Care First Class (UK) Limited

Cherry Lodge

Inspection report

6 Manningford Road
Druids Heath
Birmingham
West Midlands
B14 5LD

Tel: 01214305986

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on the 30 and 31 August 2016. At our last inspection on 17 and 18 September 2015, we found the service to be requires improvement in all the areas inspected and was not meeting the regulations in one area. This related to people, who used the services, being unlawfully deprived of their liberty, for the purpose of receiving care, because the provider had not sought lawful authority to do so. A requirement notice was issued. The provider sent us an action plan detailing what action they had taken.

During this inspection we found the provider had made some improvements to the service. Although we found some further improvement was still required.

Cherry Lodge is a residential long term care home providing accommodation and residential care for up to 46 people. The home also provides short stay interim beds for people discharged from hospital, who may require further assessment of their care and support needs before returning to their own home. At the time of our inspection 38 people were living at the home.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of the inspection, the acting manager showed us they had started the application process to become the registered manager.

At the last inspection, we found that staff understood their responsibility to take action to protect people from the risk of abuse and harm, because the provider had systems in place to minimise the risk of abuse. However we saw that staff did not always follow the assessments to minimise the risks associated with people's care and this put people at further risk of injury. At this inspection we found there had been some improvement.

People were supported by a sufficient number of staff on duty to meet people's identified needs. The provider's recruitment processes required improvement to ensure suitable staff were recruited. People were supported by suitably trained staff.

People were supported to receive their medicines as prescribed.

At the last inspection we found the home had not been maintained to an acceptable standard of cleanliness. Although we found there had been an improvement, further improvements were still required.

At our last inspection we found that people did not participate in interests and hobbies that were personalised to their individual needs. There had been some improvement, however further improvement was required to meet people's individual choices.

At the last inspection we found relatives had experienced inconsistencies as to the effectiveness of the complaints process. At this inspection, systems were still not in place to help the provider learn and develop the service from feedback and outcomes of complaints and required improvement.

At the last inspection we found although systems were in place to monitor the quality and safety of the service, they had not always been effective. We found there had been a slight improvement in monitoring the quality of the service but that the systems required further improvement.

At the last inspection the provider had not always recognised when the care being offered had put restrictions on people's ability to choose and move around freely. At this inspection we found there had been some improvement.

People were supported by caring and compassionate staff who demonstrated a positive regard for the people they were supporting. Staff understood how to seek consent from people and how to involve people in their care. Although preserving some people's dignity had not been consistently maintained.

People were able to choose what they ate and drank and were supported to maintain a healthy diet with input from dietary specialists.

People were supported to receive care and support from a variety of healthcare professionals and received treatment if they were unwell.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Because the standard of cleanliness within the home had improved, the risk of infection to people had been reduced. Although further improvement was required.

People were at risk of having their care needs unmet because their assessed needs for care were not always followed by staff.

People had received their medicines as prescribed.

People felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were arrangements in place to ensure that decisions were made in people's best interest. However, the process for assessing a person's capacity to make a decision required improvement.

People were supported by suitably trained staff.

People enjoyed the meals provided and were given snacks and drinks at regular intervals, or when requested.

People received support from healthcare professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were treated with respect.

Individual staff demonstrated kindness and compassion.

People were supported to maintain their independence because they were involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received a service that was not always based on their individual needs.

People were supported to participate in a range of group or individual activities but these were not always centred on the person's individual choices.

The systems in place to listen and learn from people's experience were not always effective.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The processes in place to check and monitor the quality and safety of the service were not effective and required improvement.

People, relatives and staff felt the new manager was approachable and the service had improved during the short time they had been there.

People felt happy with the service they received.

Cherry Lodge

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 30 August 2016 with a return announced visit on the 31 August 2016. The inspection team consisted of one inspector, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health difficulties.

Before the inspection, we reviewed information we held about the service. This included information about deaths, accidents and safeguarding alerts that the provider is required to send to us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authorities who purchased the care on behalf of people to ask them for information about the service and reviewed information that they sent us on a regular basis.

