Springdene Nursing And Care Homes Limited

Spring Lane

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 22 March 2016. The inspection was unannounced. Spring Lane is a care home registered for a maximum of 63 adults. At the time of our inspection there were 57 people living at the service.

The service is located in a large purpose built building. We previously inspected the service on 20 February 2014 and the service was found to be meeting the regulations inspected.

Spring Lane had a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a warm and friendly atmosphere at the service. The staff we met were caring and kind and treated people with dignity and respect. People using the service informed us that they felt safe at the home and the staff in general were kind and patient.

Care records were not always easy to read because of handwriting or to navigate through due to the system for collating the information. Although care plans were up to date they were not always person centred.

People living at the service had good access to healthcare and relatives told us they were kept fully informed if there were any changes in people's health conditions.

People living at the service were relatively happy with the food. We were told by people living there and their relatives it had improved recently. We saw there was a plentiful and varied range of food available. People's cultural and religious needs were facilitated by staff.

We looked at the administration of medicines. Medicines were stored safely and controlled drugs were safely administered and recorded. There were some issues with the recording of 'as needed' medicines. We also noted medicines for one person were being crushed without the necessary paperwork fully in place. This was rectified by the manager following the inspection.

Staff had been carefully recruited. Staff felt supported and there was evidence of regular supervision taking place in the last 12 months. Staff knew how to recognise and report any concerns or allegations of abuse and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

There was documentation relating to complaints and incidents in place, and people's money was well managed.

There was a wide range of activities at the service with good community links. The two activity co-ordinators had devised differing plans to cater for the broad range of needs in terms of people's cognitive abilities and preferences.

The registered manager carried out audits in some key areas but in other areas there was a lack of records to confirm actions the registered manager told us he had taken. The registered manager had a visible presence within the home, and was thought well of by the people living at the service and their relatives. Whilst staff meetings with senior care workers took place regularly, there was less evidence of meetings with the majority of care staff in the last 12 months.

The service was located in an accessible building on five floors with a lift to each floor. Communal bathrooms had accessible bathing equipment. There was a garden at the rear of the premises for use by people living at the service.

We found the building was clean and tidy, although there were some issues with monitoring infection control in some areas. We have made a recommendation in relation to this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were issues related to infection control in some areas.

One person had been receiving medicines in a crushed form without authorisation from a medical practitioner.

People using the service told us they felt safe and staff understood safeguarding and what to do if they had any concerns regarding a person's safety.

Effective recruitment practices were in place.

Is the service effective?

Good

The service was effective. Staff were trained in key areas to enable them to provide care.

Staff were supervised on a regular basis.

People's health needs were met by the service.

Is the service caring?

Good

The service was caring. People living at the service and their relatives told us the majority of staff were caring, patient and kind.

The Namaste massage programme had been introduced this year and the service were developing memory boxes to aid reminiscence work.

People's religious and cultural needs were met by the service.

Is the service responsive?

Good

The service was responsive. There was a wide range of activities at the service and the co-ordinators had different programmes to meet the needs of people with varying degrees of cognitive ability and preference.

Complaints were dealt with promptly and appropriately

Is the service well-led?

Requires Improvement

The service was not always well led. There were not robust quality assurance processes in place to follow through on actions from medicines audits.

Care staff were not routinely being involved in the running of the home.

The registered manager was considered approachable by people living at the service and their relatives.

Spring Lane

Detailed findings

Background to this inspection

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

The inspection took place on 22 March 2016 and was unannounced. It was undertaken by two inspectors for adult social care, a specialist advisor with nursing experience and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included information provided by the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with eight people who lived at the service, eight members of staff including the registered manager, the area manager and a member of the kitchen staff. We also spoke with a health and social care professional who regularly worked with the service. After the inspection we spoke with four relatives.

We also looked at fourteen care records related to people's individual care needs, three staff recruitment files including supervision and staff training records. We look at the records associated with the management of medicines.

We reviewed documentation related to essential services and documents relating to the management of money.

As part of the inspection we observed the interactions between people and staff and discussed people's care needs with staff. We also looked around the premises including the garden area.

Requires Improvement

Is the service safe?

