The Poplars Care & Support Services Limited

The Poplars Nursing Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 06 September 2018 and was unannounced. At the last inspection of the service in December 2017 the provider was rated as Good in all five key questions. At this inspection, we found that the key questions of Safe, Responsive and Well Led were now rated as Requires Improvement.
We inspected the service as we were made aware a person's advance wishes in respect of resuscitation had not been followed. The provider had taken steps to ensure this avoidable and concerning event did not reoccur for other people and had notified the appropriate external agencies.

The Poplars is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Poplars is registered to provide care, nursing and accommodation to a maximum of 58 older people, some with a physical disability. At the time of the inspection, there were 51 people living at the home.

There was no registered manager in post, an acting manager had been in the role since January 2018, but had yet to register with CQC. The acting manager was not available on the day of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was taking measures to ensure that a registered manager was appointed.

This is the first time that the service has been rated Requires Improvement.

Administration and recording of medicines given was done safely. Medicines were not always stored adequately or safely. Staff understood the procedures they should follow if they witnessed or suspected that a person was being abused or harmed. Staff were available to people, but there were concerns over numbers of staff. Staff were not always recruited safely. Accidents and incidents were responded to appropriately, but recordings did not always reflect this. The environment was not always safe for people.

Staff had the skills and knowledge required to support people effectively. Staff had an understanding of the Mental Capacity Act and how best to support people in line with its principals. People felt the meals were adequate and staff were supportive when people required assistance to eat. Staff gained people's consent before assisting or supporting them. Staff received an induction prior to them working for the service and could access ongoing training to assist them in their role. Staff could access supervision and felt able to ask for assistance from management should they need it. Staff supported people's healthcare needs.

Staff were caring towards people. People were encouraged to retain an appropriate level of independence and choices were given to people where it was appropriate. Privacy and dignity were maintained on most occasions.

Care plans were in place and updated monthly, but were not reviewed annually with the person's input. People's preferences for how they wished to receive support were known and considered by the care staff. There was some level of activities, but this was not consistent. People knew how to raise complaints, but the recording of them was not clear. End of life care was considered.

There had been a lack of registered manager for some months and not everyone knew who the acting manager was. There had been a lack of opportunity for people and relatives to share their opinions on the service. Quality assurance audits were carried out, but these did not identify concerns in all areas and did not always give enough information. We received notifications as required.

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 consistently safe.
Medicines were not always stored adequately or safely.

Staff were available to people, but there were concerns over numbers of staff.

Staff were not always recruited safely.

Staff understood the procedures they should follow if they witnessed or suspected that a person was being abused or harmed.

Is the service effective?

Good

The service was effective.
Staff had the skills and knowledge required to support people effectively.

Staff had an understanding of the Mental Capacity Act and how best to support people in line with its principals.

Staff gained people's consent before assisting or supporting them.

Staff received an induction prior to them working for the service and could access ongoing training to assist them in their role.

Is the service caring?

Good

The service was caring.

Staff were caring towards people.

People were encouraged to retain an appropriate level of independence.

Choices were given to people where it was appropriate.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not reviewed in a timely manner.

The process for dealing with complaints was disorganised.

Activities were not carried out consistently.

End of life care was considered.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not everyone knew who the acting manager was.

There had been a lack of opportunity for people and relatives to share their opinions on the service.

Quality assurance audits were carried out, but these did not identify concerns in all areas and did not always give enough information.

We received notifications as required.

The Poplars Nursing Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident where a person did not receive assistance and Cardiopulmonary Resuscitation [CPR] from staff when they should have done. The provider has taken steps to address this sad event and the staff member no longer works within the service. Appropriate steps have been taken to keep people safe by referring this incident to the appropriate external agencies.

This inspection took place on 06 September 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector, a specialist nurse advisor, a member of CQC's medicines team and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. This included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. On this occasion we did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took the information we had received into account when we inspected the service and made the judgements in this report.

We spoke with four people who lived at the home and three relatives. As some people were unable to tell us their views of the service, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with five members of staff, the deputy chef, the activities coordinator and the provider.

