HC-One Oval Limited

Copper Hill Care 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 24 July and 3 August 2018 and was unannounced.

Copper Hill Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Copper Hill is a large nursing home, spread across five separate units located on the outskirts of Leeds city centre. It provides residential services, nursing care services and dementia care services for a maximum of 144 people. This was the first inspection we have carried out at this location since a change to their registration in December 2017. On the first day of our inspection there were 113 people using the service and 115 on the second day.

There is 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.

There were not always enough staff to meet people's needs. The tool used by the provider to calculate staffing had not ensured there were enough staff on one of the units where people living with Dementia and challenging behaviour received care. Staff who worked on this unit told us there were not enough staff. People and relatives also shared these views about staffing.

Since the change of registered provider in December 2017, the completion of staff supervision and appraisals had varied across the five units. records relating to supervision and appraisals was not always complete. Most staff we spoke with did not think the new policy provided them with enough supervision.

Staff training records showed that not all staff had completed training they required for their role.

There were quality monitoring processes in place. The provider had an overview of audits of the service provision and completed detailed checks around any issues raised, to ensure these were addressed. However, issues we found relating to staffing had not been identified through these processes. This meant they were not robust.

A number of the units had not yet transferred paperwork such as people's care records to HC-One (the new provider) documents. Staff told us they had not been given adequate time to complete this but with new admissions were using the paperwork of the new provider.

The provider had a safe system for the recruitment of staff and appropriate checks were conducted prior to staff starting work, to ensure their suitability for the role.

Medicines were managed safely. Staff were knowledgeable and received training around the management and administration of medicines.

People told us they felt safe. We saw there were measures in place to monitor people's safety, such as observation charts and analysis of falls data to identify and address risks. There were risk assessments in place where needs had been identified, for example when a person was at risk of falls.

Staff understood their responsibilities with identifying abuse and reporting safeguarding concerns.

The home was clean and free from odours throughout. Maintenance checks were completed on the building and equipment, with any areas for repair addressed promptly.

Staff received an induction which included training to help them carry out their roles effectively. Training was updated regularly and staff had their competency checked.

Care plans were written using person centred details, care staff referred to these for guidance and updated them regularly in the event of a person's needs or preferences changing. Records were well documented and there was clear involvement with health professionals in a timely manner when assessed and required.

People were supported to attend healthcare appointments.

People were helped to eat and drink enough to maintain a balanced diet. We received many positive comments about the food and people appeared to enjoy their meals.

Staff adhered to the Mental Capacity Act (MCA) and asked for people's consent before carrying out care and support tasks. For people who lacked capacity to make decisions for themselves, best interest decisions were arranged with health professionals and relatives input.

Staff encouraged people to be as independent as they could be and knew people's levels of independence to be able to support them appropriately.

People told us they felt staff were caring, helpful and kind to them. They felt staff respected their wishes and that their privacy and dignity was maintained.

We observed staff to be caring and supportive towards people who used the service. Interactions were friendly and showed us that staff knew people well. People spoke positively about the staff who cared for them.

Policies were in place to support staff in promoting equality and recognising people's diverse needs.

The provider had a policy in place regarding the Accessible Information Standard.

Activities were arranged within the service including exercise, arts and crafts, games and entertainment.

Complaints were responded to thoroughly and efficiently by the management team.

The provider sought feedback from people and their relatives to improve the service.

We received positive feedback about the management team at the service. Staff told us they felt supported

and listened to by the registered manager.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not ensured there were sufficient staff on duty to meet people's needs.

People were safeguarded from the risk of abuse.

Medicines were consistently managed in line with national guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive supervision and training required for their roles.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

People were supported to eat and drink enough to maintain a balanced diet.

People were assisted to receive coordinated care and to access ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People's privacy, dignity and independence were promoted.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

Confidential information was kept secure.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There were arrangements to listen and respond to people's concerns and complaints in order to improve the quality of care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes were in place to assess and monitor the service. However, these were not robust as the inspection team identified concerns relating to staffing.

