Care Uk Community Partnerships Ltd

Sunningdale

Inspection report

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Ratings

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

Overall summary

Sunningdale is situated to the east of the city of Hull, near to public transport facilities and there are local shops within walking distance. The service is registered to provide accommodation and personal care for a maximum of 49 people some of whom may be living with dementia. All the rooms are for single occupancy. There are sufficient communal areas, bathrooms and toilets on both floors. There is an accessible garden and car parking at the front and rear of the building.

The service has a registered manager. 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.

We undertook this unannounced inspection on the 7 and 8 October 2015. At the last inspection on 3 December 2014, the registered provider was non-compliant in the

Summary of findings

safe management of medicines and records. We issued compliance actions for these areas and received an action plan which told us what the registered provider was going to do to address these issues.

We found there were improvements in records but an on-going concern with the management of medicines. Some people had not received their medicines as prescribed. Although we could not see there was a direct impact on the people who used the service, for example, there had been no complaints that people had been left in pain, there was the potential for this. You can see what action we told the registered provider to take at the back of the full version of the report.

We found the quality monitoring system, for example audits regarding medicines had not been wholly effective. It had not identified or, when they had been identified had not addressed, errors in medicine management. We also found some issues in how information was communicated to staff and how they worked together as a team in periods of high need.

We found staff were recruited safely and were employed in sufficient numbers to meet people's needs, although there were still shortfalls in nursing staff which were currently filled by agency nurses. Recruitment was continuing for permanent nursing staff. We found there had been some instances when the deployment of staff at peak times could have been managed more effectively. This was mentioned to the registered manager to address.

We found there were policies and procedures to guide staff in how to safeguard people who used the service from harm and abuse. Staff received safeguarding training and knew how to report concerns. Risk assessments were completed to guide staff in how to minimise risk and potential harm.

Staff had access to induction, training, supervision and appraisal to help them develop their skills. There had been an incident reported to the Care Quality Commission of staff not adhering to training and policies and procedures regarding moving and handling and infection prevention and control. The registered manager was dealing with this with the individual staff involved.

We found people's nutritional needs were met and menus were varied. The food provided to people was well-presented and in good portions.

People had their health needs met and received additional treatment and advice from a range of health care professionals in the community.

People were treated with respect and supported to make their own decisions and choices. When they had been assessed as lacking capacity to make their own decisions, staff acted within the law and held best interest meetings with relevant people present. We observed staff support people and their relatives in a kind and compassionate way. There was a range of activities for people to participate in and links had been made with the local community.

People felt able to make complaints. There was a policy and procedure to guide staff.

We found the environment was suitable for people's needs and was clean and tidy.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Some people had not received their medicines as prescribed.

There was sufficient staff on duty but the deployment of staff at peak times was not as effective as it should be to meet the needs of people in the nursing unit upstairs.

Staff were recruited safely and training in safeguarding guided them in how to keep people who used the service safe from harm and abuse.

Is the service effective?

Requires improvement

The service was not always effective.

We found there had been some instances when people's health and nutritional needs had not been fully met. People received treatment and advice when required from a range of community health professionals. Meals were varied and well-balanced.

Staff received training, supervision and appraisal to help them develop their skills and feel confident supporting the people in their care. There had been an incident when staff had not followed training and guidance in moving and handling and infection prevention and control.

People were supported to make their own decisions and choices. When they lacked capacity for this, staff acted within the law and held best interest meetings for important decisions that may involve restrictions.

Is the service caring?

Good

The service was caring.

We observed staff interacted with people in a kind and caring way. People and their relatives were offered support and reassurance in times of need.

People were treated with respect and their privacy and dignity maintained. We saw people were kept informed about events happening in the service and they were involved in planning their care.

Staff kept people's confidential information safe.

Is the service responsive?

Good

The service was responsive.

Care was provided to people in a person-centred way. Assessments and care plans contained social histories and information about how people preferred to be cared for.