We looked at the care records for four people as well as 12 people's medication records. We checked four

records held in relation to staff recruitment and training. We looked at accidents, incidents, complaints and systems in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The key question of Safe was rated as Good in December 2017. At this inspection the rating has changed to Requires Improvement.

On the day of our inspection we discovered some incidents which meant that people were not always supported safely. We found that a door leading to an area undergoing extensive renovations was unlocked and a pair of pliers had been left in a corridor. This was raised with the provider who told us that this should not occur and that it was staff error. They told us staff would be spoken to and took immediate action to rectify our concerns. We saw no risk assessment in place to ensure staff had guidance to reduce the risks. We also found large amounts of medicines that had arrived from the pharmacy for use in the upcoming month were kept in areas of the home not appropriately equipped for their storage. At one point during the day these medicines were stored within a 'family room', which was unlocked. A staff member told us this was down to a 'lack of room'. The provider took action to move the medicines to the medication treatment room which was locked and temperature controlled. They also told us that they would speak with staff regarding ensuring that a correct procedure for storing medicine was followed. We saw that food thickener, used to assist people with swallowing difficulties, was left in an open kitchen. The label was damaged so there was no way to identify who it had been prescribed for. There was no evidence as to who had left it unattended. There is a requirement to provide correct storage for such substances to ensure people do not accidently ingest the powder, which could fatally impact upon their health. The provider told us that staff would be spoken to about such dangers.

Accident and incident reports did not consistently provide evidence of what action had been taken to avoid re-occurrence or how specific risks had been mitigated. There was not always evidence of any oversight the provider had in order to identify patterns and trends. We saw that a number of reports completed were limited to brief information only such as 'paramedics called' or 'paracetamol administered'. We found where a person had bruising and a skin tear following a fall the accident report did not contain any action taken or any outcome. The provider told us this had been identified by them and plans put in place, with the nurse on duty responsible for completing the accident/incident form. However, we found that this was not carried out routinely. We found for a specific incident where a person who was taken ill had not been resuscitated, despite no 'do not resuscitate' order [DNAR] being in place, action had been taken. The staff member was no longer employed and we saw evidence that the provider had met with the remaining nursing staff to ensure that this situation did not happen again. We also found that a DNAR 'grab sheet' with information required in the event of an emergency was placed with Medication Administration Records [MAR] charts within care plans.

People and relatives had differing opinions on the amount of staff available. One person told us, "I do a lot for myself and there are enough staff when I need it" and, "I feel quite safe, there's always staff on hand". However, another person told us, "Not enough staff, so busy". A relative told us, "They need more staff to spend more time with people. They [staff] are run off their feet" and, "There never seems enough staff to look after people. Yesterday at 12.00 o'clock a resident was asking to go to the toilet. There was no-one in the lounge to help them. There is one staff here sometimes with 14 people". However, one relative said "If

[person] needs anything, changing or toilet they come when I ring the bell, they come in three minutes".

On the day of our inspection we saw there was enough staff to meet people's needs and preferences, but staff told us they were consistently short staffed. One staff member told us, "The staffing level here is horrendous, we are all exhausted, some people aren't getting the care they need. I feel some are neglected. We just can't spend time with people". They added that some people were not washed and dressed until much later than required as they were needed to do more jobs than practical. Another staff member told us, "Staffing levels are up and down. If there is any less then some washes [of people] get done after lunch but the residents don't mind". Another staff member told us "I wish there was more time to spend with the people as the practical side is demanding. Sometimes I pray for another pair of hands. It's a bit of a conveyer belt and it is physically tiring and emotionally tiring". Staff told us as agency staff were not used problems mainly occurred when staff members called in sick and their shifts were not covered.

Records demonstrated that staffing levels regularly fell below required levels. Although completed staff rotas were not available for us to review on the day of our inspection, we reviewed staffing levels based on the 'flash focus meetings' that the manager or deputy manager completed daily. These meetings included findings from a walk around of the building and a discussion between the different departments within the home and covered issues like staffing levels, resident concerns and housekeeping issues. We reviewed three months of these documents. They showed that the required staffing levels based on the provider's dependency tool was regularly not met. The provider told us they acknowledged staffing as an issue that required action and showed us advertisements they had put out onto recruitment websites and interviews they had booked with potential employees. The provider said that they hoped that this recruitment drive would help the situation.