Care staff understood their responsibilities so that risks and regulatory requirements were met.

The service worked in partnership with other agencies.

Copper Hill Care 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 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 took place on 24 July and 3 August 2018 and was unannounced.

On the first day, the inspection team comprised of two adult social care inspectors, three specialist advisors who were supporting with medicines, nursing care and governance. Three experts by experience also attended on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. All three experts had experience of caring for relatives.

Before the inspection took place, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

During the inspection visit we spoke with 21 people who used the service and with 11 relatives. We spoke with the registered manager, the clinical service manager/deputy care home manager, the head of care, the regional quality director, the area director and the hotel services manager. We also spoke with 15 care staff which included unit managers, nursing staff, care staff, activity staff and a cook. We observed care on all five units of the service which included care that was provided in communal areas. We looked at the care records for 12 people and 57 medication administration records (MARs). We also looked at records which related to how the service was managed including staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

Requires Improvement

Is the service safe?

Our findings

There was not always enough staff to ensure people's needs were met safely. Stokesley and Redwood unit provided care to people with complex needs including dementia and challenging behaviour. Staff told us that people had a level of needs which meant they required at least two staff or sometimes three staff to support them with their care needs. We reviewed dependency rating documents which confirmed that on Redwood unit, four out of eight people required full assistance with all of their care needs. On Stokesley unit, three out of eight people needed full assistance and five out of eight people needed three staff to assist them with their mobility. Rotas we reviewed showed staffing levels across both units were seven staff during the day and five staff at night. However, there had been times when these numbers could not be achieved. For example, in July 2018 there had been 12 shifts, six on each of the two units, which were short of at least one member of staff.

Staff told us some people needed to have staff place them in 'safe holds' whilst delivering personal care. Safe holds are used by staff when a person using the service may show distressed or unpredictable behaviours during the delivery of care. Staff said this often required three staff to ensure this was carried out safely. We saw current staffing levels meant this could not be achieved without leaving other people without supervision. The units often used agency staff but these staff were not trained in 'safe holds'. This meant they were unable to assist the regular staff when caring for people.

On Redwood unit at night there were two staff. The regional quality director told us that staff from Stokesley would provide cover on Redwood unit when needed. Staff told us this was a very difficult situation because it often meant leaving people to assist the other unit, and ultimately meant people had to wait. This often led to people becoming distressed and unsettled.

People who were cared for on these units were not always able, due to their cognitive impairments, to share their opinions with us so we observed care in communal areas and saw staff were very busy.

We spoke with the registered manager about staffing. They explained that they had been very responsive and had supported staff with increased numbers at busy times. We spoke with the regional quality director who showed us how the provider monitored people's dependency and arranged staffing in line with this. They also said that some people's dependency rating documents had not been completed accurately and required updating. We were told an update would be sent to us to clarify people's dependency levels and staffing levels for the units. We did not receive this.

People we spoke with gave mixed feedback about staffing levels. Comments included, "There should be three at night but very often it's two plus an agency person. That means that the two permanents have to keep telling the agency person what to do and also that person doesn't know us very well. That's when I feel vulnerable." "They are short staffed sometimes" and "They could do with a few more staff day and night, but I don't have to wait long if I press my buzzer."

Relatives told us, "I do feel my relative is safe here, everyone is friendly, the only thing is there is never

enough staff. I can always hear someone shouting for assistance when I come." "I don't think there is enough staff here they are on the go all the time. Staff are leaving because of it. There is a high turnover of staff."

All of the staff we spoke with told us there was not enough staff. The use of agency was of concern to most staff as they felt the level of training completed did not ensure they had the correct skills and. Staff also told us that when more than one agency staff was on the same shift it was very difficult for them to work alongside them.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from harm as staff understood safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff had undertaken adult safeguarding training and were confident that any concerns reported to the registered manager or provider would be dealt with. The registered manager had made appropriate referrals to the local adult safeguarding team when necessary and notified the Care Quality Commission (CQC) of any incidents.

