Halton Services Limited

Parkfield House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Parkfield House nursing home provides long term accommodation with nursing care for up to 44 older people, some of whom were living with dementia. There were 33 people living in the service at the time of the inspection and one person was in hospital.

This inspection was unannounced and took place on 8, 11 and 12 July 2016.

During our last inspection on 4, 5 and 11 August 2015 the provider was not meeting the legal requirements in relation to ensuring that the care or treatment that was planned, recorded and delivered was linked to people's needs and preferences. At this inspection we found that although there were still areas that needed further review and improvement, overall we saw that the information recorded in people's care records was more person- centred and detailed. This included, recording people's individual preferences and likes and dislikes.

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.

We recommend the provider reviews recognised guidance on designing and using the environment that takes account of people's needs. In particular for people living with the experience of dementia and other needs they might have such as visual impairments.

We recommend the provider seeks recognised guidance on providing suitable activities that meet people's needs.

There were systems to monitor and audit the service and plans for improvement. However, these had not picked up on the areas we found at the inspection that needed addressing.

People gave us complimentary comments about the service they received. People felt happy and well looked after. However, there was mixed feedback from some staff and a relative about the service and how it was run, including staffing levels. We saw that staffing levels had been reviewed and had decreased but we found no evidence that people were at risk of neglect or were not being cared for effectively.

People's needs were assessed prior to their admission to the service and were reviewed on a regular basis. Risk assessments were in place that reflected current risks for people at the service and ways to try and reduce these.

People's capacity to consent to their care and treatment had been considered and assessed. The registered manager had acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff knew people well and understood how to meet their individual needs. We observed positive relationships between staff and people at the service and their relatives or visitors.

People were supported to maintain relationships with those who mattered to them.

There were procedures designed to safeguard people and the staff knew what to do if they thought someone was at risk of abuse.

Staff received training to help them undertake their role and were supported through supervision and appraisal.

Staff had been suitably recruited.

Medicines were stored, administered, recorded and disposed of safely. Staff were trained in the safe administration of medicines and kept records that were accurate.

People's nutritional needs were assessed and they had a variety of freshly prepared food.

The staff worked with other healthcare professional to assess and meet healthcare needs.

There was an appropriate complaints procedure and people and their relatives knew how to make a complaint.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People using the service told us they felt safe. Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures.

The provider carried out checks to make sure staff were suitable to work with people using the service.

There were enough staff to meet people's needs and this was kept under review.

Safe arrangements were in place for the management of medicines and staff had received training in administering medicines to people.

Is the service effective?

Good

The service was effective. Staff worked well as a team and received training to provide them with the skills and knowledge to care for people effectively.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being met.

People's healthcare needs were monitored and they were referred to the GP and other healthcare professionals if needed.

We recommend the provider seeks national guidance on providing a suitable environment for people living with dementia.

Is the service caring?

Good

The service was caring.

The staff showed people respect and offered them choices.

People told us they liked the staff and found them caring.

We observed some interactions which were kind, considerate or polite.

Is the service responsive?

Good

The service was responsive.

The majority of care records were up to date and accurately reflected people's changing needs. Information that was found to be out of date and needed reviewing was addressed.

People and relatives were confident to raise any complaints and systems were in place to record and investigate these.

Is the service well-led?

Requires Improvement

The service was partially well-led because the registered manager had the qualifications and skills to manage the service effectively and had made improvements. However, there were areas that required further improvement to ensure the service ran smoothly and safely.

There were mixed views on the running of the service.

Systems were in place to monitor the quality of the service and areas for improvements were identified and addressed. Work in this area was ongoing.

Parkfield House 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.

This inspection took place on 8,11 and 12 July 2016 and was unannounced.

The inspection was carried out by a pharmacist inspector, two 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. The expert for this inspection had experience of supporting a person who was living with the experience of dementia and had previously owned and run a care service.

Before the inspection, we reviewed the information we held about the service, including notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the quality monitoring team at the local authority to gain their views of the service.