We found that recruitment checks included identity checks, a work history and a check with the Disclosure and Barring Service (DBS). The DBS check would show if a person had a criminal record or had been barred from working with vulnerable adults. Safe practice was not consistently followed when checking a staff members suitability to work with their previous employer. The provider told us that this was something they would be improving in the future.

People told us that they felt safe. One person said, "I'm very safe, never had a fall". A second person told us, "It's been [a number of] years since I arrived. I was very poorly when I came in. They said I wouldn't last the week but all these years on I am still here. That makes me feel reassured and safe". A relative told us, "[Person] has been here a number of months. They seem very safe here".

Staff had a good understanding of how to keep people safe from abuse. One staff member told us, "Safeguarding is for vulnerable adults. Keeping people safe. We need to know their needs like if someone is one to one or at high risk of falls". Another staff member told us "If we see any injuries we report it to the nurse and they record it. We also report any little changes like if someone is quieter than usual. We report any bruises and document it on a body map."

We found risk assessments in respect of individual people were in place that included, but were not limited to; continence, manual handling, falls risk, personal care, nutrition and hydration. We found people at risk of developing pressure ulcers were nursed appropriately and turned when required. Skin care was carried out and the use of any creams was recorded. Equipment used to aid people was in a good state of repair and checked adequately. We found evacuation plans were in place, giving information on how people should be moved from the home safely in the event of an emergency. Staff were familiar with these plans.

People told us that they received medicines as prescribed. One person told us, "They [staff] come with my

medicines twice a day". We observed a medicine round that was carried out appropriately and in an unhurried manner. Where some people administered their own medicines, the correct process was carried out. Nurses told us that they had received training on administering medicines and felt comfortable in doing so. People were often prescribed medicines on an 'as required' basis. There were protocols in place which gave nurses sufficient information to know when these were needed. Medicine records seen had been completed correctly. Incidents related to medicines were handled appropriately and where staff had made an error there was a system to recheck and re-establish competence for medicines administration.

Staff appeared to have a good understanding of infection control and we observed them to be working in line with good infection control practises. One staff member told us "We always wear protective clothing like gloves and aprons. We just use them once and then throw it away." They went on to say that there is a notice on a person's door if there is any barrier nursing. On the day of our inspection we saw evidence of this. One staff member told us, "We keep all [person's] plates separately and have special bin with disinfectant". We found that all checks related to infection control were in place.

Good

Is the service effective?

Our findings

The key question of Effective was rated as Good in December 2017. At this inspection the rating continued to be Good.

We saw there were assessments in place to detail people's needs at the point of admission and found these were used to inform people's risk assessments and care plans. We saw the provider consulted with other professionals, the person and significant others at the point of admission. We saw people's assessments considered important information including people's heritage, past life and any personal characteristics protected by law, for example age, gender and disability.

People told us that they felt that staff knew how to care for them. One person said, "They [staff] know everything about me, quite professional I think", "The majority are skilled. The new one's are watched by senior staff", and "Yes, I do [think they are skilled] very well trained. They are polite with me". One person told us they had previously had concerns which were now resolved and said, "They've [staff] got to know my needs now. The regular staff know but the other staff, I have to tell them what I need to wash and where to place the catheter. I also have to explain how my pads go on". Relatives told us, "The way they [staff] act and look after [person] tells me they are well skilled". A second relative told us, ""Yes, they seem quite skilled and efficient".

Staff told us that they received a two-week induction, which included time to shadow other staff when they commenced employment at the home. Staff new to care would receive training in line with the Care Certificate. The Care Certificate is a national set of standards relating to good care. Staff spoke positively of the training. One staff member told us, "The training is good. We have manual handling every year. It is really beneficial as we are using hoists all of the time". Another staff member said, "I think the training here gives me what I need to do my job". We found some recent training had included Safeguarding and Mental Capacity.