Risks associated with people's safety and wellbeing had been identified. These included risks related to mobility, falls, skin care and choking. Steps to manage and reduce risks were reflected in people's care plans. We observed staff using the correct equipment when assisting people to move safely. Staff were competent and ensured each person understood what they were doing.

Medicines were safely managed in line with national guidelines. These included there being a sufficient supply of medicines which were stored securely. They were also kept at the right temperature which is important so that they do not lose their therapeutic effect. The care staff who administered medicines had received training and had been assessed to be competent to complete this task. There was written information about the medicines each person had been prescribed to receive and records showed that these had been administered in the right way. We also saw care staff correctly giving the medicines at the right times. When medicines were no longer needed they had promptly been returned to the pharmacy.

We observed that people's consent was sought when medicines were administered. People who were prescribed medicines on an 'as required' (PRN) basis had proto-cols in place. These provided staff with guidance as to under what circumstances they should administer these medicines. The directions for administering topical medicines, such as creams and lotions, were detailed and well documented. The recordings for topical medicines were consistent and evidenced that the administration guidance was being followed.

Systems were in place to analyse accidents and incidents so that lessons could be learned to help keep people safe. This meant the service could quickly establish why they had occurred and what needed to be done to help prevent a recurrence. An example of this was people who were at risk of falling being considered for referral to specialist health care professionals so that care staff could be advised about how best to keep the people concerned safe.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. Up to date certificates were available for electric portable appliance testing, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists. Risks associated with moving people in the event of an emergency in the home had been assessed. Personal Emergency Evacuation Plans (PEEPs) were in place which provided in-formation for staff to follow on how people should be supported to evacuate in the event of an emergency. A robust business continuity plan

was in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

Prevention and control of infection was appropriately managed. The service was clean throughout with no unpleasant odours. People using the service and visitors said the home was always clean. Staff had access to personal protective equipment, such as gloves and aprons, and we observed them using protective equipment appropriately.

The provider ensured safe recruitment practices were in place to protect people from unsuitable staff. Staff files contained the necessary information, including pre employment checks such as two references; a Disclosure and Barring Service check (DBS) and full employment histories. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the skills and knowledge of the staff. Relatives told us, "The staff seem to be very aware of people's needs so they must have been trained." Some staff told us they felt frustrated about the reliance of 'on-line' and workbook training, and some staff felt disappointed they were not receiving practical guidance particularly in relation to issues with Dementia. Other staff told us they were not sure when they needed to attend refresher training but thought there was a system in place, held centrally, which would alert them when needed. We have referred to staff training more in the well led section of this report.

We asked staff if they had received supervision and appraisals. Supervision is a one-to-one support meeting between individual staff and their line manager to re-view their role and responsibilities. We received mixed feedback from staff across the service regarding the frequency of supervision provided. Some staff told us they received monthly supervision, others said two or three monthly. Two staff said they had only received supervision in a group setting. Records we reviewed supported the inconsistency in completion of supervision and appraisals that staff told us about. We will refer to this in the well led section of this report.

New staff received an induction to ensure they worked safely and effectively with people. This included meeting people, shadowing experienced, staff familiarising themselves with people's care and support plans, policies and procedures and the environment. New staff also completed the Care Certificate (a nationally recognised training course for staff new to care) which enhanced their understanding of the expectations placed on health and social care workers when providing care.

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. We saw that the service had consulted with relatives and healthcare professionals as part of the decision-making process. This ensured that people's previous wishes and healthcare needs were taken into account when making decisions in the person's best interests.

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. The service had made applications for DoLS authorisations as required and the service was compliant with the conditions of the DoLS for each application.

The registered manager and staff were aware of their responsibilities in respect of consent and the need to involve people as much as possible in day-to-day decisions. During the inspection, staff involved people in their care and acted on cues from people with regards to their wishes. People confirmed staff always asked their permission before providing support and respected their right to say 'no'.

