. There was no record this person had completed any shadow shifts, and the rota stated the person had completed a night shift. Another person, who had no previous paid care experience, and was at times working complete shifts. Concerns were also expressed in one of their references about their reliability and ability to work without supervision.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

In respect to staffing levels, the manager said she scheduled five care staff on duty in the morning from 8am until 2pm, four care staff from 2pm until 8pm, and three care assistants on waking night duty between 8pm and 8am. In addition to these staff, the manager worked during the day, Monday to Friday. There was a deputy manager. The service also employed cleaning, kitchen, administration, laundry and maintenance to help ensure the service ran effectively.

The manager said if staff were off sick she always ensured, where possible, bank or agency staff were employed, to avoid staff shortages. However, the manager said she was working towards minimising the use of agency staff by employing more staff who could be called upon in emergencies.

People and their relatives had mixed views about staffing levels. People told us they felt that staff always seemed busy and that there were not always enough staff available to fully cater for their needs, particularly when responding to call bells. We were told: "They are always short staffed, or they say they are. Sometimes I wait five minutes for them to help me but other times it is 20 minutes." Another person said "It depends on if they are busy or not. They don't come quickly if they are busy." A third person said, "When I press my call bell, they come in to me and turn off the alarm and made some excuse or other, and go again without asking me what I wanted. When they don't come back, I press the button again, but it's the same thing. It just goes round and round like that." However a relative told us: "Staffing levels seem to be good. There is always someone there when you need them."

Staff views were variable about staffing levels. We were told: "I would not say there is any problem with staffing levels. It is generally good to be honest. I do not mind doing 12 hour shifts. I am used to them now." Another member of staff said, "It is pretty good if you have a full complement of staff it runs quite well." However we were also told: "Down the bottom end most people are 'doubles' (needing support from two staff), and I think we could do with an extra set of hands. It can be quite stressful here. This is my third 12 hour shift of the week and I feel tired. Shorter shifts would mean you would be more focussed." Another member of staff confirmed this: "Residents down the 'bottom end' (zones 3 and 4), are really struggling to stand so it takes longer….in the morning it is absolutely hectic," and, "We start staff lunches in the middle of residents' lunches so it seems abit more stretched then." Someone who had worked at the service for a while told us: " For the level of care the residents need it is debatable whether 4-5 (staff) people are enough.; But it depends on who is on. I would be happier if there were 5 on all shifts. In the afternoon when it goes down to 3 and a senior, and there are meds (medication) rounds to complete it can get tight." Subsequently we remain concerned about staffing levels at the service and we recommend they are reviewed.

We recommend staffing levels are reviewed to ensure that people's needs are consistently met.

We observed staff safely using hoisting equipment; for example when moving people from wheelchairs to more comfortable seating. This was carried out according to best practice for example talking through with the person what staff were doing, and carrying out the manoeuvre slowly and carefully.

We were told people felt safe at the service. One person said, "I like it here and feel safe." Relatives said, "People are safe," and "Oh yes people are safe. They are doing their best." Staff told us, "There is nothing to be worried about as far as I can see," and, "Everything I see is done safety. The moving and handling, medicines administration, and the care are all safely done."

At the last inspection we were concerned that a matter of alleged abuse had not been investigated appropriately. Since the last inspection the service had made appropriate referrals to safeguarding when they had a concern about a person's welfare. No referrals had been made by other agencies about care at the service. At the last inspection the service has been subject to a systemic safeguarding process due to concerns raised about the care of several people who used the service. The process was closed as the local authority judged suitable actions had been taken about the issues raised.

The service had a satisfactory safeguarding adult's policy. All staff had received training in safeguarding adults. The manager said safeguarding processes were discussed with staff at team meetings. The staff we spoke with, demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and satisfactory action taken to ensure people were safe.

At the last inspection we were concerned risk assessment procedures were not appropriately implemented. We were concerned there was a failure to assess and take suitable action to minimise risks. This included risks of malnutrition, dehydration and diabetes management. Since the last inspection, the manager told us, each person now had suitable risk assessments in place. The manager informed us risk assessments were regularly reviewed for each person. Risk assessments we saw included preventing poor nutrition and hydration, skin integrity, falls and pressure sores. Health and safety risk assessments were completed for all areas of the building, as well as tasks which may present a risk.

The manager said people who lived at the service had capacity and consequently the service minimised restrictions as much as possible. This was evident at the inspection. We saw people walking around the building, spending time in their bedrooms and encouraged to make a range of choices such as what to

wear, what to eat and how to spend their time. The manager said staff supported people to maximise choice and independence.

At the last inspection we were concerned about record keeping at the service. People's care plans were not always up to date. Other records were often insufficient, hard to find, or incomplete. At this inspection, the process of transferring care records to an electronic system had been completed. Consequently all care records were stored electronically and accessible to all staff through either a lap top or a mobile device. Care records could also be printed off for people who used the service, their representatives or other professionals. Other records about the management of the service were stored with the administrator, or in the manager's office. Records we inspected were mostly satisfactory, although there were some ongoing issues with care records as outlined elsewhere in this report. All care staff had access to care records so they could be aware of people's needs, although some of the newer staff were still struggling to use the system. We were told there was ongoing training for these staff to learn the systems

The manager said there were formal handovers in the morning and in the evening. The manager said a 'Flash Meeting' occurred each day at 11am. At this meeting senior care staff, heads of cleaning, maintenance and catering got together for ten minutes to discuss any key issues, and take further action if necessary. Along with staff handovers, this process enabled staff to share information and concerns about the care of people. The service also had a communication book so any relevant information could be shared between staff.

