Ringdane Limited

South Quay Care Home

Inspection report

Cowpen Road
Blyth
Northumberland
NE24 5TT

Tel: 01670351831
Website: www.fshc.co.uk

Date of inspection visit:
02 May 2018
03 May 2018

Date of publication:
16 July 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 and 3 May 2018 and was unannounced. This meant the provider and staff did not know we would be coming.

We previously inspected South Quay Care Home in April 2016, at which time the service was meeting all regulatory standards and rated good. The service was rated requires improvement at this inspection.

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

South Quay accommodates a maximum of 58 people across two separate units. One of the units is for older people. One of the units specialises in providing care for people with a neurological condition. During our inspection there were nine people on the neurological unit and 33 people on the older person's unit. Some people who used the service received nursing care.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Required improvements to fire doors, bathrooms and the outdoor space had not been completed by the provider.

Premises had been visited by the provider's Resident Experience Care Specialist but, as yet, no improvements had been made.

People who required input from physiotherapy had not always received this, whilst some people who required one-to-one support from staff had not always had this planned effectively. Care staff worked extremely hard to ensure detrimental impacts on people were limited due to these provider failings.

There were sufficient staff in order to keep people safe although the provider used a dependency tool more suited to establishing staff levels for older person's care, whereas one of the units specifically supported people with complex physical needs. We have made a recommendation about this.

Premises were generally clean with infection control practices followed and sufficient domestic staff in place.

Staff had received safeguarding training, were clear on their responsibilities and could give examples of when they had acted effectively to keep people safe.

People who used the service interacted well with staff and told us they felt safe. No relatives or external professionals we spoke with raised concerns about safety.

Risk assessments were in place and were reviewed regularly, with involvement and advice from external specialists where appropriate.

Medicines administration practices were in line with good practice and the nurse we spoke with demonstrated a sound understanding of people's medicinal requirements.

Pre-employment checks of staff remained in place, including Disclosure and Barring Service checks, references and identity checks, as well as Nursing and Midwifery Council (NMC) register checks of nurses.

Aside from the concerns regarding physiotherapy, people had accessed external healthcare professionals such as GPs and dietitians to get the support they needed. Staff liaised well with these professionals.

Staff received a range of mandatory training and training specific to people's needs.

People were encouraged to have healthy diets, enjoyed a range of mealtime choices and were protected from the risk of malnutrition.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Relatives and external professionals confirmed staff had formed good relationships with people.

People were encouraged to remain independent and access their local community, whilst activities co-ordinators encouraged community groups to visit the service. This reduced the risk of social isolation.

The atmosphere at the home was calm and relaxed. Person-centred care plans were in place and reviewed regularly.

People who used the service, relatives and professionals we spoke with gave positive feedback about the staff team but acknowledged the service needed to improve, specifically with regard to the premises. Staff felt they were not always listened to by senior management but worked well as a team and with their immediate line managers.

The culture remained one focussed on caring for people in a dignified, personalised way, but this was largely down to the passion of the care team and not the provider, who needed to make a range of improvements to service provision.

We found the service was in breach of regulation 9 (Person-centred care) and regulation 15 (Premises and Equipment).

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

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.

Remedial work to ensure internal fire doors were fit for purpose and bathrooms were refurbished had not happened.

Staff displayed a good knowledge of people's medicinal needs and appropriate systems were in place to ensure the safe administration of medicines.

There were sufficient staff to ensure people were not at risk, although the provider needed to review its dependency assessment system as staff sometimes had to cover additional duties on a shift to keep people safe.

Staff demonstrated a good awareness of their safeguarding responsibilities and had acted pro-actively in the past to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people who had previously benefitted from physiotherapy session had not received this on an ongoing basis.

The premises were in need of refurbishment and the outdoor space, once a well-used resource, was overgrown and in need of maintenance.

Staff worked well with a range of healthcare professionals to ensure people's health and wellbeing was maintained and care planning was well informed.

People enjoyed a range of meals and staff supported people patiently and with respect at mealtimes.

Is the service caring?

Good

The service was caring.

