Sutton Veny House Limited

Sutton Veny House

Inspection report

Sutton Veny
Warminster
Wiltshire
BA12 7BJ

Tel: 01985840224

Date of inspection visit:
25 September 2017
26 September 2017

Date of publication:
16 November 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 25 September 2017 and was unannounced. The inspection continued on 26 September 2017 and was announced.

Sutton Veny House is set in 25 acres of land and provides accommodation and nursing care for up to 28 people including people with dementia. 22 people were living in the home at the time of our inspection. The home is split across four floors. There are nine bedrooms on the ground floor five of which are en-suite. The first floor is accessed by a passenger lift or two sets of stairs. There are 10 bedrooms on the first floor and a further two on the second floor. A hair salon, the kitchen and laundry are on the lower ground floor. People had a communal dining room, a drawing room and veranda which led out into a level access garden.

The service had a registered manager in place. 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.

Sutton Veny House was not always managed well. Nine out of 12 staff told us that the registered manager was not approachable. We were given several examples of when the manager had either been abrupt or dismissive. We were told that this made some staff sad and upset. The registered manager felt that they were approachable. However, they were able to recall some examples of when they may have been abrupt with staff and raised their voice at them in public areas of the home. This did not demonstrate an open or inclusive approach and supported what staff had told us. Following the inspection the registered manager told us what actions they were going to take in reflection of the feedback given.

Medicines were being stored and administered from two areas in the home. This meant that there was a risk of nurses getting distracted during administration which increased the risk of medicine errors. The registered manager told us that a temporary clinical room would be identified to house all medicines and equipment.

We were told that six monthly reviews took place with people, family, professionals and staff. However, these were currently out of date and new meetings were being arranged. We noted that some meetings should have taken place in July and August 2017.

The registered manager had a good awareness of the Mental Capacity Act (MCA) and training records showed that staff had received training in Deprivation of Liberty Safeguards (DOLS). The service completed capacity assessments and recorded best interest decisions. This ensured that people were not at risk of decisions being made which may not be in their best interest. Staff also had a good understanding of the principles linked to MCA.

There were enough staff. Sutton Veny House had recently taken some new admissions with complex needs.

These included people who required two staff to assist them. Following the inspection the manager confirmed that an additional staff member had been put on to morning shifts.

People and staff told us that the service was safe. Staff were able to tell us how they would report and recognise signs of abuse and told us they had received safeguarding training. We reviewed the training records which confirmed this.

Care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about how they lived their lives. Each person had an electronic care file which also included guidelines to make sure staff supported people in a way they preferred. Risk assessments were completed.

Medicines were administered by registered nurses. Medicine Administration Records (MAR) reviewed showed no gaps. This told us that people were receiving their medicines as prescribed.

Staff had a good knowledge of people's support needs and received regular mandatory training as well as training specific to their roles for example, pressure area care and dementia.

Staff told us they received regular supervisions which were carried out by management. We reviewed records which confirmed this. Competency assessments in areas such as personal care and feeding had recently been introduced to ensure safe practice and reflective learning took place.

People were supported to maintain healthy balanced diets. Food was home cooked using fresh ingredients and people said that they enjoyed it. Food options reflected people's likes, dislikes and dietary requirements. The chef told us that they baked birthday cakes for people.

People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with ongoing care needs.

People told us that staff were caring. We observed positive interactions between staff and people throughout the inspection. This showed us that people felt comfortable with staff supporting them.

Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes, interests and communication needs. Staff told us that they all had individual usernames and passwords to access the electronic system and that passwords were changed regularly.

There was a system in place for recording complaints which captured the detail and evidenced steps taken to address them. People and relatives told us that that they felt able to raise concerns or complaints and felt that these would be acted upon.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

Quality monitoring audits were completed by the management team and provider visits were carried out by the regional manager. The registered manager reviewed incident reports and analysed them to identify trends and/or learning which was then shared. This showed that there were good monitoring systems in

place to ensure safe quality care and support was provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was mainly safe. There was an increased risk of medicine errors. Medicines were being stored and administered from two areas in the home which meant nurses could get distracted whilst preparing and administering medicines. The manager acted on this effectively during the inspection.

There were sufficient staff available to meet people's assessed care and support needs.

People were at a reduced risk of harm because staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were at a reduced risk of harm because risk assessments and personal emergency evacuation plans were in place and up to date.