We spoke to staff about supervisions. One staff member told us, "I find them beneficial as it's all about me. We talk about training and what I am doing well". Another member of staff said, "I have supervision as required dependent on need and issues". We found that staff felt supported and that there was always a senior member of staff they could go to.

People told us that they enjoyed the food. One person said, "I enjoy the food" another said, "Yes, it is okay". A relative told us, "Yesterday it was lamb mince and something else. It looks nutritious". We found a difference of opinion regarding if people received a choice of meal. One person told us, "I have a choice of breakfast, but not lunch or evening meal", however, another person said, "I get a choice of two meals". The provider was informed of this and they felt that a small number of staff may be omitting to offer a choice of meal and this would be raised with them. They told us of their plans to introduce a system of showing people two separate meals as a visual prompt. We observed people being supported to eat in a caring and effective manner, with staff checking the temperature of the food and ensuring people had time to eat. Care plans around eating and drinking were reviewed monthly. Where people experienced weight loss their GP

was contacted and we saw examples of people being prescribed specific shakes and a fortified diet.

We saw people receiving drinks throughout the day and people told us that they received drinks, however some people said that they would like to receive more regular drinks. The provider told us that this would be arranged. We saw that where people were required to have fluids monitored their intake was appropriate. Some people told us that they would like to be offered more snacks. The provider told us that recently the food budget had gone up to allow for this. They told us that they felt that this was important, as they knew that for some people having some nice food can be the highlight of their day. We were informed of how more culturally diverse foods and snack boxes for small appetites had been recently introduced. We observed people being offered snacks throughout the day.

We saw staff members communicating positively with each other. One staff member told us, "handovers are really useful". Another staff member said, "We get to know people by reading notes and attending handovers.". One staff member told us "Its fantastic work and we have good communication skills. I speak Punjabi with a resident who speaks this language. There is always someone who speaks Punjabi allocated to each shift". We found that handovers had recently been improved. The provider told us of how handovers between shifts were previously not robust and things were being missed and as a result a communication book was implemented, which staff told us was positive. A nurse told us that staff members were quick to alert her to any skin concerns related to people.

People told us that if they needed to they could see a health professional. One person told us, "My GP comes and assesses me regularly. The carers check with me and tell the nurse [if I am unwell]". A staff member told us, "Some people can't tell you what is wrong if they are ill, but you can tell by little changes in their behaviours that something is not right and the GP". Records demonstrated that people were supported to attend hospital appointments and information from those visits was shared with relevant staff to ensure changes to treatment were actions. Referrals were in place to specific care services in relation to people's mobility and re-assessment of equipment. People were referred to professionals such as the chiropodist and dentist as required.

The home had recently undergone an extension which offered a large homely space that was meeting people's needs. A large lounge and dining space was being refurbished and the provider told us that this would be complete within the next few weeks. However, there was no evidence that people had been involved with the refurbishment and décor. The older part of the home had tired décor and the environment did not feel well cared for. An example of this was people's curtains not being hung correctly in their bedrooms with some missing hooks leading to them being unsecure. Staff told us that the on-site handyman had been informed and we saw him tending to the curtains throughout the day.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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, and whether any conditions on authorisations to deprive a person of their liberty were being met and found they were. Where it was felt necessary a mental capacity assessment was carried out and people's general mental health needs were also acknowledged.

Staff had a good understanding of Mental Capacity. One staff member told us "We make the best decisions

for people if they can't make decisions for themselves. If they wanted to leave we would go with them if people have a DoLS, but some people who have capacity can go out alone which is nice". We found that best interests decisions had been taken to ensure that people's rights were protected, for example in circumstances where people were restricted by equipment such as bed rails. Where medicines were being given covertly [without people's knowledge] there was a policy in place and the decision to administer medicines this way had resulted from a meeting with professionals and family members.

One person told us, "They ask before doing anything". We saw staff seek consent where people required support with personal care. An example being staff asking people, 'can I help you with that' and 'are you comfortable'. We saw staff asking people's consent before assisting them to eat and helping them to move from where they were sitting.