Our findings

People were unanimous in feeling safe. They told us "I feel very safe". "I am well looked after" and "My family are happy that I'm here as I wasn't safe at home. I kept falling." The majority of people felt their possessions were secure at the premises. One person told us they had experienced a theft which had been investigated. Everyone had the facility to lock away valuables.

We discussed the processes involved in safeguarding vulnerable adults with the registered manager and three members of staff. The staff explained how they ensured the safety of people living in the home. They were all clear about whom they would report any concerns to and were confident that any allegations would be appropriately reported and fully investigated by the registered manager. We asked staff what they would do if they felt management did not support them. All understood their duty of care and were aware of the provider's policy on whistle blowing.

We noted that the provider had initiated seven safeguarding alerts in the past year. Records showed us the provider had co-operated with partner agencies including the local authority and acted appropriately to ensure the safety of people who used the service.

We assessed how the provider recruited staff and looked at the electronic recruitment records for three members of staff. The recruitment process included a written application form and attending a face to face interview to ensure the potential staff were suitable to work with vulnerable people. We found all appropriate checks had been completed before any new member of staff commenced work. This information was recorded and held electronically at the provider's head office. Further checks included written references and a Disclosure and Barring Service criminal checks. This meant staff were considered safe to work with people who used the service.

Following an accident or an incident, a form was completed. All forms were seen by the registered manager and referrals were made as appropriate, for example to the falls team. The registered manager carried out audits of the records on a regular basis in order to identify any emerging themes or patterns. In one example a person had fallen whist attempting to pick something up from the floor. A risk assessment had been completed and a subsequent action plan developed. This involved the purchase of a "helping hand" so the person would not have to bend down to retrieve items they may have dropped. We were aware that the registered manager was the only person completing the forms. We discussed this with the registered manager who undertook to ensure all staff were aware they should complete forms at the time of any incident being reported.

We saw premises and equipment were appropriately maintained to keep people safe. We saw regular checks and audits had been completed in relation to fire, essential servicing of gas, electricity, water and equipment. Fire safety equipment and other health and safety checks had been completed.

We looked at how the service ensured there were sufficient numbers of suitable staff to meet people's needs and keep them safe. There were divergent views as to the level of staffing between the staff and some

people living at the service and their relatives.

We asked people living at the service if they thought there was enough staff. People had a range of views. We were told "Yes there is enough staff." "It's tight after 5.00pm." and "As care goes, mornings are a problem with everyone needing help to get up. Their needs are greater than mine." Two relatives told us in their view there was some pressure on staffing. One noted that there appeared to be less staff at the weekends, but this was not born out by the rota as there were the same level of care staff on at the weekend as during the week. Another relative expressed concern that the level of staff support available meant their family member was not always being mobilised to walk daily. We discussed this with the registered manager who undertook to check that people who had been identified as needing assistance mobilising by the physiotherapist were getting this input on a regular basis.

During the inspection, we saw staff responded promptly to people's needs on all units visited. However, we noted during the inspection staff seemed stretched during lunchtime on the floor which accommodated people with the highest dependencies. For example, on the day of the inspection only four out of nine people could eat independently, and there was three staff providing support during lunch. This meant staff had to move between tables and people sitting on the sofa and lounge chair to support people to eat at regular intervals throughout the meal time. This meant people were waiting whilst another person was being attended to. We discussed this with the manager who told us that he was able to move staff from other areas of the service to assist with lunchtime support for people with the highest dependency levels. The registered manager told us he continually reviewed the level of staff based on people's level of dependency. We spoke with four staff with regard to staff numbers and all stated in their view there was always enough on duty to meet the needs of people who used the service.

At the time of the inspection we were aware there were seven vacancies for care staff. The registered manager told us cover was being provided through a mixture of agency and bank staff with permanent staff also working overtime.

From looking at records and from discussions with staff we found the service had good links with other health care professionals to make sure people received prompt, co-ordinated and effective care. There were processes in place to ensure relevant and appropriate information was shared
with other providers when people were admitted, transferred or discharged to another service.

We noted people had a personal emergency evacuation plan, which set out the assistance they would need in the event of an urgent evacuation of the building. These were kept in each person's care plan so they could be readily accessed in the event of an emergency.