People were at a reduced risk of harm because medicines were managed safely, securely stored, correctly recorded and only administered by nurses.

Is the service effective?

Good

The service was effective. Capacity assessments were completed and best interest decisions were recorded. This meant people were not at risk of decisions being made that were not in their best interest.

People's choices were respected. Staff had some understanding of the requirements of the Mental Capacity Act 2005.

Staff received training, supervision and appraisals to give them the skills and support to carry out their roles.

Staff were supported and given opportunities for additional training and personal development.

People were happy with the food served which was home cooked. People were supported to maintain healthy balanced

diets.

People were supported to access health care services and attend hospital as and when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff who used person centred approaches to deliver the care and support they provided.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected each person's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Six monthly reviews took place with people, families, professionals and staff. However, these were not all up to date.

People were supported by staff that recognised and responded to their changing needs.

People were supported to take part in activities which were linked with their own interests and hobbies.

A complaints procedure was in place which was up-to-date. People and their families were aware of the complaints procedure and felt able to raise concerns with staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager did not always promote or encourage an open working environment.

Staff told us the registered manager was not approachable.

Regular quality audits were carried out to make sure the service

was safe and delivered high quality care and support to people.

Sutton Veny House

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 inspection took place on 25 September and was unannounced. The inspection continued on 26 September 2017 and was announced. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience on day one and a single inspector on day two. The specialist adviser had clinical experience and expertise in elderly care and nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience related to elderly, people with dementia and complaint investigation.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

The provider had completed and returned a Provider Information Return (PIR) from us. 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 spoke with five people who used the service, a health professional and three relatives. We also spoke with the registered and deputy manager. We met with 12 staff. We reviewed seven people's care files, policies, risk assessments and quality audits. We looked at three staff files, the recruitment process, staff meeting notes, training, supervision and appraisal records.

We used a Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We observed staff interactions with people, a pottery session and observed a meal time in the drawing room.

Good

Is the service safe?

Our findings

Medicines were being stored and administered from two areas in the home. Controlled drugs were stored securely in a cabinet which was small and staff told us should be replaced with a larger one. We observed nurses having to walk between two areas when preparing and administering medicines. This meant there was a risk of nurses getting interrupted or distracted whilst administering medicines to people. We discussed this with the registered manager who told us that they were planning to renovate the nurse's station into a clinical room to house all medicines and equipment in new cabinets. The registered manager said that they would discuss using a vacant room as a temporary clinical room until the planned work in the nurses station had started and was completed. This would reduce the risk of any medicine errors happening. Following the inspection we received confirmation that an area had been identified and works had started on creating the temporary clinical room.

A piece of equipment which delivered a steady flow of injected medication was being used by one person. We found that the administration prescription was clear with clearly labelled contents. However records stated that nurses should complete four hourly overnight checks. We noted that this had not been recorded as being completed from 22.00 hours on 24 September until 08.55 25th September 2017.Records were also unclear as to when the piece of equipment had been recharged. The registered manager told us that they did not let the driver go below 18% battery power and always made sure that there was at least 24 hours' worth of charge. The registered manager confirmed that the checks had not been recorded that night and said that they had reviewed all other checks during the night. We were told that these had been completed and signed for. We reviewed other checks during the inspection such as fire equipment and hoists and found these to be up to date and complete.

Two people self-administered some of their own medicine. One person had a risk assessment in place however, the other person did not. This was discussed with the deputy manager during the inspection who completed one. This captured the information about the risk and identified measures to take to reduce further risks to the person.

Medicines were signed as given on the Medicine Administration Records (MAR) and were absent from the pharmacy packaging which indicated they had been given as prescribed. We observed a nurse sitting and ensuring each person actually took their medicines, this was unhurried and interactive. The nurse also cross referenced medicines against the MAR and dotted the MAR simultaneously – only signing after administration. People were happy with this arrangement and reported receiving them on time.

There were enough staff at Sutton Veny House. A few staff however felt there were not enough staff to support some new admissions with higher needs. Other staff and people who used the service felt there were enough staff. A person said, "I think there are enough staff. They all seem to like each other which makes a happy home". Another person told us, ""Yes there is enough staff for me, even at night. I know them all by name". We discussed this with the registered manager who told us that they were aware of the staffing levels and had just agreed with the provider that staffing levels could increase. This would take four morning staff up to five. We were told that this would be effective from 1 October 2017.

