Care UK Community Partnerships Ltd

Muriel Street Resource Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 January 2018 and was unannounced.

Our previous comprehensive inspection was undertaken on 25 and 26 January 2017 and we rated the service 'Requires improvement'. During the inspection in January 2017, we did not find any breaches of The Regulations. At that time, the provider had been working on meeting the action plan submitted to the CQC following the focused inspection in September 2016. Although significant improvement had been observed in January 2017 more improvement were still required. At this inspection in January 2018 we observed ongoing progresses in improving the quality of the service delivery had been taking place at the home and more improvement were still needed.

Muriel Street Resource Centre provides nursing care to men and women with a range of needs including physical disabilities, dementia and mental illness. The home is able to accommodate a maximum of 63 people over three floors. There were 48 people using the service on the day of the inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager with the support of the deputy manager and the clinical lead had worked continuously on addressing areas for improvement that had previously been identified at our previous inspections.. Our overall observation was that the safety and quality of the service provided had significantly improved.

At the previous inspection, we found that the provider had not managed the administration of topical creams appropriately. At this inspection, we found that this issue had been fully addressed and there were clear records when staff administered creams to people.

At the previous inspection, we found that staff had not received a yearly appraisal of their performance. At this inspection, we saw that the home was in the process of completing staff yearly appraisal and staff had received formal supervision.

At our previous inspection, we found that some people's records were stored electronically and some in a paper form and it was difficult to find up to date information about people's care. At this inspection, we saw that this issue had been fully addressed and it was clear which documents staff should look at for up to date information on people.

At the previous inspection, we saw that staff had not always acted in a caring way towards people. At this inspection, we saw the management team had been proactive in addressing any staff conduct issues. However, we observed that some staff practices during a handover process needed further improvements to ensure they supported people in a thoughtful and compassionate way.

There were limited meaningful social and leisure activities at the home. This area of the service provision needed to be improved. The management team were taking action to ensure the quality and the amount of meaningful activities for people would increase.

The provider had a range of systems to ensure the service delivery was continuously monitored and improved. However, a few of these had not been that effective because the provider had not identified the areas that we found during the inspection, as needing improvement. Whilst the service was rated 'Requires Improvement' at a previous inspection, improvements made by the provider had not been sufficient to rate the service 'Good'. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. You can see what action we have asked the provider to take at the back of this report.

People told us they felt safe at the home. The management team had been working towards providing staff with additional training to increase staff awareness of their role in relation to safeguarding people.

Staff levels were maintained in relation to people's needs. The registered manager was planning to increase staff numbers following new admissions to the service.

New staff received induction and they said it was helpful. We noted the home needed to improve how they evidenced the induction process for each individual staff member to ensure each staff member completed their induction as required.

There were regular service users meetings and satisfaction surveys carried out to encourage people to have their say about the service provision. However, there was no feedback mechanism in place to inform people about actions that had been taken following their comments.

People were involved in the planning and reviewing of their care and their care plans were person centred. However, some improvements were needed to ensure people were supported in understanding and for them to be more aware of the care planning and reviewing process.

We saw that medicines were managed safely and there were appropriate systems in place to ensure any errors in medicines administration had been identified and addressed.

The provider provided care that was safe. Risks to people's health and wellbeing had been assessed and staff demonstrated a good knowledge on how to support people safely. Robust systems in place ensured people lived in the safe and clean environment. Accidents and incidents were monitored by the management team and actions were taken to reduce to possibility of them reoccurring. Correct infection control arrangements protected people from avoidable infection contamination. Appropriate recruitment procedures in place helped to protect people from unsuitable staff.

Staff received training and had the skills to support people effectively. The management team monitored staff competencies. Identified gaps in staff's performance were managed through additional training or a performance management process.

People's care and support needs had been assessed before they moved into the home. The deputy manager managed the referral process to ensure the home was able to meet the care needs and preferences of new people who would use the service.

People were supported to have a nutritious diet that met their nutritional needs and personal preferences.

People received appropriate support during mealtimes and we saw they were dining in a peaceful and caring atmosphere.

Staff supported people in having access to community health professionals and services when required. Good communication between the staff team and external health professionals helped to address people's health needs promptly.

The service had worked within the principles of the Mental Capacity Act 2005 (MCA). People were not unlawfully restricted. Any decisions on people's behalf were made in their best interests. Staff asked for people consent before providing care and support.

The majority of people told us they knew who to speak to if they had any complaints about the service. We saw that the management team dealt with all received complaints appropriately.

