Sirona Care & Health C.I.C.

Cleeve Court Community Resource Centre

Inspection report

Cleeve Court
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Tel: 01225396788

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27 June 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 27 June 2018. At the last inspection the service had not stored medicines for disposal safely which was a breach of the Health and Social Care Act (HSCA) 2008. At this inspection we found these were now stored safely, however, there were other shortfalls in the safe management of medicines.

Cleeve Court Community Resource Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cleeve Court Community Resource Centre accommodates up to 45 people across two separate floors Lansdown View and Kelston Rise, each of which have separate adapted facilities. The service specialises in providing care to people living with dementia. At the time of our inspection there were 42 people living at the service.

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 2008 and associated Regulations about how the service is run.

At the previous inspection we found medicines for return or disposal were not stored safely. This had been rectified and these medicines were now stored safely, however, we found shortfalls in the recording of medicines. This was a breach of regulation.

The provider had not always notified us of all the incidents that occurred at the service. This was a breach of regulation.

Staff at the service were trained and supervised and were positive about the care they delivered. However, morale was mixed due to changes in the staff contract.

People and their relatives were complimentary about the care delivered by staff. The service delivered care using the Butterfly Model which focussed on people's emotional well-being. Staff were warm, caring and respectful in their interactions with people. It was evident people were at ease and felt safe with staff. Relatives told us, and compliments received by the service confirmed, that they had been happy with the way their loved ones had been cared for.

Staff treated people with warmth and kindness. They respected people's privacy and dignity and supported people to be as independent as possible.

The environment had been adapted and decorated to support the needs of people living with dementia.

Signage was clear and easy to understand. Different areas of the service had been decorated to give a homely feel and furnished with familiar objects for people to see. The service had received a number of awards previously for the care delivered.

People were supported to eat and drink enough, and alternatives were available if they did not like the meal choices. Drinks were available throughout the day.

People's health care needs were met; the service had good links with the GP, district nurses and the community mental health team. There was positive feedback about the service from these professionals.

We found one breach of the Health and Social Care Act and one breach of the Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report

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.

Medicines were not always managed safely.

The provider did not always follow their falls assessment policy.

People were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff followed best practice in supporting people living with dementia.

Staff received training and supervision.

People were supported to eat and drink enough.

Staff knew the principles of the Mental Capacity Act (2005) and sought consent from people providing care and support.

Is the service caring?

Good

The service was caring.

Staff were warm and compassionate and focussed on people's well-being.

People and their relatives felt cared for and well-looked after.

People's privacy, dignity and independence was respected.

Is the service responsive?

Good

The service was responsive.

People received individualised care.

People and relatives were confident that if they had any

concerns they would be listened to.

People received caring and compassionate care when they approached the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's systems and processes had not always identified shortfalls in the recording of medicines.

The provider had not informed us of all incidents as required by the regulations.

People and their relatives were complimentary about the service.

The service had been nominated for, and won, awards for the standard of dementia care

Cleeve Court Community 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 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 27 June 2018 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. We checked the information on the provider's website. The provider had not been requested to complete a Provider Information Return (PIR).

Some people at the service may not be able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

We spoke with 17 people who used the service, three relatives, 11 members of staff including a registered manager from a sister service, who attended to support staff, and the provider's strategic safeguarding lead. The registered manager was on leave at the time of our inspection and we spoke with them by telephone following our inspection.

We looked at nine electronic care records and spoke with a health professional who was visiting the service.

We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, seven recruitment and training records, policies, and audits. We received further information electronically which we had not been able to view during the inspection due to the registered manager's absence.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. Medicines were not always administered safely in line with the provider's policy.

On Landsdown View, the medicines were dispensed in the care office and then taken to the person for administration. The member of staff signed the medicines administration record (MAR) before they had administered the medicine. Medicines should only be recorded as administered when the person has taken them.

On Kelston Rise, medicines were administered from the office and handed to a support worker, who took the medicines to the person for administration. The senior signed the MAR chart and the support worker signed a separate sheet as having witnessed the administration. The registered manager explained this had reduced the length of time taken to carry out a medicines round, however we are concerned this is secondary dispensing and potentially increases the risk of administration errors.

