Life Care Corporation Limited

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection which took place on 24th & 25th November 2014. Life Care Corporation Limited is a care home for older people and is registered to provide care for up to 41 older people.

The service is provided in a large detached building which is located near to public transport. The home provides a range of services for older people, some of whom may be living with dementia. The home is divided into two units arranged over two floors.

The home is 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 time of the inspection the manager had been working in the home for two weeks following her return from extended leave.

The home had a range of methods to ensure that people were kept as safe as possible. Care workers were trained

Summary of findings

in and understood how to protect people in their care from harm or abuse. People told us they felt safe and could talk to staff and the manager about any concerns they had.

At the last inspection of 9 June 2014, we asked the provider to make improvements to ensure that people were safeguarded against the risk of incorrect use of pressure relieving mattresses and bed rails. This action had been partially completed.

Individual and general risks to people were identified and were generally managed appropriately. However, risk assessment records were not always updated when changes occurred. All of the established staff team members had knowledge of the people and their needs. However, records relating to the support of people did not always reflect the care provided as they were not always accurate or up to date.

At the last inspection of 9 June 2014, we asked the provider to make improvements to ensure that all staff had undergone appropriate checks before they started work. This action had been completed.

The home had a robust recruitment process to ensure that the staff they employed were suitable and safe to work there. The service had a core of stable staff who communicated well with each other and had built strong relationships with the people living in the home. However, there had been a high turnover in staff numbers over the previous six months which meant that not all staff had an in-depth knowledge of people's needs.

At the last inspection of 9 June 2014, we asked the provider to make improvements to ensure where the person receiving care lacked capacity to consent only those lawfully able to give consent on their behalf were involved. This action was ongoing.

The service understood the relevance of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Appropriate actions were taken in relation to people's capacity to consent to a range of decisions relevant to the particular individual. Staff had received generalised Mental Capacity Act 2005 training. This training was an e-learning package completed online. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. Deprivation of Liberty Safeguards DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager, senior staff and some care staff demonstrated their understanding of consent, mental capacity and DoLS. However, although most staff could describe the principles of consent and mental capacity one staff member did not know what MCA was.

The service had involved families and requested best interest meetings where appropriate. For example, an application for urgent authorisation for one person had been made. This concerned divided professional opinion about their capacity to make a decision to leave the home which required a meeting to establish what was in the best interests of the person. The use of bed rails had resulted in DoLS applications being made and these were all recorded in the care plans.

Care plans gave some information on how people gave consent and how staff should support them to make decisions. For example, there were signatures for consent for photographs to be taken. We saw staff giving people choices and encouraging them to make decisions for themselves. All staff told us that they always seek peoples consent with everyday decisions such as what to wear, when to go to bed and what to do with their time. However, no records of these decisions were found in the care plans seen.

People were not given the opportunity to participate in many activities. Generally people were treated with dignity and respect. They were involved in all aspects of daily life and assisted to meet any spiritual, behavioural or emotional needs.

The house was well kept but repairs were not dealt with promptly. Cleanliness was an issue in communal areas and some bedrooms.

People and staff told us the registered manager was very approachable and could be relied upon to respond appropriately to requests or concerns. However, there had been a general deterioration in all aspects of the home during the registered manager's absence.

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?

Requires improvement

People were not always safe.

People's medicines, specifically creams were not always recorded as given to them at the right times or in the right way to keep them as healthy as possible.

Staff knew how to protect people from abuse and people felt safe living there.

Any health and safety or individual risks were identified but written risk assessments were not always up to date or reviewed regularly.

Is the service effective?

Requires improvement

The service was not always effective.

Staff understood and were aware of the need to obtain peoples consent.

People's mental capacity to make decisions and deprivation of liberty issues were documented in care plans.

People were not always involved in the planning and updating of their care.

People were not always helped to see G.P s and other health professionals in a timely manner to make sure they kept as healthy as possible.

The home did not provide an environment at mealtimes which was supportive of people enjoying their food.

Is the service caring?

Requires improvement

The service was not always caring.

Staff treated people with respect and dignity.