The home had managed the end of life care of people with sensitivity. This matter had been discussed and recorded to ensure people's wishes were known and respected, as required.

Staff were encouraged to contribute to the service development and they were committed to improving the quality of the service delivery.

There were quarterly service users and relatives' surveys. The management team had taken actions to ensure the home addressed issues raised in these surveys.

External health and social care professionals spoke positively about the changes and improvement carried out at the home.

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 safe

Medicines were managed appropriately and actions were taken to address any medicines administration errors.

People felt safe at the home. The management team had been working towards increasing staff knowledge on their role in relation to protecting people from abuse from others.

Staffing levels were maintained in relation to people's needs and in line with current staff funding.

Risk to people health and wellbeing had been assessed and staff had guidelines and the knowledge on how to provide safe care.

There were robust health and safety system in place and people lived in a safe environment. There were also systems to help protect people from the risk of the spread of infection.

Appropriate recruitment procedures were in place and followed to help protect people from unsuitable staff.

Is the service effective?

Good

The service was effective

Staff were supported in their role. They had received a formal supervision and they were in the process of completing a yearly appraisal of their skills.

New staff received induction prior to working with people. We noted improvements were needed to ensure staff induction was appropriately documented.

Staff had the skills to support people and any gaps in staff performance were managed through further training and a performance management process.

People's care needs and preferences were assessed. A thoughtful referral process ensured the home accepted people whose needs and preferences they could effectively meet.

People's dietary requirements were met according to their nutritional needs and personal preferences.

Staff supported people to access health professionals and services when they needed them.

Staff had a good understanding of the Mental Capacity Act 2005 and how to support people using the principles of the Act.

The accommodation was clean and free of hazards. People were involved in making decisions about the décor at the home.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff's practices during morning handover has not always been considerate and needed improving.

There were quarterly residents' meeting. However, improvements were needed in how the home reported on actions taken following the meetings.

People and their family members spoke positively about the staff at the home.

Staff protected people's privacy and dignity when providing personal care. People could choose if a male of female worker supported them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were made in how the home stored care records. Most up to date information about people's care was available in their care files.

People's care plans were comprehensive and person centred. Improvements were required to ensure people understood the care planning and review process so they could engage better in this process.

People had limited access to fulfilling and varied activities in the home that met their individual needs.

People knew who to speak to if they had any complaints and the majority of people knew the home's complaints procedure.

The staff managed people's end of life care with sensitivity and people's wishes and preferences were taken into consideration when planning and delivering this care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team worked consistently on implementing changes and addressing previously identified issues at the home.

There were systems in place to ensure the service delivery was monitored and actions were taken to address any issues.

External health and social care professionals spoke positively about the management team at the home and the changes they had made at the home.

Muriel Street Resource Centre

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 checked 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 8 and 9 January 2018. The first day of the inspection was unannounced and we informed the registered manager that we would return the following day.

The inspection was carried out by one inspector, a nurse specialist advisor, a pharmacist specialist advisor and two Experts 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.

CQC was aware of a past incident that took place at the location related to the unexpected death of a person as a result of choking. At the time of our inspection this incident was subject to a coroner's investigation and as a result this inspection did not examine the circumstances of the incident.

Before the inspection, we reviewed the information we held about the service. These included people's feedback, notifications of significant events affecting the service and the Provider Information Return (PIR). PIR 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.

The registered manager was not present at the time of our inspection, however, we contacted the registered manager on 15 January 2018 to give a brief feedback about the inspection and to discuss aspects of the service provided by the home.

During our visit, we spoke with members of the management team including the deputy manager and a

clinical lead. We also spoke with 12 staff members including two team leaders, three health care assistants, four nurses, the maintenance worker, the chef and the activities coordinator.
We spoke with 25 people who used the service and seven relatives and friends visiting the home.

Many of the people using the service were unable to share their experiences with us due to their complex needs. Therefore, in order to help us understand people's experiences of using the service, we observed how people received care and support from staff. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three external health and social care professionals who visited the home during our inspection.

We looked at records which included care records for 17 people, recruitment, supervision and training records for eight staff members, and other records relating to the management of the service, such as, health and safety checks, team meeting minutes, medicines and people's care records audits.

Following the inspection, we received feedback from two external health and social care professionals and the Multidisciplinary Team regularly visiting Muriel Street Resources Centre.

Good

Is the service safe?