During our inspection we spoke with 16 people, eight relatives, three health care professionals, the acting manager, the provider and 13 staff that included care workers, team leaders, kitchen and domestic staff. Because some people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to four people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included; three staff recruitment and training files. This was to check suitable staff were recruited, trained and supported, to deliver care to meet each person's individual needs. We also looked at records relating to the management of the service and a selection of the provider's policies and procedures, to ensure people received a quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found improvements were required to infection control. We saw there had been some improvement although there remained an unpleasant odour on the ground floor. We asked people, their relatives and staff for their views about the cleanliness of the home. One person said, "My room is cleaned." One relative told us, "I think it is very clean, [person's name] room is lovely and cleaned every day." Another relative said "Sometimes there can be a bit of a smell but that's to be expected really." A staff member told us, "There has been a huge improvement from when I first started, staff have started to be trained in infection control and one communal bathroom is being refurbished." Another staff member said, "We tell the provider what we need and it is delivered quickly, we never run out of cleaning materials." During our inspection, we saw staff had access to and used cleaning materials and protective clothing when supporting people.

Some of the issues identified at our last inspection had been actioned. We found broken and missing bathroom fittings and tiles had been repaired and replaced. Clinical waste was not left unattended and had been disposed of correctly. However, we saw the upholstered furniture in the main reception area was stained and the smell of urine in that area was strong. The acting manager explained one upholstered chair in the reception area had recently been 'deep cleaned' and the provider confirmed she had purchased additional deep cleaning equipment to clean the remaining upholstered chairs. The provider also told us there were plans to replace the main downstairs lounge carpet. We saw cleaning schedules had been introduced by the acting manager and, according to the training plan, infection control training had been delivered to five of the 41 staff. There was currently no staff member responsible for infection control although the acting manager had identified a staff member for this role. Staff told us the new cleaning schedule had helped them to target areas that required a deep clean on a more regular basis. We saw there was one bathroom on the first floor that was not adequately cleaned. The acting manager told us the bathroom was not used by people living at the home and all communial bathrooms were going to be refurbished.

Risk assessments had been completed for people when they first moved into the home. We saw equipment such as pressure relieving mattresses and cushions were in use to support people who were at risk of developing skin damage. However, identified risks to people were not consistently managed. For example, risk assessments for two people had identified they were at high risk of falls, confirmed with entries in the accident book. We saw both people had a number of falls during a period of time and the risk assessments had not been updated to reflect these falls. We saw when both people had fallen and sustained injuries to the head, the response from staff was inconsistent. The records showed medical intervention had not been consistently requested and the people had not consistently been kept under close observation following the head injuries. The risk assessments should have contained information for staff on what to do in the event of a head injury sustained as a result of a fall. The acting manager had already identified in the PIR sent to us there were gaps in peoples' risk assessments and told us they were addressing this as a matter of urgency. The acting manager also told us staff would be instructed 'immediately' on what to do in the event of a head injury. While we were at the home, she introduced a procedure, for head injuries attained during a fall, for staff to follow and this was added to the provider's processes.

People were supported by staff with their medicines. People we spoke with told us they had no concerns about their medicines and confirmed they received their medicines on time and as prescribed by the doctor. One person told us, "They [staff members] give me my medication." We saw staff administering medicine wore a brightly coloured tunic, over their uniform, with writing on the tunic that said not to disturb the staff during the medicine round. This clearly identified to people and visitors the staff responsible for administering the medicines with a view to reducing the risk of interruptions so as to avoid medicine errors. A visiting professional explained they had no issues and found the staff were 'pretty good.'

We reviewed four people's medicine recording sheets and found there were people who required medicine to be given 'as and when'. We found protocols that provided guidance for staff when people required pain relief were in place. We saw one person asked a member of staff what their medicine was and why they needed it.

Safety checks of the premises and equipment had been completed and were up to date. We saw a spillage being dealt with by care staff. Safety signage was used and people that walked by the spillage were guided away from the area affected by staff. Staff explained what they would do in the event of an emergency. For example, staff were able to explain what action to take in the event of a fire. The provider safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

The provider had a recruitment process in place to make sure they recruited staff with the correct skills and values, however, the process required improvement because Disclosure and Barring Service (DBS) good practice was not being followed and the provider was not checking references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people. The acting manager took immediate action and requested staff members to bring in the required paperwork for up to date DBS checks to be completed.