Staff were without exception caring and patient with people who

used the service.

The atmosphere in the older person's unit was vibrant, with positive relationships between staff and people who used the service. The communal areas had a homely, welcoming feel.

Staff communicated well with people and people confirmed they were given choices and their independence encouraged.

Is the service responsive?

Good

The service was responsive.

Two activities co-ordinators were passionate about their roles and ensuring people had access to a range of hobbies and interest meaningful to them.

Surveys were used on an ad hoc basis to seek people's feedback about all aspects of the service.

Complaints were responded to in line with the provider's policies.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Despite being aware of the improvements required to the service, senior leaders had failed to ensure these improvements had been implemented.

Staff and people who used the service spoke positively about their immediate line management and how they worked as a team, but felt they were not always listened to by management.

Regular auditing was in place and did identify ad hoc areas for improvement in record keeping and maintenance.

South Quay Care Home

Detailed findings

Background to this inspection

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

We visited the service on 2 and 3 May 2018 and the inspection was unannounced. We did this to ensure the provider and staff did not know we were coming. The inspection team consisted of one adult social care Inspector and one 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 service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

During the inspection we spoke with 11 people who used the service and three relatives. We observed interactions between staff and people who used the service throughout the inspection. We spoke with 16 members of staff: the registered manager, the regional manager, a compliance manager, four nurses including the deputy manager, four care staff, two kitchen assistants, two activities co-ordinator and the handyman. We looked at five people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. Following the inspection we contacted three external professionals.

Requires Improvement

Is the service safe?

Our findings

Work required to improve fire doors had been identified over a year previously but had not been undertaken. We saw quotations and initial survey work had been completed but that the required works had not been actioned, despite repeated correspondence from the registered manager to the relevant managers in the organisation. This meant some fire doors were not to the required standard. Other areas of the premises were in need of remedial work. There was one bathroom on the ground floor and one bathroom on the first floor which had been closed for over a year. On the ground floor this meant the working bathroom was used to store additional bathing equipment, meaning anytime the bath was used staff had to remove this additional equipment.

The impact on people of one bathroom on the neurological unit being closed was limited as everyone had a room with an en suite shower and only one person chose to have a bath. Similarly, no one we spoke with in the older person's unit raised concerns about the availability or regularity of bathing facilities. People on the older person's unit told us, "I get a bath regularly," and "I like my hair washed and they respond very quickly whenever I want it." Notwithstanding that, there was clearly an impact on staff, who had to work around the lack of bathing spaces and the associated storage problems. The registered manager and area manager acknowledged these works needed completing as a priority.

The carpeting throughout the older person's unit showed signs of wear and discolouration and had been in place for a number of years. The registered manager confirmed they had recently been visited by the provider's lead on dementia friendly environments, the Resident Experience Care Specialist, with a view to making a number of changes to the décor, including carpets. After the inspection the provider stated the condition of the carpets did not fall within the remit of the Resident Experience Care Specialist. Notwithstanding this, the carpets were in need of replacing.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and Equipment.

We found the premises to be generally clean, although noted a malodour on the older person's unit on the first day of the inspection. This was not present on the second day of the inspection and we found there were sufficient domestic staff on duty. The service had an infection control champion in place but had not sent a representative to the infection control meetings they had been invited to last year. The manager confirmed they intended to send a representative this year. People who used the service and relatives raised no concerns about cleanliness.

Contracts were in place to ensure equipment was maintained and serviced to ensure safety. This included electrical installations, fire alarms and fire-fighting equipment, lifting equipment and lighting. We saw there had been a fire inspection earlier in the year, where advice was given to put in place evacuation training for all staff. We saw this was planned as a mandatory training session for staff.

We reviewed the storage, administration and disposal of medicines and found practices were safe and

generally in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

There were no errors in the medication administration records (MARs) we reviewed and these were complemented by photographs of each person, emergency contact information and allergy information. Where people had medicines prescribed as 'when required' we saw there was a specific protocol in place for each medicine explaining when and why that medicine may be required. This is good practice. A sample of medicines showed they were safely stored, with opening dates entered onto creams that had been opened. Room and fridge temperatures were checked regularly to ensure medicines were kept at an appropriate temperature. We undertook a sample stock check of controlled drugs and found this to be in keeping with the controlled drugs book. Controlled drugs are medicines liable to misuse. The nurse on duty demonstrated a strong awareness of people's medicinal needs.