Medicines were stored in appropriate medicine trolleys which were kept in the care office and excess stock was kept in a secure storage room. The temperatures of the storage rooms and care offices were not recorded. The temperature in the storage room on Kelston Rise was 29C on the day of the inspection which is above the recommended 25C maximum storage temperature for many medicines.

Many MAR charts had hand written entries. This was when staff had transcribed details of a prescription or alteration onto the MAR. Hand written amendments had not been signed by the person who did the transcribing or checked to make sure they were accurate. Signing hand written amendments and getting them witnessed reduces the risk of transcription errors. A member of staff stated they were aware of the need to have handwritten amendments signed and witnessed, but that it was not happening.

One person's MAR chart had a 'post it' note attached indicating a medicine should be given daily. It was also possible the post-it note could fall off and this information would be lost resulting in the person not receiving this medicine. Administration records indicated that the person had received two capsules daily which was different to the printed instruction on the MAR. This meant that the person was not receiving the correct prescribed dose.

Staff did not always record the application of topical medicines such as creams which meant the provider could not be certain people were always receiving these prescribed medicines correctly. The frequency the topical medicine was to be applied was not always stated on MAR charts. Guidance was not always in place for prescribed topical medicines. For example; one topical medicine had been prescribed to be applied three times a day as per care plan and body map.It had not been administered and there was no guidance available for its use. Topical medicine application recording (TMAR) sheets were kept in people's progress and evaluation folders in the care office. There were numerous gaps in administration records. For example; for a person who had a cream prescribed for daily application, there were nine gaps over 23 days. A member of staff told us previously topical MAR charts were kept in people's rooms, but staff had not always recorded

administration. Charts were moved to people's progress and evaluation folders in the office so that support workers would sign these when filling in their daily reports. This had not been successful and had introduced retrospective recording, which is poor practice

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person received their medicines disguised in food or drink. The provider had ensured a best interest decision was carried out for this and had consulted the pharmacist to check the medicines could be given safely in food and drink

Medicines that required storage in accordance with legal requirements were kept securely and their receipt, administration and returns recorded in an appropriate register. Two signatures were evident for each administration. Regular stock checks were not undertaken however the stock levels of two of these medicines were checked and found to be correct.

There was mixed feedback about staff availability to meet people's needs and the service relied heavily on bank and agency staff. People told us, "There are not always enough staff, I think they have difficulties getting staff and we have agency people; it doesn't bother me.", and, "Staffing levels vary, but they are all nice people." However another person commented, "Staff come in and out, there is always someone when I need them." Relatives we spoke with gave mixed feedback, we were told, "Some days there are not enough staff because they have some highly dependent residents who take a lot of time", whilst another relative said, "Staffing levels are brilliant, there are always people around."

All the staff that we spoke with said there was not always enough staff to meet people's needs. They reported this was worst on late shifts. One staff member said, "The staffing levels are much worse than they used to be," and another told us, "With three in the evenings it's challenging, but we get it all done." A staff member said that, "No-one wants to do lates. It's too much." Staff noted that the numbers on each shift had not changed, but they felt that the complexity and needs of the people that they cared for had increased. Staff reported that bank and agency staff were frequently used when insufficient permanent staff were available.

Staff said they were concerned that their workload was such that they did not always have the capacity to meet people's safety related needs. For example, one staff member told us that because they were assisting people in bedrooms, they could not observe communal areas, and were concerned that they would not see an incident or be present if someone fell.

The registered manager told us they had recently recruited to five vacant posts and that an additional staff member had now been funded by the provider. This staff member could be deployed on either early or late shifts dependent on people's needs. Staff rotas showed that planned staffing levels were met.

Care records did not always provide enough information about specific risks for an individual, or how staff could keep people safe. Care records for people who had had several falls were not always up to date, clear, or following the provider's procedures. The provider's guidance stated that a, "Falls risk screening tool" should be activated, "If the resident has had three falls, and after the procedural guideline for falls has been followed. "We looked at the care records of two people who had more than three falls in a short period of time. One person fell on four occasions over a six week period And another person had eight or more falls in one month. Neither of these individuals had a completed falls risk screening tool in their care record.

The records had been updated, but the changes were not always clear. For instance, in response to the question, "Is the resident at risk from falling?" an initial risk assessment had been updated on 5 May 2018 however, both 'Yes' and 'No' were ticked, and it was not clear which was the most recent. In another record, we saw updated information about a person's mobility in the initial assessment, but the change was not reflected in the monthly review of the care plans.