The registered manager had also completed a Provider Information Return (PIR). This is a form that asks the provider/registered manager to give some key information about the service, what the service does well and improvements they plan to make.

We used different methods to obtain information about the service. As the majority of people were not able to contribute their views to this inspection, we used the Short Observational Framework for Inspection (SOFI) to observe care and interactions between people and staff. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection, we also spent some time carrying out general observations of interactions and the support being delivered to people. We looked at records, including four people's care plans, seven staff records and records relating to the management of the service. We spoke with six people who used the service, three relatives, a visitor and staff including the registered manager, clinical lead nurse, four nurses, three care assistants, the administrator, the cook and one activity co-ordinator.

Good

Is the service safe?

Our findings

People we spoke with confirmed they felt safe living in the service. Comments included, "Oh yes, if it wasn't I would tell them," "There are no violent residents here. It is like being in your own home," and "Yes, I feel safe, because it (moving to the service) was what I needed. I was on my own. As far as I am concerned it was very good for me." When relatives were asked if they felt their family member was safe living in the service, they all said they felt they were. We saw pictures in the service that informed people what to do if they were not feeling safe and at risk of harm.

Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. They could describe the action they would need to take, including the documents they would need to complete, such as body maps and incident reports. One staff member said, "If there is an issue you can report it to the local authority." The service had a safeguarding policy and procedure in place. Staff told us they were familiar with and had access to the whistleblowing policy. This indicated that people were protected from the risk of abuse.

The registered manager raised alerts of incidents of potential abuse to the local authority. They also notified the Care Quality Commission (CQC) as required of allegations of abuse or serious incidents. The registered manager worked with the local authority to carry out the necessary investigations in response to any concerns identified to support people's safety and wellbeing. The provider kept a log of all safeguarding alerts including details of the concern, who was involved and the outcome of investigations.

There were various checks carried out on the environment and the registered manager told us that care staff were checking the water temperatures. The records showed that the maintenance person had been checking the temperatures every six months, with the last check completed in December 2015 where there were no issues identified. Following on from the inspection we received confirmation that new thermostatic mixing valves had been fitted to each water outlet to make it easier to check each water supply to ensure they continued to be within a safe temperature range. The provider also confirmed that the maintenance person would now check the water temperatures on a more regular basis, starting fortnightly and then once a month.

People lived in an environment which was appropriately maintained. Windows were equipped with restricting devices to prevent people from climbing or falling from these and these were checked regularly. The exits from each floor, to the stairs and for leaving the building were controlled by key pad codes. The service was also divided into zones so that staff could respond quickly and know where there were problems or incidents occurring.

Staff took part in fire safety training and practice fire drills. The registered manager told us that the next drill would include night staff as they had not recently been involved in a drill. The fire risk assessment carried out in August 2015 had identified action points and the registered manager had an action plan recording that the recommendations had been met.

There were regular checks on fire safety equipment. The provider employed a maintenance worker who made checks on the environment and carried out repairs. We saw records of safety checks and service records for gas safety and portable electrical equipment. All of the checks and service records we viewed were up to date.

The risks to people's wellbeing and safety had been assessed and there were plans for staff to help keep people safe. For example, the risks for people when moving safely around the service, those associated with their health, skin integrity and nutritional intake were recorded. However, in one person's care file we saw a potential risk highlighted within their care plan which did not have a risk assessment linked to this particular need. On day two of the inspection we saw this had been completed to inform and guide staff on how best to support the person. Risks were reviewed each month by the nurses and any changes in needs would trigger a risk assessment to be updated or developed.

There were up to date personal emergency evacuation plans (PEEPs) for people who used the service. These included important information about the person and information for staff and emergency services on how to assist each person safely and the assistance required for each individual.

People were protected from the risk of repeated injury and appropriate action was taken when people fell. The staff recorded all accidents and incidents and the action they had taken to keep people safe and contact medical services. The records included a check by the registered manager and action taken to prevent a repeat of the accident and involved reviewing risk assessments and care plans.

