Norse Care (Services) Limited

Ellacombe

Inspection report

Ella Road
Norwich
Norfolk
NR1 4BP

Tel: 01603613173
Website: www.norsecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 10 and 12 May 2016 and was unannounced. The service provided accommodation for up to 42 people who require nursing or personal care. There were 40 people living in the home when we inspected, some living with dementia.

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 was a registered manager in post.

The home was safe and staff understood their responsibilities to protect people from harm or abuse and had received relevant safeguarding training. Staff were confident in reporting incidents and accidents should they occur.

There were effective processes in place to minimise risk to individuals. Assessments had taken place regarding people's individual risks and clear guidance was in place for staff to follow in order to reduce risk.

Staff had received some training in areas specific to the people they were supporting and this helped to make sure that people received care individual to their needs. However, there were some areas where improvements to staff competence were needed.

Staff understood the importance of gaining people's consent to the care they were providing to enable people to be cared for in the way they wished. Applications for the lawful deprivation of people's liberty (Deprivation of Liberty Safeguards) had been made and staff promoted choice where people had variable capacity. The home complied with the requirements of the Mental Capacity Act 2005 (MCA).

People were supported to access healthcare wherever necessary and in a timely manner. People's nutrition and hydration needs were met, however drinks were not always available to everyone throughout the day.

People's privacy and dignity were promoted and they had good relationships with staff who were kind and caring towards them. People were encouraged to be as independent as possible and make their own choices. At times people had to wait for a long time for their call bell to be answered, so their needs were not always met in a timely manner.

Staff had good knowledge about the people they cared for and understood how to meet their needs. People planned their care with staff and relatives.

There were not enough hours dedicated to the provision of activities in the home so people were not always supported to maintain any interests.

The management team was visible throughout the home and people found them approachable. They found the registered manager was responsive in addressing any concerns. People were encouraged to provide feedback on the service.

There were some systems in place to monitor the quality of the service and these were used to develop and improve the service, however there were some areas where improvements were needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by a sufficient number of competent staff. Staff had a good awareness of how to keep people safe.

Medicines were managed and administered safely.

Risk assessments were in place for individuals and their environment and these were followed and reviewed to minimise avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought consent, and people were supported to make their own choices. Staff had some effective training but improvements were needed in the area of continence care

People had access to a choice of nutritious food, however drinks were not always available throughout the day to everyone.

People had timely access to healthcare services and staff followed advice given from healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Staff respected people's privacy and dignity.

People were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not enough time dedicated to activities, therefore people were not always stimulated and supported to follow their interests.

People's needs were not always met in a timely way.

Staff knew the people they were caring for well and reported any changes or issues promptly, therefore were responsive to people's changing needs.

People and relatives were involved in their care planning. People knew how to raise concerns and these were acted upon.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The provider had some effective quality assurance processes which helped improve the service, however there had been some concerns which were not picked up.

The culture of the staff in the home was improving. Staff morale had improved following recent changes and were developing their work as a team.

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Detailed findings

Background to this inspection

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

The inspection took place on 10 and 12 May 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with eight people living in the home and eight visitors. We spoke with two visiting healthcare professionals and nine members of staff in the home. The staff we spoke with included the registered manager who had been in post since January, the deputy manager, two team leaders, three care workers, a domestic worker and an additional team leader who also worked for eight hours as an activities coordinator.

We reviewed care records for five people who lived at the home and checked a sample of medicine administration records. We reviewed a sample of other risk assessments, quality assurance records, recruitment files and health and safety records. We looked at staff training records and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

One person told us, "The staff make me feel happy and safe", and this was echoed by others who lived in the home that we spoke with. Staff knew what signs to look out for in cases of suspected abuse, and were able to tell us how they would report any concerns, and who to. There was additional information about this in staff rooms within the home with contact details. We saw that staff knew how to carry out processes that were in place in order to protect people from abuse or harm, which contributed to people's safety.

One person told us, "Yes, I'm quite happy and safe, I had several falls before I came here. [Manager] has it that one person walks with me all the time". People's care records contained individual risk assessments of their mobility. Where people had sustained a fall, associated action plans were in the care plan resulting from it. Risk assessments had been carried out in other areas including for people's nutrition and pressure care. Staff were able to tell us how they look for any pressure areas, one team leader told us, "I think we're excellent on pressure care, as soon as anyone sees anything they tell us". Where needed, additional equipment such as a pressure relieving mattress had been supplied. Systems were in place to minimise the risk of people developing pressure ulcers, and where a risk had been identified by staff, prompt action was taken. However, there were no risk assessments in place for more detailed aspects of people's personal care, mental health and continence. This meant that there was a risk that people were not assessed properly in terms of their mental and emotional wellbeing.