Summary of findings

People had the opportunity to participate in a range of activities in groups and individually with the activity co-ordinators.

There was a complaints policy and procedure and people felt able to raise concerns.

Is the service well-led?

Requires improvement 

The service was not always well-led.

There was a quality monitoring system but this had not been wholly effective in addressing shortfalls in the management of medicines.

There was a concern that communication and teamwork had not been as effective as it should be to ensure all staff received appropriate information and worked well together to meet the needs of people who used the service.

There were systems in place to gain people's views such as meetings and surveys and to feedback this information.

Sunningdale

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 8 October 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience [ExE]. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service for example, people living with dementia.

We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

We spoke with the local safeguarding team, the local authority contracts and commissioning team and a health professional about their views of the service. There were no concerns expressed by these agencies apart from an inconsistency regarding the use of agency nurses.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with nine people who used the service and eight relatives. We spoke with the registered manager, deputy manager who is also a nurse, two senior care workers, four care workers, an activity co-ordinator and an administrator.

We looked at eight care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 36 medication administration records [MARs]. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Sunningdale. Comments included, "I've heard fire alarms tested several times, the doors shut automatically", "I like it here, there is nothing at all wrong here" and "Yes, I do feel safe here." People said about staff attendance to them, "They're usually pretty quick."

We spoke with several relatives. One group of relatives who were visiting their family member said, "Definitely [person's name] is safe here, they are looked after really well." Another relative said, "When I leave here I know that [person's name] is safe and it has taken that worry away from me." Two relatives did comment that staffing numbers had been an issue. We observed during the day that the call bells were answered quickly.

At the last inspection on 3 and 4 December 2014 we had concerns about the management of medicines and we issued a compliance action to ensure this was improved. We found there were still concerns regarding the administration of some people's medicines and they had not received them as prescribed. Errors had been made in the timings of pain relief patch applications to several people who used the service. When we checked care records, we found people had not been in pain as a result of these errors and staff organised a GP to review one person's pain relief on the day of inspection. We found one person had received a weekly medicine after a gap of eight days and on one other occasion this had been missed altogether. We found there were gaps on some people's medication administration records [MARs] so we were unsure why the medicine was omitted. On some occasions when people had declined medicines, there was no recourse to their GPs for advice and possible change in treatment plans. We found stock control for two people's pain relief patches had not been managed effectively as they had arrived late which had affected their application. Also there was an overstock of one person's medicine which meant a large quantity had to be destroyed. Medicines were stored safely and appropriately.

The on-going issues with medicines management meant there was a continued breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which is now held within Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We found staff had been recruited safely and all employment checks had been carried out prior to new staff starting work. These included exploring gaps in employment on application forms, obtaining references from previous employers and ensuring disclosure and barring [DBS] checks were carried out; this helped to ensure only suitable people worked in care home settings. Potential staff attended for an interview, although we found the discussions held with them were not fully recorded. This made it difficult to audit how employment decisions were made and was mentioned to the registered manager.

We found there were now sufficient staff on duty to meet the needs of people who used the service. There had been concerns from staff about staffing levels at specific times and there had been a reliance on agency nurses which had led to inconsistences of practice. A new full-time nurse had started at the service the week before the inspection which should help to resolve issues during the day. However, there was still the use of agency nurses at night until recruitment was complete. The registered manager told us there was a shortage of qualified nurses to work in nursing homes in Hull and recruitment had been difficult. They also told us they used two specific nursing agencies and planned the required shifts each month with them so the same agency nurses could be obtained. This helped to ensure some consistency. A health professional confirmed to us there had been some inconsistencies with qualified nurses on duty. They said, "The use of agency nurses has led to inconsistencies of practice especially with medicines management."