Recruitment processes were followed to ensure suitable staff were employed. Checks were carried out for each new member of staff including two references and disclosure and barring service checks (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with vulnerable adults. Where staff were registered with the Nursing and Midwifery Council, checks were also in place to ensure their registration was still current.

We observed people interacting in ways that demonstrated they were comfortable in the presence of staff, for instance laughing and joking with them in communal areas. People who used the service told us, "The main thing is, it's '24/7'. Somebody is here all the time so I feel safe," and "There are no problems." Relatives told us they had confidence in the ability of staff members to keep people safe.

There was a consensus of opinion that staffing levels sometimes led to people having to wait longer than they would like for support. One person said, regarding responsiveness to the call bell system, "Occasionally they forget," whilst another said, "Sometimes if they are serving meals you can't get them to come to do toileting." Relatives told us, "Sometimes there are staff shortages and a lot of the girls are very stressed," "There's not enough staff on the unit," and "The (neurological) unit is graded the same as the other unit. It shouldn't be graded the same as they have different needs." This was in reference to how the provider calculated the number of staff required. We reviewed this and the registered manager and area manager agreed the tool was better suited to calculating staffing for older person's services (whereas the neurological unit at South Quay supported people with complex physical needs).

The impact of these staffing levels was that, on occasion, staff were asked to work on different units at short notice, and also to cover one person's one-to-one support time whilst also working to support others. One person should have had one-to-one support from 5-10pm every day but we found this was not scheduled for two days per week, each week. This meant other staff, already on duty, had to provide one-to-one support for this person in addition to ensuring everyone else on the unit received appropriate support. Staff members confirmed, "We do struggle with staffing. We get everything done because everyone pulls together but there should be more staff," and "There is no time for residents now – it's task after task, like a conveyor belt."

We recommend the provider review its use of the dependency tool in place, and the relevance of that tool to the service user group in the neurological unit, to ensure staffing levels are appropriate to the needs of people on both units.

Staff understood their safeguarding responsibilities and knew how to contact external agencies should they have concerns about the service. Appropriate training and policies were in place.

Risk assessments were in place and specific to people's individual needs, for instance in relation to people's mobility, diet and behaviours. These were regularly reviewed and external advice sought where necessary. Accidents and incidents were documented and shared with the appropriate level of management via the provider's database, with actions being taken to help prevent similar incidents in future.

Requires Improvement

Is the service effective?

Our findings

Staff had completed a range of training in areas such as safeguarding, Mental Capacity Act 2005 (MCA) awareness, whistleblowing, infection control, safeguarding, moving and handling techniques and pressure care. Training had also been given to meet more individualised needs, such as Huntingdon's awareness training and percutaneous endoscopic gastronomy (PEG) feeding. This is where a tube is passed into a person's stomach when they are unable to take food orally. Whilst this training had a beneficial impact on people in that they were able to receive this care from staff who knew them well, the provider needed to ensure there was a better system in place to document staff competence in this practice in future years. The registered manager had access to online records of each staff member's training record and we found there was a high level of compliance in terms of staff completing the required training.

The manager and regional manager told us there were plans to roll out the provider's dementia awareness training framework. This would mean staff would be better prepared for supporting a higher proportion of people who may be living with dementia.

We found evidence of good outcomes for some people who used the service. For example, one person was unable to take food orally on admission to the service and was therefore on a PEG diet. After referrals to and advice from the Speech and Language Therapy Team we saw they were now able to have a pureed diet and thickened fluids. This meant support from external professionals had been utilised to improve people's quality of life. This was not the always the case however and we found that people who had previously received physiotherapy under the previous provider no longer did so. For instance, one person's care planning made it clear that they should be helped, under physiotherapy or occupational therapy supervision, to walk up and down a corridor as a means of improving their mobility. This was no longer happening. Other people who used the service had also previously benefitted from physiotherapy involvement and required more specialist review and input. Whilst care staff were pro-active in encouraging people to continue the relevant exercises, and we received a range of positive feedback in this regard, the registered provider had not ensured appropriate physiotherapy provision was in place. The registered manager and regional manager agreed to make individual referrals to physiotherapy where required as a matter of urgency.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred Care.