The provider had systems in place to make sure staff were suitable to work with people using the service. Staff recruitment files we looked at included application forms, interview questions and answers, two references, proof of identity and Disclosure and Barring Service (DBS) checks. The nurse's personal registration numbers were noted so that the registered manager could check to ensure they were registered with the Nurse and Midwifery Council (NMC). The registered manager obtained information about agency staff used, such as their DBS number and training they had completed so that they had some background details about them. One visitor who was at times, albeit briefly, alone with people using the service and who had been visiting the service for some time, did not have a DBS check carried out on them. The registered manager confirmed that until they had completed this then the visitor would not come back to the service.

We received mixed feedback about staffing levels from the staff and relatives. One staff member said when everyone who should be working had turned up to work then there were enough staff to meet people's needs. A relative said that staff were busy and "you could always do with more" but they felt there were enough staff working when they visited. A second relative told us, "I would say it is about right." A visitor commented that "you don't see staff rushing about or panicking." However, one relative reported that since some staff had left the service they did not feel there were enough staff and that people did not go out as much. They did confirm that the care was good and people were well looked after. In addition, some staff said there was not enough staff for them to carry out all the tasks they needed to. One staff member told us, "the last few months there was not enough staff." Another staff member said there was not enough time to complete the paperwork.

Since the previous inspection there had been a review of staff member's roles and responsibilities along with the numbers needed to support people safely. Some days when there should be six care assistants on a day shift there were times when there were only five working. We were told by the registered manager that this occurred when staff called in at short notice to say they were sick and a replacement could not be found. The registered manager was aware of where there were vacant shifts and filled these with agency care assistants if staff did not work overtime. The service no longer used agency nurses as there were no

nurse vacancies. The current care assistant vacant posts had been recruited to and the registered manager confirmed they were in the process of obtaining the necessary employment information. They also told us that they monitored the rota to ensure staff did not work too many days, or nights, in a row to ensure staff were not working excessive hours and therefore could be tired.

Furthermore the registered manager reviewed the dependency levels of the people using the service every month to check that there were sufficient numbers of staff working. They confirmed that when there were hospital appointments the activity coordinator whenever possible, took people to these as one of them drove the service's transport and so was out of the service a shorter period of time than a care assistant would be. One staff member said if a care assistant attended a hospital appointment with a person using the service then it "can be stressful" as this left the service down a member of staff possibly for several hours.

We viewed three months staff rota's from March 2016 for both day and night staff and these showed that for the majority of the time there were the current agreed numbers of staff working, unless a staff member called in sick. We saw no evidence during the inspection that people had to wait a long time to be supported and assisted by staff and we talked with the registered manager about the different feedback we had received so that they could continue checking that the staffing levels were suitable and to consider looking at if there could be alternative arrangements made when there were hospital appointments.

We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in locked medicines trolleys. Current fridge temperatures were taken each day (including minimum and maximum temperatures). We found that the provider had taken the appropriate action to keep the medicines in a cool box whilst the transfer to the new fridge took place. This assured us that medicines requiring refrigeration were stored at appropriate temperatures.

People received their medicines as prescribed. We looked at eight MAR charts and found no gaps in the recording of medicines administered. The provider had a homely remedies protocol in place. Although one of the stock quantities of medicine did not reconcile to that kept in the records (loperamide, a medicine for diarrohea), overall there was a good overview of the management of these medicines.

We spoke with one person who reported that they received their medicines in a timely and correct manner. Staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, such as, one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the person. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance).

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's individual needs were not controlled by excessive or inappropriate use of medicines. For example, we saw eight PRN forms for pain-relief/laxative medicines. There were protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

Medicines were administered by nurses that had been trained in medicines administration. We observed a

medicines round and found that staff had a caring attitude towards the administration of medicines for people. Staff did not wear a protective vest during the administration of medicines. However, they were not disturbed during the medicines round we observed. The provider informed us that they would look to purchase these.