Staff told us they felt shortages occurred upstairs on the nursing unit at certain times of the day and on certain days. They said this was due to some staff assisting with care tasks more than others; they told us all the staff did not always work as a team as much as they could. Comments included, "I like working here, there are good and bad days; it's a struggle when staff ring in sick on the day", "It was busy this morning and we didn't get a proper handover", "Sometimes we get the floater [additional member of staff based downstairs] but it's not very often", "It's not usually as chaotic as today; it's been especially busy – when we

Requires improvement

Is the service safe?

have seven carers on there is no problem" and "Sometimes the activity coordinator helps at meal times and that makes a big difference." We spoke with the registered manager about how the deployment of all staff could be utilised to address this issue quickly and resolve pressures some staff felt had occurred. The registered manager told us this would be addressed straight away in discussions with staff. The staff team had been particularly busy the two days of the inspection as there had been staff sickness and two people died who were in receipt of end of life care. In addition, the family of another person who had recently died had arranged for their funeral to go from the service.

There were policies and procedures to guide staff in how to safeguard people from harm and abuse and how to report any concerns. Staff confirmed they had received safeguarding training and in discussions were able to describe the different types of abuse, signs and symptoms and the actions to take should they witness harm or abuse.

We saw risk assessments were completed to help minimise incidents and accidents. These included areas such as moving and handling, nutrition, falls, tissue viability, smoking, hot drinks, behaviours that could be challenging and the use of equipment such as bedrails and hoists.

The service was clean and tidy. Staff confirmed there was plenty of personal, protective equipment [PPE] to use to prevent the spread of infection. There had been some instances when the practice of individual staff regarding infection prevention and control was witnessed as not being of an acceptable standard. This was mentioned to the registered manager who was to address this individually with the members of staff in supervision. In discussions during the inspection, staff described how they would maintain good infection control practice when supporting people with personal hygiene needs. This involved the use of PPE, effective hand washing techniques and appropriate washing and disposal of soiled items.

Equipment used in the service was maintained appropriately so it was safe to use. People who used the service could choose whether to have their bedroom doors open or closed as each was fitted with a mechanism linked to the fire alarm system. There were coded entry pads for security at the entrance and on some doors within the service such as the sluice rooms and treatment rooms. Generally security was good as people rang to be let in and were asked to sign in. On the day of inspection one person was let in as a person who used the service was going out. They were observed walking around for a couple of minutes until approached by staff; they were expected as they were viewing the service. The administrator told us this was a one-off incident and usually people were greeted at the door.

Requires improvement

Is the service effective?

Our findings

People who used the service told us they liked living there, they enjoyed the meals and had choices about what to eat. Comments included, "The cook asked me yesterday what I wanted", "I do look forward to my meals, my food is mashed up for me", "Food is nice, always nicely cooked", "Food and meals are first class" and "[Person's name] is a fantastic cook." People told us they could make their own choices and decisions. Comments included, "I like it here; I have freedom and can smoke in the garden when I want to" and "Yes, I get up and go to bed when I want; the carers take me for a bath – I do enjoy a bath."

A relative told us they thought staff were trained to be able to meet their needs. They said, "They seem to know what they are doing."

We found people's nutritional needs were met although on the second day of the inspection we saw people on the nursing unit upstairs had not received a mid-morning drink. We saw people received fluids at other times of the day. During lunchtime we observed some good staff practice when supporting people to eat their meals and other occasions when this could be improved. These points were mentioned to the registered manager to address with staff. Staff told us there had been a recent change in the organisation of support to people in the nursing unit who required full assistance to eat and drink. Two meal sittings had been arranged so that all available staff could support people. They said this had eased the situation somewhat.

Menus were varied and offered choice and alternatives. Special diets were catered for and meals of different textures produced to assist people with swallowing difficulties. Catering staff were aware of people's likes, dislikes and special nutritional needs. Assessments of people's needs in relation to their nutrition were completed and care plans were formulated to guide staff. We saw the care plans described the portion size people preferred, likes and dislikes and what amount of support they required. They also described what snacks they liked in between meals and how they took their tea and coffee. Nutritional risk assessments were completed using a recognised tool and people were weighed in line with the analysis of risk; this could be weekly or monthly as required. We saw dieticians and a specialist gastrostomy nurse were involved with some people whose nutritional intake was compromised or if they received nutrition through a tube directly into their stomach. These health professionals provided treatment plans and advice for staff and people who used the service.