People and relatives felt there were enough staff, although there were some mixed views from staff members. One person told us, "There is always plenty of staff walking around if you need any help." A staff member said, "No, I don't think there is enough staff but [acting manager's name] knows and is seeing to it." Another staff member said, "Sickness is covered by our own bank staff and occasionally agency but there hasn't been any agency for ages." We had been told there had been shortages in the past. The PIR detailed there were 31 staff members but since taking up the position of acting manager, in mid July 2016, staff numbers had been increased to 41. A relative told us, "Staffing has got a lot better." We saw that call bells were answered in a reasonable length of time and there was sufficient staff on duty to meet people's needs.

People we spoke with told us they felt safe living at the home. One person said, "It is very safe here." Another person told us, "I have seen the staff rush when someone falls." A relative said, "I think people are safe here." People and relatives told us they could raise concerns with the acting manager if they were worried. Health care professionals we spoke with 'felt' their clients were safely cared for at the home. All the staff we spoke with had a clear understanding of how to safeguard people. They told us what they would do if they had concerns about people and how they were being looked after. One staff member said, "People are safe because the staff are good and will ask if we are unsure." Staff told us they had received safeguarding training and were clear about their responsibilities for reducing the risk of harm. Staff told us about the different types of abuse and explained what signs they would look for that could indicate a person was at risk.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the provider had not met the regulations and applied for the appropriate authorisation to deprive people, living at the home, of their liberty in order to keep them safe. The provider was issued with a Requirement Notice. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection 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. We found there had been some improvements and the conditions of the Requirement Notice had been met.

Staff we spoke with demonstrated limited knowledge of DoLS, nonetheless they identified people who they felt could be put at risk if they were not restricted, for example, from leaving the home unsupervised. We saw that some people were closely supervised and had been subjected to a restricted practice, in their best interest, to prevent injury to themselves or others. The PIR showed 16 people had their liberty, rights and choices restricted in some way but only six DoL applications, up to December 2015, had been submitted. However, we found further applications had been submitted by the acting manager in July and August 2016. Because the acting manager had submitted further applications to the supervisory body; we found the provider had met the legal requirements under the legislation.

Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "We ask people and if they can't actually tell us, you can tell by their facial expressions and their reactions if they are happy." One person told us, "Yes, the staff do ask if it's alright first before they do anything for me." 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. Care records showed that the MCA principles had been considered, however the mental capacity assessments were not person centred and were identical on all the plans we had looked at. An assessment of a person's capacity must be based on their ability to make a specific decision at the time it is needed to be made and not the person's ability to make decisions in general. A person may lack capacity to make a decision about one issue but not about others. The acting manager explained they had identified the need to amend the provider's MCA document. The provider confirmed this was an area they would review.

The acting manager recognised that important decisions needed to be individual to the person and those people without family support required the involvement of health and social care professionals. She continued to explain the process to arrange 'best interest' meetings. For example, an Independent Mental Capacity Advocate (IMCA) arrived while we were at the service to meet with one person. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions; including making

decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one, such as a family member or friend, who is able to represent the person.

People spoken with told us they were happy with the way staff supported them. Staff we spoke with said they were supported by the management team in carrying out their roles. One person told us, "Staff give me plenty of support, I would always go to the staff if I had any sort of problem." Another person said, "I feel the staff have the skills to look after me, they do a good job." A relative told us, "The staff are very good and supportive during the time my relative has been there." Staff members spoken with all told us they felt supported by the acting manager and were happy with the training they received from the provider. One staff member explained, "The training is very good and since [acting manager's name] has arrived we have received more training." We saw that staff received training and refresher training updates were in the process of being reviewed and arranged for 2017.

The PIR had identified staff had not always received supervision or an annual appraisal. One staff member told us, "I hadn't had a supervision until the new manager arrived." Another staff member said, "I'm relatively new and have had supervision but I can approach the management team at any time." We saw from three staff records that supervison and appraisals had not been consistent. However, all the staff spoken with told us they held daily 'handovers' with each other to discuss people's support needs and were confident to approach the management team if there were any concerns.