The registered manager took us through the staffing level policy which supported managers to assess and monitor their staffing. The registered manager told us that people's individual needs were considered too and then the budget was agreed by the provider. The recent increase in staffing numbers told us that this system was effective.

We noted that one person had a wound described as 'like a cigarette burn' reported on 5th September 2017. The dressing records were completed, but no safeguarding alert was raised. We discussed this with the deputy and registered managers who told us they would action this. On day two of our inspection we were shown that an alert had been sent to the local safeguarding team who had confirmed they had management plans in place to reduce any further risk to the person. Staff were able to tell us how they would recognise signs of potential abuse and who they would report it to. Staff told us they had received safeguarding training and training records we looked at confirmed this.

We reviewed the home's safeguarding policy which was up to date and included reference to the new Care Act principles

People, relatives and staff told us that they felt the service was safe. A person said, "yes I feel safe because the staff are here and they look after me". Another person told us, "I feel safe from fire, water and starvation". Another person said, "I feel safe here because everyone is friendly and bright. Never feel threatened". A professional told us, "People are getting safe care".

People's freedom was supported and respected. We observed people being supported by staff to move around the home. A person told us, "I have freedom here. I can go out when I like with staff. I also smoke and am supported out on to the veranda".

Staff told us that they felt the service was safe. They were able to tell us what systems and processes were in place to reduce and manage risks to people. For example, a staff member said, "Sutton Veny is a safe home for the people. We all have training and use equipment. There are risk assessments and guidelines in place which we all follow".

People's care files identified people's individual risks and detailed control measures staff needed to follow to ensure risks were managed and people were kept safe. For example, people who were assessed as being at high risk of falls had risk assessments in place. We also found that people who required support with mobility had risk assessments in place which identified equipment to be used, the number of staff required to move people safely and what sling sizes and other equipment to use. Staff were able to tell us what these assessments said and where they were kept. These demonstrated that the service ensured safe systems and practice were in place to minimise and manage risks to people.

People had Personal Emergency Evacuation Plans (PEEPs) which were up to date and formed part of their care plan. These plans detailed how people should be supported in the event of a fire. The registered manager told us the health and safety of the home was checked on a daily basis by the employed maintenance person. All equipment was inspected and serviced in accordance with statutory requirements.

Recruitment was carried out safely. We reviewed three staff files, all of which had identification photos in them. Files included application forms, employment history, job offers and contracts. There was a system in place which included evaluation of potential staff through interviews, references from previous employment and checks from the Disclosure and Barring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager was aware of the Mental Capacity Act (MCA) and worked within the principles of this. They told us that staff had received training in Deprivation of Liberty (DOLS) and the Mental Capacity Act. The training record we reviewed confirmed this. We spoke to staff and asked them what the MCA meant to them. Staff we spoke to were able to tell us that it was about choices and decision making. Sutton Veny House had a policy on the MCA in place, capacity assessments were carried out and where necessary best interest decisions were made and recorded appropriately. Care files evidenced that people with capacity had consented to their care by signing their plans, whilst those who did not had been assessed and agreement made by key people involved in their care via a best interest meeting. One person had been assessed as not having capacity to make decisions about their life and wellbeing. The persons file recorded that this person had an advocate. We found that best interest's decisions such as a safe swallow plan had been agreed and signed by all parties. Another person who lacked capacity had a best interest decision made in relation to receiving covert medicines. We noted that parties involved included the family and GP. A person said, "Yes, they do ask my permission". This told us that people's consent to care was always sought in line with legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). At the time of inspection DOLs authorisations had been made for three people and one application was with the local authority. Where people's DoLs had conditions in place, these were being met.

Staff were knowledgeable about people's needs and told us they received regular training which related to their roles and responsibilities. We reviewed the training records which confirmed that staff had received training in topics such as infection control, fire safety, moving and assisting and first aid. We noted that staff were offered training specific to the people they supported for example dementia and nutrition. In addition to this we found that staff had achieved or were working towards their diplomas in health and social care. The registered manager showed us learning packs that they were just starting to deliver to staff. These covered topics such as diabetes, hydration and infection control. The registered manager told us they were going to look at how staff could best demonstrate their learning after these learning sessions. A staff member told us, "I get enough training. It helps us deliver safe care". Another staff member said, "We do a lot of training but some of it is basic".