We saw people's health care needs were met although since the last inspection, there had been an incident when the care of one person's feeding tube had not been managed appropriately by an agency nurse which had resulted in the person's admission to hospital to change the tube. We also saw one person had a sore eye; the registered manager was to ensure their GP was told.

Care files showed us people had visits from a range of health professionals including GPs, consultants, district nurses, specialist nurses, podiatrists and opticians. In discussions, staff were clear about how they recognised when a person's health was of concern, for example when they showed early signs of chest and urinary tract infections or when fragile skin was at risk of breaking down. They described the action they would take to prevent people's health deteriorating and the professionals they would contact for advice and treatment for them. For example, one care plan looked at stated, "[Person's name] has chronic obstructive pulmonary disease and emphysema – observe for chest wheeze and breathlessness and inform GP" and another stated, "Staff to use all opportunities when assisting with personal care to check risk areas of heels, elbows, buttocks, hips, shoulders and spinal areas – any redness problems to be reported immediately so medical advice can be sought." People who used the service confirmed they saw their GP or other health professionals when required. One person said, "The nurses that come here are the same that visit me at home, which is nice." One person had a wound care plan for a pressure ulcer that had been acquired prior to admission to the service. These documented when dressings took place and there was evidence of improvement in skin condition as a result.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. We found there had been improvements in staff's understanding of the Mental Capacity Act 2005 [MCA] and DoLS since the last inspection. Records showed relevant staff had completed MCA and DoLS training. The registered manager told us

Is the service effective?

applications for DoLS were underway for specific people who met the criteria and they were awaiting authorisation by the local authority. We saw when people were assessed as lacking capacity to consent to care and make their own decisions, best interest meetings were held to discuss options; these included ensuring relatives and other relevant people had input into discussions about decisions. For example, with decisions about active resuscitation, covert medication and the use of bedrails and specialised chairs that restricted movement.

We looked at the care plans to check what action had been taken to ensure the people were cared for using least restrictive practices. One care plan described the restrictions in place for the person due to their complex care needs. We saw the restrictions were required to keep the person safe.

The training records showed staff completed a range of training considered essential by the registered provider. This included, fire safety, first aid, MCA/DoLS, safeguarding, infection prevention and control, moving and handling, health and safety and medication management. There was other training available such as catheter care, stoma management, Diabetes awareness, pressure care, wound care, documentation and care planning. One member of staff said, "I think we do have enough training." Despite the training staff received, there had been an episode of care reported to the Care Quality Commission that indicated staff had not followed training and policies and procedures in moving and handling or infection prevention and control. This had affected the care of one person although they had not been placed at risk. We spoke with the registered manager about this and they will be speaking to individual members of staff to ensure there is no repeat of the incident.

In discussions, staff described how they ensured people made as many choices and decisions as they were able to. They said, "We ask people what they want to do and what they want to wear or eat." We saw care plans described how people would make choices and reminded staff to respect decisions. For example, we saw the following phrases written in care plans, "Will say when she wants to be supported", "Chooses own clothing", "She will choose when she wants to be engaged with her peers or staff" and "Explain everything fully to [person's name] to ensure they have understood what is said."

Staff spoken with confirmed they received supervision meetings. These were completed individually or sometimes as a group. A clinical manager was employed by the registered provider to complete 'clinical supervision' with qualified nurses. There was an annual system to look at the development needs of staff and this year's personal development reviews [PDRs] had just started. The registered manager told us the heads of departments had received their PDR and these were to be cascaded to all staff.