People's clothes were sometimes damaged by laundering and people were not always wearing their own clothes.

Staff responded to people with patience and understanding.

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us that their needs were met and staff responded to requests without delay.

It was not always clear if people were listened to and care was delivered in the way that people chose and preferred.

People were not offered many daily activities which helped them to enjoy their life.

It was not clear what action had been taken in response to concerns and complaints about the service.

Summary of findings

Is the service well-led?

The service was not always well-led.

Records were not always up to date and information was hard to find in people's personal files.

People were pleased with the return of the registered manager who was making improvements and trying to make sure that staff maintained the attitudes and values expected.

The home did not regularly check that the home was giving good care.

Changes to make things better for people who live in the home had started and development was continuing.

Requires improvement

Life Care Corporation Limited

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.

This inspection took place on 24th and 25th November 2014 and was unannounced. The inspection was undertaken by one inspector and a specialist nursing adviser. We reviewed information provided in the Provider Information Return (PIR) and from notifications made to CQC by the service. A notification is information about important events which the service is required to tell us about by law. The PIR is a form the provider completes which details information about the service and includes the areas where it performs well and identifies when and where improvements are needed.

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 talk with us. We looked at care plans, daily notes and other documentation relating to people who use the service such as medication records. In addition we looked at auditing tools and reports, health and safety documentation and a sample of staff records.

We had contact with a range of people associated with the service including people using the service and their relatives. We spoke with the manager and staff and reviewed a range of documentation. A community nurse and local authority representatives provided us with information about the home before and after the inspection.

Requires improvement

Is the service safe?

Our findings

At our inspection of 9 June 2014 the provider was not meeting the requirements of Regulation16 HSCA 2008 (Regulated Activities) Regulations 2010. Safety, availability and suitability of equipment. The registered person had not made suitable arrangements to ensure that equipment provided was used correctly (relating to pressure relieving equipment and bed rails).

At our inspection of 9 June 2014 the provider was not meeting the requirements of Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010. Requirements relating to workers. The registered person had not been operating effective recruitment procedures to ensure people employed for the purposes of carrying on the regulated activity were of good character.

The provider sent us an action plan on 22 July 2014 describing how they were going to make improvements to meet the requirements. They were asked to review the action plan and provide specific dates when they would meet the requirements of the regulation. A revised action plan was received on 2 August 2014. At this inspection the provider had partially the requirements of the regulations.

The provider's recruitment processes were thorough. Checks had been carried out to establish the suitability of staff to work with vulnerable people. These included the applicant's conduct in previous employment, physical and mental fitness and the disclosure and barring service (DBS) criminal record checks. Staff told us these checks had all been completed before they began working for the service and they had undergone a formal interview process. We were told by the manager that there were no active staff disciplinary actions taking place.

People told us they felt safe in the home. One person said, "Oh yes, I feel safe alright," and a relative visiting the home commented that she was very happy that her husband was kept safe in the home by the staff.

Risk assessments were carried out for each person but records did not always reflect that assessments were reviewed when any changes to their support needs occurred. The home environment was assessed as well as individual risks such as those associated with moving and handling and assistance with medicines

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Environmental risk assessments included radiator covers, lighting, gas boiler and slips, trips and falls. In addition, areas we saw that were assessed and monitored were wide ranging and comprised areas, such as pesticides, fencing, electrical wiring, smoking, portable equipment, asbestos and use of lift, hoists and wheelchairs.

Various fire safety checks were undertaken including fire doors, call points and alarm tests. Regular fire drills were conducted in the home. We received a report dated 30 October from the Fire Safety inspector that the home had addressed previous deficiencies and he was satisfied that the home complied with relevant legislation.

A maintenance book recorded any necessary repairs. However, there was no systematic way of auditing maintenance issues which were left for staff to report and it was not always clear when issues had been addressed. We were told that maintenance was addressed by regular visits from contracted plumber/electrician and a general handyman.

However, various door handles were broken throughout the home and two dining chairs had broken arms. We were told by the registered manager that these issues had been reported and were awaiting repair. Some staff told us that things had gone downhill since the registered manager had been absent on extended leave. However, there was an air of optimism that things would improve now that the registered manager had returned. One relative told us that there had been a "huge investment in the house in the last 18 months which is appreciated".