Other risks had been identified and appropriate actions had been taken. For example; one person whose overall condition and mobility had deteriorated, had been assessed as being at risk of developing pressure ulcers. Staff had ensured they had been promptly assessed by the district nurse and provided with appropriate pressure relief equipment. They had also been referred to and seen by, the occupational therapy team, complex intervention team and their GP. Another person who was at risk of developing pressure ulcers had appropriate pressure relief provided and was having their position changed in bed at the intervals recommended by the district nurse.

People told us they felt safe at Cleeve Court Community Resource Centre, "I am safe, staff pop in, we get on like a house on fire; there are two or three people here I would talk to if I was worried, or tell my [relative]", and "I am very happy here, they are lovely to me, I can talk to my key worker if I am worried." Relatives said, "My [name] is very safe because staff are amazing, they will take time and explain everything; staff all pop in and speak to my [name], and know and really understand my [name].

Staff had received training in how to protect people from harm and abuse. One staff member said, "I'd bring up my concerns in supervision" and when asked about what they would do if something was urgent, were clear that they would raise issues with a senior support worker or a manager at the time. All staff said that they would report any concerns that they had about poor care. There was a policy available to guide staff on how to report and to whom.

Staff reported any potential safeguarding concerns and completed an incident form. This was reviewed by the registered manager who told us they would discuss with the local adults safeguarding team or the Complex Intervention Team (CIT) if the person was on this caseload. Records showed action was taken to support people and prevent re-occurrence.

The provider followed safe recruitment procedures for staff. Checks were carried out before people were employed. This included proof of identity, a completed application form, reference checks and a Disclosure and Barring Service (DBS) record. A DBS check allows employers to check the applicant does not have any criminal convictions which would make them unsuitable to work with vulnerable people.

People were protected from the risk of infection. People's rooms, bathrooms, toilets and communal areas of the home were clean and free from malodours. Staff said they had enough cleaning equipment and products to be able to carry out their role effectively. They confirmed they had received training about infection control and the control of substances hazardous to health (CoSHH). The registered manager undertook quarterly infection control checks and identified where action was needed.

The laundry was clean, tidy and staffed seven days a week. Washing machines and driers were appropriate for task and were said to be reliable. A good practice laundry guide was displayed and disposable gloves and aprons were available. We were told support staff were good at ensuring soiled laundry was separated from other laundry into specific bags suitable for loading straight into machines. The kitchen was clean and tidy; however the cleaning schedule record had not been completed between the 9 – 27 June 2018. This meant the provider could not be sure how often the kitchen had been cleaned on these dates. The service's food hygiene star rating had been reduced from five to four following an inspection in November 2017. We

were informed it had been reduced due to the temperatures hot meals were served at from kitchenettes not being recorded.

The provider had a contingency plan in place should events disrupt the running of the service. Plans were in place to cover the current industrial action taking place across the provider's services.

The provider carried out regular checks and maintenance on equipment used within the service such as slings and hoists, and other equipment used to support people.

Good

Is the service effective?

Our findings

Cleeve Court Community Resource Centre offered support to people living with dementia using the Butterfly Model which aims to deliver best practice in dementia care. Staff had received training in dementia and throughout the inspection we observed staff delivered personalised care in their interactions with people and in accord with this model.

People told us they felt staff were well trained, capable and competent to look after them well. Comments included, "The permanent staff are definitely efficient," and, "Individual staff are good." Relatives told us, "They are definitely well trained, they know what they are doing, they explain and can always give an answer; they are on the ball and notice if there is something wrong, they don't take chances and will call the doctor. I have attended two review meetings since my loved one has been here, but staff will tell me how they have been on the days I don't visit."

Staff told us that they had relevant training to carry out their roles. This included regular update training. Staff said that they had regular supervision sessions and personal development plans were in place. Supervision was usually with a senior support worker, but staff were also able to speak with other members of the team or the registered manager at other times.