There were risk assessments in place for the building and environment, including building work which was underway at the time of the inspection. Lifting equipment, heating and electrical equipment had been tested. We found that equipment for detecting, preventing and extinguishing fires was tested regularly and that staff had training in this area. Each person living in the home had a risk assessment in place and there was information for the fire service on evacuating people individually. We saw that equipment identified as part of this risk assessment was available.

There were enough staff to meet people's needs. Most staff we spoke with confirmed that there had been recent increases in staff numbers. Two visiting healthcare professionals told us that they had not seen evidence of staff shortages. Staff reported that certain times of day such as mornings and evenings were more difficult and referred to not having enough time to spend with people in addition to providing care-related tasks. They said that they felt rushed at times and did not have additional time to talk with people. The manager said that the additional hours advertised for evening staff and activities would help with this. During the day of the inspection we observed that during the morning one person waited thirteen minutes for their bell to be answered. Staff were attentive to people's needs when they provided care for them.

We looked at the staff rota and saw that staffing levels had improved recently. The manager told us that they had just advertised for two additional vacancies to cover evening shifts, mealtimes and activities. In the meantime, the manager told us they were staffed according to their dependency tool, appropriately. They said that the extra care hours would be to take any strain off the care workers. The activities were being covered for 16 hours per week . They had also advertised for an additional activities person for six hours daily which may assist with mealtimes. With regards to maintaining expected staffing levels, the manager

showed us a dependency tool which they used to determine staffing and allow hours for people with higher dependency and people living with dementia. We concluded that there were enough staff to ensure a safe standard of care was maintained. We found that although at times staff were under pressure, it did not impact negatively on people's safety at the home.

The provider's recruitment policies and induction processes were clear and so contributed to promoting people's safety. Staff confirmed that they had not been allowed to commence work until relevant checks and training had been completed, and records reflected this. We looked at three recruitment records and found that appropriate checks were made before staff were recruited, such as criminal record checks and references. The registered manager told us that volunteers went through the same checks as permanent staff, and were not allowed to work within people's own rooms. This showed that an appropriate approach had been taken to maintain a high standard of care and that only people deemed suitable, in line with the provider's guidance were working at the service.

People were given their medicines in a safe manner using a comprehensive system administered by staff that were trained to do so. New staff shadowed others on medicines rounds before being observed by more experienced staff and being deemed competent. People living in the home confirmed that staff supervised them taking their medicines, and that they knew what they were taking and what for. Regarding 'as required' medicines, these were clearly recorded and one person confirmed that they were always offered it, saying, "I feel well looked after, they give me paracetamol for my back pain, I take it several times and it does help".

There was a storage room for medicines and this was kept at the correct temperature. Other creams, lotions and ointments were kept in cupboards and clearly labelled. However, the medicines trolleys that were used regularly throughout the day by team leaders were not always locked away securely when not in use. This was not in line with the policy which stated that they should have been locked either against a wall or in a room. Some people living in the home had the opportunity to administer their own medication and this was stored and recorded appropriately.

There were red tabards available for staff to wear during medicines administration, which they did not use. The manager told us these should have been used, and would have facilitated understanding for the people living in the home that staff were undertaking the medicines round. The risks of being interrupted during the medicines round was therefore increased as there were three different members of staff doing the medicines rounds on one floor at the same time, which could be confusing when people are sitting in different rooms.

We looked at a sample of medicines administration records and found that they were detailed with pictures of each person on the front of their individual sheet along with information such as how they preferred to take their medicine. The front sheet included succinct details such as allergies people had, which were repeated on each page of their medicines chart. This helped to minimise mistakes being made by staff. Staff audited the signatures within the charts every week, and this had reduced instances of missed signatures. However, there were still some missed signatures for eye drops and inhalers in the sample that we looked at. This meant that there was a risk of not knowing whether or not somebody had received the medicine. The manager stated that it was difficult to know who had made the mistakes, and that the improvements within the area of medicines administration were still on going. They stated that they had made a lot of improvements already in medicines administration and increased staff accountability which had helped.

Requires Improvement

Is the service effective?

Our findings

One person living in the home told us in relation to receiving personal care, "Some of the carers leave a lot to be desired, they haven't had the training". This was confirmed by two members of staff and another person living in the home, who raised some concerns regarding continence aids such as catheters and stomas. Some people told us that this happened more with agency staff being on shift. One person living in the home told us this had caused them some discomfort. The risks of not having training in catheter care could increase risks associated with infection and discomfort for people. Staff told us that several staff members did not know how to fit catheter bags properly and that they had not asked for help from more experienced staff with it. Although staff had received valuable training some staff would benefit from further training in continence aids. The manager informed us that she would organise some relevant training straight away.

