Care Quality Commission

Fairburn Chase Health Care Limited

Fairburn Chase

Inspection report

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Ratings

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

Overall summary

Fairburn Chase is located on the outskirts of Castleford town centre. It is a purpose built home providing nursing and personal care for up to 73 people from the age 18 upwards. The home is divided into four units each with a unit manager.

This was an unannounced inspection carried out on the 17 March 2015. At the last inspection in July 2014 we found the provider had breached one regulation associated with the Health and Social Care Act 2008.

We found people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had failed to be maintained.

We told the provider they needed to take action. At this inspection we found improvements had been made with regard to the breach. However, we found other areas of concern.

At the time of the visit the service had 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

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the registered person had not protected people against the risks associated with medicines. This was in breach of regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always receive regular individual supervision of their work which could enable them to express any views about the service in a private and formal manner. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy living at the home and felt well cared for. People's care plans contained sufficient and relevant information to provide consistent, person centred care and support. People enjoyed a range of social activities and had good experiences at mealtimes. People received good support that ensured their health care needs were met. Staff were aware and knew how to respect people's privacy and dignity.

We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

Robust recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work.

People who used the service told us they were happy living at the service. They said they felt safe and knew how to report concerns if they had any. We saw care practices were good. Staff respected people's choices and treated them with dignity and respect. The home was clean and there were, overall, no malodours.

There were systems in place to make sure people were not deprived of their liberty unlawfully. The manager was aware of their responsibilities regarding the Deprivation of Liberty Safeguards.

People told us they enjoyed the food in the home and there was a good variety of choices available.

Records showed that the provider investigated and responded to people's complaints, according to the provider's complaints procedure.

The manager explained their quality assurance processes were informed by the provider's quality assurance policy. They were required to complete a monthly analysis document that recorded the quality and safety of the service. This included analysis of all accidents, infections and complaints for submission to the provider.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Health and Social Act 2008 (Regulated Activities) Regulations 2014 come into force on 1April 2015. They replace the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Recruitment process was robust this helped make sure staff were safe to work with vulnerable people.

People told us they felt safe. The staff we spoke with knew what to do if abuse or harm happened or if they witnessed it.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive regular individual supervision of their work which could enable them to express any views about the service in a private and formal manner.

People had regular access to healthcare professionals and prompt referrals were made when any health needs were identified.

The service was meeting the requirements of the Mental Capacity Act 2005.

Staff understood how to support people who lacked capacity to make decisions.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care and support they received and their needs had been met.

Staff spoken with understood how to treat people with dignity and respect and they were confident people received good care.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

Is the service responsive?

Good

The service was responsive.

We found care plans were, detailed and gave a good overview of the needs of people who used the service.

There were systems in place to ensure complaints and concerns were responded to.

People were supported to be involved in activities that met their needs.

Summary of findings

Is the service well-led?

Requires Improvement 

The service was not always well-led.

People who used the service knew who the registered manager was and spent time interacting with them. Some people who used the service told us they saw the registered manager about the home and had regular conversations with them.

There were effective systems in place to assess and monitor the quality and safety of the service.

The provider worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Fairburn Chase

Detailed findings

Background to this inspection

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

This inspection took place on 17 March 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, pharmacist inspector, specialist advisor in dementia and an expert by experience with older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 46 people living at the home. During our visit we spoke with 15 people who lived at the home, two visiting relatives, 10 members of staff and the registered manager.

We observed care and support being delivered. 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.

As part of the inspection process we also spent some time looking at documents and records that related to people's care and the management of the service such as training records, staff recruitment files and policies and procedures. We looked at all areas of the home including the kitchen, people's bedrooms and communal bathrooms.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority and Healthwatch. Healthwatch feedback stated they had no concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with made positive, complimentary statements relating to their care. They all were clean, informally but well dressed and all were in extremely good spirits. They spoke openly and without anxiety and had clear freedom to move around the building at their own will, including those that used wheelchairs. People who used the service told us; "Care here is second to none", "I am very happy here" and "Staff here have helped me to walk again."