Our findings

At the previous inspection, we found that the Muriel Street Resources Centre had not managed the administration of topical creams correctly. At this inspection, we saw that creams had instructions about their administration detailed on the Medicines Administration Records (MAR) and individual cream charts. We saw that creams administration was recorded regularly and there were no gaps in recording.

We looked at 25 MAR over all three floors in detail. We saw one gap in the recording of the administration of medicines, which happened one day prior to our inspection. We could not be certain whether one medicine was given. We counted 19 random samples of supplies of medicines over the three units and could reconcile all but one with the records of receipts, administration and disposal of medicines. The medicine we could not reconcile had been recorded as given but the stock check suggested that it was not administered. This error happened during the night prior to our visit. We instantly brought both errors to the attention of the service's clinical lead. We saw that the clinical lead had immediately discussed this with a multidisciplinary team (MDT) of professionals who were visiting that day. This meant they sought professional advice on what action should be taken to ensure people were safe. The clinical lead also spoke to staff responsible for medicines administration on the shifts when the errors were made to ensure these did not happen again.

We saw monthly internal and external medicines audits for the last three months. Errors and incidents were logged and we saw that action was taken when an error occurred. Regular medicines checks and the prompt action by the clinical lead in relation to the issues identified by us assured us that overall medicines were managed safely.

We saw that all MARs had clear information on what medicines people were prescribed and how to administer it. When people were prescribed certain medicines there were corresponding documents available to ensure staff had clear guidelines on the purpose of medicines and how to manage people's health appropriately. For example, a person prescribed insulin for their diabetes had a detailed chart recording blood glucose and sites of injections and dosages administered. Several people were prescribed patches and oral medicines for pain relief and we saw that there were care plans in place and the GP regularly reviewed their pain relief. We saw patch charts to record the site of application. If people were prescribed medicines to be given as required (PRN) there were protocols in place so that staff knew when and how often they should be given.

Evidence showed the home had managed people's medicines with respect to people's human rights and preferences. We saw that all people had assessments in place to describe how they liked to have their medicines given. When people had their medicines given in a covert way, we saw that there was a multidisciplinary agreement in place showing this was agreed as being in people's best interests.

We observed that medicines were stored in a safe way, locked in clinical rooms. Temperatures were recorded daily in the clinical rooms and for the medicines fridge so that the potency of the medicines could be maintained. Controlled drugs were stored appropriately and records showed the stock levels were all accurate.

The home had up to date medicines policies and procedures available and we saw records of recent medicines training and competency assessments of staff trained to administer medicines.

People told us they felt safe at the home. Their comments included, "I very much feel safe in the presence of staff" and "I feel safe within this care home and staff always listens when I speak". Family members also thought their relatives were safe at the home.

There were systems in place to help protect people from harm and abuse from others. We saw that identified safeguarding concerns had been managed promptly by the management team and actions were taken to ensure people were safe. Evidence showed the home had worked alongside the local authority, CQC and other professionals. This helped ensure the information about people's safety had been shared and people were protected from harm.

Staff we spoke with told us they received safeguarding training. When describing the principles of safeguarding they concentrated more on the health and safety aspects of protecting people rather than ensuring people were safe from abuse and harm from others. We spoke about this with the registered manager and the deputy manager. They both told us they had already identified gaps in staff knowledge and they were working on providing additional safeguarding training. One external professional told us, "The current management team had reduced the number of safeguarding concerns due to ensuring staff received appropriate supervision and training."

People told us they often experienced staff as being busy and they felt there could be more staff on the shift. They told us, "When the call button is pressed, it usually takes staff 2-3 minutes to assist", "I sometimes feel rushed as staff are often very busy" and "There should be more staff, but they told me that they have enough." We saw that there were at least four staff members on each shift on each floor. These included three care staff and a senior staff member per shift for each floor. Due to people's more complex care needs, there was also a nurse per shift on the ground and first floor of the home. We spoke about this with the registered manager. They told us increasing of the staffing levels had been a constant point of discussion with the service commissioners and they would like to have more staff on each shift. At the time of our inspection, the registered manager was maintaining staffing levels in relation to people's needs. They also assured us that staff numbers would increase together with the admission of new people.

The home had assessed risks to the health and wellbeing of people who used the service. We saw that staff were provided with guidelines on how to support people safely. Completed risk assessment were personalised and it was evident that care and control measures were in place to manage any identified risks. Examples of risk assessments we saw were associated with risk of choking, falls, manual handling, pressure ulcer prevention, independent use of cutlery and the environment people lived in. Staff, we spoke with demonstrated a good knowledge about risks to people and precautions to take in order to ensure people were safe and receive necessary care.