Accidents and incidents were recorded but there was no record to show that a systematic review of occurrences took place which could identify trends or patterns. It was therefore not possible to be confident that appropriate action had been taken to prevent further accidents or incidents from occurring.

Before the inspection the local authority commissioning team had raised concerns with regard to staffing levels at the service. The views of staff on staffing levels varied. Some told us that there were generally enough staff, especially if other staff did not call in sick at short notice. One staff member told us "there's enough staff and we work well together". During the inspection we found there were sufficient staff available to keep people safe. The number of staff required was determined by the needs of the people using the service and adjustments were made

Requires improvement

Is the service safe?

to staffing levels if people's needs changed. However, we observed that not all staff appeared to be alert to responding to peoples' needs and required the intervention of other staff to direct them as necessary.

Staff were able to tell us about the signs and symptoms of abuse and what action they would take if they suspected it was occurring. They were confident that the manager would take any necessary action to prevent any type of abuse. The home had a whistleblowing policy which staff were aware of. Staff knew their responsibilities with regard to keeping people safe and one member of staff said, "If anything was going on I'd report it straight away to the manager or if I thought they were doing nothing I'd go to the safeguarding team."

People received their medicines safely. Staff had received training in the safe management of medicines and their knowledge had been tested. Staff told us their competence was checked during observational checks on their work carried out by the senior staff. Medicines were provided by a community pharmacist in a monitored dosage system (MDS). An MDS is a special container, used by pharmacists when filling people's prescriptions. There was one administration and one restock trolley used in the home. We observed the administration of medicines during the lunchtime period. The senior undertaking the task ensured that the procedure was followed accurately. The registered manager told us that there had been no medication errors since the last inspection.

We saw recording sheets in some bedrooms for the application of prescribed creams. These creams were recorded on medication administration records (MARS) but were not recorded as applied on the recording sheets in some bedrooms. The application recording sheets lacked clear instructions about how and where to apply the creams. Community nursing services told us that there had been delays in reporting tissue damage to them.

Before the inspection a district nursing manager told us that they had concerns about the infection control procedures in the home. During the inspection carers were seen wearing aprons when assisting people. Gloves were put on to assist someone in the toilet. There was an infection control checklist in place which staff were required to complete when various tasks were completed. However, this was not dated and actions identified were not signed as completed.

The cleanliness of rooms was raised in quality assurance questionnaires and in discussion with relatives. Feedback included "Sometimes rooms could be cleaned better. Cleaner seems to use water for floor which does not address any odours" and "Only improvement is the cleanliness of bedrooms". The lifts were collecting debris in door sliding areas and there were used tissues under the beds in some bedrooms. We were told by the registered manager that there were plans to use a specialist company for management of odours.

One cleaner had been employed for a month. There were cleaning schedules in place to ensure that all tasks were signed as completed. However, these records had not been signed for the previous four weeks and no spot checks had been signed for as required by the home's quality assurance processes. Cleaning products were obtained from the local supermarket with alcohol wipes, gloves and aprons being supplied by a specialist supplier.

The provider had appropriate plans to manage emergencies in place. These were recorded in a Business Continuity Plan. This provided staff with direction to ensure people's needs would continue to be met during and after an emergency. It was noted that no arrangements for alternative accommodation was included in the evacuation plan in the event of serious incidents such as flood or utility breakdown. Staff were able to describe the action they would take in the event of an emergency such as fire.

Requires improvement

Is the service effective?

Our findings

At our inspection of 9 June 2014 the provider was not meeting the requirements of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010. Consent to care and treatment. The registered person had not made suitable arrangements for establishing the consent of people to their care and treatment, or the consent of another person lawfully able to provide consent on that service user's behalf.

The provider sent us an action plan on 22 July 2014 describing how they were going to make improvements to meet the requirements. They were asked to review the action plan and provide specific dates when they would meet the requirements of the regulation. A revised action plan was received on 2 August 2014. At this inspection the provider had met the requirements of these regulations.