As part of the inspection we looked at the management of medicines. We found medicines were stored appropriately within locked trolleys that were kept in a room behind the lounge. This area had a wall thermometer that showed a record of temperatures taken. This was seen to be within the recommended storage range for medicines. The system in place for ordering of medicines was appropriate and the service utilised a local pharmacy provision. A repeat prescription system that provided a four week dossette box was seen. There was ample evidence of medicines being prescribed, ordered and administered in a timely manner.

We saw a register of carers signatures and initials, the entries in this sheet did not correspond with some of the initials seen in the medicine administration charts (MAR) charts. Some initials were single letters. Best practice is to avoid abbreviations on medicines records. In a large care home use of both letters as initials would provide clarity regarding who had administered the medicine.

The controlled drug register entries tallied with the observed MAR charts and the disposal and refusal register was also accurate and correlated with entries in the observed MAR charts. There were evident and effective systems in place to regularly check the controlled drugs, via a hand over record when two staff were present, that was observed and confirmed by the senior carer. The staff rota showed suitable care staff available to complete the medicine round.

We observed the administration of the medicines. The carer administering the medicine was observed to check with each resident and follow accurately each step of the administration process. Each resident had individual dossette boxes, these were clearly marked with each dosage requirement and were colour coded with regard to the time of administration. These correlated with the individual MAR charts which included key information including personal details such as the person's room number, GP details, any allergies or reactions and a photograph of the person.

We noted a lack of accurate recording of 'as needed' (PRN) medicines. For example, in one case staff had administered PRN pain relief medicine to a person living at the service for four weeks. The prescription stated one or two tablets when required. We were not able to see from records whether they had been given one or two tablets on each occasion. Therefore it was not possible to audit accurately the PRN medicines. We discussed this with the registered manager who undertook to address this issue.

We also saw evidence of covert administration of medicine taking place that included the crushing of medicines. Paperwork had been in place since November 2014 to authorise covert medicine being given to this person. Best practice suggests that the process is reviewed regularly to ensure there is still a need to give medicines covertly. No review had taken place since November 2014, although the paperwork had a section to record the planned date of review and review meeting findings.
The registered manager told us they had not had any permission to crush the medicines until they had spoken with the GP and pharmacist in the preceding week, although they had been crushing them for several months. The GP and pharmacist had agreed to crushing the medicines from the next cycle of medicine administration at the end of March 2016. We discussed these issues with the registered manager who undertook to carry out a review of the person's capacity to make a decision in relation to medicines to confirm they still lacked capacity and required them being given covertly, and contact the GP/pharmacist and next of kin as part of that review. He also undertook to ask the GP for immediate permission to crush the tablets. We saw from documentation sent to us the day after the inspection that the registered manager had obtained the necessary documentation from all parties to legally crush medicines and had carried out a review and updated the paperwork to continue giving covert medicines for this person due to their mental incapacity.

We looked at the management of people's money and saw that the service held small amounts of money for people. There were receipts to account for expenditure and the registered manager told us that he and a team leader checked the records against actual money held once a month.

As part of the inspection, we undertook a tour of the home, including some vacant bedrooms, communal bathrooms and communal areas. We noted the environment looked clean throughout however, we noted there was no soap for handwashing in two of the communal bathrooms and one small kitchen on the second floor for handwashing. This was replenished throughout the day.
We noted that the main kitchen fridge contained food that was sealed and dated, and good hygiene was evident. The fridges on the first, second and third floor contained milk and juice for use by people living at the service and provided a space for staff to keep their food. We found food in the first floor kitchen uncovered and food that was a month out of date. We were told this was food belonging to staff. It was immediately removed.

We found food in the second and third floor small fridges that was not labelled with the date of opening. We also found a container with out of date food in it. A member of the care staff told us the food in the container belonged to a staff member on that floor. They agreed to throw it away that day.
We found milk and juice in the second floor fridge that was opened and not dated, and milk in the fridge on the third floor that was opened but not dated. We asked the staff when the milk and juice was opened and they told us that day.

We spoke with the person responsible for housekeeping and the registered manager regarding these issues. Whilst the housekeeper checked cleanliness in other areas, we were told fridge checks on each floor had not taken place in recent months. There were no records of spot checks of communal bathrooms or the small kitchens on the first, second or third floor by the housekeeper although we were told they took place.

