Four Seasons (Evedale) Limited

Charnwood

Inspection report

24 Station Road
Carlton
Nottingham
Nottinghamshire
NG4 3AX

Tel: 01159404441
Website: www.fshc.co.uk

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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**

Summary of findings

Overall summary

The inspection took place on 3 and 4 February 2016 and was unannounced. Charnwood is registered with the Care Quality Commission to provide personal care, nursing care and accommodation for up to seventy four people. There were forty six people living at the service at the time of our inspection.

Charnwood consists of two separate units on the same site. One provides personal care and is known at Charnwood House. The other provides nursing care and is known as Charnwood Court.

Charnwood is required by the CQC to have a registered manager, which they did have at the time of our inspection. 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.

At the time of our last inspection of the service on 14 and 15 January 2015 we identified the provider was in breach of one Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was not an effective system in place to regularly assess and monitor the quality of the service provided. We asked the provider to take action to make improvements in the area of good governance. We received an action plan dated 15 June 2015, in which the provider told us about the actions they would take to meet the relevant legal requirements. During this inspection we found that the provider was meeting these legal requirements.

People told us they felt safe. The provider had policies and procedures in place to protect people at risk of abuse. Staff could identify the different types of abuse and knew how to raise any concerns. The registered manager had made relevant referrals if people were suspected of being at risk of abuse. The service had responded to accidents and incidents, but had not always taken action to keep people safe and reduce the risk. The building and environment were not well maintained in places, and we found four radiators that could pose a burn risk to people due to their excessive heat and lack of protective covers. We also found an unsafe bath panel.

The provider had not always followed up on any risks that the recruitment process identified to make sure staff were suitable to work at the service.

People received their medicines on time. The medicines were stored of and disposed of safely by staff that were trained to administer medicines. However, we noted that when the service administered controlled drugs, the second person checking the medicine had not always had training to be able to safely support this task.

Staff approached people in a caring way which encouraged people to say when they needed support. When

supporting people with behaviours that may challenge, we noticed staff used techniques such as distraction, and a calm approach. Staff had developed positive relationships with people and their families.

The CQC monitors the use of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had followed the correct process to submit applications to the supervisory body for a DoLS, where it was identified this was required for people who lack capacity. However some of the care plans showed inconsistent of understanding of the Mental Capacity Act and its uses.

Staff enabled people to make their own choices and decisions about the care they received, where possible. Staff involved relatives and other professionals when important decisions had to be made about people's care.

Staff involved other professionals in a timely manner when required, and ensured people were supported with their healthcare needs. People were encouraged to participate in activities, and the home had a full and varied activities programme.

People's nutritional needs were met, and they had a choice of food and drink, including specialist diets where required. People's preferences, routines and what was important to them had been assessed and recorded.

Staff did not always feel supported, and were not always confident they could raise any concerns with the registered manager, or that they would be listened to.
People and their families were aware of the complaints process, but some issues they raised were not dealt with promptly. There were systems in place to monitor and improve the quality of the service provided, but these needed time to embed.

People and their relatives were given some opportunities to give feedback their views and opinions on the service.

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.

Staff had been trained to recognise the signs of abuse and knew who to report to in case of any concerns.

Staff had not always been safely recruited.

People did not always think there was enough staff to meet their needs, but we did not observe people having to wait for support.

Medicines were stored and administered safely.

There were some environmental risks that the service had not acted upon

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a range of training and support to meet people's needs.

Staff did not always understand their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, and care plans showed some inconsistencies in regard to the MCA and DoLS.

Staff contacted relevant external health care professionals when required to meet people's health needs.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were kind and helpful.

People and their families were supported to be involved with their support needs.

No one was using an advocate at the time of our visit but information on the advocacy service at Charnwood House was out of date.

Is the service responsive?

Good

People's care and support needs were regularly reviewed to make sure they received the right care and support.

Staff were knowledgeable about people's preferences and needs.

A range of activities were available for people to participate in.

Is the service well-led?