There were effective systems in place to ensure people lived in a safe and clean environment. We saw evidence of regular health and safety checks, cleaning checklists, fire checks and equipment maintenance records. We saw when any maintenance issues were identified, they were promptly addressed. We observed that the home was clean and free of any hazards that could put people at risk of harm.

We saw the home had a robust process in place for the reporting of accidents and incidents. A central accident and incident register was regularly reviewed by the registered manager. The deputy manager told us, accidents and incidents were discussed in various team meetings. This was to ensure lessons were learned and the possibility of similar accidents and incidents reoccurring was minimised.

There was an appropriate recruitment procedure in place to ensure only suitable staff supported people. We saw that new staff had appropriate recruitment checks completed before they started working at the home. These included criminal records checks, staff's right to work in the UK, references from previous employers and relevant professional qualifications. The deputy manager provided us with the list of up to date nursing pin numbers for all the nurses employed at the home. This meant they were registered with the Nursing and Midwifery Council (NMC) and they were allowed to work as nurses in the UK.

The service had systems in place to ensure effective infection control. There was an infection control policy in place to guide staff on how to effectively protect people from the risk of avoidable infection contamination. Staff received appropriate training and they were able to describe various infection control measures. During our inspection, we talked with a person who had contracted an infection, which could be contagious to others. Before entering the room, staff were able to advise us which protection measures to take in order to avoid the infection contamination.

Good

Is the service effective?

Our findings

At our inspection in January 2017, we identified that staff had not completed their yearly appraisals. At this inspection, we found that yearly appraisals were in the process of being completed. The deputy manager told us first appraisal meetings took place at the beginning of December 2017and they were scheduled to be completed by the end of January 2018. All staff we spoke with told us they had competed or had planned their appraisal meeting. We saw examples of three completed appraisal documents, which confirmed these were taking place. Following our inspection the registered manager informed us that all but one appraisal had been accomplished.

Since our last inspection, 16 new staff members had commenced their employment at the home. New staff were required to complete a two weekly induction process. They were also asked to complete the provider's induction book within the first three months of their employment. New staff's progress was discussed with respective line managers in three and sixth monthly probation review meetings. We looked in personnel files for six staff who started their employment at the home within the last 12 months. We did not see an induction book in any of these files. On request, the deputy manager provided us with one fully completed induction book. We saw evidence of one three monthly meeting in one staff file. Consequently, we could not say how the induction process for individual staff members was progressing. We discussed this with the deputy manager. They explained new staff kept the books while completing them. They said the probation review meetings were taking place, however, documents confirming this were not always placed in staff files.

The deputy manager provided us with a copy of an induction plan with the induction schedule for each new staff member. This included information on policies and procedures, various elements of the service provision, information on e-learning and expectations around different aspects of staff's roles and responsibilities. We also saw a copy of an induction matrix, which was regularly reviewed by the registered manager to ensure staff completed their induction. Staff we spoke with said they received induction before they started working with people. They said it was useful and included shadowing of other staff and induction to the building. We saw that induction was discussed in staff individual supervision. The registered manager told us the induction process was important and staff skills were thoroughly assessed before they started working with people. For example, we were told about a staff member who did not pass their probation period, as they had not progressed with developing the appropriate skills to care for people. Two other staff had received enhanced support to increase their skills to standards required by the home. This evidence reassured us that an induction had been taking place. However, the home needed to improve how they evidenced the process for each individual staff member. We discussed this with the deputy manager who agreed they would look into this matter.

Following our inspection, the registered manager informed us that all completed induction books had been placed in staff files. The home was also in the process of implementing a system to ensure the induction for each staff member was clearly recorded in staff files and available for the audit purpose.

People using the service thought staff had the skills to support them effectively. They said, "Staff know what

they're doing" and "The staff understand everything I need and they're very careful". External professionals also said staff had skills and knowledge to support people effectively. One professional stated that staff would benefit from additional retraining on how to support people with behaviour that might challenge the service.

The training matrix provided by the deputy manager showed that the majority of staff completed their mandatory training within the required period. These included dementia awareness, safeguarding, infection prevention moving and handling and the Mental Capacity Act 2005 (MCA) training. We saw that when staff had not done so, a formal reminder letter had been sent and discussion about completing the training was held in staff supervision. The registered manager explained they were monitoring staff training, however, some gaps in training completion had been related to technical difficulties in accessing the provider's training software. The registered manager said this had been now addressed and staff were provided with allocated time and a training computer to support them with finalising their training. All staff we spoke with told us they were provided with training and information when training was due to be renewed.