Since the inspection further food hygiene training for staff had been arranged. Fridge and bathroom checks were being undertaken and records kept of spot checks.

We recommend there are systems in place to check infection control procedures in all areas of the service.

Good

Is the service effective?

Our findings

We asked people living at the service if they thought the staff had the necessary skills and knowledge to do their job. We were told "Yes on the whole." "Yes they understand and explain things." And "I would say so." Three out of the eight people we spoke with were less confident. One person told us "I don't think they fully understand what I need." Relatives we spoke with told us they felt staff were suitably trained and two relatives told us they were much more confident with their relative living at this home than they had been in previous homes. One relative told us "On the whole the service is very good."

All staff completed induction training when they commenced work in the home. This included an initial orientation induction, training in the organisation's visions and values, the care certificate and mandatory training. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. New staff shadowed senior staff to become familiar with people and their needs and the routines within the home.

Staff were provided with appropriate training opportunities and confirmed the courses were relevant to their role. We noted the provider had a training plan in place for all staff which included a mixture of face to face learning provided by internal and external providers. Staff reported they had received safeguarding training when they commenced working at the home. We were able to confirm this by reading the provider's records of training. We noted staff had access to detailed internal policies and procedures on safeguarding vulnerable adults to guide their practice in this area. The mandatory training included safeguarding, moving people, safe handling of medication, health and safety, Mental Capacity Act and dementia care.

The manager told us information about the staff training was collated and placed on the provider's staff training matrix. We were able to confirm this by reading the matrix.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us he had put in applications for the people living on the third and fourth floors in 2015 but did not have the paperwork to evidence this. We saw two urgent applications for DoLS. The registered manager told us he would ensure all relevant DoLS paperwork would be completed by the end of April 2016.

Four staff we spoke with specifically with regard to the MCA and DoLS told us they had received training on the MCA and we found they had a working knowledge of the principles associated with the Act. We also noted there were detailed policies and procedures available on the MCA and DoLS for staff reference.

Staff told us they were provided with regular supervision and they were well supported by the management team. The supervision sessions enabled staff to discuss their performance and provided an opportunity to plan their training and development needs. We saw records of supervision during the inspection and noted a variety of topics had been discussed. The registered manager also carried out an annual appraisal of each member of staff's work performance, known as a personal development review.

We looked at how people were supported to maintain good health. Records we looked at showed us people were registered with a GP and received care and support from other healthcare professionals. People's healthcare needs were considered within the care planning process and we noted there was a separate section in each person's plan detailing any healthcare conditions. From discussions with staff and by reading records contained in people's care support plans we found the home had developed good links with other healthcare professionals and specialists to help make sure people received appropriate and effective care.

When we asked people about the food at the service we were told "On the whole it's pretty good" and "Yes the food is good and we do get a choice." Two out of the eight people we spoke with were less enthusiastic. For example, one person told us "There's a good mixture of ingredients but not made the best of. Kitchen could do better." Another person told us "They could do with a different chef." Relatives we spoke with told us the quality of food had improved and was in general good. One relative thought there was still room for improvement. We observed the lunchtime meal. The meal was served hot and was nicely presented.

We found people's nutritional needs had been assessed which helped determine whether they were at risk of dehydration or malnutrition. People's weights were monitored and appropriate professional advice and support was sought when needed. Staff were aware of people's dietary preferences and were able to provide specialist diets. There was a system in place which ensured people who required special diets [whether due to religious, cultural, health reasons or because of preference] received the appropriate food. We were able to speak with the chef and auxiliary kitchen staff who confirmed how the system operated.

The premises were fully accessible with a lift to all floors. Most rooms on the lower floors had en suite facilities including a walk in shower. On the fourth floor there was a toilet en suite, but no shower. Communal bathrooms were available on all floors.

Good

Is the service caring?

Our findings

We asked people if the staff were caring and patient. We were told "Yes on all counts." "Yes most of the time." One person told us "The staff always have time to talk and listen". Another said "Yes I feel this is my home." Only one person out of eight told us "Not especially. Some are just there to do a job." Relatives we spoke with told us they found the staff in general caring and patient. One relative told us "There's the odd one or two staff that aren't but they don't last long there." Another relative told us "Carers are almost all friendly and helpful. A few are outstanding but a few are not so good." A relative told us they had been particularly grateful for the support and patience shown to their relative when they first moved in as it had taken some time for them to settle.