The service had a whistleblowing policy so if staff had concerns they could report these without feeling they would be subject to subsequent unreasonable action for making valid criticisms of the service. Where concerns had been expressed about the service; for example if complaints had been made, or there have been safeguarding investigations; the registered persons had carried out, or co-operated fully with these.

Equipment owned or used by the provider, such as specialist chairs, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced, and repaired as necessary. A staff member told us, "There is enough equipment and it is well maintained and is always checked."

Health and safety checks on the premises and other equipment were carried out appropriately. The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as 'satisfactory'. Records showed manual handling equipment had been serviced. There was a risk assessment to minimise the risk of Legionnaires' disease, and systems were in place to take action to minimise the risks identified. There were smoke detectors and fire extinguishers throughout the building. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked. The service had a fire risk assessment.

The manager said when people had any behaviours which the service found challenging, these would be recorded in individuals' care plans. However, at present, none of the people exhibited such behaviours. Staff recorded all incidents that occurred and these were reviewed by senior staff.. The manager said the service would discuss any concerns about people's behaviour (for example as a consequence of dementia) with relevant professionals such as community psychiatric nurses.

At the previous inspection we had concerns about the operation of the medicines system. For example, about records kept regarding the administration of creams, the lack of written protocols for 'as required'

medicines, recording of refrigerator temperatures, and some aspects of staff training and competency assessment. We found that overall there were improvements in the operation of the medicines system. For example there was additional guidance available to help staff decide when it would be appropriate to give doses of 'as required' medicines, staff had received further training and competency checks, and improvements had been made to the way storage temperatures were monitored.

New systems for recording the use of creams or other external preparations were in place. Staff used an electronic device to record when these preparations were applied. There were separate paper records kept in people's rooms but these were not always completed. We checked the records for two people and found that there were gaps in the electronic records where it was not clear if staff had applied preparations, or whether they had not been needed or had been refused. One person's records showed the application of 'cream' but did not state which preparation was being used. It was not possible to be sure from these records whether care staff were applying external preparations appropriately and when needed. Staff completed daily and monthly audits; however these had not picked up any issues with the recording of creams and ointments, which showed that audit systems in place were not entirely effective. However, one relative told us that although in the past management of medicines and application of prescribed creams had in the past been poor, this had much improved. We were told: "In the past medication was a nightmare. There was a time when (my relative) returned from respite (a short stay) here, with their inhaler and it was evident that staff had not given them the inhaler four times a day. Now they are on the ball and I have no concerns with the medication or the cream which the carers apply for them."

The provider had a suitable policy regarding the operation of the medicines system based on current guidance such as issued by the Royal Pharmaceutical Society and NICE. Senior staff and the manager were responsible for the administration of medicines. These staff had received suitable training about the operation of the medicines' system. Medicines were given to people at the correct times. Suitable administration records were kept. There were no gaps on medicine administration records. At the time of the inspection nobody self-administered their own medicines. Suitable systems were in place for medicines which required additional security. The service had suitable systems in place to order medicines, ensure they were stored securely in locked, purpose built cabinets, and where necessary disposed of safely. The service had suitable procedures about the covert administration of medicines, but these currently were not required. People's behaviour was not controlled by excessive or inappropriate medicines. Some people did have some prescribed medicines to help them manage distress or confusion, (for example as a consequence of dementia or mental health issues) but these medicines were prescribed and reviewed by external medical professionals. When these were prescribed to be given 'as required', rather than at specific times, guidance was in place about when they should be given.

People had suitable links with their GP's, consultant psychiatric nurses and medical consultants who prescribed and reviewed people's medicines. Where necessary staff appropriately consulted with medical professionals to ensure types of medicines prescribed, and dosages, were helping people with their health needs. One of the senior staff, who administered medicines told us: "I would say the medicines system is well managed. We have been going through a process of improving the management. We work as a team now to take responsibility for it, so I would say there is an improvement."

The service had suitable arrangements in place to ensure the home was kept clean and hygienic. The service had suitable policies about infection control which reference to national guidance. Senior staff understood who they needed to contact if they needed advice or assistance with infection control issues. Suitable numbers of cleaning staff were employed and had clear routines to follow. Staff understood the need to wear protective clothing such as aprons and gloves, where this was necessary. A relative told us that in the past the person's bathroom was not always kept clean and the waste paper bin was not emptied frequently

enough. However recently there had been an improvement in the standard of cleanliness in the person's bedroom and the home was always found to be clean.

People said the laundry service was good. We were told, "They come into my room three times a day. My clothes are washed and ironed here, and they put them back in my wardrobe for me," and "They do my clothes nicely and there are always plenty of towels."