Staff received regular one to one supervision. We looked at the supervision matrix provided to us by the registered manager. We saw that the majority of staff had at least four supervisions within the past 12 months. Eight staff members received less frequent supervision. The registered manager was able to explain what contributed to it and what action had been taken to ensure staff attended their one to one meetings. Supervision notes we saw indicated that staff's skills and their role was discussed. We saw evidence of two staff being supported through a performance management support plan. We noted that through additional support staff successfully completed their enhanced performance management period. This assured us that the management team at the home was proactive in supporting staff and addressing any identified gaps in staff skills and performance.

We saw there was a robust care and needs assessment process before people moved into the home. This included visiting people prior to their admission and obtaining full documentation about their needs from respective health professionals. We saw examples of completed assessment documents. The assessor explored with people matters relating to people's health care needs, personal circumstances and any known behaviours that could challenge the service. Gathered information was then used to ascertain if the service could meet people's needs effectively. We saw that the registered manager had monitored all referrals. The home maintained a referral spreadsheet, which reflected various stages of the referral process and its outcomes.

The staff supported people to have sufficient food and drink that were nutritious and reflected people's health needs and personal preferences. People's dietary requirements were recorded in their care plans and relevant information was passed to the catering staff. The chef we spoke with had good knowledge about the nutritional needs of the people at the home. They knew which people required soft or pureed diet or had specific requirement relating to their religious beliefs or cultural preferences. We saw an information board in the kitchen area detailing dietary needs of each person living at the home. This meant the kitchen staff had easy access to this information and could provide food accordingly.

All but one person told us they enjoyed food at the home. Since our last inspection the home had worked on improving the mealtime experience for people. We saw that tables were nicely dressed, and there was a nice ambience in each dining room. The management team had encouraged care staff to eat with people to keep them company and encourage people to eat more. Staff told us, "It is nice to eat with people. It is more social and people eat more as a result." There was a "protected meal times" rule during all mealtimes. This meant that people were not disturbed to take medicines or for any other reason. People could choose what they eat. We observed how during lunch staff brought round a tray with examples of the two main choices

plated up so people could decide what they wanted. One person was served an alternative meal, which was not on the menu. Everyone had juice or water and everyone had been served within 10 minutes.

We saw regularly completed MUST chart. MUST is a screening tool to identify adults, who are malnourished or at risk of malnutrition. These were used to monitor people's weight and we saw actions were taken to alter people's diet if they suddenly gained or lost weight. Records showed that people had been referred to specialists where needed. These included doctors, a dietitian and a speech and language therapist [SALT]. A staff member told us, "[A person] was eating and coughing. So we discussed it with the doctor and the person was put on a mashable diet." We saw that appropriate choking risk assessments were in place to ensure staff had guidelines to follow when a person was at risk of choking while eating.

People's healthcare needs were met and they had access to health services when they needed them. There was good communication with external health professionals, and any changes to people health and wellbeing were promptly addressed. There was a monthly MDT meeting which helped to pick up changes to people's health and to make appropriate referrals quickly. External health professionals told us, "Staff are very engaged in making care and quality of life the best it can be for residents including advocating for them to access dental/optician services and have access to funds" and "The staff always include me in discussions about patients I care manage. Any changes in their health or condition they immediately alert me and have always been willing to have a meeting to discuss issues and a way forward. "

The MCA provides a legal framework for making particular decisions on behalf for 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 lacked 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA.

Where people required an assessment under DoLS to be deprived of their liberty, the provider had submitted applications to the relevant local authorities and the deputy manager followed up on these applications to check if they had been authorised. We saw that DoLS had been regularly discussed in staff team meeting and thematic "take ten" meetings. "Take ten" meetings were shorter mini meetings taking place daily to allow senior staff to stay up to date with any changes or events that were taking place at the home.

Staff received training in the MCA and they had a good understanding of how to support people using the principles of the Act. They said, "Even when people do not have the capacity they can make some decisions "and "We always need to make decisions in people's best interest. People can choose what to wear or eat and you may need to guide them." People using the service told us staff always sought their permission before providing any care and support.