We looked at four MARS for people who were administered their medicines covertly. This is where medicines would be hidden (often within food) or crushed usually due to the person refusing to take their medicines or if they were unable to take them with water. This had been agreed by the relevant professionals and family members in accordance with legislation and recommended guidance.

The registered manager stated that no medicines incidents/ near misses had been reported recently. They demonstrated the correct process verbally of what to do should an incident/near miss arise in the future. This was in-line with the provider's policy.

Good

Is the service effective?

Our findings

The staff received an induction when they first started work at the service. They also shadowed experienced staff. Some of the induction documents we viewed had either not been dated or we saw on one document the same date recorded for the whole induction. The registered manager confirmed that new staff did not work through the induction in one day and that this had been incorrectly dated. They said this would be checked in future to clearly show when new staff shadowed experienced staff and when they went through each area of the induction to the service. If staff did not hold a nationally recognised care qualification then they worked through the care certificate modules. This is a set of introductory standards that health and social care workers adhere to in their daily working life to provide compassionate, safe and high quality care and support.

Staff received ongoing training in important areas of their work and we viewed a sample of training certificates. This included, infection control, fire safety, nutrition and moving and handling. Additional training was also provided on dementia awareness, pressure care and customer care. One staff member said the training had been "useful."

Staff were supported through one to one and group supervision and the records confirmed this form of support and guidance was made available for staff. One staff member told us, "Sometimes I feel I get enough support for my job." Another staff member said they received one to one support but also "if I had an issue I wouldn't wait for the meeting to talk with the manager." Staff also received an annual appraisal of their work and staff we asked confirmed they had received this if they had worked for over a year in the service.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. We found the registered manager understood their responsibilities under the MCA and was aware they would need to apply to the local authorities responsible for funding people's care for authorisation to restrict people's liberty in order to keep them safe. We saw applications made to the local authority and the registered manager monitored when people had been assessed and when their DoLS was due to expire so that they could reapply. We saw no examples of people being deprived of their liberty unlawfully.

We found that people who were receiving their medicines covertly had the appropriate authorisation and input from professionals. For example, there was evidence of a best interests meeting, mental capacity assessment and a medicines form which was signed by the GP and the pharmacist.

Staff had received training in MCA and DoLS and understood people's right to make choices for themselves and where necessary, for staff and other professionals and family members to act in someone's best interest. One staff member told us, "I have to give people choices every day and not assume they can't make

a decision." Another staff member said, "this is not a prison," and "it is about ensuring people's dignity and rights are respected."

There was a do not attempt resuscitation order in place for some people who lived in the service. This meant that if their heart stopped the staff should not attempt to resuscitate them. A relative confirmed they had been part of the decision making process for their family member in relation to this sensitive subject. We saw evidence that these decisions had been made with the consent of the person (where they had capacity), their family and their doctor. The reasons for the decision had been recorded. The registered manager confirmed these were checked and reviewed and would be looked at again as the service now had a new GP.

We saw people being given a choice of meals and drinks during lunchtime. People's comments on the food included, "We have more variety now" and "I get plenty of food." A relative told us, "My (family member) is easy to please, I would say that. But she does like her food here." The cook confirmed they knew people's food preferences, if they required their meals to be pureed and if they were at risk of choking or had swallowing difficulties. The cook said they checked if people were happy with the meals and we saw evidence that they cooked meals from scratch.

We saw on one person's fluid records that the target fluid intake had not been recorded meaning that staff would not know what the person should have each day to ensure they were hydrated sufficiently. The amount the person had drunk was also often recorded as the same amount and we queried if staff knew they had to record the amount the person drank not the quantity given to the person. The registered manager checked all the records where people required food and fluid to be monitored and amended the forms clearly noting the target amount for the person for each day.