Catering staff were on duty from breakfast time until the evening. Suitable procedures were in place to ensure food preparation and storage met national guidance. The local authority environmental health department has judged standards to be satisfactory.

Senior staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us if they had concerns management would listen and take suitable action. The manager said if she had concerns about people's welfare she liaised with external professionals as necessary, and had submitted safeguarding referrals when she felt it was appropriate.

The service kept some monies on behalf of people for when people needed to purchase items such as for toiletries and hairdressing items. Some people's finances were handled solely by the person's representatives. Records of expenditure were kept, including receipts, where this was necessary. The registered persons did not act as appointee for any people who used the service, and staff did not have any access to people's financial accounts. We checked monies, kept by the manager, and records kept and these were maintained to a good standard.

Requires Improvement

Is the service effective?

Our findings

The manager said when staff started working at the service they received a full induction. The induction lasted three days. On the first day the new member of staff was required to complete all on-line training in fourteen subjects such as safeguarding, mental capacity act, dementia care and fire safety. An orientation checklist was also completed which outlined who was responsible for what in the organisation, issues relating to the building, basic care issues, staffing, health and safety and quality assurance. The member of staff also completed two shadow shifts. These were over two 'long' (double shift) days of 12 hours each. The manager said the induction could be longer. "If someone was not quite grasping," learning the tasks they needed to perform. After the shadow shifts were completed the person was paired with a senior care assistant who assessed if the person was competent to carry out their tasks.

The staff we spoke with said about their induction: "I had a few shifts shadowing (2 x 12 hour shifts), then I did the elearning." E learning is computer based learning. Another member of staff, who was new to care, said: "I am still getting used to it…I have not read the care plans yet. I am working as a 'second' (so was not working on their own) on 'double handed care'. "

The manager was aware of the Care Certificate, which is an identified set of national standards that health and social care workers should follow when starting work in care. The manager said staff were required to complete the organisation's on-line training as part of evidencing the member of staff had the knowledge to achieve the Care Certificate. The manager confirmed new staff were currently completing the Care Certificate. The process was said to last up to 6 months.

We inspected induction records for seven staff, six of whom had started working at the service since November 2017. Six of the seven staff files inspected contained an orientation checklist. One of the orientation checklists was only a third complete. Only three of the six staff who had started work since November 2017 had a record showing they had completed shadow shifts. There was no record on any files that any of the staff in the sample had commenced or completed the Care Certificate. The staff concerned had completed or commenced required on-line training.

We were concerned about the procedure of new staff having to complete fourteen modules of on-line training, within three days, when they first started to work at the service. We were concerned whether staff could realistically retain the required information, particularly if they had not worked in the care sector before.

We were concerned that we witnessed a member of staff, who was according to their file, on their second day at the service and being shadowed, being left in the dining room, at times alone with up to 13 people, without an experienced member of staff. This was despite the member of staff being additional to the basic rostered staff on the day. We witnessed the staff member speak inappropriately about a person. The staff member was left to support people although according to their file they had not had recent professional experience working with elderly people.

Some of the staff, for who we assessed their training, had not fully completed their training in first aid, and moving and handling. Although in most cases people had completed the theory training, there was no record that some of these staff had completed the practical training which is essential in both cases. According to records there were also gaps in the delivery of the practical element of fire training for new staff. Lack of full completion of fire training, moving and handling training and first aid training, for these staff, was particularly concerning as some of these staff were completing night shifts, where they may be required to deal with emergencies often unsupervised and without management support. Adding to this concern, some of these staff were also working with another member of staff for whom training was incomplete. One of the night staff had no record to verify whether they had received any training or not.

The service had a comprehensive training programme to assist staff to carry out their roles. The training staff were required to complete included: first aid, fire safety, infection control, moving and handling, first aid, safeguarding and dementia awareness. Staff also received training about diet and nutrition, health and safety, medication awareness, and equality and diversity. The majority of training which staff had to complete was on-line based. However, there were also 'practical' elements to training for moving and handling, first aid and fire safety. We raised concerns that a sample of staff we assessed had not received the practical element of this training. According to records, although the majority of staff had completed most of the E Learning, between a third and half of staff, had not completed practical elements of the required training.

The staff we spoke with confirmed they had received a lot of training. One member of staff commented, "We do E Learning. There is no hands on training. It seems very similar questions, not much variability." The member of staff said they had not had any specialist training about dementia although they had completed an E Learning course about this subject.

Staff told us they felt supported in their roles by colleagues and senior staff. There was always a senior member of staff on duty, except, at times, during the waking night period, who staff could approach if they needed help. Senior carers were also responsible for leading shifts and ensuring the effective day to day management of the service, particularly if the manager and deputy manager were absent from the service.