The registered manager had adapted the environment to meet the needs of people with dementia. People had pictures on their doors, for example one person had pictures of a new baby in the family whilst others had pictures of pets or hobbies and interests. Communal areas had been decorated to be homely and provide visual and tactile stimulus for people. Communal lounges had furniture, fireplaces and furniture arranged in groups. They were bright and airy. The dining room had china cups and saucers and corridors had lots of pictures with seating available in suitable places. Scarves were placed on handrails for people to touch. There were familiar objects for people such as sewing machines and other household objects. Bathrooms were decorated with pictures to ensure they felt homely for people rather than clinical. People had access to outside space on verandas and to a garden. We saw people freely accessing these.

The registered manager used research based assessment tools in order to assess people's tissue viability (Waterlow) and nutritional needs (MUST). Where these indicated the need for intervention appropriate measures were in place. One person's support file contained researched based information, produced by the NHS, about mixed dementia, which the person had been diagnosed with.

People were supported to eat and drink enough. People were offered hot and cold drinks throughout the day. We received positive comments about the food which included, "If I don't like what is on the menu they will do me something else, like tinned tomato soup which is my favourite" and, "I have lovely food, I can eat what I want, I am never hungry." We observed people's lunchtime experience on both floors of the service. Sufficient staff were present and were supportive towards people as needed. The meal was relaxed and people were not rushed, and there was conversation and interaction. Staff spent time with people, and sat down to eat with them. People's preferences in relation to what they liked to eat and drink was documented in the records that we looked at. In one record it stated, "No milk as a drink, but has it in rice pudding /

custard."

Staff told us people were offered the option of two main choices at meal times. Where able, people chose their options the day before, but we were told they cooked enough food to ensure that there was enough if people changed their mind on the day. A list of people's dietary requirements was displayed in the kitchen. A range of snacks were available in the kitchenette areas on the floors. People's weight was monitored and they were assessed for the risks of malnutrition and dehydration.

Staff at the service worked closely with local health providers. Records showed that people had been reviewed by the GP, district nurse team, physiotherapist and mental health teams. We saw evidence of positive feedback to the service from GPs and district nurses. They had praised the professionalism of the staff.

Staff sought consent before any intervention using questions such as; "Would you like me to....? Can I....? " and people confirmed this was usual practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training in the MCA and Deprivation of Liberty Standards (DoLS). They could explain the key principles of these pieces of legislation.

Consent and assessment of capacity were usually considered in line with legislation and guidance. Where people were able to, they had signed care plans and reviews in their care records.

We looked at care records and found that DoLS applications had been made to the relevant authorities, and that these were being correctly implemented. Staff had worked with relatives and other professionals to ensure decisions were informed and made in people's best interests.

Good

Is the service caring?

Our findings

People and their relatives were very complimentary about staff. We were told, "I love them all, they are so friendly and kind to me; I think they like talking to me, I could tell them anything, they treat me like a daughter would, I am very comfortable with them when they wash and dress me" and, "Staff are good and kind, they look after me so I don't have to worry, I appreciate all they do for me." Relatives told us, "I like the staff, they have a laugh and joke, I trust them." Relatives we spoke with said they were confident people were always treated with respect and dignity.

One relative had given detailed feedback about their positive experience of all aspects of their relative's care at Cleeve Court Community Resource Centre. Statements included, "My [relative] was cared for with respect, dignity, empathy, sensitivity and infinite patience as were all the residents, as I observed whenever I visited", and, "I truly believe my relative could not have received better care anywhere."

The registered manager told us that they aimed to make the service have a family feel where people felt cared for. They explained the Butterfly Model was about feelings and supporting people emotionally. The provider had received positive feedback from relatives which included, "The family had peace of mind that their mother was being cared for in such a loving environment" and, "I cannot find words to express my family's appreciation of the staff. The carers gave their love, their commitment, their compassion and their comfort to [Name]. But it was not only my [Name] who received this dedication; it was shown and given to all the residents."

We saw positive interactions between staff and people. Staff were kind and patient, they came down to the level of people when speaking with them. Staff used humour, touch, and terms of endearment appropriately. People were comfortable and relaxed in the company of staff. We observed a member of staff ask a person if they could wait five minutes until they had finished what they were doing then they would come back. After about five minutes the member of staff returned, approached the person and said they were free to go with them to their room to do what they had asked.

One member of staff said, "I love my residents", and another spoke positively of the atmosphere in the service, describing it as "Homely" and as somewhere that they would be happy for their family members to be cared for.