The accommodation at the home was laid out over three floors. Each floor was occupied by people with specific care needs such us mental health, general care needs and people living with dementia. Each person had their own bedroom and could access the communal facilities which included two lounges and a dining room on each floor. The home was clean and free of unpleasant odours. The home was currently going through a refurbishment programme. At the time of our inspection, the work on one of the floors had already been completed. We were told that people using the service were involved in choosing the colour scheme. The deputy manager provided us with documents showing that people were encouraged to

participate in how they would like their environment to look like and that their suggestions were followed.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection, we found that people had perceived staff as "moody" at times and we saw one instance when staff had not acted in a caring way towards a person using the service. The interim manager at the time had assured us they would speak to staff to address this matter and they would manage this through a performance management intervention if needed. At this inspection we saw that improvements have been made and further improvements were needed.

Records showed that if staff had been identified as acting in the way that could be perceived by others as unkind or uncaring this was picked up by the management team and managed formally in staff one to one supervision. In June 2017, additional training was provided to staff to improve their skills on how to work sensitively and effectively with people using the service. Thirty staff members attended.

However, during this inspection we observed staff practice during morning handover needed improving. We saw staff walking around as a team of at least four, entering room by room and handing over information about people to the next shift. We saw that the way it was done could be perceived as intrusive and not always welcomed. For example, staff entered the room of one person who started shouting as they realised staff were inside. Staff reassured the person, however, they stayed in the room talking about the person rather than removing themselves. In another example, staff approached a room that was locked from the inside by a person. Staff immediately asked their colleagues for a master key to open the room rather than knock and ask if the person was ok and was willing to see the staff. While staff were looking for the key, we saw how the person opened the door stating that they were well and ready to start the day. In another example staff walked into the room where a person was still asleep. A staff member leaned over the person stating, "She is breathing". We spoke about our observations with the management team. They agreed that the practice observed by us required addressing. The registered manager told us about their ongoing work to improve the handover process so it was sensitive and respectful to people as well as informative to staff members. They assured us they would provide more guidance and support for staff on this matter.

We also saw examples of staff acting in a compassionate and kind way. We saw staff offering morning tea to people who got up earlier, laughing and joking with people, kindly explaining what they were going to do before providing support. In another example, a staff member spoke to a person in their language. We saw the person responded happily and was engaging well with the staff member.

People using the service and their family members gave us mostly positive feedback about the staff at the home. They said, "It's nice here. If you are kind to [staff] they are kind to you. It works both ways. We all get to know each other; especially the staff, they get to know you" and "[Staff] are very good. They're very nice to me. They are sociable. We don't go short of anything." One person told us, "I get on with most of the staff members, but some can be abrupt as they are very busy." Family members said us, "They're looking after [my relative] fine. I'm very happy with the care. Any small thing they will ring me. Yes, she's very well looked after" and "They're very good here. [My relative] always looks clean and tidy and her room is lovely. It's always kept tidy." People also told us that new staff had always introduced themselves before providing them with support.

Staff spoke kindly about people they cared for. Their comments included, "The team cares about people. Staff talk with them and ensure people have enough food and drink" and "We give people the best we can. We sit with them and listen. I love my job as I always care for people." The registered manager spoke fondly about the staff team and their efforts to provide people with kind and dignified care experience.

The home supported people in embracing who they were and what was important to them. The deputy manager old us that individual keyworkers supported people in completing their life stories. These allowed staff to find out more about people they supported. We saw examples of life stories in people's care files. People were supported to have access to the communities and faith groups related to their spiritual, social and other personal needs. This included links with the local church, LGBT (lesbian, gay bisexual and transvestite) community and others.

Staff protected people's privacy and dignity when providing personal care. All people we spoke with told us staff always asked their permission before carrying out any personal care. Staff told us, "I close the door and curtains. I tell people what I am doing so they are not afraid" and "I speak to people to make them feel comfortable. I explain what I will be doing and if they do not want, I will not pursue but I will wait a few minutes and ask again." Records showed, and people confirmed, they could chose if a male of female worker was providing them with personal care.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found that there were inconsistencies in where information about people's care and support were recorded and stored as the provider kept electronic and paper records. This could lead to confusion in terms of accessing up to date information regarding the care and support needs of people at the home. At this inspection, we saw that this had been fully addressed. We saw that people's files consisted of comprehensive and up to date information about them. Documents that were initially completed on the computer were printed out and it was clear which documents staff should looked at for up to date information. The registered manager told us, they carried out regular file audits to ensure all document were up to date. Our observation confirmed that this was the case. Files were in good order and included a document index at the front. We saw that documents were stored accordingly and it was easy to find any information.