Requires Improvement

The Service was not always well-led.

People were given opportunities to give their views of the service but this still required further work to ensure all people's views were captured.

People that used the service and relatives were not always confident that complaints would be dealt with by the management team.

Staff, people and their relatives did not always feel the registered manager was approachable or that they were valued.

Charnwood

Detailed findings

Background to this inspection

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

The inspection took place over two days on February 3 and February 4 2016, and was unannounced.

The inspection team comprised two inspectors, a specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience we used had personal experience of supporting a person who lived with dementia.

Before the inspection we contacted local health and social care teams for feedback. We contacted the Healthwatch team. Before the inspection, we asked the provider to complete 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 looked at the statutory notifications received from this service. Statutory notifications contain information about serious incidents about which the provider is legally obliged to tell us.

During the inspection, we spoke with ten people who used the service, and three relatives of people. We spoke with the registered manager, the area manager, and the area quality manager. We talked with a registered nurse who worked at the service, along with a care manager, two senior care staff, two care staff, the cook, kitchen assistant, and the maintenance person. We spoke with three external healthcare professionals. We looked at the maintenance and service records for the equipment, including legionella and fire risk assessment.

We checked the provider's policies and procedures. We reviewed the care records of ten people who used the service. We observed the lunchtime experience for people. We observed how staff interacted with people. We checked the kitchens, food storage and meal planning. We observed a medicine round and checked that medicines were being safely managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. A person we spoke with said, "You can trust all the people around you." Another person said, "Oh, yes, I feel very safe." A relative we spoke with told us, "[Person's name] has been better since they've been in this home. I'm happy they are safe." Staff were aware of the signs of abuse and what their role was in protecting people from abuse and avoidable harm. Staff said they had received safeguarding adult training and were aware of the provider's policy and procedure, and what action was required. Some people did not feel so confident when staff were assisting them to move. A person stated, "They can be a bit rushed and hurried – they don't move me so gently. We raised this with the manager, who agreed to carry out observations of practice and we asked for a referral to be made to the local safeguarding team.

The provider had the necessary pre-employment checks in place in order to make sure that people were suitable to work in a care setting. However we found the provider was not always taking actions to minimise any risks identified in the recruitment process. This meant the management was not always following the safest recruitment procedures. We raised our concerns with the management team, and they agreed to undertake all the necessary risk assessments following our visit.

Each person had risk plans in place to identify their level of risk. For example, some people had risks associated with their mobility needs and skin. Where equipment had been identified to reduce these risks, we saw this was in place and available for people. Risk plans had been reviewed monthly. Care plans contained information for staff about interventions in place to reduce these risks. We saw evidence of this recorded in charts, and also by observing staff during our visit. This ensured people were protected from unnecessary risks. Staff told us how they protected people's safety and reduced risks. One staff gave an example of how a person's risk of falls had been managed. They said, "We involved the occupational therapist and following their recommendation some equipment was purchased to alert staff when the person had got out of bed. It's been amazing in reducing the risks." Staff also talked about ensuring the environment was safe and hazard free. Care plans contained appropriate risk assessments

We observed a person with swallowing difficulties had been left a drink without thickener added to it. This person had been assessed as being at risk of choking and had been prescribed a thickener for their drinks. We were concerned that, if a relative or visitor who may not know the person needed their drinks thickening gave the drink unthickened, this could be unsafe for this person. There was not adequate signage in the person's room alerting people that they required drinks to be thickened. We raised our concerns to the registered manager. They told us drinks were thickened just before they were offered.

The majority of staff working in Charnwood House told us that they thought there was sufficient staff available to meet people's individual needs and keep them safe. Staffing levels reduced in an afternoon and some staff felt this impacted on people's safety. One staff member said, "When staffing reduces in an afternoon this can mean there is only one staff left in the lounge." Feedback from visiting healthcare professionals was positive about the staffing levels provided in Charnwood House, and the skills mix of staff available. One healthcare professional told us, "There are always staff available when I visit."