We found the layout of the environment suitable and met people's needs. Corridors were sufficiently wide for people who used wheelchairs and there was equipment such as raised toilet seats, assisted baths and grab rails throughout. There was appropriate signage to act as reminders to assist people living with dementia. We observed the service was clean and tidy with no malodours at all. This was confirmed in discussions with relatives who commented on the cleanliness and pleasant environment for people.

Good

Is the service caring?

Our findings

People who used the service were very complimentary about the staff and said they were well-cared for. Comments included, "I'm very happy here; the staff are lovely and I like the meals", "The carer's are lovely", "The staff are brilliant", "I have a nice room and I chose the wallpaper; the handyman came and did it for me", "The staff are perfect; there is nothing for me to worry about here", "So nice the carers, they look after me", "Carers are really kind; personal care is very good and "It's good [the care provided], I definitely couldn't manage at home; the staff really look after me."

Relatives also commented positively on the care their family member received. Comments included, "The care that [person's name] gets is good."

A health professional stated, "There is no problem with the carers, they seem to have clients best interests at heart. They have good relationships with people."

People told us that staff were polite and respectful. We observed staff knocking on people's bedroom doors before entering. On arrival at the service, the cortege of a former resident was leaving from the home for their funeral and a group of staff were lined up outside paying their respects to the person and their family. This was appreciated by the family.

We also observed staff support the relative of a person who had died on one of the mornings of the inspection. This was done in a caring and compassionate way.

In discussions, staff described how they promoted privacy and dignity and in most instances staff put this into practice. There was one instance when a moving and handling episode could have promoted a person's dignity more effectively. The registered manager was taking action regarding this with individual staff involved. One visitor told us there was a spelling mistake of their relative's name on their bedroom door. This was mentioned to the administrator and a new nameplate ordered.

We observed people were free to move about the service independently and staff supported when required. We saw staff provided explanations to people prior to delivering care and support or assisting with moving and handling tasks such as transfers into comfortable chairs or wheelchairs. They gave people time to respond to questions and instructions during moving and handling tasks.

We saw some call bells had clips so they could be attached to bedclothes and so be easily reached for people. One person told us their call bell had slipped to the floor and they were unable to summon assistance and the clip now resolved that issue. The person said they were happy with how this problem was sorted out for them.

We observed during lunchtime that a health professional had arrived to see their patient but was asked by staff to return when they had finished their meal. This helped people to have 'protected mealtimes' so they could enjoy this important part of the day without interruptions. Staff were observed supporting people to eat their meals at a pace suitable to their needs. They spoke to people throughout the meal and described what was on the plate for them. This was a social occasion for people with background music and as one person described, "A good bit of banter." We did note that staff spoke quite loudly at times and one person told us this could occasionally be too loud. This was mentioned to the registered manager to discuss with staff.

We saw care plans involved people in decisions and it was clear they had been written following discussions with people who used the service and their relatives. The care plans contained preferences, likes and dislikes.

There were four colourful notice boards in the entrance which provided people with information about menus, quality survey feedback, dates of meetings, how the service was involved in caring for the environment, pictures of staff, coming events and activities on offer. We saw the registered manager had displayed the Care Quality Commission's overall rating for Sunningdale which was awarded after the inspection in December 2014.

The registered manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. We found people's care files in daily use were held in the staff offices on both floors. Staff records were held securely in lockable cupboards in the administrator's office. Medication administration records were secured in the treatment

Good

Is the service caring?

rooms on each floor. The registered manager confirmed the computers were password protected to aid security. We saw staff completed telephone conversations with health professionals or relatives in the privacy of an office.

Good

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to their individual needs. They said there were activities for them to participate in when they wished to and they were offered one to one sessions with the activity co-ordinator. Comments included, "They [activity co-ordinator] really do get you interested and involved", "[Activity co-ordinator's name] comes and sits and talks, they are nice", "They offered me one to one activities if I wanted" and [Person's name] is bed bound really but is taken to activities."