The outdoor space, acknowledged as a space full of potential and previously a focal point for vegetable and flower growing, was no longer well utilised. The grass was overgrown and the greenhouse no longer used. One person who used the service told us how they used to enjoy carrot growing competitions, whilst another said, "The garden used to be nice. The garden has died now." The registered provider advertised for a gardener during our inspection and agreed the outdoor space was a missed opportunity to enhance the lives of people who used the service.

We received good feedback from a range of external professionals about levels of staff knowledge and

engagement with them with a view to improving outcomes for people. One told us, "They do a lot of respite so they have to be clued up. They do go out of their way to accommodate requests," and another said, "The staff can give you a good background generally – they know about people's conditions and there is always a nurse on hand." Care files contained pre-assessments of people's needs and regular reviews. We found information in care files to be relevant and up to date.

The 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. DoLS applications were clearly recorded and monitored to ensure the registered manager applied for new authorisations in time should they be necessary. People's consent was documented in care files. Where people who used the service did not have capacity to consent to a decision we saw a best interests decision had been made. We found one such decision had not documented the people involved in that decision. The registered manager agreed to review this decision as a priority.

Staff received regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We saw supervisions had not taken place in December 2017 and January 2018 but, since then, had been happening. Staff meetings also took place, on average every three months, and this was not as regularly as staff would have liked. One said, "We get updates but it can be a while - sometimes you feel out of the loop."

People had a choice of meals and gave positive feedback about the range of food available. People were supported with their nutritional needs. Kitchen staff demonstrated a good knowledge of people's varying dietary needs and the kitchen was well stocked and maintained, whilst a trolley service offer healthy snacks and baked goods during the day. We observed two lunchtimes and found people were supported adequately by staff, with some warm interactions noted. We found the experience did not live up to the registered provider's description of mealtimes as a highlight of the day. The registered manager and regional manager acknowledged there was scope to improve mealtime experiences and had recently hired a new cook, who was due to start. They acknowledged there had been a turnover of cooks and hoped the new cook would bring a range of new ideas. Notwithstanding that, feedback was unanimously positive regarding the content and size of people's meals. People told us, for example, "It's good food and there are lots of choices," "Meals are varied and really quite good," and "We'll put on two stone of weight by the time we get out of here!" Where people chose to have their meals in their room this was respected. One person told us, "I have my breakfast in bed and it comes quickly. I am well looked after."

Other than the physiotherapy issue identified, people were supported to access external professionals to monitor and promote their health. People's care plans contained records of involvement with GPs, dentists, opticians and other professionals involved in their care. Relatives we spoke with felt people's needs were well met and told us, "I feel all their needs are catered for – the only concern sometimes is staff numbers," and "They are well looked after."

Good

Is the service caring?

Our findings

People who used the service told us, for example, "Staff are partly like your family," "There are very, very good carers here," "They will do anything for you," and "They are lovely, they are all nice." Relatives we spoke with agreed, telling us, "Staff always shout 'hello' to us." We found, whilst staff were under significant pressure to complete their duties, they did so whilst never compromising on the dignity they afforded people who used the service.

We found the atmosphere was welcoming and vibrant, with staff actively engaging with people they passed and activities co-ordinators ensuring that people who did not want to take part in group activities still felt included. People confirmed, "It feels just like a home of your own," and "I like this place – I never want to go anywhere else." Relatives we spoke with also described the service in homely terms, for example "They had a bigger room in another home but once they got here they didn't want to move."