We looked at the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stocks and other records for nine people.

All medicines were administered by qualified nurses or trained care staff. We observed part of the morning medicines round on two units. The medicines administration records were completed at the time of administration to each person, helping to ensure their accuracy. Written individual information was in place about the use of 'when required' medicines to assist staff in their decision making when administering medicines. Protocols were in place for the safe administration of medicines via a PEG (Percutaneous endoscopic gastrostomy) tube, when necessary. However, contrary to the homes medicine policy a written assessment had not been completed for one person who had chosen to self-administer some of their prescribed creams.

Staff administering medicines were aware that some people had medicines that should be given at certain times such as, "before food". However, formal arrangements were not in place to help ensure this always happened in practice. Similarly, there was no system in place to alert staff when Parkinson's medicines were due in order to reduce the risk that these may be unintentionally delayed.

Clear records of GP advice were made when new medicines were prescribed and these were promptly started. However, arrangements were not in place for confirming peoples' medicines (medicines reconciliation) with the prescriber or other authoritative source on admission or re-admission to the home.

We found that medicines including Controlled Drugs were kept safely and adequate supplies were maintained to allow continuity of treatment.

The registered managers at the home completed regular medicines audits and action plans were completed. Medicines errors and incidents were appropriately reported and acted upon. However, the home's investigation focussed on any immediate actions rather than learning from events and sharing information to reduce the risk of reoccurrence. Additionally, staff kept a record of medicines discrepancies however, these were not analysed to identify areas for improvement. One recent entry recorded that a person had been given only one capsule when two were prescribed. A check of medicines stocks and records for two people showed that this type of error had reoccurred. The registered manager told us that a new clinical lead had been appointed and would support the oversight of medicines handling at the home.

We found that the registered person had not protected people against the risks associated with medicines. This was in breach of regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were clear about safeguarding. They had received training as part of their induction programme or as an update. They were able to describe different forms of abuse, what they would look for and what they would do if they had concerns. They all said that they would feel confident in reporting any issues to the manager or senior member of staff on duty. **"**If someone was shouting, you'd always try to think how your family member would feel." All the staff spoken with were aware of the whistle blowing policy but stated they had not had to use it.

The home is divided into four units and we found the all to be clean, well maintained, in very good decorative order and spacious. Rooms that we saw when looking round were personalised. There was absence of malodours. The building was fresh and well aired. Throughout the building, well stocked dispensers of antiseptic gel and hand creams were available for both people who used the service and staff to use.

In one of the care plans we looked at the person had had diarrhoea and vomiting and there was a clear plan of care which provided a detailed breakdown of what staff should do to ensure that risk of infection was minimised.

We had detailed discussion with staff about the recent changes to staffing on the units. This was also discussed

Is the service safe?

with the registered manager, during the visit. Staff raised concerns about the changes to staffing during the morning shift on Cygnet Unit from 6 staff to 4 staff. They explained that the impact of this was that people were kept waiting to be supported to get up, showered and dressed and then were quite late for breakfast. For some people who had a late breakfast at 11.00, lunch at 12.30 followed on quite soon. For people who were up and ready for breakfast earlier, staff told us that they struggled to support them to eat and drink as they were conscious of other people waiting to get up.

A further impact which was explained to us by a care worker on Cygnet unit was that they were involved in carer duties for a lot of their time and was unable to provide support for the team leader on the unit and develop their own skills in their senior role. They told us, "I feel unsafe; we used to have 5 carers and the unit manager now we only have 4." They said, "There are 10 assisted feeds and people who have to be sat up to eat, there are still people in bed that want to get up, meal times are the key area of concern." They went on to say, "At the next staff meeting, we'll get the consensus of the staff to see how they feel." They described to us the needs of all 18 people living on Cygnet unit and whether they required the support of one or two carers. At that time 12 people required two people and five people was supported by one person. Only one person was independent. They said, "People get up when they're ready." The registered manager told us they would look at how staff were deployed and their activities.