People told us they felt able to raise concerns. Comments included, "I'd go to the manager if I had a complaint" and "I'd tell her [pointing at the registered manager]." One person told us they would have liked more baths during their respite stay and another stated, "At home I have a shower every day. I would like a shower; I will make up for it when I get home." We checked out these issues with the registered manager to ensure staff were meeting people's preferences for personal care and they were resolved on the day. We found staff were unable to move one person with a hoist due to their current health condition so their care plan regarding personal care had been adapted to meet these needs.

At the last inspection on 3 and 4 December 2014 we had concerns about records in relation to risk assessments and care plans, therefore we issued a compliance action to ensure this was improved. We found improvements had been made in these areas.

We saw people who used the service had assessments of their needs completed prior to admission and these were kept under review. The assessments included areas of risk so that staff could analyse how to minimise risk whilst helping people to remain as independent as possible. We saw the assessments covered all areas of people's needs and staff also obtained assessments completed by health and social care professionals.

The care files we examined evidenced that the assessment information was used, in conjunction with discussions with people who used the service and their relatives, to help formulate plans of care. We saw the plans of care were very personalised and would provide staff with guidance on how to support people in a person-centred way. For example, one care plan described the person was very private and preferred to spend most of their time in their own bedroom. It detailed the television programmes they liked to watch, the name of her pet, what she liked to talk about with staff, how important her family was to them and how the person transferred from bed to their chair with a hoist. Another care plan described the person's anxieties and how this transferred into behaviours which could be challenging to staff and other people. It gave staff good information in how to manage the person's behaviours so they and staff remained safe.

The care plans contained lots of preferences for how people wished care to be provided and also how people communicated their needs. For example, we saw entries in care plans such as, "She likes a cup of tea before bed and knows when she wants to go to bed", "Small appetite, prefers small portions. Staff need to be aware she will not eat her food immediately and likes staff to leave it for her to eat when she is ready; if meals are hot staff should encourage her to eat them", "He prefers to eat in his room or in the lounge with a small table in front of him", "He likes a full English breakfast, fish and chips, puddings and bananas" and "He is able to verbally communicate but not does always remember names."

The registered manager told us two staff were employed as activity co-ordinators which meant there was someone to provide social stimulation to people from 10.30am to 4.30pm, seven days a week. During the inspection, we observed the activity co-ordinator had organised an event for people to participate in. They visited people in their bedrooms to tell them of the planned event and to invite them to participate. We saw relatives also joined in the reminiscence activity which included people sharing their memories of favourite places. We observed the activity co-ordinator ensured everyone was involved, however small their contribution. During the activity, we saw people were offered a drink and at the end they were thanked for sharing their memories. There was also a session with skittles. We saw people enjoyed the activity sessions. We spoke with one of the activity co-ordinators and they said, "I love working with people who have dementia and getting even the smallest reaction from the residents is so rewarding."

There was a range of activities indicated on the notice board. These included, exercise sessions, ball games, reminiscence, quizzes, bingo, arts and crafts, games and one to one sessions. There were items, books and magazines for people to touch and pick up. Staff used 'doll

Good

Is the service responsive?

therapy' with one person as this brought them comfort. There was also a notice in the entrance inviting people who used the service and their relatives to an event to celebrate 25 years of Sunningdale which included a 1970's themed party, live entertainment and food and refreshments from the era.

The registered manager told us they held a 'luncheon club' at the service. This was a local community initiative and enabled older people living nearby in sheltered housing to visit the service, meet and chat to people who lived there and receive lunch for a small fee. They were also invited when local entertainers visited the service. Some people who used the service had accessed a coffee morning at a local school in aid of Macmillan Nurses and also attended a fun day held there.

We saw the service had a complaints procedure on display. This told people how to make a complaint and how to escalate it if they were unhappy with the outcome of any complaint investigation. A visitor told us they had felt able to raise a complaint and a meeting had been arranged to 'sort things out'. The registered manager dealt with formal complaints and made a record of them. There was a more in depth policy and procedure and a flow chart to guide staff in how to manage complaints.