Some people told us: ''the food is good'', "no problems with meals". Others told us that they were not offered a choice and there were a lot of processed foods used. People were asked for their preferences each morning for the main meal of the day. In one of the dining areas people were not offered choices of food. However, staff reported that many people had forgotten what they had requested but there were always alternatives on offer. One staff member told us that the food needed to improve as there was no real choice and there were was no choice at all at breakfast. There was a four weekly rolling menu in place and food was ordered from a local supermarket each week. Any specific dietary needs were planned with input from dieticians.

Lunch was scheduled each day for 12 mid-day. Following tea time additional snacks were offered at 7pm. There were coffee and tea dispensers available in the dining area where people could help themselves to drinks. Care staff undertook the preparation of the meals. Some staff told us that they enjoyed the cooking whilst others said it could leave them short of carers to fulfil their caring responsibilities. Fruit was available in the conservatory and one person's relative told us that he saw fruit was offered during mealtimes when he visited. We saw drinks being offered at various times throughout our visit.

The provider had plans to engage a private company to bring pre-chilled meals into the home starting in January 2015. Preparation for this change had included meetings with people and their families to seek their views and tasting sessions had started to obtain feedback about peoples' preferences and the overall quality of the food.

One relative told us that he was not sure if the water in his mother's bedroom had been there for more than a day. Fluid charts in some bedrooms had not been fully completed. When we asked staff about this they said that some staff were good at filling them in but others were not.

People were assisted to eat their meals by care staff, if required. We observed that staff encouraged people to eat their meal and offered them alternatives if they were reluctant to eat what they had chosen earlier. Some staff interacted with people positively, for example, asking if people were comfortable and explaining what the food was. They treated people with respect, used quiet calm voices and behaved professionally.

The layout of the dining area was open plan with the lounge seating area. This arrangement did not offer everyone the opportunity to eat their meal at a dining table. We were told that those people who sat in an armchair with a small table chose to have their meal that way. We observed toward the end of the meal that someone wanted assistance to go to the toilet. They were told that they needed to wait as someone was using the toilet. There was only one toilet for communal use on the ground floor. This meant that people whose bedrooms were on the first floor did have to wait to use the toilet when the communal one was occupied.

The service used a recognised system for recording people's health needs and the outcome of consultations with health care professionals. Records noted healthcare appointments and any necessary follow up actions. Referrals were made to other professionals such as GPs, tissue viability nurses and the mental health team. Visits by chiropodists, district nurses and G.Ps were recorded.

Information received from health professionals noted that there were sometimes issues with moving and handling due to staff not understanding what was required. There were also communication difficulties with some staff due to language barriers. The staff we spoke to were able to give a good account of peoples' needs and said they knew where to look in the care plan if they needed more information. Alternatively they said they would ask a colleague before providing care when unsure of what was

Requires improvement

Is the service effective?

required. However, we noted that monitoring charts for the use of creams and fluid and food intake records were not always being kept up to date. Some staff reported that others "didn't bother". This meant that some people could be at risk of skin tissue break down before appropriate health care professionals could be alerted.

The registered manager told us that they were arranging for one GP to be allocated to the home who would visit regularly. This would support consistency and provide a more responsive service to peoples changing health needs. An enhanced services care plan was being introduced for those people with high care needs. It was hoped that the proposed arrangements with a single GP would provide appropriate regular and up to date information about those people's particular changing health care needs.

The home had an induction programme for new care staff. This included the use of various formats such as DVD's and e-learning which was tested by questions and independently analysed by a third party. Training covered a wide range of topics including dementia, safeguarding, Mental Capacity Act (MCA) and first aid. One staff member told us that they had not received a proper induction and had been: "thrown it at the deep end".

Care staff told us that there were opportunities for ongoing and additional training. They gave examples of core training such as safeguarding, moving and handling and first aid. They also said that they received specialised training such as dementia care, food hygiene and care planning. Some staff had completed National Vocational Qualifications at level 1 and level 2. The registered manager had undertaken training for train the trainer for manual handling and first aid. She told us that further in house training was planned.