One staff member on Teal unit said of staffing, "It was understaffed you weren't able to give the time that you should be able to give, reading the paper, doing physical exercises with people"

Another said of the morning routine "It's like a conveyor belt, bath/shower get them up, next bedroom." We talked with the unit manager who explained that the assessment of need for one person living on the unit highlighted the need for one to one support for 6 hours per day. There were currently not enough staff to be able to support their identified need and so the unit manager had applied for additional funding. The registered manager was in the process of submitting this application. On the day of our visit the home's occupancy was 46. The registered manager told us the staffing levels agreed within the home were being complied with, and this included the skill mix of staff.

We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people. Disciplinary procedures were in place and this helped to ensure standards were maintained and people kept safe.

From the care plans we observed that where people had fallen, an accident form had been completed. All details were documented and this was located in the file at the back of 'individual forms'. We saw that in the care plans, risk assessments were in place for all aspects of care. Positive risk assessments had been put in place where people had discussed and agreed the risks involved in specific activities.

Care records were well detailed and included assessments of multiple medical, psychological and social domains relevant to an individual's wellbeing. Where care needs were identified, detailed plans were drafted to address these needs appropriately and were tailored specifically to be people centred.

Preferences were also recorded regarding food preferences, activities, privacy, hairstyle, clothing, footwear and bathing/washing products.

Life histories were also available, and whilst there was only one person currently residing at Fairburn Chase with a diagnosis of dementia on the day of inspection, such detail would serve this person well. Records were kept in relation to Do Not Resuscitate (DNR) status. Of those records we saw they had been regularly reviewed and dated correctly. We spoke with staff who knew which people these were for and what it meant.

Requires Improvement

Is the service effective?

Our findings

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We saw a supervision schedule was in place for 2015. However records we looked at showed not all supervision and appraisals were up to date. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the care plans there was detailed information about people's specific dietary requirements. We saw that the catering manager was involved in the planning process; the Malnutrition Universal Screening Tool (MUST) had been used to assess the likely risks. There was evidence of involvement from the dietician. We saw a support plan for one person who was PEG fed. This was detailed and clear about how the support was provided.

We saw a plan of care for someone who was supported to eat and drink. They required help with eating, drinking and encouragement to chew and swallow before taking another mouthful. We saw that they had a recorded weight loss which was identified as being related to a urine infection. Advice was sought from the nurse and the situation followed up with a GP and recorded.

People's nutritional needs were assessed during the care and support planning process and we saw people's likes, dislikes and any allergies had been recorded in their care plan.

We observed the lunch time meal provided to people. The food looked appetising and wholesome with provision made for people to take their meals in a dining area or in their own rooms. Those people we had an opportunity to talk with looked happy with their meals, one person told us that on some occasions, they could get meals from a local Chinese take away for a bit of variety.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There was no one with a DoLS in place on the units we looked at. Mental capacity assessments had been undertaken and we saw evidence in the support plans that these were undertaken in relation to people's ability to make decisions and take informed risks.

The unit manager explained this process to us and we saw evidence that this had been carried out. For example: one person who had been prescribed thickener in drinks, for swallowing difficulties told staff that they preferred not to have the thickener. The unit manager had undertaken a mental capacity assessment and assessed the person as having capacity to make a decision. The risks associated with drinking without a thickener had been discussed and documented on a positive risk assessment pro-forma. This was supported by a detailed plan of care which clearly described the support required from staff to enable the person to eat and drink with minimum risk. The manager said that they fully supported people's rights to make decisions if they were able to do so. The manager said, "I can have a Chinese meal or an Indian meal whenever I want to, they should be able to have the same choices." They explained that the person was exploring eating other foods that they enjoyed and risk assessments would be put in place to support and manage this in the same way.