People told us that staff promoted their independence. People said, "At first they started doing all my personal care, but they know I can manage so now I do things for myself" and "I like to be independent and I wash my own panties and socks, it is something I can still do." Staff supported people who had sensory impairment with skill and respect. We observed staff supporting a person who was visually impaired. Staff knew the person's needs and abilities well, and skilfully guided the person verbally and physically to ensure they were safe. Staff balanced reassurance and support with independence.

People were supported to maintain relationships that were important to them. Relatives were always welcome at the service and were encouraged to feel at home. One relative said, "I spend four hours visiting

my loved one on alternate days, when I am here I do everything for my relative that I would do as if they were at home, from bathing, dressing, hair washing, assisting with meals, hoovering, dusting and cleaning the bathroom, in fact everything other than giving medication." Another relative told us, "I visit daily, I don't need to but I want to, I want to spend time with my loved one while it is possible."

Staff were clear that they would always aim to maintain people's dignity. They explained that they would ensure doors and curtains were closed, cover the person, and always consider the preferences of the individual when carrying out personal care tasks. One staff member explained, "I always try to think about them. With [name], he can do most of it himself, but when he's coming out of the bath I hold the towel up (demonstrating creating a screen at chest height) and turn my head a bit, just so it's better for him." People confirmed that staff ensure their privacy, and always knock prior to entering their room, and ensure the door is closed and curtains drawn before they commence personal care.

People were supported to make choices in how they spent their time and received their care. One person said, "I can please myself what I do, I like sitting in my room with the door open, as people pass they call out and say hello, but if want to go to the dining room they bring me a wheelchair and take me; I can go out in the grounds if I want." Another person said, "I can please myself in all things except going out, I have to wait for my [relative] to come and take me in the car."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We were told, "They come straight away, I don't have to wait long", and, "They come ever so quickly if I want them."
Throughout the day we observed staff spending time with people, sometimes sitting with them. People living at the service gave mixed responses about this.

Staff told us that 'Person centred' meant, "The person is key to everything" and "Having the person at the middle of what we do." All the staff we spoke with told us about how important it was to them that they knew the people who lived at the service, and they understood them and their preferences. Staff said that they were encouraged to get to know people by talking with them, reading care plans and attending regular handovers.

Some people knew about their care plan, whilst others did not. One person said, "My care plan is in my room, they didn't need to ask me anything because I transferred from another place", whilst a second person told us, "I don't know what is in my care plan but it is kept in my room and I could look at it if I wanted to." A third person said, "I haven't got a clue about my care plan."

Information about people's preferences and personal histories was available. Some people had personal information on the door of their bedroom. Many bedroom doors were decorated with photographs and memorabilia of significance to the person.

Some care records had less personal information than others. For example, one record provided a lot of detail about a person's bedtime routine, including their preferences, habits and timings, but no such information was available in another person's record. We found limited information about people's personal care details, for example what people liked to wear, or men's shaving preferences. Care records contained a 'daily programme' sheet. This detailed habits and routines such as waking and sleeping times, individual preferences and routines. Permanent members of staff knew about people's preferences however, and they were able to describe how they used this knowledge to support people.

Some activities were available at the service, although staff reported that these were less likely to happen currently because less permanent staff were available. Staff told us that a local school and choir had previously come to the service, and that trips to the beach and days out had been arranged. Staff said that they would like to be able to be more involved in providing a wide range of activities, but felt that they did not have sufficient staff to do so currently. The registered manager told us they would have student placements starting in September and planned to have them run a community café for people.

People told us they knew how to complain but had not felt the need. We were told, "I can speak up for myself, I wouldn't worry about telling them if there was something bothering me." Relatives said, "If I had any problems I would go straight to the manager, but I have no complaints or concerns. My relative is not a mixer and has never wanted to join in, [Name] has never been pressurised to do so; staff are always popping in and having a few words with her; my [Name] is getting all that she needs, in the way she wants it." A

second relative said, "I have a copy of the complaints procedure, but I'm not likely to use it". They went on to say there had been one issue and, "I spoke to the manager who sorted it out."

