

Prime Care Homes Limited

Clitheroe

Inspection report

Eshton Terrace
Clitheroe
Lancashire
BB7 1BQ
Tel: 01200 428891

Date of inspection visit: 9 and 13 July 2015
Date of publication: 25/08/2015

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



Overall summary

The inspection was carried out on 9 and 13 July 2015. The first day of the inspection was unannounced.

The Clitheroe is a detached property close to the amenities of Clitheroe town centre. The home provides personal and accommodation for up to 24 older people. At the time of the inspection there were 18 people accommodated at the service. The accommodation is provided over 3 floors, accessed by a passenger lift. There are 18 single bedrooms and 5 double bedrooms. There are two dining rooms, two lounges and a conservatory. To the front of the home there is an enclosed patio area with garden furniture and car parking spaces.

The service was managed by a registered manager. 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 on 22 May 2014 we found the service provider was not meeting legal requirements relating to: medicines management, care planning processes and quality monitoring and consultation systems. We therefore asked the provider to take action

Summary of findings

to make improvements in respect of these matters. Following the inspection we received action plans from the provider telling us they would meet the legal requirements by 19 July 2014. At this inspection we found sufficient action had been taken to make improvements.

During this inspection we found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there were not enough staff available at the service to make sure people received safe and effective care. We also found people's concerns and complaints were not always properly responded to and managed.

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

There had been a high turnover of staff at the Clitheroe. We therefore made a recommendation about attracting and retaining suitable staff to work at the service.

People spoken with had mixed views about the management and leadership arrangements at the service. One relative told us, "I think the home is well organised and managed, the manager is approachable." But some people also made comments which suggested they lacked confidence in the way the service had been run and were not convinced the recent improvements would continue.

There were processes in place to manage and store medicines safely. However some further improvements were needed and the registered manager took action to rectify these matters during the inspection.

People using the service did not express any concerns about their safety, security and wellbeing. Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Staff confirmed they had received training on safeguarding and protection.

Recruitment practices made sure appropriate checks were carried out before staff started working at the service. However some improvements were needed on ensuring appropriate records are kept.

There were processes in place to maintain a safe environment for people who used the service, staff and visitors. However we noted there was no call point fitted next to one shower. There wasn't a specific audit on the control and prevention of infection; however the registered manager took action in respect of this matter.

We observed examples where staff involved people in routine decisions and consulted with them on their individual needs and preferences. Staff spoken described how they involved people with making decisions and choices. Discussion meetings had been held and people had opportunity to complete satisfaction surveys.

The MCA 2005 (Mental Capacity Act 2005) and the DoLS (Deprivation of Liberty Safeguards) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. We found appropriate action had been taken to apply for DoLS and authorisation by local authorities, in accordance with the MCA code of practice and people's best interests.

People's needs were being assessed and planned for before they moved into the service. We found the care planning process reflected a person centred approach to care and support. People had been involved as much as possible with planning their care. Systems were in place to monitor and respond to changes in people's needs and circumstances.

Healthcare needs were monitored and responded to. The service had developed good working relationship with health care professionals. We observed people being supported and cared for by staff with kindness and compassion. We saw people were treated with dignity and respect and people indicated consideration was given to their privacy. People spoken with made some positive comments about the staff team at the Clitheroe; they described them as helpful, nice and kind.

Most people made positive comments about the meals provided at the service. We found action had been taken to improve the catering arrangements in response to people's comments. People's individual dietary needs; likes and dislikes were known and catered for. The menus included choices. Various drinks were readily available and regularly offered.

People were keeping in contact with families and friends. Visiting arrangements were flexible. Arrangements in place to provide activities and entertainment; people had mixed opinions about the programme of activities; however we found this had been reviewed and was being further developed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Although people did not express any concerns about their safety, we found there were not enough staff available at the service to make sure people received safe and effective care.

The way staff were recruited was safe as satisfactory character checks were carried out before they started work.

Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures.

We found there were some safe processes in place to support people with their medicines. Some medicine management practices needed to improve and action was taken to introduce safer systems.

Requires Improvement



Is the service effective?

The service was effective.

People's health and wellbeing was monitored and they were supported to access healthcare services when necessary.

Most people said the meals were good and they were appropriately supported with their dietary needs.

The service was working towards meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Arrangements were in place to train and support staff in carrying out their roles and responsibilities.

Good



Is the service caring?

The service was caring.

People made positive comments about the caring attitude and kindness of staff. During our visit we observed respectful and considerate interactions.