The manager said staff should receive supervision every month. Supervision is a process where members of staff sit down with a supervisor to discuss their performance, any goals for the future, and training and development needs. However, there were limited records of supervision. Although the staff records we inspected were for staff who had started work at the service from November 2017, there was no record that a senior member of staff, or supervisor had formally met with these staff to check how they were settling in to their roles, and provide any guidance. This may have happened informally, but there was no record. We inspected the record for a member of staff who had worked at the service for several years, and who we had been informed there had been some performance issues with. For this person, there was a record of four meetings between November 2015 and June 2017. We were also provided with a summary of a further four discussions which took place between May 2017 and October 2017. There were no other records. We inspected the records of five other established staff. Three staff had a record of three supervision sessions (most recently in October 2017). Another person had one record in November 2017 although this member of staff only started working at the service in the autumn. One night member of staff had no records of staff supervision, despite receiving a final written warning in November 2017. Finally one night carer had no records of supervision despite starting to work at the service in November 2017. We therefore judged the supervision system was not working effectively.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

However, staff we spoke with said they could approach senior staff for help and support if they had a problem. We spoke to staff about their experience of supervision. Staff told us, "I had supervision 3 or 4 months ago with the last manager. It was quite short and sweet. If we have any concerns the door is always open and we are free to discuss things with the manager," and "I have found it supportive."

The support we witnessed people receiving at meal times was mixed. We carried out four observations of meal times. On one occasion we observed one person receiving very good support from a member of staff. The member of staff sat with the person, helping them to eat a cooked breakfast. The member of staff provided gentle encouragement and support. Hand over hand guidance was provided, the person was offered lots of choice, and given time to eat at their own pace.

During lunch on the first day of the inspection our observations were generally positive. Staff provided timely support to people, and the meal was a pleasant occasion. People were not rushed. The choice of food looked good and smelt appetising and most people appeared to enjoy the dining experience. Staff spoke with people while they were providing assistance. The meal was unrushed. Where people required assistance with mobility, staff did so in a safe and gentle way. Staff used moving and handling equipment, such as handling belts, appropriately. Other people moved freely either with frames or with the assistance of staff. However although we did see some staff sitting with people to assist them, we also saw some staff standing while they provided support, when it would have been more relaxed if they had sat down when they were helping people.

We were concerned about the support which people received on other occasions. At breakfast time, on the first day of the inspection, we observed the support for one person who was helpfully supported to come to the dining room, and supported to order a cooked breakfast. When the food was served the person was not given any help to eat. After approximately 15 minutes, one of the cleaners reminded the person to eat their food, and cut the food up. The person slowly ate their breakfast but it was unclear if the person would have done this unless the cleaner had prompted them. None of the care staff, who had come into the room and then left, provided any support for the person. The person did not eat all their breakfast. The person sat in the dining room from 10:00 until 11:30 when the staff member asked them to go to the lounge. The person returned to the dining room at approximately 12:15, and did not eat much of their lunch. The staff seemed unaware the person had only recently had their breakfast, or the person might become hungry later.

We observed the lunchtime on the second day of the inspection. People were kept waiting for up to 20 minutes for their food to arrive, and sometimes when a neighbour, at the same table, had been served. The tables had not been wiped after breakfast, and no cutlery had been placed on the tables. As a consequence when people were brought their meal, they then waited again until staff brought them a knife and fork. Similarly salt and pepper was not always on the tables and this had to be requested by one person. One person was angry at the cutlery they were given. Although the member of staff tried to initially reassure them it was correct, the member of staff turned around and said "I will get you a trowel in a minute." When people's sweets were provided, they were not given a spoon, although this was again provided after a delay. One person, (who had previously required assistance to eat) was left with their sweet, and no spoon. Subsequently they lifted the bowl to their mouth, until the cook provided a spoon, and after a gap, a member of staff came to assist the person.

There was only one member of staff, who was constantly in the dining room during the meal time. Six staff were on the rota as working during this period. At some points there were up to 13 people in the dining room with this one staff member. Other staff came and went to assist people in their bedrooms, or carry out other tasks, but there was little obvious communication between the staff so they knew what help people required. As a consequence two people were helped, during a period of approximately one hour by up to

three different staff. Therefore, and due to gaps in the support of up to 20 minutes, people were being fed food which was not hot. On some occasions staff sat with the person they were assisting, but on other occasions they stood next to them. After the meal people were served tea in teacups but with no saucers. We have previously reported about this at other inspections. After the inspection, we were told that usually staff would have been able to provide people with more support, but this was limited on the day of inspection, as one of the inspectors was interviewing some of the staff members individually. There were however a total of six care staff, plus the manager, on duty.

On another occasion we did not think staff helped people to eat in a supportive manner. One person clearly could not feed themselves despite their care plan stating they could. This person was tipping a glass and using their finger so they could access their drink. This was despite there being staff in the room.

On another occasion we also witnessed a person trying to eat a bowl of Rice Krispies on their own but was unable to do so. There was a member of staff in the dining room, but the member of staff did not offer any help. This continued for about 10 minutes, and again the same member of cleaning staff, mentioned earlier, intervened to help the person. Later one of the care staff provided some assistance.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

We spoke to people about the food. People said they were given a choice and were provided with plenty of regular drinks. We were told, "The food is good," "Generally the food is very good, but today it was not very warm." However we were also told, "It is better now. It used to be always cold. If you do not like something they will give you something that you do like." Relatives said: "They will do (prepare different options) whatever people want."