People's preferences and special diets, such as blended meals and any allergies, were taken into consideration. Staff completed food and fluid charts and regularly weighed each individual to monitor their health. Comments made by people included; "The food is ok, I like salads but there is always a choice and we have morning and afternoon snacks and drinks" "I think they are a few different things at lunchtime. They ask what you want" and "The food is alright I suppose but it's not cooked like I would do it." People were offered a variety of meal options. In addition, staff told us if someone did not want what was on the menu that day they would provide another alternative. We saw people were offered tea and coffee or cold drinks from a tea trolley during the morning and afternoon. Biscuits were offered in the morning and biscuits or chocolate eclairs in the afternoon. There was also fresh fruit readily available on all units. This meant people were protected from the risks of inadequate nutrition and dehydration.

The service consulted with health professionals in a timely manner. Changes in people's behaviours or conditions were well documented and the service was quick to make referrals. We saw there were referrals to the Speech and Language Therapists (SALT) for people who experienced difficulties with swallowing. The guidance from the SALT referrals was then documented in the care plans and the kitchen staff were made aware. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

Arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included written information likely to be useful to hospital staff when providing medical treatment.

The premises were well maintained and there were large bright communal spaces on both floors. Each unit had a spacious lounge and dining area, all had easy chairs as well dining tables and chairs. There were smaller quiet lounges with easy chairs and small tables for people to use. Communal areas were decorated in traditional style, in keeping with the relaxed atmosphere at the home. The garden space's also provided a pleasant space for people and their relatives. We saw several people and their relatives accessing the garden patio spaces. People's bedrooms were personalised with photographs and personal mementos.

Good

Is the service caring?

Our findings

People told us that staff were very kind, caring and friendly and we saw that interactions were warm. We received positive comments about staff which included, "They're all very nice with us", "It's their job to look after us but they are smashing" and "The best thing is the caring it is really good and I can always chat to staff and they sit and listen."

Relatives we spoke with told us, "The staff are fantastic. I come every other day and I've seen nothing but kindness towards people here", "I think the care is conscientious, caring, kind and tolerant as well as respectful" and "The best thing is my relative is well looked after and is happy here."

During the inspection, many people we observed spent their time sitting in the main lounges and dining rooms in the company of staff. These rooms are large and spacious, bright and well-furnished areas. Furniture was arranged in clusters of chairs and we observed a lot of interaction between people. People told us they had a choice in how they spent their day. Some people chose to stay in their rooms, watching TV, or listening to music. Staff were observed to interact with people in their rooms as they passed by, and there was no evidence of social isolation.

People told us that staff respected their privacy and dignity. We saw that staff knocked on bedrooms doors before entering and closed toilet doors when assisting people.

People's independence was encouraged. A relative told us, "The staff are very supportive and encourage my relative to use their Zimmer frame to get around." Several people used aids to assist with their walking. Staff ensured this equipment was close at hand and on occasion reminded people to use their frame to keep them safe.

Most people we spoke with were not familiar with a care plan, although relatives we spoke with told us they felt involved in the care of their relative and were kept in-formed. One relative said, "I am involved with my relative's care plan and I have a copy of it." Another relative told us, "We had a review of my relative's care plan a few months ago and we are involved in any decision making regarding them."

People had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family, friends or solicitors who could support them to express their preferences. The service had developed links with an independent Leeds based advocacy service. Advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People whose first language was not English were supported by staff, who also shared their language, to have laminated cards to aid their communication with all staff at the service.

Suitable arrangements had been made to ensure that private information was kept confidential. Written records which contained private information were stored securely when not in use. Computer records were

password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

People's needs had been assessed and from these, care plans had been created for each person. Most people and their relatives had been involved in the creation and the reviews of these. People's care plans were detailed and contained clear in-formation about people's specific needs, their personal preferences and routines. Step by step guidance was provided for staff where needed which helped ensure staff fully understood people's needs and ensured people were supported in a consistent manner. This was particularly important for the people who had communication difficulties.