New staff completed an induction into Sutton Veny House and shadow shifts took place. New staff files held induction records which included the Care Certificate. The Care Certificate is a national induction for people

working in health and social care who have not already had relevant training. We found that the induction programme covered areas such as; introduction to people, accidents/incidents, health and safety, tour of the home, records and rotas. A new staff member told us, "My induction was good. I did shadowing to see how things are done. I feel settled in". This demonstrated that people were supported by staff who had received effective inductions and had the knowledge and skills they needed to carry out their roles and responsibilities.

We reviewed staff files which evidenced that regular supervisions and appraisals took place and were carried out by the management team. A staff member mentioned that they found supervisions very useful and confirmed that they took place regularly.

People, relatives and staff told us that the food was good. The chef told us that the food was locally sourced and that meal were mostly all home cooked. People were able to choose from two choices for lunch and dinner. Alternative options were available should someone change their mind on the day a certain meal was served. The chef was able to tell us people's likes, dislikes and dietary requirements. A person said, "The food is excellent. Choice – yes you have a menu. Yes, you have enough to eat and drink. Yes they do ask during meals, if you are Ok about the flavour, always asking me to have a second lot. They always see if you are happy". Another person told us, "Really good, always a meat or veg option. More than enough. I choose to eat in my room". Another person said, "It's good food, we have a choice". A staff member told us, "A person has asked for poached egg tonight for supper. They have requested that the crusts be cut off. I have informed the kitchen". We found that food and fluid charts were completed where appropriate, and were up to date. People who had dietary requirements and safe swallow plans in place were up to date and the staff and chef were aware of these. This demonstrated that the service was supporting people to eat and drink enough whilst maintaining healthy balanced diets.

We observed a meal time. People were supported to wash their hands before eating. Eight people were sat at a table in the drawing room. There was a relaxed atmosphere in the room however we noted that it was very quiet and that people ate in silence. A staff member joined the people to eat their lunch. Staff asked people if they had enjoyed their lunch and if it would be ok to take their dishes. We noted a choice of dessert being offered to people which included fruit salad, apples, bananas and yogurts. This was followed by teas and coffees. People appeared comfortable in staff company. We observed that meals for people who had chosen to stay in their rooms were taken promptly to them to ensure food was served hot. The chef told us that people had a cake made for them on their birthday.

People were supported to maintain good health and had access to healthcare services. We noted that appointments were recorded in people's care files and communicated between the team during handovers. We saw that community professionals like GP's and community nurses visited the home and that people were supported to appointments. We saw the hairdresser offering people the opportunity to have their hair done on day one of our inspection. A GP visited the home on day one and a chiropodist on day two. The registered manager told us they had a good working relationship with a local surgery and that regular GP visits took place on Wednesdays.

Good

Is the service caring?

Our findings

We observed staff being respectful in their interactions with people. Throughout the inspection the atmosphere in Sutton Veny House was relaxed and homely. A person told us, "I use to visit a lot of care homes in my career so I know what some homes are like. This one is lovely. There is a fresh smell, homely feel and nice atmosphere".

People felt that staff were caring, knew them well and spent time with them. A person told us, "The staff are very, very kind, night and day. I can talk with them and they listen. Yes, they have enough time for me, if not they excuse themselves. I understand that. You never mind what you ask them. They will always support me if they can". Another person said, "I would rate the care good. Staff are caring, pleasant and cheerful". Another person told us, "The staff are, pretty brilliant". The person said that they knew the staff and they knew (name) "well". "Nothing negative to say, they listen and have time for me".

We asked staff what caring qualities they felt they had. A staff member said, "I'm caring. I'm confident, understanding, listen and I'm patient. My peers are caring too, there is good team work". They went onto say, "We are all a big family. People are treated fairly, are involved in activities and we make people feel at home". Another staff member told us, "I like to think I'm caring. It's in my nature. I have an elderly parent and children". Another staff member said, "I feel I'm caring. I'm always on time, happy to help and I'm trustworthy. My priority are the people living here. My colleagues are also caring".

Staff were seen to get down to people's level when communicating with them and made time to listen. We observed staff acknowledging and talking to people who appeared comfortable and engaged. We overheard and observed a member of staff assisting a person with a meal in their room. The staff member showed empathy and had meaningful conversations with the person.