People we spoke with told us they were offered choices at every meal and had access to drinks. One person said, "The food is very good with plenty to eat, you would never go hungry here and they [staff] are always offering drinks especially on days like today when its so hot." Another person told us, "I like the food it's lovely." We saw the day's menu was displayed on a board in the dining room. The dining room staff were organised and lunch was served to people with a choice of drinks. People were also offered a choice of sauces with their chosen lunch and received their choice of dessert. All meals looked well presented. We saw that people who chose to eat in their own rooms received their meals without delay and that meals were plated and covered to keep the food hot. We saw that staff supported people to access snacks and drinks throughout the day.

Staff we spoke with said people were assessed to meet their individual dietary needs and ensured people received a healthy and balanced diet. One staff member explained to us how they would use food supplements to thicken drinks to aid swallowing and fortified foods to support people at risk of losing weight. We saw that people's dietary needs, preferences and allergies were shared with kitchen staff. Where appropriate, referrals had been made to a Speech and Language Therapist for support (SALT). A SALT is a healthcare professional that provides support and care for people who have difficulties with communication, or with eating, drinking and swallowing.

We saw visiting professionals attended to people to assess and review the person's care and support needs. For example, a GP, district nurses and social worker. People told us they were regularly seen by the GP and health care professionals. One person said, "The doctor has been today." Staff spoken with were knowledgeable about peoples' care needs and how they preferred to be supported. A relative said, "We're very impressed with the home, [person's name] was a bit nervous before they came but we think she has settled in very quickly." Health and social care professionals had told us they found the staff to be knowledgeable of peoples' health and support needs. Staff would contact them, when a person's needs changed, which supported people to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring and kind. One person said, "The staff are lovely, very kind." Another person told us, "I am very happy with the care I receive here, nothing is too much trouble for them. I find them very compassionate, they don't rush you to bed, you please yourself and in the morning they respect you by knocking on your door to see if you are awake. Couldn't wish for better." A relative told us, "Most of the staff are good, especially [staff name] but some just do the job. It's got a little better since the new manager has come in." Another relative said, "I've never seen staff behave in a way that wasn't caring, they all seem very nice." A staff member told us, "The atmosphere is homely and welcoming." People we spoke with told us they could approach staff. We saw throughout the two days, people would come into the main office to speak with the acting manager or deputy manager and approached staff who were working within the home.

People we spoke with told us staff listened to them. Staff explained how they supported people who could not express their wishes, for example, once they got to know people, they could tell by facial expressions and body language whether the person was happy with their care. Staff spoken with explained they would make sure they would deliver care in a way the person was happy with. If the person was not happy, staff told us they would leave the person for a while, then return later to check if the person had changed their mind. Staff told us they treated people with kindness and empathy; we saw they understood people's communication needs and gave people the time to express their views.

There were a number of people living at the home with dementia. We saw one person became upset and presented behaviours that could have compromisedtheir dignity. Staff responded to the person in a caring and calm manner, their approach was flexible to meet that person's individual needs. As a result of this interaction, the person became calm and was supported by staff to maintain their dignity. One person told us, "I find the staff very respectful." We saw that staff knocked on people's doors, referred to people by their preferred name and were polite and courteous.

A number of people were supported to walk by the staff at a pace suitable for that person. In the downstairs lounge, we saw the interactions between staff and the people were respectful. We asked staff how they would encourage people to maintain their independence. One staff member said, "I help people to wash and if they can, I encourage them to wash themselves." Another staff member told us, "I show people different clothes and ask them which ones they prefer and they will point or gesture to the one they like the most." We saw people were dressed in individual styles of clothing that reflected their age and gender.