People said their dignity and privacy was respected. People were supported to be as independent as possible.

Staff expressed and awareness of people's individual needs, backgrounds and personalities.

Good



Is the service responsive?

The service was not consistently responsive.

Requires Improvement



Summary of findings

Although some people were confident complaints would be appropriately dealt with, we found concerns and complaints were not always properly responded to and managed.

Arrangements were in place to find out about people's individual needs, abilities and preferences. People were involved with planning and reviewing their care.

People had opportunities to take part in social activities. However, the provision of activities was under review in response to people's comments.

People were supported to keep in contact with families and friends. Visiting arrangements were flexible.

Is the service well-led?

The service was not consistently well led.

People had mixed views about the management and leadership arrangements at the service. We found improvements had been made in several key areas. However, there was a lack of clarity around leadership and accountability. There was a high turnover of staff which had an impact of continuity and beneficial relationships.

Requires Improvement



Clitheroe

Detailed findings

Background to this inspection

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

The inspection was carried out on 9 and 13 July 2015. The first day of the inspection was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service, including statutory notifications received from the service and previous inspection reports. We also contacted the local authority's contract monitoring and safeguarding teams and the district nursing service.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection we spoke with six people who used the service and three relatives. We talked with three care assistants, the cook, the handy person, registered manager and two health care professionals.

We spent some time with people observing the care and support being delivered. We looked round the premises. We looked at a sample of records, including three care plans and other related documentation, staff recruitment records, medicines records, consultation surveys, complaints records and audits. We also looked at a range of policies, procedures and information about the services and accommodation provided.

Is the service safe?

Our findings

People using the service did not express any concerns about their safety, security and wellbeing. They made the following comments: “I feel safe here” and “I have always felt safe here.” A visitor told us, “I visit every day; I have never seen any poor practice, no shouting or anything like that.”

We looked at how the service managed staffing levels and the deployment of staff. There were 18 people accommodated with a range of differing needs and abilities. We asked people using the service for their views on staff availability, they made the following comments: “Staff do come (when using the call system) but it takes a long time,” “They don’t have time to do what they should do” and “The staff are run off their feet.”

Prior to the inspection, we received information of concern around the lack of sufficient numbers of staff on duty at the service. The registered manager openly described circumstances where it had been difficult to maintain the necessary staffing levels. This was a result of staff being unavailable for work at short notice. We found processes were in place to try and arrange cover and agency staff were being contracted where possible. We were also told there had been difficulties in recruiting suitable staff. Staff spoken with indicated there had been some improvements in staffing arrangements, however, they said, “I think we need more staff,” “When all the staff are on duty it runs perfect,” and “The only issue here is the lack of staff, when there is not enough we don’t have time to do things.” Relatives described circumstances when there had been only two staff available, however, one told us, “I have noticed some recent improvements in staff numbers.”

We looked at the staff rotas which indicated there were usually three care staff on duty in the mornings, afternoons and evenings, with two staff on duty at night. The manager usually worked each week day and was on call. However there was no specified on site management hours cover at weekends. There were occasions where staff had worked excessive hours and the registered manager had worked ‘hands on’ on the care rota to ensure people’s basic care needs were met. The cooks finished work after lunch; therefore carers also had some responsibilities for cooking at teatime, this meant they were taken away from care duties. There was a cleaner and a handy person employed at the service. However we found the cleaner was working

as a carer and the handyperson therefore had additional cleaning duties, which meant there could be a deficit in the provision of consistent cleaning and general maintenance tasks.

There was no structured process in place to demonstrate how staffing levels had been decided, or were being monitored, to ensure there were sufficient suitable staff available to meet people’s individual needs and to keep them safe.

The registered manager assured us action had been taken to improve the staffing structure. We found progress was being made to recruit additional staff, including carers and a cleaner. A deputy manager was also due commence employment at the service; however we would expect the staffing arrangements to be consistently sufficient and appropriately managed, to minimize and avoid any disruption to people’s well-being and safety.

The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet all the needs of people living at the home. This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found people who used the service were not protected against the risks associated with the unsafe use and management of medicines. We reviewed the medicine management processes and found sufficient progress had been made. We observed people being given their medicines safely and with respect. One person told us, “They bring my medicines on time.”

Processes were in place to support people who chose and were able to manage their own medicines. We discussed with the registered manager the value of routinely completing an assessment, to show involving people with their medicines processes had been effectively considered. We found medicines were being stored safely and securely. We noted the temperature in medicine store was not being monitored and recorded to ensure conditions are appropriately regulated, however the registered manager took action to rectify this matter.