There were end of life plans in place in some of the records we looked at, but these had not always been filled in, or in some cases were very brief. For example, one person's record detailed a preferred undertaker, but no other information, and another only stated, "Would like to be cremated." Having more detailed information in place can enable people to discuss their choices and preferences around how they would like to be cared for at the end of their lives.

A person who was nearing the end of their life was receiving appropriate care. They were pain free and comfortable. Staff were changing their position regularly and offering sips of fluids to keep the person's mouth moist as they had difficulty swallowing. Their room was quiet, with subdued lighting. Records showed that they had received visits from their GP and district nurse.

One relative had written to the service after their loved one had passed away. They were highly complimentary about both their relative's experience and the support they had received, "[staff provided] so much support I can never thank them enough." The service had received positive feedback from both a local GP and district nurse about the quality of their care for people at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

The provider's governance systems had not always identified shortfalls in the management of medicines and care records. Medicines audits had not identified shortfalls where staff had not adhered to the policy on medicines management and shortfalls in care records had not always been identified.

The registered manager had not always notified us of important events that occurred at the service. We looked at approximately half the incidents for 2018 and identified six incidents which should have been notified to us. These included allegations of abuse, for example when one person living at the service had hit or pushed another person. A notification is information about important events which affect people or the service which the service is legally obliged to submit to the Commission. We clarified this with the provider's strategic safeguarding lead and the registered manager that all such incidents should be notified as soon as possible who agreed to review the procedure for notifications.

This is a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents .

The provider had systems in place to monitor the effectiveness of the service. There was an overview of training and supervision. Regular infection control audits had identified actions needed and had recorded their completion. There was a system in place to enable the registered manager to have an overview of incidents.

People and their relatives were complimentary about the service and felt the registered manager was approachable. People told us, "I know [Name] the manager, she comes sometimes; I can go and knock on her door to see her if I want", and, "It is lovely here, everyone is so friendly, [Name] (the manager) is easy to talk to, I could go to her." Relatives commented, "There is a lovely atmosphere here, staff are here for the residents, they are all, including the manager, very understanding. There is good communication, if I am not visiting, they will ring me if there any concerns; I have recently filled out a questionnaire", and another said, "I think this home is first rate, I have developed personal relationships with stable staff and recommended it to others; good communication, I have asked to be called at any time there seems to be a problem as my relative can't tell them." This relative confirmed that staff had contacted them on an occasion they did not understand the person's behaviour and they had been able to explain.

The registered manager explained their service's visions and values. Since becoming the registered manager they had implemented the Butterfly Model of dementia care. They told us that since implementing this model they had reached a high standard. The registered manager had received positive feedback from Dementia Matters who award the accreditation, who remarked, "You have made a wonderful home with the support and sometimes challenge of your team." The service had received an award from the provider entitled, "Sirona Star: A Shining Example of Excellence."

The service had links with a local school and pupils visited weekly. They offered placements to social care students from Bath Spa, arranged for people to visit Bath farm and had a range of pets and animals brought

into the service.

One health professional who worked closely with the service told us, "I really like their can do attitude and find them very supportive to service users and carers, they have been very open minded about taking complex cases including cases that have been placed via the Court of Protection. The staff are always very welcoming to new service users, and carers. The manager is very approachable, supportive and flexible in a crisis. All the staff communicate very well with the Team and the Team can tell that have been trained in the Butterfly approach."

Staff told us that there were sometimes staff meetings, but that these were not held very regularly. They felt that they could raise issues or make suggestions to senior support workers or the registered manager at any time. One person said, "It's a great team. There are no problems with the team."

A large number of staff had worked at the service for many years. One staff member said, "Working here is like family – the staff and the residents." Although they were positive about their roles, staff morale was being negatively affected by proposed contractual changes by the provider. This had recently led to some staff taking industrial action. The provider had ensured staff absence was covered. This staff discontent was reflected in the staff survey conducted in April 2018. Staff were generally positive about their colleagues and the care they delivered but demonstrated dissatisfaction with the provider

Staff told us that they felt well supported by the registered manager. One said, "I always see the manager day to day. I can discuss things with her," and another staff member noted, "The manager comes out and helps us if we're short." However, another staff member stated that they felt, "Undervalued" and that the registered manager did not listen to them or their requests.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission without delay of any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured staff followed the medicines policy on the recording of medicines.