The care plans we saw showed the involvement of people and their relatives in developing and reviewing these. We saw that various comments and contributions made by people and their relatives were clearly stated in the care plans. However, people we spoke with told us they had not seen their care plans and did not contribute to their reviews. We spoke about this with members of the management team. They assured us they would look into this matter and take action to support people in better understanding and being more aware of the care planning and reviewing process.

Care plans we saw covered a range of people's care and nursing needs. This included information related to moving and handling, skin care, breathing and circulation, mental well-being, pressure ulcer prevention and administration of medicines. Any specific physical health conditions, such as diabetes, current infections and others were also detailed in the plans. The information was clear and staff were provided with sufficient guidelines on how to support people.

Care plans included information on people's personal preferences, life style choices, culture and religion requirements and how people communicated with others. Staff we spoke with gave us examples of people's choices and preferences. This indicated staff had a good knowledge about people's they supported.

During our two day inspection we observed there were limited meaningful social and leisure activities at the home. The feedback from people using the service and their relatives varied. Two people told us they took part in activities, which included playing ball games, drawing or visiting the local day centre. The majority of people we spoke with said there was not much happening at the home. People's comments included, "They used to have exercises twice a week but it's only once a week now", "There isn't a lot of activities to do" and "I haven't got a lot of activities and wouldn't mind some more." Relatives told us, "I can't stand the way they're just left sitting [in the sitting room]. Sometimes when I come in [the staff] are busy and they are all just left sitting here. Even if a staff member is in the room they sit at the desk doing notes on the computer with their back to them and they can't see what's going on."

We saw there were out of date weekly activities timetables displayed on each floor. It was updated on the second day of our visit. On the first day of our visit, we saw a sing along session taking place on the second

floor. All people in the room were encouraged to take part, however, only a handful did. There was no alternative activity provided for those who would like to do something else. We also observed activities on the ground floor of the home. We saw that there were four people gathered in the room watching TV and one staff member who was sitting at the computer completing notes. Ten minutes into our observation a staff member started a game of skittles with people, which lasted ten minutes. Following this, the staff returned to writing their notes and people to watching TV. We saw there were no alternative activities offered.

On the second day of our inspection, we saw a game of bingo. A number of people were brought from different floors and we saw they enjoyed the game. We observed that apart from short-timed events, on both days there was not much happening and people spent most of the time in various lounges watching TV or listening to the music. We spoke with the lifestyle coordinator employed by the home. They were keen on providing people with interesting things to do. However, we observed that they spent time on tasks, such as, making a list of toiletries people would like to buy from the home's beauty shop. This took them away from providing and arranging social, and leisure activities for people.

We talked about our observations with the deputy manager and the registered manager. They agreed the provision of activities at the home should improve and they were taking actions to facilitate changes. For example, the registered manager was in the process of employing more appropriately trained staff to provide meaningful activities at the home. Following our visit, the registered manager informed us they had successfully interviewed and offered a position to an additional lifestyle coordinator.

The deputy manager told us about various social and leisure projects that had already been introduced or were in the process of implementation. The activities already taking place included sessions with a trained therapy dog, dance therapy and chair based exercises provided by an external company. The home had recently started weekly visits by children from a local school. The aim was to spend time with people and accompany them in various activates. The deputy manager had also arranged support from the local community club. The club would provide various activities to people using the service at the home as well as at the club's location. This project had been scheduled to commence within the two weeks from our inspection.

The home had a complaint policy in place. We observed that it was displayed at the entrance to the home. This meant that people who lived at the home but had limited access to this part of the building might not have seen it. We discussed this with the management team who agreed to make the policy more visible and accessible for all of the people who use the service. There was a system for recording complaints and compliments. Records showed there were three formal complaints made since our last inspection. We saw that the home's management team had appropriately dealt with all three complaints. All people we spoke with, but one, told us they never had to complain and they knew who to speak to if they were dissatisfied with the care and support provided. They told us, "I can complain to staff I have a problem. They do listen" and "Depending on the complaint, I know who to speak to."

The home had managed people's end of life care needs with sensitivity. The clinical lead told us this had been discussed with people and if appropriate their family members at the point of people's admission. The aim was to have a good understanding of what people's wishes and preferences were if they passed away. People had a Do Not Attempt Cardiopulmonary Resuscitation (DNAR) form, completed and signed by the person's doctor, which highlighted any discussions between the person's doctor, the person if they were able to and/or the person's relatives. The end of life care plan included information about any anticipatory medicines that might be needed to promote comfort at the end of life. We saw that these were reviewed by the community palliative care team.