Requires improvement

Is the service well-led?

Our findings

Some of the people who used the service and some of the relatives knew the registered manager's name but others were unsure. Some people told us the registered manager came around the service to visit them and check they were alright but others said they did not see them as often as expected. One person who used the service said, [Registered manager's name] is a good manager. She comes and talks to me and I see her when she does a round."

Comments from relatives included, "Cleaning has improved and the staff are marvellous with [person's name]." One relative suggested they had not been listened to but a meeting had been organised to address issues.

We found there was a quality monitoring system which consisted of audits, checks and methods to obtain people's views. The audit system had not worked effectively in identifying and addressing shortfalls in medicines management. However, we saw there was a monthly audit schedule and this had been successful in identifying other shortfalls and planning action to address them. The registered manager completed a 'monthly manager's report' which was sent to the registered provider's clinical development manager for checking; they would contact the registered manager for any further information or to check on action taken. This included incident analysis such as medication errors or choking episodes, acquired infections, pressure ulcers, safeguarding referrals, hospital admissions and any death that had occurred. Senior managers visited the service to complete monitoring checks and the registered manager stated they completed two spot checks at night and two at weekends throughout the year.

Some staff said the registered manager's workload meant they were office-bound most of the day which prevented them from assisting in care tasks when the workload was particularly heavy. The registered manager told us they monitored the staff workload and would be available to assist staff when required. Staff stated they could raise issues with the registered manager and regional manager, although some stated the response to the issues and communication could be improved. The registered manager confirmed that because of the confidential nature of some issues raised, staff would not always know when these had been addressed.

Staff told us that they worked in separate teams of twos during shifts but there were times when the staff team as a whole did not work together as well as it could. For example, we were told some senior care staff and some nurses did not assist with personal care tasks. Also sometimes the activity co-ordinators assisted at mealtimes but this was not consistent. Some staff stated domestic staff could be utilised more to assist with bed-making at particular times to free up care staff. There was a reliance on agency nurses for night shifts and until recently this had also been the case for day shifts. Staff said this had affected team working as some agency nurses had conflicting ideas about their role and contribution to care tasks. We spoke with the registered manager about this and they will hold team meetings and discuss the expectations of team working with all staff and any nurses provided by agencies.

We found there were two systems of shift handover which operated within the service. Staff told us the shift handover on the nursing unit upstairs did not always provide them with full information about each person's needs and concentrated only specific issues that had occurred. They then spent time finding out information by word of mouth from other staff, which had the potential to affect the care provided to people. Staff on the residential unit downstairs said their handover involved a discussion about each person's needs and worked well to update staff who had been on days off. We spoke with the registered manager about these differences and they told us they would address them straight away.

The registered manager was aware of their responsibilities and notified us of incidents that affected the welfare of people who used the service. There had been one occasion when we had not been notified about an incident when the registered manager was on annual leave. The registered manager told us they would ensure this was addressed in future.

We found there had been staff meetings and 'resident's meetings' where people were able to express their views. There had been a relative's satisfaction survey in 2014 and a staff survey in 2015 completed by the registered provider. There had also been a 'resident's survey' completed by an external auditor. The main points of this information were displayed in a 'You said, We did' poster on the notice board in the entrance.

We spoke with the registered manager about the structure of the organisation, the support systems in place and the

Requires improvement

Is the service well-led?

culture and values of the registered provider. The values included 'making a difference', 'seeing the world from the point of view of people who use the service' and 'continually striving to improve'. We saw staff were provided with an employee handbook. This detailed their responsibilities and expectations of how they were to conduct themselves to adhere to corporate values. We found these values were transferred into practice.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who used the service were not protected against the risks associated with ineffective management of medicines. Regulation 12 [1] [2] [g]

The enforcement action we took:
We have issued a warning notice for Regulation 12, Safe care and treatment, to the registered provider and registered manager. They have to be compliant with this regulation by 20 November 2015.