However, some staff on the nursing side felt there was not enough staff, especially as some people in the nursing side were cared for in bed upstairs. We looked at the duty rotas. The rotas showed the days when cover was needed, and reflected the staffing numbers the provider had told us about. The registered manager told us two staff had recently been recruited to fill vacancies and these staff were waiting for the necessary checks before starting work.

Following our inspection we received some information of concern advising that a relative made contact, and told us that sometimes, no staff were in the lounge on the nursing side for over twenty minutes when they visited. Some people relied on staff to meet their needs and if people were left alone in the lounge; they had no way of calling for help if something was wrong. We raised this with the registered manager who said they would ensure the lounge was always covered by staff in future.

In people's care records we saw people's dependency needs were assessed and reviewed. The registered manager told us they used this information to assess what the staffing levels were required. The area manager told us the home was staffed above the levels recommended by the dependency tool. The registered manager told us they had recently recruited one full time new staff member, and one bank staff member.

During our inspection, we did not see people having to wait for support at Charnwood court, We did not observe call bells being left unanswered. However, mealtimes were observed to be more difficult there as some people needed support to eat and were in upstairs rooms. This meant that staff were taken from the dining area and some of the people upstairs had to wait longer if they needed support to eat.

People told us they received their medicines on time when they were needed. A person we spoke with said, "They always help me take my tablets. I know what they're all for too." We observed the administration of medicines and saw the required checks were made against the medicines administration record (MAR) and staff stayed with the person until they had taken their medicines. We heard them explaining the purpose of the medicines and answering people's questions about the reasons the medicines were required.

Staff administering medicines had completed training in medicines administration and although only two staff had had their competency assessed over the last year, we saw documentation to show that these checks had started for the remaining staff.

We found on the nursing unit, carers were required to act as a second checker for controlled medicines. Controlled drugs are a group of medicines that are specially restricted by the Misuse of Medicine Act 1971and subsequent legislation, and so these medicines require additional checks before they can be given to people. The staff doing these had not completed training to undertake this role. We raised this with the registered manager, who agreed to provide this training for the staff that carried out the checks on controlled drugs administration.

Processes were in place for ordering medicines. Medicines were stored in and disposed of in a safe manner. Protocols were in place to provide staff with additional information about medicines which were prescribed to be given only as needed.

We saw that, for people who required a hoist to assist them to move, the provider was not using separate slings for each person. This could be a source of cross infection, so we raised this with the registered manager, and they agreed to source separate slings for each person.

We saw people had personal evacuation plans in case of fire, but these tended not to be personalised or

detailed to each person's individual needs.

Maintenance and service checks were completed on equipment and the environment. We saw records that confirmed these checks were up to date. We identified two concerns with regard to the environment which posed a risk to people. This included two new radiators in both premises. that were too hot to touch. These could have injured people if they had fallen against the hot surfaces. We discussed this with the registered manager, who told us the radiators had been recently fitted and radiator covers had been ordered. In the meantime, the affected radiators were turned off until they could be made safe. The provider had not completed a risk plan in relation to the hot radiators, but we saw they did so at our request before the inspection finished on the second day. This ensured staff knew how to reduce the risks until the covers were fitted.

We saw a bath panel in a ground floor bathroom was loose, with sharp protruding edges. This could have caused a serious injury to people. The bathroom was open and could have been used. We raised this with the registered manager and maintenance person who repaired the bath panel during our inspection.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff were adequately trained to do their jobs, One person said, "They've [staff] got enough skills, just not enough staff." Another person added, "I highly recommend them." Staff told us that they had received appropriate training for the needs of people in their care. They said that this included additional training the community care home team had provided. Staff told us they were up to date with their mandatory training which was completed via e-learning. Some staff said they would have preferred to undertake "hands on" training as they felt they did not absorb e-learning in the same way. We shared this information with the registered manager and regional manager. They said that they were aware that this style of learning did not suit all staff, but said they supported to staff to complete any necessary training.