We spoke with other staff about their understanding of the Mental Capacity Act 2005 and they were able to talk confidently about how it impacted on the way they cared for people. One member of staff said, "it's all about helping people to make their own decisions." Another member of staff said, "Even if someone lacks capacity they can make some decisions, we are here to assist them."

We saw in all of the care plans that we looked at that people had been involved in decisions and had been asked for their consent. Where a person had difficulty communicating verbally staff had clearly written how that person preferred to communicate and given information about the signals they used, eye contact and ways in which they indicated their preferences. One plan stated, "As I cannot speak to you and express how I am feeling, you will need to observe me and my facial expressions. I also "talk" with my eyes and cry sometimes." Support plans were either signed or 'marked' by the person.

All of the plans that we looked at had been written in the first person. In each section of the support plan there was a section which stated "The service user has been involved in formulating the plan." We saw that this had not always been completed. There were examples of the person's signature on some of the sections of the plans. The care plans had a photograph at the front of the plan and these people had given their consent to the photograph being used in this way.

Requires Improvement

Is the service effective?

People's health records inspected demonstrated good levels of communication and access to both internal and external healthcare provision and professionals. These include GP, District Nursing, Speech and Language therapy and dental services.

Care records were well detailed and included assessments of multiple medical, psychological and social domains relevant to an individual's wellbeing. Where care needs were identified, detailed plans were drafted to address these needs appropriately and were tailored specifically to be people centred.

We saw when a referral was identified by staff as being needed; this was made swiftly and without delay.

Staff said they had a regular handover at the start of each shift and if they had been away for a few days the unit manager/ nurse would provide an update on any changes to people's health and care needs. Staff said they read the care plans when they had time and when we talked with staff they were well informed about people's individual care requirements. We saw that daily notes – called "A day in my life" at the back of the care plans had been completed throughout the day and night. These provided a record of the support provided for people.

The bedrooms and communal rooms for Teal and Cygnet unit were all situated on one floor. There were communal lounges and dining rooms. Corridors were wide enough for the access of wheelchairs. Floor surfaces were smooth for people to be able to wheel themselves around the building. The activity room was quite tight for space and people struggled to manoeuvre themselves around the activity tables in a wheelchair. There were three activity staff and one facilitator supporting 10 people when we observed activities.

Staff told us they had undertaken mandatory training and had regular updates. They said that the training matrix which was usually up in the office, had been taken down and so they were unable to check when they were next due to attend the training. When we spoke with the manager, they said the matrix was up to date and on line. We were shown evidence of this.

The physiotherapist had recently started in post and said that the 7 day induction that they had undertaken was excellent and covered what they needed to know. They explained there was a workbook to work through over a 3 month period which would be signed off by the clinical manager. We looked at the folder and found that it included detailed sessions on policies and procedures.

When we spoke with the physiotherapist they explained as part of their role, they would be providing training to care staff so that they were able to position people effectively and would also be involved in delivering manual handling training for staff.

Care staff said they had received supervision. This was either as a group or on occasions one to one. However this was infrequent. The unit manager told us they undertook supervision as a group. We were told the role of the senior carer was also to provide one to one supervision but when we spoke with the senor carer on Cygnet unit they told us that since the reduction in staffing levels they did not have as much time for senior duties as they were working as a carer. This was discussed with the registered manager who agreed to look into it.

The people we spoke with felt staff supported them well and they knew the individual needs of those service users they also indicated they felt staff had the appropriate training to do this.

Staff told us training was generally good. We specifically asked about staff understanding related to dementia care. The manager informed us that a great deal of training was provided in house but should specialist knowledge be required, external training would be sought. This was evidence when we looked at staff training files.

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with all told us they felt the staff were caring and supported them or their family member very well. People's comments included; "I am well looked after and the staff are really nice, they could not treat me any better."

Staff we spoke with described ways they promoted privacy and choice and how they aimed to ensure that people's independence was maintained. The care plans we looked at referred throughout to positive ways in which staff would support people to maintain their independence.