The manager said the service's menu had just been reviewed by discussing people's likes and dislikes at the resident's meeting. The manager said people had three or four choices of meal at lunchtime and in the evening. At breakfast time people could have cereal and /or toast, eggs or a full cooked breakfast. In the evening people were offered sandwiches or a hot snack such as soup or eggs. Currently there were no people who used the service who had specific cultural or religious preferences about the food they ate. There were currently no vegetarian or vegans using the service.

Some people had special diets due to their health needs, and some of these people needed to have their fluid and food intake monitored. Some people needed help with eating and drinking as they were unable to feed themselves. In the past concerns had been raised by relatives, and other organisations, that some people were being missed out from receiving meals. The manager said she had resolved this matter by ensuring people who needed assistance, and people who had their meals in their bedrooms received their meals first. Meals were appropriately spaced and flexible to meet people's needs.

The service had suitable processes to holistically assess people's needs and choices. The manager said no new people had moved into the service recently. The manager said the assessment process followed would involve the manager going out to assess the person to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Completed assessments subsequently assisted staff to develop a care plan for the person, so care was delivered in line with current legislation, standards and guidance.

Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability

or age. The registered provider had an anti-discrimination policy which covered staff and people who used the service. A member of staff said, "I definitely believe people are treated fairly. There is no discrimination here."

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was limited. There was however a call bell system which people could use to alert staff in an emergency.

People said they could see a GP or other health professionals if they needed to. We witnessed one person say to the manager, "I feel terrible." The manager immediately offered to contact the GP, and said a cup of tea would be brought down to the person's bedroom. Some people said they saw a chiropodist every month, and opticians, dentists and district nurses all visited the service. In the past there had been some concerns about communication between district nurses and staff at the service. The manager said there was now a process where she met with the team leader of the district nurses on a monthly basis, to discuss people's care and also resolve any issues around communication. One of the staff described relationships with external professionals as: "Pretty good really. Recently we had a nurse who came in and did a demonstration about best practice in stoma care."

The manager said where appropriate referrals were made for additional support from external professionals such as occupational therapists, and speech and language therapists. Where staff had concerns about somebody's welfare the service had good links with professionals to ensure any changing needs were reassessed, and, for example, if necessary, hospital admissions were arranged for people where their needs could be better met. The manager said they felt referrals to external professionals were actioned in a timely manner, and there were no significant delays in people subsequently receiving support. One of the seniors said, "Whenever I have dealt with making referrals I would say they are pretty good at getting back to us in good time."

External doors, at the service, were locked for security reasons. People who lived at the service could either ask staff to open the front door, or alternatively were given the code to the key pad. People who were physically able, or had mobility aids, said they could move around the building as they wished. One person said, "I can go wherever I like if I want to. I have a frame and can go outside when the weather is ok." There was a decking area, where people could sit outside, particularly when the weather was pleasant, as well as lawned areas around the building. People could receive visitors either in their bedrooms, the dining room or the lounge. Activities took place in the lounge or an adjacent sun lounge. The building was very clean and well decorated. There was limited pictorial signage so this may be confusing for some people if they were unable to find their way around. The registered provider told us they aimed to make the building more dementia friendly in the future. People said they never felt cold at the service.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we were concerned there was insufficient information available for us to ascertain if

people had mental capacity, and what actions were being taken, if the service judged somebody lacked capacity. Some people had varying degrees of capacity, so if there were significant decisions needing to be made about people's health care needs these were made through the best interest process, and in liaison with the person's power of attorney (if the person had one).

The manager said all the people accommodated had capacity and subsequently none of the people who lived at the service had a pending or approved DoLS application. However the manager said it was possible that one person may need to be assessed due to their decreasing capacity. Each person had a mental capacity assessment on their file. No physical restraint was used at the service. The manager said staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and this was evident in training records we inspected. However, staff knowledge about the Mental Capacity Act, from discussions we had with some of them, was variable and it was not clear whether they had fully understood the training they had received.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were positive about the care they received from staff. People told us,: "The staff are a good lot," "I get on with all of them," "I am happy enough here." Relatives said, "(My relative) is happy here. (They) like the staff. I am happy," "The staff are very good. You can always approach them and they will help you." A member of staff said, "In the last couple of months things have got better. There are a lot of new staff last week and this week." Other staff told us, "I love all the residents here. They rely on me and trust me. I know their preferences which is nice," and, "I have no concerns about any of my colleagues practice. If I did I would report it. The care is really good. We have a plan each day so there is accountability for staff to provide care for people."

We received a very positive report from one relative who told us their relative, 'Would not be happy anywhere,' but since they had moved to the service they were now getting dressed in the morning and joining in with activities, all of which they would have previously not done. The person seemed to enjoy life much more since living at the service, and was 'a completely different person.'

We did receive some information of concern about some staff. Two people said that although staff were generally kind and caring, one person said, "Some of the younger ones are not so good, they do not dry me properly and I feel really damp afterwards when they dress me. If they are busy…they say 'couple of minutes' but that ends up being a couple of hours sometimes." One person also said, "Some of them are very rough."