People had been supported to maintain relationships with family members and friends they said were important to them. One person said, "I have a visit from my daughter and she takes me out." Another person told us, "My son visits regularly." A relative told us "There had been restrictions on visiting times, but since the new manager has arrived it is much better." Another relative said, "I come regularly and the staff always make me feel welcome and give me a cup of tea." We saw a high number of relatives and friends visiting their family members. There were opportunities for relatives to meet on a first floor lounge for privacy or in the person's bedroom; giving people the opportunity to meet with their relatives in private.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that people and most relatives were not confident their concerns would be addressed. At this inspection we found there had been some improvement. One person told us, "I don't have any complaints but if I did I'd go in there [pointing to the office]." Another person said, "I'd probably tell my son and he could tell the manager." A relative said, "We're hoping with the new manager in place things will get better, there has been some improvement although we have had to raise a couple of things." Another relative told us, "We are very happy with the home and have no complaints at all." We looked at how complaints had been managed and found there had been none recorded since our last visit. We had received information about two complaints but could not see where these had been recorded. The acting manager explained they were currently working with one family about a complaint they had but was not aware of any others. There were some action plans written up following historic complaints, but they had no outcomes recorded to help the provider identify trends. Identifying themes and trends from complaints would enable the provider to learn and further develop the service

At our last inspection, we found there was a mixture of opinions about communication between the home and relatives. At this inspection, we found there had been some improvement. One relative told us, "I know the home has had its problems, but the new manager seems to be doing a good job." Another relative said, "[Person's name] hasn't been here very long but I always get a call if there is something wrong, they [staff] are very quick to let me know." Health care professionals we spoke with told us, they felt the provider responded appropriately to requests made by them.

We found the large lounge on the ground floor was busy and noisy. A person told us, "It does get very loud in here, it can give me a headache." Another person said, "It can get very busy." A relative told us, "My relative finds the main sitting room very hectic and busy, she prefers the tranquillity of the smaller sitting room." We saw there was a smaller lounge on the ground floor that was empty for most of the day. Although we saw visiting relatives use the room we did not see people who lived at the home use it. We asked the acting manager why staff did not encourage people to use both rooms. We were told that both lounges were used regularly although this was not our experience.

At our last inspection we found that people did not participate in interests and hobbies that were personalised to their individual needs. We found at this inspection there had been some improvement but further improvement was required. We were told that all staff shared responsibility for providing activities for people to do. Most of the people we spoke with told us they 'were bored' or 'watched television all the time'. One person told us, "There really isn't much to do, I just watch the telly." Another person said, "They do bingo and someone comes in to sing." We saw one person, that lived at the home, played the piano for people to listen to. There was a mixed response from the relatives we spoke with. With some saying they thought there was sufficient hobbies and interests for people whilst others felt more could be done by the provider. One relative said, "The staff have enough to do with looking after people, they don't have time to sit and carry out activities for people as well, I'd like to see some sort of activities person." We did not see any person centre activities or hobbies although we saw some people were reading newspapers and magazines. Staff did attempt to encourage people to participate in group lounge activities while we were

there, for example, singing and some were dancing to music. We told the provider and acting manager what people and relatives had told us about the lack of activities. The acting manager said they were looking to introduce some additional interests in the home and that it was under review.

Staff we spoke with were able to tell us about people's individual needs, their likes and dislikes. People and relatives we spoke with confirmed most staff supported them in a way that was responsive to their individual needs. One staff member told us, "We discuss the person's likes and dislikes with them and we do try and work to the person's preferences and choices." Another staff member said, "Each person is assessed by the seniors when they first come to the home and we also speak with their relatives." We saw that people's changing needs were kept under review, although reviews were not always consistent. We spoke with the acting manager who told us they had already identified there was some inconsistency with reviews and this was currently being addressed. Staff we spoke with confirmed that daily handovers took place within the home and any changes to people's needs were discussed with them, to ensure that there was no negative impact on the care and support people received.

People we spoke with told us staff would speak with them about how their care and support should be given. One relative told us, "The home has been very good making sure mum receives one to one care from the staff." People's care plans generally reflected the care and support people received. The care plans confirmed an assessment of people's care and support needs had been undertaken when they first moved into the home and these had been reviewed. We asked staff how they ensured people were involved as much as possible when assessing the person's needs. Staff told us they would speak slowly to people and give them time to respond. They continued to explain how they would show people, for example, different clothes offering them a choice. One staff member said, "When you get to know people, you know what they like."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that improvement was required in the quality assurance systems that monitored the quality and delivery of the service. At this inspection we found there had been some improvement made but systems in place to audit the service remained ineffective at identifying areas that required improvement.