Good

Is the service caring?

Our findings

The key question of Caring was rated as Good in December 2017. At this inspection the rating remained Good.

People told us staff were kind and compassionate. One person said, "All the staff are nice and kind, no concerns about them". Another person said, "I always tell staff what I want, they are friends of mine". A relative told us, "I think they are always caring, all very good. I have never seen them uncaring here". A staff member told us, "I love caring. I wasn't sure I would be able to do it but I love it. I enjoy making people feel comfortable". We saw some positive examples of good interactions between people and staff. These included people assisted into wheelchairs very slowly and spoken to with great care taken to support them, staff making eye contact with people and calling them by terms of endearment. We also saw a staff member encouraging a person to do stretching exercises whilst making sure they were comfortable.

One person told us, "I don't need choices. I ask and they do it". A relative told us, "[Person] makes choices when they can". We saw a staff member giving a person the choice of staying in the lounge or going to the dining room to eat saying, 'It is your choice my dear' and the staff member didn't rush them when they took their time to decide.

People told us how staff encouraged them to be independent, with one saying, "Staff support me to do things for myself". Another person said, "I can get myself up into my wheelchair myself, they let me do it. A relative told us, "[Person] can't do much to be independent, but staff encourage them to feed themselves". One staff member told us, "We always ask people and try to encourage them to be as independent as possible like passing them the flannel rather than doing it for them.

One person told us, "My carers are always respectful, just like my friends. I have no concerns at all". A second person said, "When I am having a bath the staff are very respectful, they close the door and the curtains". However, one person did tell us, "Most carers knock on my door first, but some new ones just walk in and I'm on the toilet". A relative shared, "Staff usually knock first and ask if [person] wants anything". A second relative shared, "I can only comment from what I have seen when I'm here. They seem to be respectful when they take [person] to the toilet". A staff member told us, "Privacy and dignity is important and common practice here. We shut all of the curtains; cover a person with a towel when washing. We always tell the person what we are doing". Staff were observed when bedroom doors were closed to always to knock on the door and identify themselves on entering the room.

Relatives told us that they were made welcome when they visited and that they had good positive relationships with staff. One relative told us, "The staff always ring me about any concerns, they are really good".

Requires Improvement

Is the service responsive?

Our findings

The key question of Responsive was rated as Good in December 2017 at this inspection the rating had changed to Requires Improvement.

People told us that they had been involved in compiling their initial care plans, with one person telling us, "They [staff] assessed me, when I came in" and a second person said, "The deputy home manager came to see me in hospital and we did my assessment". A relative told us, "They assessed [person's] needs when they first came in". A second relative said, "I was involved in [person's] care plan initially". We found that although staff carried out monthly updates to care plans and risk assessments, there was no annual review giving people a chance to discuss their ongoing care. One person shared, "I have to ask them [staff] how my care is going because they never tell me". People we spoke with confirmed that they had not been given the opportunity to be involved in any review of their care and therefore any updates of their needs had come from the perspective of staff. The provider shared that this was an area that they had not focused on, but they would take steps to make changes.

One staff member told us, "The care plans are really informative and we get told if things change and the nurse updates the support plan". Information within care plans included, but was not limited to; assistance required for personal care, support to dress and eat, continence needs, nutrition and health. Care plans related to medicines were updated monthly or as required. People's likes and dislikes and their life history was also noted. Pre-admission information included detailing the support people needed and any possible risks was available.

One person told us, "They [staff] never tell me about activities, there's nothing going on here". A second person said, "I don't know about activities, no-one has said anything. I would take part if I knew about them". We saw that most activities were carried out in small groups, with not everyone having the opportunity to get involved. For example, we saw a reminiscence session taking place with five people, but across the room four people were sat around a television that was turned off. A staff member told us how four people had individually been taken to church, but we saw no evidence of this being a regular activity. We found that events planned for some days showed that 'tea and biscuits' was planned as an activity. During our inspection we found that a number of people were sat either watching television or sleeping in chairs. The provider told us that activities were an area currently being improved upon and that they hoped that the recruitment drive meant that more staff would be available to assist with activities.