The registered manager described the processes in place to order and manage medicines. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. A new medicine system had been introduced, which included ongoing audits. This was an MDS (monitored dosage system) for medicines. This is a

Is the service safe?

storage device designed to simplify the administration of medicines by placing them in separate compartments according to the time of day. The MAR (medicine administration records) provided clear and detailed information on the prescribed items, including a description of the medicines, dosage instructions, possible side effects, a photograph of the person and a body map diagram for use with topical creams.

All records seen were well presented and organised, complete and up to date. The MAR included entries to verify the specific dosages of any “as necessary” and “variable dose” medicines. There was information in the care records around people’s involvement and support needed with their medicines. However there no defined individual protocols with the MAR. These are important to ensure staff are aware of the individual circumstances this type of medicine needs to be administered or offered. The registered manager took action in respect of this matter during the inspection.

Staff responsible for administering medicines had previously completed medication management training. They had also watched training DVDs on medicines and further training had been arranged with the pharmacist. We found processes were in place to regularly assess staffs competence in this task. Staff had access to the service’s medicines policies and procedures and nationally recognised guidelines were available for reference.

The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. Staff spoken with had an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse and neglect. They told us what action they would take if they saw or suspected any abusive practice. They confirmed they had received training on safeguarding vulnerable adults. We found there was information available at the service on local advocacy services. However, there were no information leaflets from the local authority or health authority on safeguarding and protection, which would help increase everyone’s awareness on keeping people safe.

We looked at how the recruitment procedures protected people who used the service and ensured staff had the necessary skills and experience. We looked at the recruitment records of one member of staff. The recruitment process included candidates attending a face

to face interview and completing a written application form. Most of the required checks had been completed before staff worked at the services and these were recorded. However we noted reasons for leaving their previous employment had not been recorded on the application form; the registered manager was satisfied with the candidate’s account of this matter and assured us appropriate records would be kept. The checks included an identification check and the obtaining of written references from previous employers. A DBS (Disclosure and Barring Service) check had been. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. One person commented, “The home is kept clean” and a relative told us, “Everywhere seems to be clean, usually there are no smells.” We found checks were being carried out on cleanliness and general housekeeping. The borough environmental health officer had given the service a five star rating for food safety and hygiene. There was no specific audit on the control and prevention of infection, however by the end of the inspection the registered manager showed us an audit tool which was to be used for this purpose.

We found health and safety checks were carried out and the registered manager and staff indicated any matters arising were attended to in a timely way. Systems were in place to record and proactively respond to accidents and incidents, including slips, trips and falls. The registered manager told us first aid awareness was included in the staff training programme and action was being taken to access additional first aid training.

Records showed arrangements were in place to check, maintain and service fittings and equipment, including gas and electrical safety, water temperatures, the passenger lift and fire prevention systems. We found fire safety risk assessments were in place. Regular fire drills and fire equipment tests were being carried out. There were procedures to be followed in the event of emergencies. We noted there was no call point fitted adjacent to one shower. We discussed this with the registered manager, who acknowledged our concerns and assured us action would be taken to address this matter.

Is the service safe?

We looked at how risks to people's individual safety and well-being were assessed and managed. One relative told us, "They do risk assessments; I have seen the notes, agreed and signed them."

We found individual risks had been assessed and recorded in people's care records. The assessments included, moving and handling, risk of falls and maintaining safety.

The assessments we looked at were different for each person and reflected risks associated with their specific needs and preferences. Plans had been drawn up to guide staff on how to manage and respond to identified risks. We found evaluation reviews had been carried out on a regular basis.

Is the service effective?

Our findings

The people we spoke with indicated some satisfaction with the care and support they experienced at the service. Their comments included: “It’s okay here,” “I like it” and “So far I’m quite pleased with it.” One relative told us, “I think it’s marvellous, I felt it was like home from home.”

We looked at how people were supported with their healthcare needs. One person told us “They send for the doctor when needed.” We found people’s medical histories and healthcare needs were considered within the care planning process. Arrangements were in place for people’s healthcare needs and general well-being to be monitored. Records were kept of people’s general condition, daily living circumstances and the care provided. Records had been made of healthcare visits, including GPs, the chiropodist and district nurses. During the inspection, a visiting health care professional told us, “They have contacted us when needed and have involved the appropriate agencies.” From our discussions and from looking at records we found people’s relatives had been contacted following any changes to their health and well-being. One relative said, “I have been involved and kept up to date, they ring if there are any issues.”