People's healthcare needs had been assessed and recorded as part of their care plans. A relative confirmed that a, "GP has come a couple of times. (Family member) had hurt their finger. Also the staff picked up that she had a urine infection and called the GP." Nursing staff were employed at the service throughout the day and night. We saw evidence that they consulted regularly with people's GPs and other healthcare professionals. There was a record of healthcare appointments and any actions from these. The GP visited three times a week and was based out of borough. They had started working as the service's GP in April 2016. The registered manager was reviewing how this was working as all referrals would now be based from the out of borough GP practice and therefore many of the usual health care professionals would be new to the service.

The environment, although clean and bright and welcoming was not fully providing a home for people with varied needs and for whom many were living with dementia. The environment did not promote or enhance positive stimulation to enable people to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do. Furthermore we were told and we saw, that some people found it hard to get out of the chairs. We saw the menu was noted for people on their tables but there were no photos or pictures of the meals people could expect to choose from. The registered manager confirmed they would ensure this would be changed and that the cook would begin to take photos of the meals. This would assist people who responded more to visual aids and could more easily make daily choices.

Some people's bedrooms had small memory boxes with a few personal items in them but this could be explored further. The notice board for activities was in the main hall and not in the lounge. People on the ground floor were mainly using the small lounge which had no natural light and was a room used to access the dining room and bedrooms and so there was a constant flow of people and staff going through this

room. We observed one person who showed signs of being stressed as it was a busy room but when they went upstairs to a lighter and brighter area of the building they appeared to be more relaxed. There was a ground floor light and spacious room which was rarely used during the inspection. The registered manager acknowledged that alterations needed to be made to the environment.

We recommend that the provider seeks national guidance on providing a suitable environment for people living with dementia and other particular needs, such as visual impairments.

Good

Is the service caring?

Our findings

People commented favourably about the staff team. Comments were, "I am well looked after, "they (staff) are very good," and "I love it here." A relative confirmed that if their family member were to need support again then they wouldn't "have a hesitation in them coming here." They also said their family member "has made friends here." Another relative told us the care was good and the staff were "kind." A visitor was positive about the service. They commented that the "Home is great for X (the person using the service)." They went on to say the person was never "forced to do anything they didn't want to do" and that they were treated as "individuals."

All the staff when asked said their priority was the people using the service. Comments included, "first is the residents, not our paperwork or our break." We observed positive interactions between staff and people using the service. Staff were jovial with people and showed patience and supported people in an encouraging and gentle manner. Staff listened to people who sometimes needed time to explain what they wanted.

We carried out observations at lunchtime on the ground and first floor. People were asked about their meal choice before it was served. We saw some different interactions on these floors. On the first floor we noted a staff member assisting a person with their meal gently and supportively. A second person who also needed help with eating was slow to eat and we saw there was no rushing and that there were social interactions between the staff member and the person using the service during the mealtime. One the ground floor we saw a staff member supporting a person with lunch and that there was a large amount of food being placed on the spoon and then they were wiping excess food off from the person's mouth. There was music playing in the background but we did not see a lot of conversation during the lunch period. We fed this back to the registered manager and they informed us that some people were at risk of choking whilst eating if there was too much chatting going on. The registered manager confirmed they would observe mealtimes to see if there were any problems.

People's preferences and routines were recorded in the care plans, including their preferred term of address and any preferences for the gender of the staff providing personal care. We saw this individual information was being developed further to include details such as preferred waking and retiring times to inform and guide staff on how to support a person appropriately.

The registered manager informed us that some people now had an independent mental capacity advocate (IMCA) which had been identified as a form of additional support for people through best interest and deprivation of liberty assessments. They would represent people's wishes and advocate on their behalf where necessary.

Good

Is the service responsive?

Our findings

At the previous August 2015 inspection we had made a breach in relation to care records and documents that were inaccurate, difficult to locate in people's files and people's interests and hobbies were not always recorded. At this inspection we found improvements, although we still identified some information within people's care files required closer examination by the registered manager to ensure they provided staff with adequate information about a person and their individual needs.