Staff felt they had access to additional training relevant to their role. A nurse told us they had regular updates on clinical areas, and had meetings especially for trained nurses. We saw evidence of the notes for these meetings. Staff told us they had supervision approximately twice a year and had an annual appraisal. We saw records of meetings that were held for the trained nurses, and a variety of issues were discussed. This is important as it helps keep nurses clinical skills up to date, and enabled them to share information about people's needs

Staff told us about the induction they had received when they commenced their employment. This consisted of training, learning about the service and shadowing experienced staff. One staff member told us, "The induction is supportive in helping staff understand their role and responsibility." We saw copies of the two day induction plan that all new staff had to complete before starting work.

We spoke with the Care Home Team. The care home team are made up from NHS professionals and work in conjunction with local care homes, to ensure best practice is followed. The Care home Team confirmed that they had provided staff at Charnwood House with additional training that included, pressure care, moving and handling, seating and needs associated with reduced mobility Visiting healthcare professionals were positive about the skill and experience of staff. They said that they found staff to be knowledgeable about people's individual healthcare needs.

We received a mixed response from staff at both units about the frequency and quality of supervision and appraisal meetings. These meetings are important for staff to discuss their work, training and development needs. Some staff said they did not receive opportunities to have face to face meetings, but were given a pre completed supervision agenda with little or no opportunity to discuss any concerns or issues. Other staff said they did have individual meetings with their line manager and that this was a, "Two-way conversation to talk about issues or concerns." Some of the staff files we looked at contained records of supervision meetings, but some were outstanding. We discussed this with the registered manager who said that supervisions were now being shared amongst themselves and the nurses, and that staff were given opportunities to raise concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).
Most staff had been trained in, and showed an understanding of, the MCA but only sixty percent had training in DoLS. We saw that the provider had applied for a DoLS authorisation from the local authority for one person, but not for some people who may have required a DoLS.
We saw some examples that people's mental capacity to consent to specific decisions about their care and treatment had been assessed and best interest decisions made appropriately. However, we saw some inconsistencies, such as where best interest's decisions had been made without the mental capacity assessment being completed. We discussed our findings with the registered manager. The area manager told us all training is due to be completed by mid-February.

We saw examples of 'Do not attempt cardio-pulmonary resuscitation orders' (DNARCPR) in care records. It was not always clear if a person had Lasting Power of Attorney in Health and welfare that gave another person legal authority to give consent on their behalf. If there is no Lasting Power of attorney in health and welfare, a family member cannot consent on behalf of a person who lacks capacity. The registered manager told us that new care record documentation was being introduced which made it easier to find and record this information. However, we were concerned that this information was not currently available. The regional manager said that they would take action to gain this information as a priority.

Staff told us that if someone presented with behaviours which challenged, they had enough knowledge what techniques would calm them and divert their attention. Staff explained they sometimes leave a person and return a few minutes later, in order to give the person some space An experienced staff member said they felt some of the newer staff needed more training in dementia care in order to be able to better support and understand the needs of people living with dementia. We reflected this back to the provider.

During our inspection, people we spoke to told us they usually were asked permission before staff assisted them. One person told us, "Most are good at asking me." Another person added, "I often get asked I think."

People were supported to make unwise decisions based on their choice, for example a risk plan was in place to support a person make a lifestyle choice that may have been detrimental to their health but that they had always done. Their decision was respected by staff.

People were very complimentary about the food and drinks at the service. We were told, "It's very good. I said it'd be nice to have liver and onions one day for a change. The next day it was on the menu!" Someone else added, "I recommend it. Never seen so much food in my life!" People's dietary and nutritional needs had been assessed and planned for. People were weighed regularly so action could be taken if unwanted weight changes occurred. We saw examples where people had been prescribed food supplements. We saw these were available and observed a person being given their supplement.

The menus contained a choice of meals and people were also given snacks between meals if they wanted them. The kitchen staff had information about people's dietary needs and preferences, and were knowledgeable about people's needs They cook told us how they ensured people received a fortified diet if there were concerns about people's weight. People were consulted about their choice of meals through daily discussions. Nutritional risk assessments and care plans were in place for people.