We were concerned about one incident which occurred on the second day of the inspection. We went to see one personat lunchtime in their bedroom. It was clear they had been incontinent of faeces. A staff member was informed the person needed to be changed. The matter was also discussed with the manager. We were concerned that staff may not have assisted the person, the person had eaten their lunch and staff had collected crockery without providing the person with suitable personal care. Records showed the person had not been changed since breakfast time. The manager said the person had been checked, and as necessary changed, although there was no record of this. One of the care staff involved informed us they did not know how to use the recording system.

There were mixed views whether people could get up and go to bed when they wished. Some people said they could, but others said there could be delays and they had to wait too long. For example, one person said "I usually get up at 6am because the night staff go at 8am. I can wait until the day staff start work, but I'd have to wait a while (for them to then assist the person.) I can choose when I go to bed." Another person said "They start to get me to bed in the middle of the afternoon, there is no choice when you (I) go to bed. I would prefer to go to bed 7-8pm." We were also concerned about the comments of another person who told us there were sometimes significant delays in staff helping them to get up and ready for the day. We were told that the person would "Wait until they (staff) tell me to get up," and, "I have been known to still be in my nightie at lunch time because nobody comes. I ring my bell and they don't bother." The person was asked if staff came and checked on them to which we were told, "Occasionally, but not very often. To tell you the truth it is lonely here. I get brought food, help to get dressed and really that is all." Another person, who said

they liked to get up at 5am, said "They don't get me up until 9am sometimes." We were also told, "You have to do what they want you to do. I ask to have a shower and a wet shave in the morning, but like today, they told me that I can't have one until this afternoon; I prefer to be shaved in the morning." We spoke to this person on the first day of the inspection, after lunch, and they were still waiting for their shave and a shower. When staff could assist the person to have a shower, they were just about to participate in the afternoon's activities, so they were unable to participate in this.

People told us call bells were kept accessible to them either when they sat in armchairs or when they were in bed. We received mixed views about whether staff responded appropriately to call bells. We observed the staff response to one person. The person rang the call bell and staff responded to the alarm within one minute. However, we did receive some negative reports from people about call bell responses. One person said that frequently they had to wait 20 minutes before they received support. The matter had been taken up and discussed with staff. On one recent occasion the matter was discussed with one of the senior staff. When 30 minutes later no support had been given, the senior was approached again, and ended up doing the task themselves. We have also raised concerns in other reports about staff responsiveness.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

We spoke to one relative, who had previously raised concerns about the service. The person said, "I really think it is getting better. There is a massive improvement, much more structure." We were also told: "The care staff changes have led to a massive improvement. (My relative) seems to be looked after better."

When people came to live at the service, the manager found out about the person's history as part of the assessment process. Relatives were also requested to fill out a life history questionnaire. This way staff could have information about people's lives before they lived at the service.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. A member of staff said, "People definitely get choices." Where possible staff involved people in care planning and review. Consultation also occurred with people's representatives such as their relatives about their care plans. People and their relatives were provided with information about external bodies (such as the local authority) community organisations and advocacy services in the service user guide, which was issued when people moved to the service. The service had 'resident's meetings' where there was discussions about the menu, activities and people invited to give their views about the service.We saw minutes of these meetings.

We spoke to a health professional about care at the service. We were told they thought the service was "Not great, but better than they were." We were told health professionals had ongoing concerns about the dependence of people living at the service, and also the ongoing need for district nurse services to have to visit the service at a high frequency. We were told that "Staff care about the residents, and there are no signs of neglect." We were told that some GP's had ongoing, and current concerns about being called to the service inappropriately, but also not being called to the service when they should be. There were also ongoing and current difficulties with health professionals visiting the service, but staff not knowing why they had been called. The health professional said these concerns were much greater with this service compared to other care homes in the area.

We observed staff making sure people's privacy and dignity needs were understood and respected. Most of the time we saw staff mixing with people appropriately in a caring and kind manner. Where people needed physical and intimate care, for example if somebody needed to change their clothes, help was provided in a discreet and dignified manner. When people were provided with help in their bedrooms or the bathroom

this assistance was always provided behind closed doors. When people were experiencing discomfort or emotional distress we observed staff providing suitable support to comfort people.

The relatives we spoke with said they could visit the service at any time. Visitors said they always felt welcome and were offered a drink. Relatives said staff always answered any questions they had. Visitors said they felt managers were helpful if they had any queries or concerns.

Requires Improvement

Is the service responsive?

Our findings

Everyone who used the service had a care plan. The manager said where possible people, and their representatives, were consulted about people's care plans and their review. One person said, "If there is any changes, and if I agree to it, they'll do it. My daughter is always involved in it." Other people said they or their families had not been involved. Care plans were detailed and included information about people's physical and mental health care needs and at least some basic information about their lives before living at the service. Care plans also included risk assessments for example in relation to people's mobility, and any risks in relation to eating and drinking. Care plans outlined people's preferences and interests.

We were concerned that some essential care tasks, were not recorded on the electronic system as completed. For example, two inspectors found no record of some creams being applied.

All staff were able to access people's care plans which were stored electronically, and accessible to staff through laptops and mobile devices, although some staff told us they had not yet learned to use the system. A staff member told us, "I can read all about the person. Important information is highlighted." Another member of staff said using the electronic care planning system was,: "Really hard at first, but I am getting used to it and now it is really easy and helpful." Relatives said they were involved in care planning. We were told: " They include me in everything. They will invite me to take part."