People gave their feedback about the activities. Comments included, the activities were, "Not bad," "I don't think they do activities. Once in a blue moon we go out on a bus, but they only did that when I pushed the matter," "I don't like activities. I like to read and I like to sit outside if the weather is good." One relative said they felt since the staff changes there were less activities taking place. Whilst in contrast another relative said staff had purchased a word search book as their family member enjoyed doing these and they had been impressed that staff had done this. The service obtained people's views via the meetings held for them every three months. the last one held in May 2016 had looked at outings.

The two activity coordinators worked on each floor and only one could drive the service transport. Each activities coordinator worked one week-end day a month and had a day off during the week when they did this. There was an activity plan each day and some trips were organised out in the community. There was also an entertainer who visited the service. Where possible people if they wanted to go out were supported to do so and there was a forthcoming trip planned to a local Lido. One person was part of a weekly gardening course which they told us they enjoyed going to. We observed activities and found on the ground floor the music was loud and people had difficulty hearing the conversation. Several people indicated they did not want to engage in the session and it was noisy. This did not demonstrate that the activities were meeting some people's needs. However, on the first floor we saw a quieter and calmer activity of reading was taking place which people appeared to enjoy and were listening to. There was dialogue taking place between staff and the people using the service, encouraging them to recall their memories. We had identified at the previous inspection that activities could be improved and the registered manager informed us that staff had begun to receive training and guidance on providing suitable activities. They also confirmed that they had requested for an optician to visit the service to provide staff with visual impairment training.

We recommend that the provider seeks recognised guidance on providing activities for people living with a range of needs.

People had their needs assessed when they moved to the service and care plans had been created to tell the staff how to meet these needs, which included people's health, social and care needs. The service had a 'resident of the day' scheme where the staff reviewed their care plan and made sure the information about people's needs was up to date. The care plans we looked at were reviewed regularly and kept up to date to make sure they met people's changing needs. There was a lot of detail in people's care folders which would take time for new staff to digest. However, there was a summary profile of people's needs which gave an overview of the person's needs and personal preferences at a glance which was informative for staff.

We found in three people's care plans some information that was vague and did not fully inform staff of the person's needs and possible ways they expressed themselves. In one person's care records there was differing information within their Deprivation of Liberty assessment and a care plan in relation to how often they needed to be checked. The registered manager was quick to ensure these people's care plans were updated and confirmed by the end of day two of the inspection that every person's main care file had been checked to ensure they were clear and informative. We were satisfied that sufficient progress had been made in relation to the required changes since the last inspection.

People's 'Life Story' had been completed on the four files we viewed. This included details of each person to give more background on their life and history, including family, hobbies and previous occupation.

The provider had a complaints procedure in place and people told us they knew what to do if they had a complaint. One person told us, "In the first instance I would see the Senior Nurse, and then I would go the Manager." Another person confirmed that "I know who I would need to go to if I needed them." Relatives said they knew who to talk with if they had a complaint. One relative said "I am fully happy with everything." They also said they would feel listened to if they did ever raise a complaint to the registered manager.

We saw the complaints policy and procedure was in the hall of the service. Complaints had been recorded, investigated and responded to, demonstrating concerns and complaints were taken seriously and addressed. Any good practice improvements that were made following on from a complaint were recorded. The registered manager was also now recording more informal complaints to ensure all comments were being recorded and dealt with.

Requires Improvement

Is the service well-led?