We observed the lunchtime experience for people. With one exception we found staff were attentive to people's needs. Staff were available to support people where required, and adapted utensils were provided for some people that promoted their independence. Staff frequently offered people a choice of drink and checked people's comfort needs. We observed one person over a fifty minute period whose only interaction was from the kitchen staff as they gave the person their meal. These staff were polite and respectful.

We checked this person's care records to understand if there was a reason why care staff had not interacted with the person during this time. There was no instruction to staff not to interact with the person. We discussed our observations with the registered manager and regional manager who told us that this would be discussed with staff.

Some people needed individual support to assist them to eat. We noticed there was minimal conversation between staff and the person they were supporting, other than occasional comments about eating. Two staff had some conversation with one another from separate tables but this excluded the people they were supporting.

From the sample of care records we looked at, we saw staff had information available to them about people's health conditions and needs. Records confirmed that referrals to healthcare professionals had been made in a timely manner when concerns had been identified. We further saw evidence that recommendations made by healthcare professionals were included in care plans. People had been supported to access health care services to maintain their health such as visits from the optician, chiropodist and GP.

Feedback from visiting healthcare professionals was positive. Health professionals confirmed that they received appropriate and timely referrals, and were confident that staff followed their recommendations to ensure people's healthcare needs were met effectively.

Good

Is the service caring?

Our findings

The majority of people told us staff were caring towards them. A person told us, "I find them very caring." Someone else added, "The majority are lovely." Some people were positive about staff but felt staff had not got sufficient time to spend time with them. A person told us, "They're ok. Yes, they will listen, but they don't spend any time with us." A relative we spoke with said, "They seem ok; they always seem sound to me." Another relative told us, "We like them [staff] here."

Staff were kind and clearly knew the people they were supporting using their preferred name. At lunch time, on the nursing side we saw a staff member had noticed that a person did not have their dentures in. The staff member asked the person if they wanted their dentures and went and fetched the dentures, washed them and returned them to the person.

We observed two staff assisting a person to move using a hoist. We saw the staff were friendly, and chatted to the person, taking special care with their limbs. After the move, staff checked the person was comfortable. Both occasions demonstrated to us that staff were caring towards people.

Some people felt involved in their care planning, but many seemed to leave this with their relatives. A person told us, "I went to one or two of the meetings on me." Someone else said, "My family deal with all that sort of thing really." Family were more aware of care planning; a few people could recall being involved but most did not seem aware of their care plans.

From our observations we found staff supported people with day to day decisions such as where people sat and what they did and that staff respected and acted upon people's choices. Staff told us that they sat with people and asked them how they felt about the care and treatment they received, but they did not record this information formally. They told us about the new care records that had been introduced, and that these would demonstrate better how people had been involved in their care. Staff told us, "They [care plans] are more user friendly." We found some care plans had been signed by the person or their family but this was inconsistent.

We saw in people's care records a booklet entitled, "My Choices. An opportunity to have my say." These provided information about the person's preferences, significant relationships and life history. This meant staff had important information available to them about people's needs.

People we spoke with told us their privacy and dignity was maintained. One person said, "They're [staff] most obliging with keeping me private." Another person stated, "Yes, they're respectful and that's important." Staff confirmed that they maintained people's privacy. One staff member said, "It's important how you talk to people [regarding maintaining dignity]. I treat people how I would want to be treated myself." A staff member gave an example of how they respected people's privacy and dignity. They told us how they supported a person to have a particular medicine in their own room for privacy reasons. We observed staff respecting people's privacy and dignity. This included staff knocking on people's doors before entering their room, and taking steps to protect their privacy. Staff supported people discreetly when

assisting people to the bathroom. People's preference to whether the person preferred a male or female member of staff to support with personal care needs was recorded.