Record keeping about people's care had improved since the last inspection, particularly due to the implementation of the electronic record keeping system. However, we did find some gaps in recording such as where food and fluid intake was meant to be recorded, weight checks (where the person's care plan had stated this was important), repositioning and turning. In regard to fluid intake, it was unclear for one person, who was at risk of urinary tract infections, what were the recommended amounts of fluids they were meant to consume. The actual amount of liquid recorded that the person drank appeared low. We had some concerns about diabetes care. For example senior staff had to sign for insulin, administered on behalf of district nurses, as district nurses would not sign for this. In respect of when people are repositioned in their beds or chairs records were not sufficiently detailed due to how the electronic recording system was configured. Where referrals had been made to GP's and other professionals, these were not always recorded in an accessible manner, for example, in the person's care plan.

A relative told us they were concerned there was sometimes, "Not much joined up thinking," about people's care needs. Their relative had been asked to "Sit up," and the staff member concerned was not aware of the person's need to have a hoist and could not sit up on their own. The person had to give the member of staff instructions how to provide their care as it was clear they did not know what the person's needs were.

An activity organiser was employed. The activity organiser provided activities between Monday to Friday, in the morning until mid-afternoon. Activities available included arts and crafts, quizzes, bingo, baking and reminiscence. Some external activities providers were used. For external entertainers including singers and musicians. Some external activities were currently regularly organised and the service had a minibus which was used for some excursions to local places of interest such as to the beach, garden centre or the

supermarket. The manager said the activities organiser was also researching new activities so there could be more variety on offer for people. During previous inspections most activities took place in the lounge. The manager said this had now changed and staff were trying to use the adjacent sun lounge more. This was very positive, as it enabled people to watch TV, or rest, in the main lounge, and people to be more engaged in the organised activities by this taking place in a dedicated space. Everyone we spoke with was positive about the activities on offer. One person said, "(The activities co-ordinator), comes into my room and paints my nails for me, he reads me poems, and does quizzes with me. He feeds me sometimes too. He is very nice."

We observed people on the second day of the inspection had a theatre group come to perform. People were clearly enjoying the show and were laughing at the performance. One person was having a glass of wine. Afterwards staff brought in the tea trolley and the entertainer stayed for a while to talk with people. People we spoke with said they "really enjoyed" the show.

Some of the people at the service had limited skills understanding correspondence due to their dementia. When people received correspondence staff would read this to people. We did not see any documentation in pictorial, audio or easy read formats. One member of staff said, "We will sit with residents and discuss any correspondence and paperwork, (or if they do not understand) with their families."

At the last inspection we were concerned about the effectiveness of the complaints procedure. The manager of the service told us there had been improvements about the recording of any complaints received. We were told the complaints procedure was issued to people, and their relatives, when they moved into the service, as part of the service's service user guide. People and their relatives, who we spoke with, said if they had any concerns or complaints, they felt they could discuss these with staff and managers. They felt any concerns and complaints would be responded to appropriately. The service had a system to record complaints made. Complaints had been recorded with a record of any actions taken by the service's management to resolve matters raised. People's relatives, said they did not think they would be subject to discrimination, harassment or disadvantage if they made a complaint. The manager said if a complaint was made, the management team would assess the complaint and its findings and use the experience as an opportunity to learn from what had occurred. People, and their relatives, who we spoke with said senior staff and the manager did respond appropriately to any concerns or complaints raised, but one relative said, "It is always followed up but (things) always slip back."

People were supported at the end of their lives to have a comfortable, dignified and pain free death. A staff member told us, "We ensure people are comfortable and respect their wishes. We try and make their surroundings nice. Fluids will be encouraged." Where appropriate people had an end of life care plan which outlined their preferences and choices for their end of life care. The service consulted with, where appropriate, the person and their representatives about the development and review of this care plan. Some staff had received training about end of life care, and the manager said more staff would receive this training. The manager said there were good links with GP's to ensure people received suitable medical care during this period of their lives.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had made a substantial investment of management time to bring change to the service since the last inspection. This involved intensive support from the organisation's regional and national management. Significant processes of regular audit had been introduced. The report demonstrates there are improvements to the service in many areas. However there is still additional work to be completed for the service to meet regulatory standards. This inspection has concerns with recruitment procedures; staff induction, training and supervision; some concerns that care was not always delivered in a person centred way, and people were not always provided with appropriate support for people with eating and drinking. The report has also highlighted again ongoing concerns about staffing levels, staff responsiveness, care planning and care record keeping, recording of some medicines, and internal and external communication. Internal quality assurance systems have not picked up many of these issues, and senior staff and the registered provider were surprised by some of our findings which had not been previously identified

The registered manager is currently on long term sick leave. A general manager worked full time at the service to cover the post. The general manager had only worked at the service since the autumn. The general manager said she was clear what changes had been required as they were outlined in the last inspection report. She outlined what changes she, along with the rest of the management team, had made since the last inspection. The manager said she had improved the complaints procedure; ensured the staff had more direction and leadership; ensured senior carers had more responsibility and accountability in line with their job role; ensured improvements around people's care and ensured the manager was more 'visual' around the service.