During the inspection, we observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. People indicated they could get up and go to bed when they chose and could also spend time in their rooms, one said, “I like my room, I can go in whenever, they pop in to see if I am alright.” People’s capacity to make safe decisions and choices about their lives was considered within the care planning process. Staff spoken with expressed an awareness of people’s ability to make choices and described how they involved people with day to day decisions. We noted care plan records included details of people’s individual preferences. We found people had been encouraged and supported to personalise their rooms with their own belongings. This had helped to create a sense of ‘home’, familiarity and ownership.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLS are part of this

legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. There was information to demonstrate appropriate action had been taken, to apply for DoLS and authorisation by local authorities in accordance with the MCA code of practice. The manager also confirmed action was being taken to make further applications. The service had policies and procedures to underpin an appropriate response to the MCA 2005 and DoLS.

We looked at how the service supported people with their nutritional needs. Most people made positive comments about the meals provided at the service. They told us: “The food is alright,” “The meals are okay,” “We are not starving and we get plenty to drink” and “The lunches are quite good.” Some people mentioned that the food hadn’t always been to their liking; however we noted a new menu had been introduced and choices were regularly offered. People said, “The cook asks us what we want,” “They give us a choice” and “Options are given and they will find something else if we want.”

We spoke with the cook on duty who explained the arrangements in place for ordering provisions, offering choices and catering for specific diets. We looked at the recently revised menus, which had been devised to include people’s known preferences and provided more scope for choices at each mealtime. Additional alternatives were also available.

Processes were in place to assess and monitor people’s nutritional and hydration needs. The care records we looked at showed people’s food likes and dislikes had been sought and their dietary needs considered. Nutritional screening assessments had been carried out, with any support needed noted in people’s care plan. People’s weight was checked at regular intervals. This helped staff to monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP’s and dieticians were liaised with as necessary.

We observed the meals service at lunch time. We noted people were sensitively served, supported and encouraged with their meals. Most people ate in the dining room; however meals could be served in people’s rooms also. The meals served looked appealing and plentiful. We saw people enjoying the social occasion of the mealtime experience.

Is the service effective?

We looked at how the service trained and supported their staff. There had been a high turnover of staff and recruitment was ongoing, this meant the delivery of some training had been inconsistent. One person commented, “Staff are not here long enough to go through all the training.” However, arrangements were in place for new staff to complete an initial ‘in-house’ induction. This included an introduction to the service’s policy and practice, watching training DVDs and completing competency work books. The registered manager confirmed action was being taken for all carers to commence an introductory training in care to a nationally recognised standard (The Care Certificate). A training plan had been devised, which identified individual and team learning and development needs, including initial and refresher training. Arrangements had been made to contract with learning providers to deliver training, on key

areas, including moving and handling, safeguarding, dementia and the MCA 2005 and DoLS. A visiting health care professional confirmed they were due to provide some training at the service.

Staff spoken with told us about the training they had received and confirmed there was an ongoing training. The service supported staff as appropriate, to attain recognised qualifications in health and social care. Carers had a Level 2 or above NVQ (National Vocational Qualification) or were working towards a Diploma in Health and Social Care.

Arrangements were in place for staff to receive regular one to one supervision and ongoing support from the manager. This provided staff with the opportunity to discuss their responsibilities and the care of people who used the service. We saw records of supervisions and plans of scheduled supervision meetings. The registered manager told us action had been taken to commence staff appraisals.

Is the service caring?

Our findings

Although there had been ongoing changes in care staff at the Clitheroe, people who used the service made some positive comments about the current care team. They told us, “The staff here are all good,” “The staff are fair good and helpful” and “The night staff are very good.” Two relatives spoken with commented, “All the staff are really nice and kind” and “All the staff are very helpful.” A visiting healthcare professional said, “All the staff are pleasant and approachable, patient care has improved.”

People indicated their dignity was respected. One person told us, “The staff are respectful.” A relative said, “They are very kind and gentle (my relative) has a nice relationship with the staff.”

We observed people being spoken with in a respectful and friendly manner; we saw examples of people being cared for considerably by carers. One relative commented, “The staff here are chosen for their personality.” Carers spoken with had an awareness of people’s individual needs, backgrounds and personalities. They gave examples of how they delivered care and how they treated people with dignity and as individuals. We found people had recently been asked for their views and preferences around the gender of staff providing personal care. Due to the changes in the staff team the ‘keyworker’ system was no longer in operation. This system would link people using the service to a named staff member, to provide a more personal service. However, the registered manager indicated the ‘keyworker’ system was to be reintroduced.