No one was using an advocate at the time of our inspection, but we asked the provider to check the information on display about advocates to ensure it was up to date

Good

Is the service responsive?

Our findings

People told us they thought the support they received responded to their needs. A person said, "I think they [staff] know my routine and that's nice." Another person added, "I have to rely on them helping me, but they know how to support me. I ring my buzzer if I need something." A relative told us, "[Person's name] can lash out if scared so they [staff] are careful not to upset their routine and the way [person] likes things done."

New documentation had recently been introduce to record people's life history, interests, routines and what was important to the person. This information supported staff to provide care and treatment based on people's personal preferences and routines.

From the sample of care records we looked at we found people's needs had been assessed before they moved to the service. Care plans were then developed and this information was used by staff to provide a responsive service based on individual needs. These contained the information needed to provide safe care to people but lacked some detail, particularly regarding their preferences. For example, how a person liked to be assisted with personal care. This is important as it shows people were being given support to have their care delivered in a way that is important to them.

People's care and support needs were regularly reviewed to make sure they received the right care and support.

We found that one person's emotional and mental health needs showed the person required support. There was no detail in the care plan about how to give this help, and the person told us that they felt unsupported. This person required two hourly checks during the night but records showed this was taking place. This meant we could not be sure the person was being provided with safe care. We discussed this with the registered manager and regional manager. They agreed to review this person's care plans as a matter of priority, involving both the person and staff.

People were happy with the activities that were available. A person said, "I like the dominoes and quizzes. We can't go outside at the moment as the weather's cold." Another person told us, "We can do skittles and play darts. We have lots to do." Other people spoke about various things such as visitors from the local church for people wanting to attend a service, and making biscuits or cakes. The activity organiser showed us some handmade chocolates and mints that people had made the day before. People had also decorated little boxes for their chocolates.

Activities were varied and aimed to include people who had different interests and abilities. People who remained in their rooms also received visits from staff and offered appropriate activities or just a chat. In the morning, we observed a group of local singers came to give a singalong in both units in the lounges. We observed the group interacting very well and both people and staff joined in. We could see that people looked happy.

We saw people playing dominoes at Charnwood House, whilst chocolates made in activity sessions the day

before were served on the afternoon tea trolley as an extra treat. People were aware of how to complain should they have had a concern. We were told, "I'd see the manager when they come over." Someone else said, "I haven't been here that long but can't find anything wrong here."

Staff were aware of the complaints procedure and what their role and responsibility was in responding to concerns or complaints they received. One staff member told us, "I'm not aware of any complaints, but I would record it and if possible 'nip it in the bud' before it escalated.

We were informed that when people moved into the home they were given a copy of the complaints procedure and it was also on display in the home. We checked the complaints file and found there were no complaints recorded. However we were aware that that a relative and also a staff member had raised a complaint. Neither had been recorded or dealt with. We raised this with the provider.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service we identified a breach with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the time of this inspection we found the provider had made the required improvements with this regulation.

The management team told us that they had introduced a system to get feedback from people and their relatives and ensure that responsive changes were made when needed. The area manager showed us the system which made use of IPads that people, their families or professionals could use to make their views known. Any feedback gathered was sent into a central data based that could be accessed by the area manager at any time.

We were told that, for people who were not mobile, the activities co-ordinator planned to take an iPad around with them to assist people to give their feedback. When we arrived at the inspection, the iPad in the entrance was not working properly, so this would have prevented people giving feedback if they had wanted to. The system had been in use for six months; records showed two people who used the service and eight relatives had provided feedback during this time. This feedback was in the main positive. As the feedback rate was so low, it was not possible for the provider have an accurate overview of satisfaction from people

The registered manager did a dally walk round, and completed various tasks, such as monitoring cleanliness, speaking to residents and checking recording charts We saw that the overall satisfaction scores of the areas assessed had improved over recent months.

The registered manager informed us that plans had been approved by the provider for redecorating parts of the home, and supplying new soft furnishings, plus the refurbishment of some of the bathrooms.