Our findings

Staff told us the care staff were "great." Other comments about the team was that there was "good communication between each other" and "we trust each other." Staff said they felt able to approach the registered manager. One told us, "you can go to the manager if you have a question." Another said the registered manager was "excellent." Staff confirmed "everyone knows their job." However, other comments were not as positive about communication, the registered manager or how the service was run. A relative said they used to "sing the praises of the home" but that now they "wouldn't recommend it" due to the staff changes. One staff member said they were not always told if someone was moving into the service. The registered manager informed us that there were daily flash meetings with the various departments in the service, which we saw taking place. This included someone from the housekeeping, kitchen and care staff teams. Here any news, appointments or issues would be raised and so staff would be aware of a new person being admitted into the service. General staff meetings also took place with the last one held in June 2016. Staff also said the care assistants were now "bottom of the food chain" and that they no longer had meetings with the senior care assistants and that although communication was good between nurses and care assistants it was not so good between management and care assistants. One staff member said "I am not happy working here anymore" and "everyone is miserable." A relative also told us that staff morale seemed "low." This feedback was shared with the registered manager for them to consider and address with the staff team to ensure the mixed feelings did not have a negative impact on the people using the service. We did not identify that people were not being supported in a caring way even though some staff said they were unhappy and shared this with us.

There were a range of checks and monitoring systems in place. We saw that the records completed by the care assistants had not been audited and we found these either too difficult to read or were incomplete. For example, one person's topical medicine record for creams that needed to be applied was hard to determine if the person had always had this cream applied as staff had written in various columns and not always in date order. For a second person their topical creams had not been signed for every day in May and June 2016. Furthermore, there were a couple of dates in May 2016 for one person where it was not filled in by staff to show what personal hygiene tasks had been carried out. The registered manager and clinical lead had not been auditing these particular care records that were stored in a separate folder to the main care file and were completed by the care assistants. They confirmed they would now carry out checks to include all care documents and during the inspection the registered manager showed us the new care file audit tool which included all care records. In addition, the registered manager had introduced a daily check on this separate second care folder so that if there were any problems then it would be picked up swiftly. There was no evidence that people had been placed at risk of neglect or harm and we were satisfied that the registered manager was receptive to the findings and quick to implement more detailed audits in this particular area.

The other audits we viewed included, looking at incidents and accidents and noting if there were any patterns or triggers that needed to be addressed to keep people safe. Other systems were in place to check the training staff completed and to make sure staff were not out of date with the mandatory subjects.

We saw evidence of several recent medicine audits carried out by the supplying pharmacy and the staff,

including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis.

Different areas important for people using the service were monitored. This included, their end of life wishes, their weight and bed and safety rail checks. This was all to ensure that any changes were promptly acted on and the necessary equipment, referrals to the GP and any other steps were taken in a timely manner.

The registered manager had been in post just over one year at the time of this inspection and was a qualified registered nurse. They had reviewed working practices and had looked at areas requiring attention. We saw the registered manager had prioritised the work that needed to be carried out and recognised that there were areas still to be looked at and improved upon. The service had applied to join the local authority's and Alzheimer's Society dementia action alliance group. This would promote the service to become more dementia friendly and the registered manager said they would be able to access resources and support to improve the lives of people living with dementia. Staff were also starting to sign up to be a dementia friend to encourage them to consider what it is like to live with dementia and how they could support people. We saw from the last inspection that although there were some shortfalls identified at this inspection, we could also see that there were lots of effective checks and systems in place in order to provide a quality service for people.

The service had been visited twice in 2016 by an external auditor who looked at different aspects of the service. The March 2016 report was available and there was an action plan in place showing where the registered manager had addressed the points raised in the report.

Relative meetings did not take place as we were told that the registered manager had an 'open door' policy and that this was more successful than holding a meeting where few relatives would attend. The newsletter, which had previously provided relatives with an update about the service had changed since the last inspection and now only highlighted activities that had taken place. Although this was placed in the hallway it was not sent to relatives. We talked about how the service provided information to relatives and the registered manager said they would ensure the content in the newsletter was reviewed and that these would be sent to relatives, which was important if they did not visit often but wanted to hear updates about the service.

Relatives were invited to people's reviews which we saw evidence of so that they could contribute to the running of the service and the support their family member received.

Satisfaction surveys were given to people using the service, their relatives and professionals. We saw from the March 2016 surveys that the registered manager had analysed the results, which overall were positive and had displayed them in the entrance hall by the front door so that they were visible for people to see. The registered manager confirmed that surveys for the staff team were still to be sent to them for 2016.