We observed people spending time in the privacy of their own rooms and in different areas of the home. People’s bedroom doors were fitted with suitable locks and people

were offered a key. We noted staff knocked on doors before entering. Carers gave examples of how they promoted privacy within their work, one said, “We always close curtains and use the screening in shared rooms.” We observed people being as independent as possible, in accordance with their needs, abilities and preferences. One person told us, “We can please ourselves what we do” another commented, “I like to do things for myself and I do.” Carers explained how they aimed to encourage people to be independent by promoting self-help and offering choices.

There was a notice board in the home, which provided information about forthcoming events and the programme of activities. Details of the local advocacy services and complaints procedures were also on display. The service had policies and procedures to underpin a caring ethos, including around the promotion of dignity, privacy and individuality. There was a guide to the Clitheroe which included useful information about the services and facilities available; however people spoken with were unaware of this information.

People were encouraged to express their views and opinions during daily conversations. One person told us, “We often have a chat after lunch.” Some people expressed an awareness of their care plans and we noted where possible, they had signed in agreement with them. Although some people we spoke with didn’t recall attending any meetings, we found residents/relatives meetings had been held and the manager indicated further meetings were being planned. Discussion meetings are useful for helping to keep people informed of proposed events, offering people the opportunity to be consulted and make shared decisions.

Is the service responsive?

Our findings

We looked at the way the service managed and responded to concerns and complaints. Comments from people spoken with included, “I would speak to the manager or the owner if I had a complaint about anything” and “I have not had any complaints, but I would tell the manager she would do something about it.” We found information on making complaints was available the service; however one relative said they were not aware of the complaints procedures. We also received comments from people which indicated they were not confident their concerns or complaints would be listened to and acted upon.

During the inspection some of the people spoken with expressed concerns around specific aspects of the service. In particular, around the shortage of staff and staff retention. Some people were dissatisfied with the laundry process, they told us of items of clothing going missing, or not being returned in a timely way. Mention was also made of the slow progress to up-grade and replace some of the furnishings and bedding at the service. We were also made of a specific complaint having been made to the provider and how this was managed.

There were some matters relating to care and support delivery which had been raised with the registered manager, some we found had been resolved to people’s satisfaction. However we looked at the service’s processes for recording, investigating and responding to complaints and found there had not been any complaints or concerns logged for more than 12 months.

People also raised some ‘niggles’ and had unanswered questions around various aspects of daily living, which we discussed with the registered manager. However we would have expected these matters to have been identified and acted upon without our intervention.

This meant the provider did not have suitable arrangements in place for receiving and acting on complaints to ensure they are effectively investigated and any necessary action taken. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found care was not planned in a way to ensure people’s needs were safely and effectively

met. We reviewed the assessment and care planning processes and found sufficient progress had been made. One person told us, “They have been around with the care plan and they asked lots of questions.”

We looked at the way the service assessed and planned for people’s needs, choices and abilities.

The manager described the processes in place to assess people’s needs and abilities before they used the service. The assessment involved gathering information from the person and other sources, such as, families, social workers and relevant others. We noted the assessment had taken into account the person’s needs, abilities and preferences. We spent time in an informal meeting with the registered manager and a relative of a person who had recently moved into the service. The relative expressed satisfaction with the way the admission process had been managed and told us, “I have been involved and kept up to date, I am pleased how they have responded to (my relatives) past history.” Another visitor said, “I am really happy (my relative) has settled in here.”

We found each person had an individual care plan. We looked at three care plans and found they included risk assessments on the specific areas of need often associated with older people. They included information around people’s background histories, preferred routines, likes and dislikes. There were care plans in response to identified needs and preferences, with directions for staff to follow on meeting the needs. Processes were in place to monitor and respond to changes in people’s needs and circumstances. We saw the care plans had been reviewed monthly. Records were kept of changes in people’s circumstances and the care provided. There were ‘handover meetings’ to discuss monitor and review people’s individual’s needs and preferences.

The care planning process reflected a person centred approach to care and support. Information was recorded in a ‘one page profile’. This focussed upon various topics including, ‘things that are important to me’ and ‘how best to support me’. There were care plans relating night time needs, social needs and activities. There was scope for spiritual/religious and cultural needs to be identified and responded to. People using the service and their relatives, expressed a mixed response of their knowledge and involvement with the care planning process. Some people had no recollection of being involved and consulted; however some expressed an awareness of their care plans

Is the service responsive?

and we found where possible people had signed in agreement with them. Carers spoken with confirmed they were aware of the content of the care plans. It was apparent the registered manager was continuing to further develop care plans to include further details around people's needs and preferences.