One person told us, "I have not complained yet. I would tell the office if necessary". A second person said, "I haven't needed to complain". A staff member told us "If the residents complain then we usually call the deputy manager and they speak to the person". People and relatives told us that they knew the procedure to take if they needed to make a complaint. There was a compliments and complaints folder but this was disorganised and it was difficult to see where the service had responded to complaints or what action had been taken following the complaint. In one instance there was a complaint where a response had not been recorded and in another there was a response but no evidence of the original complaint. There was a 'complaints register' form but this did not correlate with the information provided within the file. The

provider confirmed that complaints were dealt with, but improvement was required in relation to recording evidence of actions carried out. We were unable to verify with any complainants as to whether their complaint had been dealt with satisfactorily.

On the day of inspection there wasn't anybody receiving end of life care, however a recent compliment to the home stated "Thank you for caring for [person] in his final weeks. You kept them safe and comfortable and our family will always be grateful for that. You provided a home away from home'. One staff member talked about how they cared for someone at the end of their life and told us, "At end of life we complete regular checks and we give mouth care and make sure that they are comfortable". We found that people had end of life plans, which included pain management, complying with persons wishes, medications, information on next of kin and funeral arrangements. Following the previous incident of staff being unaware of how to support a person in relation to DNAR staff we spoke with now understood the correct action to take.

Requires Improvement

Is the service well-led?

Our findings

The key question of Well Led was rated as Good in December 2017. At this inspection the rating had changed to Requires Improvement.

The Poplars does not currently have a Registered Manager. The current acting manager had previously been registered with CQC as manager of the service, but had left for employment elsewhere. They had subsequently returned and had taken up the position of clinical lead, however when the registered manager left the vacant position was offered to them. The provider told us that delays in registering had originated from the clinical lead considering the post of manager and delays in DBS checks being returned.

We saw that audits were carried out, but how they had been recorded made it difficult to assess if there were any patterns in events. In particular, in relation to falls and skin issues. We found that some audits had been taken in the form of Key Performance Indicators [KPI's] but that they only gave numbers not information. For example, one audit just recorded 'three falls' and gave no other information and where people had pressure sores a number of recordings just noted 'no improvement'. The provider talked us through the actions that had actually been taken and told us of how this would be recorded clearly in future. We saw that audits did not always identify concerns, for example one staff member only had one reference on their staff file, but this had not been identified as part of an audit. Monthly medication audits were conducted and we saw that actions were taken from the findings of those audits. We saw that effective audits were also in place with regards to the environment of the home.

People told us that they hadn't been asked for their opinions on the service. Telling us, "I haven't seen a survey requested" and, "I have never done a survey". We found four completed feedback forms, but they were not dated and therefore there was no evidence as to when these had been implemented. We found that there had also been no recent meetings for people and relatives to share their views and this coupled with the lack of reviews of care meant that people were not being able to have an input on the care they received. The provider told us that they planned on carrying out more effective surveys soon and they took people's feedback verbally, but had failed to record it and so had no evidence, but would do so in future.

Staff told us that they didn't attend regular team meetings, but said that they could go to senior staff, the manager or provider if they needed support and the provider told us, "The manager has an open-door policy for staff".

One person told us, "I think I have seen the manager, not too sure if it was them". Another person said, "I know the manager, I can't remember their name". People also told us that they were familiar with the provider. Staff members gave differing opinions on the acting manager and one told us, "The current manager is very good, supportive, approachable and visible and the providers listen and respond to the staff team's needs". Another shared, "The manager is approachable. I can tell them concerns and I feel they listen". Other staff members told us that they felt that manager was, "Ok, but not the best" and "The manager sometimes tells staff that she just doesn't have time for them, but the provider listens".

Staff members told us that they understood how to whistle blow should they need to. A whistle blower is an employee who takes their complaint to an external agency when they believe that adequate action has not been taken by their employer.

We saw that previous inspection ratings were on display in the home and the website had a link to the report on the CQC website. We also received notifications as required to enable us to see how concerns had been dealt with.