Members of staff said about the manager, "She is okay," "She has come in and is trying to turn things around," " She has a job to do to turn this place around and we need to support her," "I think she is a really good manager. I think she is brilliant at her job. If she sees something she is not happy with she will address it straight away. Some staff do not like that but I think she is really good," "She is willing to listen and to try things" and "There was a clique of staff, who were very unfriendly, and who wanted to keep things the way things were. We have a lot of new staff to make the place better." Relatives said, "I can only speak highly. She has always responded well, and tried to sort it out when I have raised an issue," " She always has time to speak to you," and, "The general day to day things seem to be much better." We were also told that the manager was, "Very proactive and approachable. She leads by example. She is a nice lady."

The manager said that her vision was of a 'Rainbow of Success,' (for example ensuring care was more person centred and people could have fun in their latter years; ensuring staff developed, had more training and were more accountable in the roles they held; ensuring staff were, where necessary, more productive; and the service could learn positively from other high performing services. The manager said she had discussed this vision with staff at team meetings, and was working with the staff group to implement it. For example, by sub groups of staff taking more responsibility for groups of people in their care. The manager recognised that cultural change was a difficult process, but was keeping her 'ear to the ground', having regular staff meetings to discuss practice and changes, and had been involved in recruiting new senior staff to assist her

in implementing the changes she wanted to make. She also said new staff had been recruited with "The right values." The manager said, from her perspective, "Staff seem to be going with me." One member of staff said, "I think the management of the service has improved a lot. There is more structure, checks are being done regularly, medication is better. Staff have a more positive attitude."

Many of the staff we spoke with were positive about the culture at the service, and about the changes that were taking place. We were told, "It is about the people out there," "It is a nice atmosphere here, there are lots going on with activities and people are happy on the whole. We have a good laugh together" and "Once everything has settled down it will have changed for the better." We were also told, "I think communication between staff and management has got much better. We have been doing 'flash meetings'. This is when everyone from the team will get together and run through how the day is going and check how the residents are." We were also told an employee of the month scheme had recently been introduced to encourage and recognise exemplary staff practice.

A relative told us, "Since the autumn and (the manager) has come on board there has been a general change in ethos. Now they respond and address things," and "I used to come at unusual times to check but I don't need to do that anymore. There are some lovely staff here."

The service had a clear management structure. In the absence of registered manager, the general manager reported to a regional manager who reported to the organisation's head of care. The regional manager, and the head of care had been actively involved in managing the service since the last inspection for example through regularly visiting the service. A deputy manager reported to the general manager. The deputy manager assisted the manager with the day to day running of the service. The deputy manager worked one day as a care shift, and three days to carry out management tasks. Senior care assistants led each shift, although there was not always a senior care assistant on duty at night. A senior took responsibility for the management of the medicines system on each shift.

The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was displayed. The manager said issues relating to previous inspections had been communicated to staff. The manager said staff had a clear understanding of their roles and responsibilities. There were policies in relation to grievance and disciplinary processes.

The manager said both paper and electronic data was stored securely, and there were systems in place to ensure data security breaches were minimised. However there were sometimes not enough laptops to assist staff. For example, one of the staff had brought in their own laptop, due to the shortage, even though this raised data protection issues.

The provider had a quality assurance policy. The service's approach to quality assurance included completion of an annual survey. The results of the most recent survey had been positive.

Regular residents' and staff meetings occurred. We saw copies of three residents' meetings which all taken place since October 2017. We also saw copies of staff meeting minutes, six of which had occurred since August 2017.

There was also a system of audits to ensure quality in all areas of the service was checked, maintained, and where necessary improved. Four organisational audit systems were in place: a daily audit of care; a monthly audit covering all aspects of the service; an audit completed by the regional manager, and an estate audit of the building. Action plans were in place if these audits raised any concerns. Within the service there were

audit systems in place for medicines, infection control, care planning and activities.

We saw several documents to verify the systems discussed such as copies of the manager's daily audit, an undated 'Estates' Audit', the regional manager's most recent audit in December 2017, and recent internal audits about medicines, infection control, meals and nutrition, and documentation. The last audits in these areas all took place in January 2018.

The service had a system where one person was deemed 'Resident of the Day." Issues about the designated person were reviewed; such as their records, activities undertaken, their medicines, their room checked, tidied and cleaned. The cook also met with the person to discuss food provided. Records for this process were kept, although these were not always completed in full for example in the case of one person the sections for review of food, and the person's bedroom had not been completed.

The manager said relationships with other agencies were positive. Where appropriate the manager said he ensured suitable information, for example about safeguarding matters, was shared with relevant agencies. One of the senior staff told us, "The relationship with all the outside groups is now a lot better and we are getting much more support."

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care. For example people raised concerns with us about support received to get up in the morning and to go to bed. We also received concerns about staff responsiveness to call bells.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive appropriate support to eat and drink at meal times

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records demonstrated that recruitment checks were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing According to records, staff did not always receive suitable induction, training and supervision so they had the right skills and knowledge to do their jobs.