In keeping with the homely and relaxed atmosphere was a focus on promoting people's own independence. One person told us, "Staff encouraged me to use my walker to get down to the lounge," and another said, "They encourage people to do things for themselves." We found this contributed to the atmosphere and meant people, for the most part, agreed they had a say in their own care and how it should be delivered and supported. This was reflected in a range of surveys we reviewed.

People were treated with dignity and respect. We observed numerous interactions between staff and people who used the service that demonstrated this and, when we asked people, they said, "They always treat me with respect" and "They always cover me and think of my privacy and dignity."

People who used the service and their relatives confirmed they were consulted regarding how they wanted care to be delivered. Staff were assigned to update people's records and when we spoke with staff they demonstrated a strong understanding of people's current needs and previous medical histories, likes, dislikes and preferences.

We observed staff communicating well with people who used the service, tailoring their style to ensure people could understand them. For example, speaking more slowly to one person or repeating themselves to another and crouching down to eye level to ensure the person was part of the conversation. Staff consistently gave people a choice and respected those choices.

People's right to religious beliefs were respected and there was a regular church service at the home. One person told us, "The church comes every Sunday for the bread and wine."

Whilst areas of the service were in need of redecoration we saw people's rooms were personalised, for example with pictures, memorabilia and their own belongings.

Good

Is the service responsive?

Our findings

We received a range of positive feedback about how staff at the service actively engaged and encouraged people to take part in activities meaningful to them. These activities were planned by two activities co-ordinators (the registered manager was also planning the introduction of a third activities co-ordinator), one based on each unit. We found them both to be passionate about their role and finding ways to help people find activities and interests they could access. For example, people had regularly attended a 'Care to Dance' event, where they could take part in a tea dance. Staff had made good bonds with the organisers of this service, one of whom attended a recent quiz event at the service as quizmaster. This was part of the service's celebration of Care Home Open Day, whereby care services welcome the local community into the service and celebrate what they do. People we spoke with had enjoyed this event.

During our inspection we saw people having manicures and taking part in a 'Bing Crosby Day', to mark what would have been his birthday. People told us, "There is always something going on – the girls who do the activities are very good and they get us to join in," and "I love my music so we listen to that a lot in the afternoons. I sing sometimes. The girls are lovely with us." Relatives confirmed there was a vibrant and positive approach to activities planning and delivery stating, "They get to do things with people their age," "There's a lot of entertainment with quizzes and animal visits." Where people chose not to or were unable to engage in group activities, we saw staff had ensured visiting singers had gone to individual rooms and sang if people chose.

Staff had a good understanding of people's needs and responded well when a change to care planning or external advice was required. The neurological unit had a keyworker system in place whereby nominated staff were responsible for particular people's care files. We saw this helped to keep care records up to date and all staff we spoke with, on the neurological unit and the older person's unit, demonstrated a strong understanding of people's needs, life histories, likes and dislikes.

The activities co-ordinators were responsible for documenting people's life histories, where they wanted to share them, in the provider's 'My Choices' booklet. We saw these were being updated at the time of inspection. The activities co-ordinator in the neurological unit had identified that the booklet was geared towards older persons and, where they were supporting younger people, they had used the booklets, in agreement with people who used the service, to celebrate their recent achievements through photographs. This was an effective way of ensuring the achievements people valued were well documented and celebrated.

Care plans were sufficiently person-centred to gain a good understanding of each person's needs and individualities. Individual care plans, such as mobility, skin integrity and medicines plans, were reviewed monthly, as were risk assessments, and updated where people's needs changed. Where external advice was provided we saw this was referred to in care planning, for example from GPs, nutritionists and nurses.

People had end of life care plans in place where they were comfortable with this and we saw Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation had been completed appropriately. This meant

people's advance wishes about where and how they would be cared for at the end of their lives was respected.

With regard to complaints, we saw these had been responded to in line with the provider's policy and people had generally been happy with the resolution. People who used the service confirmed they could raise concerns with members of staff and were comfortable doing so. Family members agreed. We also saw the provider undertook regular surveys from people who used the service, which were compiled and reviewed each month. The majority of responses were favourable in all areas and there were no major concerns highlighted via this means.

Requires Improvement

Is the service well-led?