People had mixed views about the activities provided at the Clitheroe. Comments included, "I get a bit fed up" and "There are not many activities." Staff indicated that they did not always have enough time for activities. However we noted progress was being made. The registered manager had recently implemented a review of the services' activities and engagement programme. This had resulted

in the provision of further individual and group activities. A relative told us, "There are more activities now, bowling, bingo, and keep fit; they are trying to get people to go out more." We noted a schedule of proposed activities was on display. Some people said they had enjoyed playing dominoes, sitting in the garden, a cake sale, reading and various outings. We found positive relationships were encouraged at the service. There were no restrictions placed on visiting; relatives and friends were made welcome at the service. One relative commented, "No restrictions on visiting. They are very welcoming, they offer drinks."

Is the service well-led?

Our findings

People spoken with had mixed views about the management and leadership arrangements at the service. Relative's comments included, "I think the home is well organised and managed, the manager is approachable" and "It's a relaxed atmosphere the manager is hands on and approachable." Staff told us, "The manager is brilliant she gets onto things straight away" and "The manager is very fair and definitely approachable." However some people also made comments which indicated they lacked confidence in the way the service had been run and were sceptical that the improvements would be continued.

There was a manager in post who had been registered with the Care Quality Commission since March 2015. The registered manager expressed a clear commitment to develop the service and described the action taken to make improvements, in particular in meeting legal requirements and responding to people's comments in consultation surveys. We also found action was being taken to develop the management structure and recruit additional staff. A visiting health care professional told us, "The service has definitely improved; the present manager is making in-roads." The local authority monitoring team also indicated progress had been made at the service.

However, we found the provider had not ensured the staffing levels and staff deployment was sufficient and appropriately managed. Recruiting staff and staff retention was problematic. We were told all but two of the carers had changes since the last inspection. We received the following comments, "There have been a lot of changes in staff, it's not a consistent team" and "There has been a high turnover of staff, they are always leaving." This had resulted in a lack of continuity of care delivery and a reduced opportunity for trusting and beneficial relationships. There were no structured plans in place to show how the risks related to staff turnover and recruitment incentives, were to be managed and addressed.

Although the management team structure was under review, at the time of the inspection there was a lack of clarity around the leadership arrangements in the absence of the manager. There were no designated senior staff or shift leaders. One person said, "We don't know who is in

charge, another commented "We wonder what will happen when the manager is not here." We recognised the service was going through a transition, however, more improvements needed to be made.

People using the service had recently been given the opportunity to complete a satisfaction questionnaire. The results from the survey had been collated and we saw the responses were generally positive. A relative commented, "I have been asked if things are okay and completed a survey." Some people had expressed dissatisfaction with the catering arrangements and the provision of activities. As a result of the consultation, we noted positive action had been taken to review these matters and make improvements. However people told us of some concerns and complaints which had not always been proactively acknowledged, managed and responded to. This meant matters may not always be taken seriously and used to develop the service and make improvements.

The registered manager and provider had used various ways to monitor the quality of the service. This included audits of the various systems, processes and the environment. These aimed to ensure different aspects of the service were meeting the required standards. We noted the audits included action plans where any shortfalls had been identified. Arrangements were in place for the provider to review audits with the registered manager. We looked at the service's business development plan which included a programme of ongoing refurbishment.

Staff spoken with described their roles and responsibilities and gave examples of the systems in place to support them in fulfilling their duties, including handover meetings and supervisions. Staff spoken with were aware of the lines of responsibility and told us communication with the registered manager was good. They said they felt supported to carry out their roles in caring for people and were confident to raise any concerns or discuss people's care. They described the registered manager as supportive and approachable. Staff were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns. The service's vision and philosophy of care was reflected within publicity material, policies and procedures and the statement of purpose. New employees were made aware of the aims and objectives of the service during their induction training.

Is the service well-led?

We recommend that the service seek advice and guidance from a reputable source, about the employment and retention of suitable staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not protected from the risk of insufficient numbers of suitably qualified, competent, skilled and experienced staff, deployed in order to effectively and safely meet their needs. (Regulation 18(1)).

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have suitable arrangements in place for receiving and acting on complaints to ensure they are effectively investigated and any necessary action taken. (Regulation 16 (1) (2)).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.