There was a staff supervision and appraisal system in place. However, most staff had not received regular formal one to one discussions with their manager or received an annual appraisal of their performance. We were told that this had come to a stop when the registered manager went on extended leave earlier in the year. Staff were very optimistic that with the return of the registered manager these support meetings would commence again. Generally staff felt supported and said they could speak to more senior staff if they had concerns or questions.

Some staff told us that they worked long shifts. For some this was out of choice and they said they would raise an issue if they found difficulties with working long periods of time. However, other staff said that they had not had any choice and found the long shifts very tiring. These individuals had been recruited whilst the manager was on maternity leave. Some staff said that there are no scheduled breaks for staff and they had to grab a drink when they could.

Requires improvement

Is the service caring?

Our findings

People who lived in the home and their relatives told us: ‘‘the staff are all lovely’’. Another said: ‘‘I’m happy here’’. They told us that the staff were very caring and kind and ‘‘treat us well’’. One person said: ‘‘if you can’t be in your home then this isn’t a bad alternative’’. Staff interacted positively with people at all times. People were treated with respect and dignity. Examples included a member of staff interacting with someone who was upsetting another person whilst they were having their toast. The staff member was smiling and spoke quietly and politely to the person and guided them gently to a chair leaving the other person in peace to eat their food. Throughout the visit staff were generally positive and caring. Some laughed and joked, appropriately with people and their attitude created a relaxed and pleasant atmosphere.

Staff were able to explain how they protected people’s dignity and how important it was to respect people and their differences. Examples given included respecting people’s choices about what they wanted to do, however, we noted that daily notes in care plans did not include entries about what choices people had made about daily living.

There was a dedicated laundry person who had been in post a very short time. Before this appointment it was the care staffs responsibility to do the laundering of clothes and bedding. People were wearing clothes which had clearly been ruined in hot washes. Several people had cardigans on that were stretched and baggy. One person’s cardigan and their slippers were dirty. Relatives told us: “Clothes seem to disappear”. “They would look better if they were ironed.” Others said: “Sometimes she wears other people’s clothes. The other day she was top to toe in clothes that were not theirs. Socks and clothes go missing all the time.” Relatives told us that clothes were all marked with their names. Another told us that she had received reimbursement for clothes which had been ruined in the wash.

People were helped to maintain relationships with people who were important to them. Relatives and friends were welcomed to the home and there were no restrictions on times or lengths of visits. Family members told us: ‘‘we always feel welcome whenever we visit’’. Staff were knowledgeable about the needs of people and had developed good relationships with them. Staff told us: ‘‘the care here is very good. We do care’’.

During lunchtime most staff were able to identify when people needed help even when they did not or could not ask for it. Some staff were directed by others to provide assistance to certain individuals. They asked people respectfully if they would like help. They showed patience with people who needed assistance but who were resistant to receiving it. For example when an individual indicated they did not want to eat the staff member assisting them spent some time gently persuading them to eat a little.

We noted that there were no napkins or condiments on the tables at lunchtime. A television was on in the background in the relaxed lounge area of the room where people were having their lunch. Overall the layout of both dining areas was not inviting or appealing in order to support a relaxed mealtime experience for people. In one of the dining areas we noted that people were not offered a choice of food.

Despite staff saying that people were involved in decisions about their care there was little evidence of their involvement in the care plans we reviewed. People had not signed their care plans and there was inconsistency in the completion of documentation. Some care plans noted people’s spiritual and cultural needs. Not all care plans included end of life care wishes. A care plan for a person receiving end of life care had not been updated. Do not resuscitate forms were completed appropriately. They noted the discussions the G.P had with individuals, families and any other relevant parties. All staff had received equality and diversity training.

Requires improvement

Is the service responsive?

Our findings

Each person had their own individualised care plan which included areas which described people's tastes, preferences and choices about how they wished to be supported. However, these were not always fully completed. Staff who had worked in the home for a length of time told us that they knew what people liked and newer staff would either ask the individual or seek advice from more experienced staff. We observed a new senior member of staff reminding other staff about good care practice such as responding to a person who needed the toilet. Staff said they read care plans and were able to describe people's needs. One example included a staff member who described a person's eating needs and what the guidelines for this person were recorded.