Staff we observed during the day showed to be caring and spoke with knowledge about the people they supported. Staff were able to describe people's needs in detail and we talked with the unit managers about different people who lived on their respective units. One carer, who worked in the Life Skills Team said, **"**It's just one of those jobs, you want to come to work."

We observed staff interacting with people throughout the day. They were patient, talked kindly with people and had jokes and banter. Staff we spoke with described the support they provided for people in general but specifically for people who they were a key worker for.

One of the visitors we spoke with stated they could visit the home whenever they wanted and had no concerns about the way their relative was being cared for. They had regular communication with staff and would have no hesitation with making a complaint. They said the standard of care being provided was excellent.

The relatives we spoke with told us they were always made to feel welcome when they visited the home and offered a drink and light refreshment. One visitor said, "They keep me informed of any changes in my relative general health and wellbeing." Another visitor said, "I have always received a warm welcome."

On the day of the inspection people looked well presented in clean, well-cared for clothes with evidence that personal care had been attended to and individual needs respected.

Care records inspected demonstrated a high level of assessment and care planning. General observation of the interactions between staff and those they care for were caring, trusting and accepting. An atmosphere of good humour and friendship was tangible throughout the establishment with people being put at the centre of care.

Care records as stated previously demonstrate an extensive level of detail is gathered in collaboration with the people. They were actively involved in decisions relating to their care. They were able to say how they wanted to spend their day and what care and support they needed. The premises were spacious and allowed people to spend time on their own if they wished.

Staff treated people with dignity and respect. We were present in people's rooms when staff came to the door, knocking before entering. They had a good understanding of equality and diversity and we saw support was tailored to meet people's individual needs.

Good

Is the service responsive?

Our findings

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of the people they were planning to admit to the service. Following an initial assessment, care plans were developed detailing the care needs/support, actions and responsibilities, to ensure personalised care was provided to all people.

The eight care plans we looked at described how people preferred to have support and the way support was to be provided was listed in detail. There was information about individual needs and the plans had been reviewed on a monthly basis.

There were details of the person's history completed in all but one of the care plans that we looked at. One person had no details of their personal history but a note on the file suggested that staff should ask family members when they next visit for information.

In relation to what people enjoyed doing with their time, some plans had more details than others. In one plan it stated, "[the person] needs staff to engage with activities to prompt social inclusion. The life skills team to be involved." We saw there was a note to make a referral to the speech and language therapy service and occupational therapy service for further advice and support. Although we looked in the plan, we could not see evidence of interventions by these professional colleagues.

In one care plan there was a reference to the life skills team within the service and the need for them to be involved in supporting this person. We spent time in the life skills room and talked with one of the staff. On the day of the inspection people were completing their preparation for a "posh afternoon tea" which was due to take place the following day. Three members of staff were involved supporting 10 people who lived in the service and they were all supported by a Wakefield Education Authority Arts worker who brought particular art work skills. People were engaged in making cakes and biscuits out of felt which involved stitching and cutting. They had made papier-mâché bowls, tea cups and saucers and other tea time related things which they were planning to use on the day. The plans for the tea were explained to us. Staff said people would be dressing up and the staff would be serving tea. There was a relaxed atmosphere in the room and everyone who was there was engaged in the activities. Some people worked on a one to one basis, others in small groups.

When we spoke with one of the life skills team members they explained that people had allocated hours for specific activities. There was involvement of people in suggestion options for outings and activities within the service. The previous week several people had been to a Chinese buffet. People went bowling and there was a wide range of arts and crafts activities to celebrate different festivals throughout the year. The activities were person centred and people had opportunities to get involved with activities that they particularly enjoyed.

When we talked with the physiotherapist and a physiotherapy assistant they provided details of the plan they had put in place for one person. They used photographs of the person in specific positions which were in the support plan. These enabled staff to be able to support the person to be in the correct position when the physiotherapists were not on duty. Staff we spoke with said they found this very helpful. The physiotherapist explained that when they were in the service, this person would be seen two hour sections a day. They gave another example of a person who they said they would see for a three hour session twice a week.