During the inspection we observed people were treated with kindness, respect and compassion. This was seen during the serving of breakfast with people being spoken to by staff in a polite and caring way. The staff were observed to respect the individual's need of privacy and dignity. We observed staff knocked on people's room door and then waited for a response before entering. Individual preferences and differences were respected. One person told us "The staff have time for you, they never rush." During the course of the day we noted good natured exchanges and communication between staff and people using the service.

Some staff reported that they knew the people well and had a good understanding of personal histories and preferences. A senior carer stated "We know the likes and dislikes of each individual resident and get to know them well". However, this was not fully reflected in the content of the care plans or daily reporting structures. We found care records varied greatly in the detail they held regarding a person's personal history and individual preferences recorded.

We spoke with the activities coordinator following the inspection who told us she had recently undertaken a project to gather information relating to people's personal histories. She had spoken with family and friends as well as people living at the service. This information had not yet been cascaded down and stored in the care records, but following the inspection we were told there was a plan to add the information to care files and a system to record staff had read it.

The key worker system which had previously operated was not currently operating due to staff vacancies. This is one method to ensure staff understood people's needs well and have time to get to know them. It is important staff who are familiar with a person update their care records as their needs change in conjunction with the person they are caring for. The registered manager told us he planned to introduce the key worker system again shortly and to ask staff for their preference of working on specific floors to facilitate a better understanding of people's holistic needs.

Two relatives told us some clothes had been mislaid, one relative told us their relative had been dressed in another person's clothes. This had caused some upset to the family member. The person to whom it happened may not have been aware due to their cognitive impairment. We spoke with the registered manager who told us that clothes were marked but not all housekeeping staff could read English sufficiently well to distinguish different people's clothes. He undertook to discuss this issue with housekeeping staff and

consider options to improve the service.

People did tell us they were helped to remain independent. One person told us "I go to bed at 10.00 every night and have a shower independently as I prefer to do things at my pace."

The residents' rooms observed were personalised. Several residents had their own furniture and several rooms seen had new hospital style beds. One person told us "I never worry when I need anything, my room has everything I need and I love my own pictures and bits and bobs".

We noted some records contained information on end of life planning. Detailed Do Not Resuscitate documents were kept in a separate folder. We looked at these. Most were completed correctly, there were some that needed additional information added to explain why the person who was the subject of the order could not be part of the discussion. The registered manager explained this was due to cognitive impairment, and undertook to review the set of forms and add any additional information required.

The people who lived at the service and the staff were from a wide range of ethnic and cultural backgrounds. People's religious needs were met by services taking place on the premises. The contracted organisation who managed the kitchen were able to cater for a wide range of diets specific to people's cultural and dietary needs.

Good

Is the service responsive?

Our findings

One person told us "I haven't had any cause to complain, but would know where to go if I did" and "Yes I would go straight to the manager." Another person told us there is "Nothing to complain about." People were in general happy with the care provided by the service. Relatives told us they felt any issues they raised were dealt with promptly and they found the registered manager responsive to their comments. One relative told us they thought there were communication issues on occasion with information not being passed between staff members. Another relative told us they were more confident when the registered manager was on the premises.

We saw there was a wide range of activities available at the service. Two full time staff were employed to provide activities. One person concentrated on working with the people with significant memory problems, mainly the people living on the third and fourth floors. These activities were often one to one, other activities included physical activity and access to the Namaste service. This new activity had started from 1 February 2016. This meant staff were trained to provide massage to people. During these sessions they also undertook reminiscence work and had begun to gather 'memory boxes' for people which contained personal photos, objects and memorabilia that was relevant to their family, friends or life. Namaste is a useful way of connecting with people with memory problems and provides an opportunity for increased physical contact in a structured way.

The activities co-ordinator for the remaining floors showed us the activity plans. They included a music and drama therapist attending the service to work with people; children from a local nursery coming in to meet with the older residents and play activities taking place in the large downstairs room. We were told local dog walkers brought in their dogs for the people to pet and there were good links with the local school for young people to visit to volunteer as part of the Duke of Edinburgh scheme and more general volunteering opportunities. There were talks arranged on cultural subjects and occasional trips out of the service. Talking with the activities co-ordinators who offered different activities for people depending on their mental capacity, it was clear they were committed to providing a broad range of activities appropriate to the wide range of people living at the service. We were told "There is always something to get involved in and we are encouraged to take part".