People were regularly given opportunities to be involved in making decisions about their care. Staff told us that they provided people with information which supported them to make choices and decisions in relation to their care, support and treatment. For example, clothing, nutrition, activities and personal care. A person told us, "I can choose when I go to bed and when I get up. I can choose my clothes for the day". Another person said, "Yes, I have enough information. I am able to make my own decisions. They (the staff), do very well with speaking to my family too, they speak to them all". We saw that people were able to bring in and personalise their own rooms. A person said, "The room was furnished but I was allowed to bring in my own table". We noted that the person's room was personalised with pictures and family photographs.

A staff member said, "I'm an encouraging person. I explain choices and give information to people. I explain the positives and negatives. I always respect people's choices". Staff promoted people's independence by encouraging and enabling them to do tasks for themselves. A staff member told us, "I encourage independence. For example, I encourage people to wash themselves where possible. Lift own arms when dressing and other tasks so they feel in control".

We saw that there were clear personal care guidelines in place for staff to follow which ensured that care

delivered was consistent and respected people's preferences. Electronic care files held person centred care plans with pen profiles of people, recorded important people involved in their care, how to support them, people's likes and dislikes and medical conditions.

People's privacy and dignity was respected by staff. Staff we observed were polite and treated people in a dignified manner. We saw staff closing doors whilst delivering personal care on several occasions. A person told us, "Yes, they (staff) are very good. With personal care, they make sure you are covered up, they knock on the door". Visitors are "made to feel welcome" We asked staff how they respected people's privacy and dignity. Housekeeping staff said, "We knock before entering rooms and ask people if they mind us cleaning their rooms. We then record choice and tasks". Care staff told us, "The team promote dignity and respect. We have a good team who are all very kind and caring". We found that the home had a dignity champion. The champion told us, "I'm training staff to continually understand people's preferences, choices and decisions. I observe staff and raise any concerns with the staff and management".

Good

Is the service responsive?

Our findings

The deputy manager told us that people had six monthly review meetings which included the person, any family, health and social care professionals, the deputy manager and a care supervisor. The deputy told us that it was good to have care supervisors at these meetings because they know the people so well. We were told that some of these reviews were overdue. We noted that reviews should have taken place in July and August 2017. The deputy manager told us that new meeting dates were currently being arranged.

There were clear personal care guidelines in place for staff to follow which ensured that care delivered was consistent and respected people's preferences. On line Electronic care files held person centred care plans with pen profiles of people, recorded important people involved in their care, how to support them, people's likes and dislikes and medical conditions.

The activities coordinator told us that they worked 18 hours a week. On day one of the inspection we observed a pottery session people attended with an external potter. We observed this session and found there to be a relaxed atmosphere with background music on and people chatting to each other whilst participating. The activities coordinator and potter were positively engaged with people. We noted that people were making tea light holders. One person said, "I want to make two, one for each of my grandchildren". Another person said that they enjoyed pottery and that it kept them amused. The activity coordinator said that they were doing hand care with people tomorrow. A person showed us that they were currently making Christmas cards. They said, "I do art in my room and make cards. I enjoy it". We noted that the hairdresser had come to the home during our visit to cut and style peoples hair. We saw a person being supported to the salon in their chair.

People had call bells in their bedrooms that staff responded to promptly. A person told us, "If I need staff I just ring my bell. I have never had to wait too long". Another person said, "I have a call bell to ring and they will come".

We observed a handover between the morning and afternoon staff. Each person was discussed and updates shared with each other. We noted that staff discussed one person who had developed a small sore on their left foot. The morning staff had responded to this by assessing for any sign of infection and arranging a GP visit the following morning. We found that records had been updated. Another person had been very wet that morning. Staff had discussed using larger pads with the person who had agreed. This was because the person had told staff they did not like to be woken at night. We were told that this change had been made to the person's care file. A person said, "Staff are responsive to our needs here". A health professional told us, "Staff are very sensible here, they call me if they are worried. I have just seen (name). No concerns regarding care. Their needs are being met". This told us that people were receiving personalised care which was responsive to their changing needs.