Staff we spoke with explained their enabling role, for example one person enjoyed smoking but was unable to hold the cigarette. Staff provided support for them and held the cigarette for them.

One visitor told us about the service providing a remote reclining chair for her relative to make them more comfortable.

People who used the service told us they were included in there care reviews and they would sign them at the end of the review (this was evidence in the care plans looked at).

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. We looked at the complaints register and saw complaints had been dealt with correctly and within the timescales set out in the complaints procedure.

Good

Is the service responsive?

The people who were able told us they had no complaints about the service but knew who they should complaint to. The relatives of two people who used the service told us they were aware of the complaints procedures and would not hesitate to make a formal complaint if necessary.

The staff we spoke with told us they would report any concerns or complaints made by people who used the service to either a unit manager or to the registered manager.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the Care Quality Commission. People who used the service knew who the registered manager was and spent time interacting with them. Some people who used the service told us they saw the registered manager about the home and had regular conversations with them. One person said, "The manager hasn't been here long but you can talk to him. One visitor spoke highly of the registered manager and told us that they would feel happy to discuss any problems with them.

Staff were able to describe the philosophy of the home in different ways but essentially that they were here to meet the needs of people who lived there, it was their home and everyone was treated as an individual. One care worker we spoke with said, "I love it here, you're a big part of their life."

Staff we spoke with were positive about the registered manager with the exception of the changes to the rotas which all staff mentioned. Staff said the registered manager was visible and talked with people who lived in the service and that they could talk with them. One person said, "The manager's very nice and very supportive." Another member of staff said, "You go to the manager with a problem and they skirt round it." Some staff said they would like to understand the reasons behind some of the changes to the staffing and that this had not been properly explained to them. "There have not been any meetings since they became manager, they are good with residents, and they'll go round talking with residents." We raised this with the registered manager that the service might not always be open and transparent.

Staff all spoke positively about the Unit managers and said they did try to keep them informed.

One staff member said the feeling that staff had about the changes were hard to hide and although they tried not to discuss things in front of people who lived in the home they were picking up on the overall mood of the staff. "There's no staff morale what so ever, residents are picking up on that and it's not fair on them, [name] a worrier she said to me 'Are you alright'." One of the unit manager explained that she had a unit meeting every three or four months and she had a "Policy of the month to focus on particular issues."

We found staff had not received regular individual supervision of their work which could enable them to express any views about the service in a private and formal manner.

We spoke with the Nurse Advisor for Continuing Care who was visiting one of the units to review the care for one person with the unit manager. Their role was to review the assessment of people for funding for York and Humber Continuing Care Team. They said they felt the service had been through a difficult time. "A lot of time we had to cancel assessments, we couldn't go ahead." "The information's a lot better the care planning is up to date." They explained they had not yet got to know the new manager but they said that their impression was that "It just seems more settled and more organised, they didn't know where they were going, it's improved a lot." They were very positive about the unit manager they had the meeting with who had returned from a period away from the service. "[name] is really, really good, they have come back and you feel more comfortable" They said there were joint agreements, action would be taken and family members are always invited to the reviews if they wished to attend.

The registered manager told us they monitored the quality of the service by monthly quality audits. We saw a monitoring report for February 2015 which included weight analysis, wounds analysis, adverse event, health and safety checks, support plans infection control, training and safeguarding. We also saw audits in place for medications. We saw evidence which showed that any actions resulting from the audit were acted upon in a timely manner. This meant the service identified and managed risks relating to the health, welfare and safety of people who used the service.

Staff we spoke with said they knew what to do in the event of an accident or an incident and the procedure for reporting and recording any occurrences. We saw safeguarding referrals had been reported and responded to appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not have suitable arrangements in place to ensure people who used the service received their medicines as prescribed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We saw a supervision schedule was in place for 2015. However records we looked at showed not all supervision and appraisals were up to date.**