The acting manager had already identified in the PIR that there were 'gaps in the recordings of care plans and risk assessments'. For example, there was some inconsistency in the recording of people's weight and fluid intake for those at risk of losing weight. We saw the acting manager had introduced a 'weight management system' and staff spoken with confirmed the acting manager had started to introduce new systems to audit care plans and risk assessments. We were shown new processes that the acting manager had put in place to support the staff around mental capacity assessments and best interest meetings. A new 'best interests' form was introduced to guide staff through the best interests process. In addition, a revised mental capacity assessment form was also introduced to ensure the assessment process was more person centred. Accidents and incidents had not been consistently recorded and there was no analysis, apart from August 2016, available to demonstrate what action had been taken and the preventative measures put in place. Because there was no consistent system to monitor trends in respect of accidents, incidents and safeguardings, since our last inspection, the provider could not be confident the records they did have would be an accurate reflection of the service. The provider had not effectively monitored the areas requiring improvement, as identified in our last report. The acting manager had started to review some processes and had introduced a separate accident and incident reporting procedure.

There was an acting manager in post and they had started their application process to become the registered manager. It is a legal requirement to notify the Care Quality Commission of any significant incidents or accidents that happen as this helps us to monitor and identify trends and, if required, to take appropriate action. We had been notified about significant events by the provider. The acting manager explained they were in the process of investigating a safeguarding, the outcome was unknown because the investigation was ongoing.

There were mixed opinions from people and relatives on whether they were asked for their views on how the service could be improved. One person said, "I have never attended any meetings but if they do have any events happening they do tell us." A relative told us, "I do recall being asked recently." Another relative said, "I don't think I've filled in any satisfaction surveys." We asked the provider if any satisfaction surveys had been given to people and relatives. They explained surveys had been posted to relatives but they had not received any responses. Although we saw there had been some resident meetings, there was limited information available for us to review because some of it had been inconsistently filed and stored and there were no copies available to us.

The administration process to return medicines that were no longer necessary and needed to be destroyed required improvement. The acting manager told us they had already taken measures to have medicines returned to the pharmacist and destroyed. We found medicines were safely stored in order to keep them

secure, but the room temperature was 26/27 degrees. The recommended room temperature for storing medicine by manufacturers is 25 degrees; temperatures higher than this could affect the medicine and reduce its effectiveness. There was no daily recording of temperatures and no processes in place to inform staff of what action to take in the event of temperatures exceeding 25 degrees or guidance on how to reduce the risk of reoccurrence. As there was no process to record the daily temperature, no action had been taken to reduce the temperature. When we discussed this issue with the acting manager, they immediately introduced a book to record the temperature and told us they would discuss with the provider about installing a fan to cool the room down. We checked the temperature later in the day and it had reduced to 25 degrees.

Generally everyone was complimentary about the service. We were told people, relatives and health and social care professionals found the new manager to be 'approachable', 'constructive' and 'organised'. One person said, "She's lovely (pointing to the acting manager), she's very helpful you know." A relative told us, "She'll [the acting manager] be good for the place, she strikes me as someone who will get the job done." One staff member told us, "Atmosphere is good, we have new staff and they all seem to be hard workers, the team work well, there is always the manager or team leader here, [acting manager's name] has said we are able to ring her 24 hours a day and told us to ring for anything." Another staff member said, "I feel valued by the management, they are fair and approachable and things are much more organised since the new manager came." People and relatives told us that they could speak with members of the management team and confirmed there was an 'open door' culture to the office. We saw that people and relatives approached the acting manager and other staff freely during our visit.

Staff we spoke with told us they were able to raise concerns at staff meetings which were held approximately every six to eight weeks. Staff were supportive of the acting manager and for the development of the service, one staff member said, "I love working here." Another staff member told us, "You do get support from the managers they come out onto the floor." We saw team meetings were held. One staff member told us, "The team meetings are much better now, we talk about how we are going to support our residents and the best way to do it, whereas before I personally didn't get anything out of them.

Although there was no registered manager in place, the management structure was clear within the home and staff knew who to go to with any issues. Staff told us they would have no concerns about whistleblowing and felt confident to approach the acting manager, and if it became necessary, to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. Whistleblowing is the term used when an employee passes on information concerning poor practice.