People and relatives told us they felt able to raise concerns and said that they would discuss them with staff or management. A person said, "I know how to complain, I have no desire to complain. If you want

something different just talk about it". Another person told us, "I have nothing to complain about. I would talk to staff if I had to". We noted in that the current complaints procedure did not have local contact names or details on it. The registered manager told us that they had just updated the homes guide for people and complaints procedure. These were sent to us following the inspection. We noted that these now had information about the regional manager and registered manager. The last complaint on file was clearly recorded and evidenced the steps taken to resolve the concerns. The registered manager told us that the person and relatives were now happy and that the complaint had been closed.

We found that people and relatives had the opportunity to come together for a meeting once a year. The registered manager told us that they ran these and that they were productive. They told us that it was a time for them to update people and families on developments, changes and involve them in future plans and changes. We noted that having tea and coffee made available in the drawing and dining room was requested by a person at the last meeting and saw that this was now in place. We also found that people had asked for ramp access from the veranda down to the landscaped garden. We noted that work had nearly been completed on this.

Sutton Veny House sent out surveys to people, families and staff. People and families told us that they had received and completed these. We reviewed the last survey results and found actions identified had been completed.

Requires Improvement

Is the service well-led?

Our findings

Sutton veny House was not always well led. A positive, open, inclusive and empowering culture was not embedded at the home. We spoke to 12 staff. Nine staff told us that the registered manager was not always approachable. Eight staff told us they had been involved in, witnessed or over heard the registered manager shouting or talking abruptly to staff. Two of staff said that this had made them sad and upset. Nine of the staff told us they would not knock on the registered manager's door if it was closed. People did not tell us that they had heard the manager shout. Staff said that they didn't feel supported with personal issues for example; annual leave, flexibility with children, salary queries. A family member described the registered manager as "aloof".

The provider sent out annual staff surveys to gather feedback from the staff. We noted that only 11 out of 37 staff had completed the survey in June 2017. One question asked in the survey was; is communication between staff and all levels of management effective. We noted that five out of 11 staff had said sometimes, one had said rarely and another had said no.

There was a whistleblowing policy in place and staff were aware of this and how to use it. We were told it had been used previously and that meetings had taken place with no real outcomes.

The registered manager told us about their management style. They said, "I try to be firm but fair. People will tell you I'm tough. I think I am approachable. I'm direct and don't soften it. I don't brush issues under the carpet. If I need to dismiss staff I will". The registered manager told us, "Staff know not to disrupt me if my door is closed. If they do they will be ground down unless it is an emergency". We discussed the feedback we had received from staff. The registered manager told us that they were surprised and disappointed at what staff had said. During the conversation they recalled three occasions when they had shouted at staff in public areas. These comments did not reflect good management or leadership and supported what staff had told us.

The registered manager told us that they would reflect on this feedback, discuss it with their manager and update us on any actions they took. Following the inspection the registered manager told us that they would be holding open sessions with staff, had arranged a team meeting to allow group feedback and discussion and asked nurses and care supervisors to explore any further concerns staff may have regarding the registered managers approach. This demonstrated a responsive approach to the feedback received.

Staff told us that there were occasions when the registered manager worked care shifts. We were told that this was mainly if there was last minute sickness. The registered manager told us, "I prefer not to work care shifts because families and people still see me as the manager and not a nurse".

We found that staff meetings took place mainly for individual departments. For example, housekeeping, kitchen, management and carers. The registered manager said that it could be very difficult to get all staff together for one meeting. They told us that they would however arrange one once the CQC inspection report

had been received so they could discuss the findings together. We noted that a carers meeting had been arranged for week commencing 2 October 2017. The registered manager said that they had sent out an agenda to staff for them to add items to. Items so far included end of life care, staffing and headline feedback from the inspection.

The management told us that they enjoyed developing staff. We were told that the provider was looking at supporting staff to achieve their nursing qualifications to become registered general nurses.

Two staff were positive about the registered manager. One staff member said, "The registered manager is amazing. People who live here love them. Very supportive". Another staff member told us, "The manager is good. I look up to them". A person said, "The registered manager is easy to get on with but I don't have much to do with them. They don't see me much which is ok".

The service had made statutory notifications to CQC as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

The service carried out quality monitoring check and audits regularly. These covered areas such as medicines, care records, environment and health and safety. Actions and comments were logged and followed up by the management team. We saw that information from incident reports was recorded. This data was then analysed to look for trends and learning which could then be shared. The provider completed quarterly audits at the service. these included sample records, checks, staffing and observing. This demonstrated that the service had systems in place to monitor, improve and deliver high quality care.