Care plans we looked at contained person centred information about people's life history. There was additional information about any likes, dislikes and hobbies. People's preferences in relation to food and drink had also been captured so that staff knew what people wanted. Each person's care plan was regularly re-viewed and updated to reflect their changing needs.

Care plans provided information about people's sensory or hearing impairment and communication needs. Staff were aware of those people who relied upon hearing aids or glasses to enhance communication. We saw people's glasses and hearing aids were in use, with the person's consent. People had access to health professionals to improve communication, for example audiology professionals and opticians.

Some people were unable to easily access written information due to their healthcare needs. We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 which requires the service to identify, record and meet communication and support needs of people with a disability, impairment or sensory loss. The provider had a policy in place which provided staff with guidance.

People had access to a range of activities available across the service. The service employed activity coordinators who worked across all five units. They told us they were well supported by the registered manager and the unit managers to engage as many people as possible in activities which were meaningful to them. We saw units were decorated with photographs of organised events including, birthday celebrations, visits from school children, valentine's day, afternoon tea in the café based on one of the units, using the garden when families visited or using the indoor garden if preferred. People told us they enjoyed the activities and were given a choice of whether they attended in a group or had time one to one with the staff. One of the coordinators had developed memory boxes with people to go outside their rooms, another coordinator told us about spending time with people one to one in their rooms just holding their hand, which meant more to the person than joining in activities. We saw that twice monthly, a therapy dog visited the service and weekly entertainment took place which people told us they enjoyed and looked forward to.

The service supported people to use technology and equipment. One person was supported by staff to write a daily journal using a lap top. The service worked with a specialist practitioner to purchase a tablet device for a person to aid their communication. Another person had been supported to correspond with relatives via email.

People told us they had felt they were treated fairly and were free from discrimination. They were able to discuss any needs that were associated with their culture, religion, sexuality. We were told a minibus was available for people who wished to attend church services. Staff told us that the needs of other faiths were being met and a priest/pastor was available should people request a visit.

People had been asked about any wishes or religious and cultural needs they would like to see actioned should they require end of life care. Where people had consented to discuss this, detailed plans were in place that covered what support they would like and what they would like to happen following their passing. This meant the provider had all of the information they required to ensure that if anyone were to require end of life care, this would be done in line with the person's wishes. The clinical service manager told us staff had completed a range of training relating to end of life care. The service had good links with the local hospice who had delivered the training. Staff told us they felt good end of life care was provided to people, and were confident in their roles around this.

A complaints policy and procedure was available and this was displayed in the reception area of the service and on each unit. People and their families were given information about how to complain and they told us they knew how to raise a concern and they would be comfortable doing so. Nine complaints had been received by the service between 3 February 2018 and 4 June 2018. The main themes were concerns over the sale of the service and staffing levels. We reviewed responses which showed some evidence of reviews of staffing levels to address concerns raised. All complaints were responded to in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Copper Hill Care Home was purchased by HC-One in December 2017. Since the change of registered provider, a new schedule of e-learning training had been introduced for staff. Training records for staff were presented to us in the form of an electronic document which was kept up to date by the provider's training team. The provider's training schedule consisted of eight modules, one of which was class-room based and one other practical training for fire drills for which all staff had to attend. The training records we reviewed showed that out of 177 staff, there were 68 staff who had still yet to complete any of the provider's training. Only nine staff had completed all the required training. Five of the modules were not available to staff until August and September 2018. We spoke with the registered manager about the training for staff. They said they had not been able to clearly establish current staff training numbers from the new systems. They told us they were worried that some staff may be out of date with training since the change of provider. Issues with training were known to the provider and recorded on the service's home improvement plan.