The registered manager told us the home does a single detailed case file audit for a different person each week. This was then fed into an IT system which generated reports. The area manager told us that this would identify any actions that were needed and could not be closed until the required actions were carried out.

We saw a recent audit of satisfaction from visiting professionals which show an overall satisfaction rate of 93.4% in the previous month. The area manager told us that all accidents and incidents are reported on an electronic system and these are then analysed to look at any theme and trends in each home. The area manager was able to download various events such as people having falls to identify if there were any areas that needed changes to be made to lower accident rates.
The provider also showed us a copy of a tool recently implemented that helps nurses assess other needs before giving medicines to people with behaviour which challenges that are prescribed 'as required.' These measures assured us that the provider has developed systems to monitor and make improvements to the service.

We received some concerns from people who used the service and relatives about the management team.

They described the registered manager as not always being approachable. A person told us, "I get a quick hello and goodbye if they come to the room. I don't really think [registered manager] is approachable." Another person added, "We see a lot of [registered manager] in the lounge. Sometimes they are all over you, sometimes they ignore you." A relative we spoke with said, "I see the registered manager pop in and out. I don't talk to them much though; they talk on their terms." A relative commented on an encounter they had with the registered manager. They told us, "I went past the office door and said, 'Have you got a pen?' The nurse in there was really brusque saying, 'No', and I said "That's no way to talk to anyone'. The registered manager was sat there too and never said a word."

A relative made contact with the inspection team after the inspection, and informed us they had made a complaint about staffing concerns. We could find no record of this during our inspection. We raised this with the management team.

All staff we spoke with made reference to the service experiencing many managers in the recent past, and that this had impacted on the service and had been unsettling for the staff team. Not all staff felt valued, and some staff gave examples of working excessive hours and weekends without any discussion or consideration from their line manager. When we checked the staff rotas, we saw evidence of this. For example, we saw a staff member had worked six consecutive weekends without being asked if they were able to do this. We raised this with the provider who agreed to take immediate action.

Some of the staff we spoke to had low morale and told us there was a culture of blame if things went wrong. A staff member told us that they had been chastised in front of other staff, rather than being taken aside for this. One staff member had raised a written complaint that had not been dealt with or recorded by the registered manager. We asked the registered manager and area manager to take urgent action on these matters and requested that all complaints are recorded in writing, and dealt with in accordance with the provider's policy.

One staff member said that the registered manager listened to any concerns and that they would go to them about anything. They said that staff meetings mainly focused more on the nursing side more than the residential side. Another staff member told us that they had had many managers and that the current registered manager was making improvements and had brought some stability to the service. Feedback from healthcare professionals was positive about the leadership. They said that they enjoyed visiting the service, and that in their opinion, felt it was well organised.

Staff understood the values and aims of the service. One staff member said, "This is people's home, we really do try and lift the atmosphere and give the best care we can." Another staff member told us, "We try and give the personal touches and lots of encouragement to keep people mobile, independent and support health and well-being."

Staff knew about the whistle blowing policy and procedure and said they would not hesitate to use if required. Staff said that they attended staff meetings and that these had increased in frequency over recent months. Staff also talked about the importance of daily handover meetings and that this was a support to them to know what was happening from shift to shift.

Some people we spoke with were unsure about residents meetings taking place. A person said, "Yes, I thinks it's [the meeting] every few months but nothing happens after it though." Other people told us, "No, I don't know anything about a meeting for us," and a relative said, "We've not had any that I know of." We asked for records of resident meetings but were only given details of one meeting held.in January 2016. We saw that the new iPad feedback system was discussed during this meeting. It was not clear how often the meetings

are due to take place.

We saw evidence that staff meetings are now taking place on a regular basis, the last of which was in January 2016 and discussed issues such as training, staffing, and documentation. We saw that some meetings are held just for qualified nurses. This had discussed the implementation of the new tool to reduce the use of as required medicines for people with behaviour that challenges. This showed us that the provider was consulting and updating staff to promote good practice.