We found care plans were not always easy to read as the writing was unclear on some records, and body client maps to note bruising or areas of redness on the skin had multiple entries on them. This meant they were difficult to understand. We found care plans were difficult to navigate through. For example the handwritten index of sections was not consistent throughout care plans seen. This resulted in a different sequence for each care plan. Not all care plans contained person centred information. For example, one care plan for a person who did not like much company noted staff to talk to her "from time to time." But the care plan did not have any social or personal information to help staff engage with them. We discussed this care plan with the registered manager who told us there was little family involvement with this person so information was hard to obtain. We found from this discussion with the registered manager that this person was part of the Namaste programme but this was not recorded in their care plan. The registered manager told us the staff found non verbal ways to communicate with this person. We discussed care planning with

the registered manager and area manager on the day of the inspection who undertook to review their systems.

We looked at the complaints file. There had been seven complaints since 2014. There had been only one complaint in the last 12 months. All had been dealt with promptly but not all actions undertaken by the registered manager had been recorded on the forms. For example it was through discussion with the registered manager we learnt that he had spoken with night staff following a complaint from one person using the service who had been woken abruptly to have care provided.

Requires Improvement

Is the service well-led?

Our findings

Spring Lane provided people living at the service with a brochure on arrival which contained useful information about living at the home. The service had a philosophy to "provide residents with a happy, warm community to live in, that feels both homely and safe at all times."

The registered manager was well regarded by relatives and people living at the service. We asked people and their relatives would they recommend the home to other people. Everyone told us yes. Some people living at the service had some reservations but were philosophical and identified some issues as 'inevitable' when living in a care home.

We saw the registered manager had held four meetings for people living at the service in 2015, with the last one in October. One meeting had been held to discuss the food as there had been some issues identified. There had not been a meeting held in 2016 at the time of the inspection. Since the inspection there was a meeting held in April and the registered manager told us he planned to hold meetings with people who live at the service monthly.

We saw the results of a survey that had been carried out in July 2015 with staff. There were many positive areas identified by staff such as 91% of staff knew what was expected of them at work and 71% of staff were happy with the training. Areas of improvement identified were in relation to recognition and praise for good work as at the time of the survey only 43% felt they received praise. 44% of staff agreed their opinion counted at work, with 31% disagreeing, and 58% of staff felt there was good communication between staff and managers. The action plan identified more regular supervision with an increased emphasis on constructive support and feedback, daily "Take 10" meetings to improve communication between the registered manager and heads of housekeeping, care and the reception area. Monthly staff meetings were also on the action plan.

At the time of the inspection the Take 10 meetings were taking place and staff spoke positively about supervision but only one staff meeting had taken place in September 2015, and one employee forum had taken place in January 2016. We discussed sharing of information with the registered manager who told us he provided information at handover for staff but was no regular frequent forum to discuss practice issues with staff or opportunities for their views to be heard. A staff member told us "I don't feel as though I am listened to." The registered manager told us employee forums would run as and when matters arose, typically three to four times a year. Since the inspection the registered manager told us he had held a meeting with staff and planned to hold them on a monthly basis. Family carers support group meetings were facilitated quarterly by senior managers, and these were valued by the people who attended them.

The registered manager collated information for key performance indicators in a number of areas. These included infections, pressure areas, falls, and deaths in the home and hospital. Monthly body mass index records were kept to ensure people were not losing weight. We saw medicines audits were taking place but we were not able to see what action had been taken to remedy errors. There were other areas where we found no records although we were told action was taken. For example, there were no records of spot

checks by housekeeping re cleanliness.

We saw care plans had been audited in July 2015 and in March 2016, 13 care plans had been audited. At the time of the inspection the remainder were being audited and updated by a senior staff member from head office. They were undertaking this audit to support the registered manager.

The registered manager could not locate copies of the DoLS submitted last year to the local authority and we were not aware of a system to prompt the service when paperwork relating to covert medicines needed to be reviewed.