Supervision and appraisal records were not completed for all staff. Documents we reviewed were in the form of appraisal documents which showed a 'first six months of the year' discussion had taken place. A section titled, 'What has been achieved' What have you enjoyed' and 'What has been challenging' had not been completed on many of the records we reviewed. We also found the documents were pre-prepared for both nurses and care staff which meant it was difficult to establish if supervision, in form of a meaningful discussion, and opportunity for the staff member to discuss any concerns, had taken place. We also received mixed feedback from staff which mainly focused on their lack of clarity around the scheduling of supervisions and appraisals under the new provider. The area director and clinical services manager told us the documentation was not being used correctly or accurately. We also found issues relating to staffing levels across the service which had not been identified by the provider. These are referred to in the safe domain of this report.

As a result, we could not be confident that the provider had robust systems in place to ensure there were sufficient numbers of staff to ensure people's needs were met safely. In addition, we could not conclude that staff were in receipt of appropriate training, supervision and appraisal to enable them to perform their duties.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A quality monitoring system was in place. This included audits from the provider for areas of the service such as falls, infection prevention and control, medicines, and equipment. The information from the audits were collated on a clinical risk register. This was reviewed monthly and ensured the provider quality assurance team had an overarching view of the quality of the service. For example, the number of falls people had were audited and the data was analysed. People at high risk were identified from the data and support systems were put in place, such as sensor equipment to alert staff to the person's movements, or increased observations to reduce the risk of falls.

The service had 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.

The registered manager was aware of their responsibilities to notify CQC of those events that adversely affected the wellbeing of people. Our records indicated that this was done when appropriate.

Staff gave mostly positive feedback about working at the service. Staff told us the registered manager was approachable, visible and would listen to any concerns raised. One staff member told us, "She (the registered manager) is a lovely woman and she genuinely cares about the standard of care at the home. If we go to her and say we are struggling, she will do something about it." Another staff member told us, "There is always a senior manager around. The head of care and clinical service manager are very visible and will always come onto the units and ask how things are going. They listen to staff and understand the issues we have." Staff reported their concerns to us about the future of the service. Some said they were finding it difficult to stay motivated but would not want to leave because of the team, and the people using the service. One staff member told us, "This is the best job I have ever had. The residents are lovely and we work really hard to make sure things are right for them."

People and their relatives gave positive feedback about staff, and the managers of the units. Comments from people included, "The unit manager is very good. I'd give her 12 out of 10. She rolls her sleeves up and mucks in and I don't think she'd ask any-body to do something she won't do herself." Relatives told us, "I didn't want my relative to go into a home but the unit manager here has made all the difference. She is always around and knows my relative's needs. I really trust the staff who work here."

The registered manager told us 'residents/relatives' meetings were held regularly on each of the units. We reviewed minutes of meetings held recently on two of the five units. We saw areas of discussion included the potential sale of the service, food provision and activities. People on one unit had raised an issue about the texture of the soup. This was addressed immediately as the chef was also in attendance at the meeting. Other areas of discussion included planned activities for the coming months. These included celebrating the royal wedding and getting out into the garden with the gardener.

Records showed that a range of regular meetings were held with staff to discuss the running of the service. We observed a daily meeting held in which discussions around people's needs and conditions took place and how best staff could meet and manage them. Handover meetings were also held on each of the units to inform staff coming on duty of people's current presentation. Minutes of other staff meetings held showed that topics discussed included care plans and records, staff training, safeguarding and managing behaviours.

The service worked in partnership with other organisations and professionals to make sure they were following current practice, providing a quality service and the people in their care were safe. These organisations and professionals included social services, healthcare professionals including General Practitioners and specialist practitioners.

All registered providers are now by law, required to display the ratings from their last CQC inspection. This includes information on display within the building as well as on the registered provider's website if applicable. The rating was on prominent display within the reception area.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of staff to ensure people's needs were met safely. Staff were not in receipt of appropriate training, supervision and appraisal to enable them to perform their duties.