Our findings

We found staff morale to be low after a prolonged period of managerial uncertainty. The service had had a number of regional managers over the past two years, and the current registered manager had handed in their notice, having previously been off work for an extended period of time. All staff we spoke with, along with a number of people who used the service and external professionals, agreed the service was one with significant potential, but that this potential had not been built upon since the last inspection. On the contrary, required environmental refurbishment had not been undertaken and required improvements, which the provider was aware of, had not happened. Quality assurance and corporate oversight systems were in place, and the issues we identified were known to the regional manager, but they had not been acted on.

For example, there were a set number of quality surveys that the provider ensured were completed regularly, as well as monthly audits of all aspects of the services. These had been completed but with a focus on completing them as an isolated task rather than taking action to improve the shortfalls they had previously identified (for instance the bathroom refurbishments). The regional manager and Resident Experience Regional Manager gave assurances that the improvements required to the fabric of the building, the use of the outdoor space, a review of physiotherapy needs and a review of staffing planning to take into account people's complex physical needs would be addressed. During our inspection the provider had begun work on the outdoor space, advertised for a permanent gardener, and arranged the five-year electrical certificate.

All people who used the service and external professionals were extremely complimentary about the care staff team. We found they consistently excelled in challenging circumstances and were at the forefront of positive feedback we received from family members. At times the goodwill of staff, not the effectiveness of corporate oversight in place, ensured people received the care they should. For example, where one-to-one hours had not been effectively planned, staff still ensured the person requiring this support received it. This was neither sustainable nor appropriate.

External professionals we spoke with shared the view that the service had failed to build on potential, for example saying, "It's generally a good service and we work well with them but I think it needs a lift, a change. We're hopeful they will improve."

Auditing was in place and, after some inconsistencies during the long-term absence of the manager, had been happening regularly and identifying the need for improvements on an audit to audit basis. We saw there were immediate smaller impacts with regard to changes such as improvements to paperwork but, as discussed above, where major changes were identified and highlighted by the registered manager, necessary works did not happen in a reasonable timescale. We saw evidence this had been escalated to the provider's relevant senior and regional managers (and that the regional manager had also conducted environmental audits of the service) but that, to date, the improvements had not happened.

Staff generally confirmed they were well supported, particularly by their immediate line managers and nurses, who they felt they could approach with any concerns. Staff worked well as a team and supported

each other well. Staff also consistently told us however that they did not feel listened to by senior leaders and that their concerns about, for example, the lack of refurbishment and the management of the rota system, had not been given the proper attention. We fed this back to the registered manager, regional manager and Resident Experience Regional Manager. They assured us staff would feel more involved in the future of the service as a new manager joined in the summer.

The registered manager and regional manager had yet to define and determine how best to manage the two distinct units at the location. There were committed staff teams who worked primarily on each unit and worked well together. We found there were occasions when staff were asked to cover shifts on the alternating unit and this had caused some frustration amongst the staff teams. As yet, the sharing of staff across the two units had not brought meaningful benefits to people who used the service.

The consensus of opinion from staff was that the registered manager had tried to make improvements but that delays in the wider organisation meant they did not always make changes. We saw evidence to support this.

The culture we experienced throughout the inspection was one of people receiving dedicated, personalised care from staff who genuinely cared for them and were passionate about their roles. The provider needed to do more to ensure staff goodwill was supported by real improvements to the areas highlighted in this report.

Community links had been made, for example through the recent Care Home Open Day, and the activities co-ordinators continued to form strong bonds with charitable groups and other organisations, such as a local church and school. Likewise, staff had gone above and beyond their roles by fundraising to purchase materials to decorate the summer house. The service had ensured people remained a part of their community.

The records we reviewed were accurate, up to date and person-centred. The registered manager had been in post for a number of years and had relevant experience. Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service in the form of a notification. The registered manager had informed CQC of significant events in a timely manner. This meant we could check appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who required physiotherapy support to improve their mobility and independence had not been receiving this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Remedial work to ensure fire doors were to the appropriate standard and two bathrooms were suitably refurbished had not been undertaken.