Relatives said they were consulted and were informed when people were unwell or their needs changed significantly. There was a care plan review process but the plans did not demonstrate that regular reviews had taken place. Risk assessments were often generic and not individual to the person. However, we saw a falls risk assessment for one person where the needs were recorded in the care plan. People's views on their care, if they were able to express them, were sometimes noted. It was not always clear how much input people had with regard to the review process. Some family members told us that they were asked about their relatives care but did not always understand what a formal reviewing process was. Community nursing services told us that they thought the care planning documentation for individual people was poor.

People and their relatives told us there were few activities organised in the home. It was the responsibility of the care staff to run activities and they told us that they were often completing documentation when they should have been doing timetabled activities. We noted that throughout our visit radios and televisions were almost constantly switched on. Staff told us that this is what some people chose. During one timetabled activity staff were updating notes and simply put music on and gave some puzzles and magazines to some people. We were told that there were plans to appoint a dedicated activities organiser on the 1st December.

Life story books had been implemented for some people and there were plans for everyone to have a record of their past lives, interests and hobbies. There was an activity file for each person which included an evaluation of likely activities individuals might enjoy. This was for the new activities co-ordinator to take forward. One relative said: "singing would be good as that always seems to go down well. But I don't know if they do it". Another relative said they had seen some activities going on when they visited and on one occasion there was card making. Residents meetings were held however, minutes for these meetings could not be located. One relative confirmed that they had attended a recent meeting which had been helpful in providing information about what was happening in the home.

People and their relatives told us they knew how to make a complaint and wouldn't hesitate to do so, if necessary. Relatives said they had raised issues and either the provider or the registered manager had responded quickly to resolve the concern. One relative said "the provider has fallen over backwards to assist. My husband is now very happy". The home had a complaints procedure available to people and their families. There was a complaints book but it was empty. There was some misunderstanding of what constituted a complaint. It was considered that only written formal complaints to the home needed to be formally recorded as such. Any other matters of concern about the home from the people, their relatives or other health/social care professionals where addressed by the management team. However, the registered manager was unable to provide reassurance that all matters of concern were responded to appropriately and according to their complaints policy from the available documentation.

Requires improvement

Is the service well-led?

Our findings

The registered manager had returned from extended leave approximately two weeks before the inspection visit. People, staff and relatives told us that the registered manager was approachable and already the home was picking up again now that she had returned. One relative said “she is very nice and tries her best. She is very approachable”. “Things are already getting better now that she’s back”. Staff said “we have a good staff team and now that ‘name’ is back things will improve”. It was clear from discussions with the registered manager that she knew the people in her care and their needs very well.

The home had held residents and relatives meetings to discuss meals and nutrition and social activities. There were invitations for meetings held in September and October. We were told that no one had turned up for one of the meetings. The registered manager told us that she sought informal feedback from relatives whenever she could whilst they were visiting. This was confirmed by the relatives we spoke to.

Staff meetings were held and the minutes for meetings held in July, September and November were completed and provided. Topics included safeguarding issues, ensuring people’s needs were met and that management were alerted to any significant changes in people’s health or wellbeing. Staff were reminded to follow dignity and privacy guidelines and to ensure that all documentation was updated appropriately.

The service had a variety of internal reviewing and monitoring systems called Quality Managers Audits to ensure the quality of care they offered people was maintained and improved. However, very few of these processes had been followed in the registered manager’s absence.

The registered manager was aware that the culture within the home had changed and staff were working in a reactive way whilst she had been on leave. Staff were not always clear about their roles and who was responsible for doing what. There had been a high turnover of staff which had undermined the consistency of care. Staff had not always felt supported. Formal support in the form of one to one meetings had been very inconsistent and for some staff non-existent. However, we found that overall staff were positive and caring towards the people in their care.

People’s needs were not always accurately reflected in care plans. All care plans followed a similar format but it was not easy to cross reference with other records such as accidents and incidents. This made it difficult to check important information quickly and ‘track’ any changes to the care plan.