Requires Improvement

Is the service well-led?

Our findings

Since our previous inspection, Muriel Street Care Centre had undergone many positive changes. During this inspection. Overall, we thought the home had made noticeable progress in addressing previously identified concerns. We observed that some areas of the service delivery still required improvements. These were related to the handover between staff teams which at the time of our inspection was taking place without due consideration for people's privacy and dignity, and recreational and social activities provided to people. We also noted that steps had already been taken by the management team to address remaining gaps in the service provision.

There was a registered manager in post. The registered manager had a good understanding of issues faced by the home. The registered manager was supported by the deputy manager and the clinical lead. Together they formed the management team that had appropriate training, experience and leadership skills to progress and develop the service provided.

The management team was instrumental in supporting the staff team who had previously expressed concerns around the management of continuity of work and staffing levels. Staff were encouraged to contribute to the service development. There was a bespoke team building session delivered by the provider. The result of the session was that staff had come out with the goal that in April 2017 the home would come out of the embargo restricting new admissions, imposed by the local authority. Due to the efforts of the team, this goal had been achieved. Staff were willing to continue their contribution to the improvements in the home. We were told, they were now aiming at getting the highest rating possible. The registered manager told us, "The best support I get is from my team; my care managers, nurses and front line staff."

Staff spoke positively about the support they received from their managers. They told us, "We have an excellent manager. She is very responsive to problems and you know she is able to be a manager. She follows you to ensure you do things right", "The registered manager works like everybody else. She does not sit behind the desk, she's always here" and "The leadership is better now. You can sit and talk to your manager.

There was improved communication between the staff and the management team. This allowed staff to be involved in matters related to the service provision. The management team had introduced a variety of team meetings. These included care staff meetings, daily handovers, clinical reviews, health and safety and daily "take ten" update meetings. The meetings schedule was displayed on each floor of the home and staff had easy access to it. We saw that meetings and their outcomes were recorded, therefore there was an audit trail of information shared and the actions agreed.

The management team provided staff with ongoing formal and informal support. Records showed that the frequency of staff supervision has improved. The management team had used a performance management process and training to address and improve staff practice. The registered manager told us that senior staff were provided with additional supervision and appraisal training to ensure the formal support was provided

in a skilful and meaningful way. They also said, since our last inspection three staff members had started an internal team leaders' course.

The management team had introduced a range of systems to ensure the service delivery was continuously checked and well led. There were detailed audits that allowed ongoing monitoring and quality assurance of all aspects of service delivery. These included regular care file audits, medicines audits and various health and safety checks. We saw that where gaps in performance were identified the registered manager or allocated by them person had taken actions to ensure improvement were made.

The home helped people to feel special and supported them in being involved in making decisions about their care. Once a month each person at the home became a resident of the day. Staff were allocated more time to spent with this person. The person could discuss and update their care plans and offer additional support if people wanted. This included providing people with specially prepared meal of their choice, deep cleaning of their room or looking at various leisure activates people would like to take part in. During a handover, we observed staff discussing how they would support one person that day. One person told us how they enjoyed a meal that was especially cooked for them.

The provider carried out quarterly service users' and relatives' surveys. We saw the management team was proactive and took actions to ensure they addressed issues raised in these surveys. For example, new menus were introduced following people's concerns about the food served at the home. In another example, changes were implemented to the laundry service as people expressed their dissatisfaction with how their clothes were managed. We noted that although actions were taken, the outcomes of the surveys had not been fed back to people and the staff. Consequently, people were not always aware of the changes that had happened and staff had not always known why the changes were made.

There were quarterly residents meeting which were important platform for driving positive improvement at the home. Minutes from these meetings showed people were encouraged to have their say about the provision of care at the home. We noted that the majority of people we spoke with were not aware of the meetings and did not remember taking part in any. Staff we spoke with were also unaware of topics discussed in residents' meeting and what changes were brought as the result.

We spoke with the management team about the lack of a feedback mechanism on actions taken following people's comments. We were assured a new feedback information board would be introduced shortly to show that people's voice mattered and their complaints or suggestions were acted upon.

The home had received positive feedback from external health and social care professionals. Everyone we spoke with commented on skills, experience and positive drive of the management team and the staff at the home. They told us, "I have no concerns about the running of Muriel Street. The home manager has put in a lot of effort on behalf of people who use the service to get extra support when care needs change", "I feel the place is run very well in comparison to where it was 18 months ago" and "Issues of concerns are no longer thrown under carpet."