The mandatory training for care staff deemed necessary by the provider included manual handling, infection control, food hygiene, dementia, first aid and fire safety. Some training was shown to have expired according to records and the provider's policy, but these had been booked for staff to attend soon. Staff had received some specialist training which they were able to tell us about, including how it had helped their practice. This included dementia training, training in older people's vision and training in swallowing difficulties. One member of staff explained how they approached people only from the front and be at eye level following the vision training, and how they communicated better with people living with dementia following training. They said, "It's changed the way that I see dementia". Another member of staff described how following dysphagia training, they were more confident to administer thickening products safely. Some staff members were studying for the Care Certificate, which is a qualification in health and social care. This enabled staff to be supported in becoming qualified in their field.

Staff told us they had supervisions and appraisals in place in order to discuss progress, concerns and any further training. We spoke with two members of staff about their induction, which they reported included shadowing more experienced staff, training and being observed by senior staff. Records confirmed this. New staff were subject to a probationary period, when their skills were reviewed, and they received feedback on their practise by senior staff. The manager told us how they worked to people's strengths and acted on any concerns. The staff we spoke with said they felt that they were well supported to carry out their roles, and that senior staff were supportive throughout the induction period and when they were undergoing further qualifications such as the Care Certificate.

Drinks were regularly provided in communal areas, and there were kitchen areas that visitors could use to make drinks. One visitor told us that their relative had not been able to have a hot drink at night. At the time of the inspection drinks were given to people at timed intervals, and offered by staff when they assisted people. We observed that at times people were left in communal areas without drinks, and after one person said they were thirsty, staff told them drinks would be around in ten minutes for the morning tea round. This approach to drinking at certain times could put people at a disadvantage if they want drinks outside of these times. The manager told us that they were planning to put trays of jugs and water in all the lounges so that people could help themselves whenever they wanted. This would make an improvement as people were offered drinks by staff but were sometimes constrained by drinks times.

Feedback about the food was mixed, with people living in the home saying that there was not enough variety. One person said, "Tea time there's no variety at all", and another said, "I prefer breakfast to lunch, but we don't get much variety, two cooked breakfasts a week, Wednesday and Saturday". We looked at the menu for the month and there were two choices for lunch every day, which people and staff confirmed. People living in the home told us that there were not always snacks available during the day, except for biscuits when they came round. A visitor to the service said, "The only complaint [relative] would have would be the food", and went on to say that it was bland. The manager was in the process of implementing a questionnaire to ask people about the food in order to give people more of what they wanted.

People told us that the cook understood their dietary needs and preferences and staff confirmed this. We spoke with the cook who told us that there was good communication with the staff and the kitchen regarding people's needs and preferences. The manager stated that plans were underway to improve tea times and include a hot option, and become more flexible with the times, so that it could be later if people wanted.

Fluid and food charts were used by staff when appropriate. One food and fluid chart we looked at had one documented refusal recorded, and the other entries were all the same food at different times. There was some inconsistency in recording food and fluids, which could pose a risk of dehydration or staff not knowing if somebody had eaten a meal or not. However, staff told us that they communicated verbally in between shifts about the person's intake and that people were being weighed regularly in order to review needs.

People's weight and nutrition were reviewed monthly within their daily care records, or whenever there were concerns. One care record we looked at showed that the person had been referred to a dietician following weight loss. We saw that people were assessed and reviewed when appropriate in order to maximise their hydration and nutritional health, and relevant healthcare professionals were referred to. The manager had recently ensured that nutrition and hydration were focussed on and acted upon which was a result of an action plan they had made when they started in the home.

We observed that staff sought consent from people during care such as supporting people to eat or when giving medicines. They asked them if they wanted to wear something to protect their clothing and where they wanted to sit. One person said, "[Staff] come and ask you what you'd like from the menu, they have a menu with pictures – they give you a choice of dessert". People were given a choice of food and drink at meal times, or in the morning if they chose to eat in their rooms. All the food was cooked on the premises. This meant that food was fresh and there was some flexibility in terms of what could be made for people.

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 interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that where mental capacity assessments had been carried out, they allowed for people's fluctuating ability to make different decisions at different times. Staff told us that they assumed people had capacity for their day to day decisions and gave choice. The manager told us that some people in the home

had been subject to a DoLS application due to their capacity and safety, and we found that the DoLS applications were detailed. Staff acknowledged the importance of making best interests decisions where people had fluctuating capacity.

People told us that they had regular access to healthcare. One person said, "They'll get a doctor for you, I have my own doctor, and the chiropodist comes once a month". People were referred to the falls team when required. One visiting healthcare professional said, "There hasn't been a time when my recommendations haven't been acted upon". Where the home was having problems accessing healthcare due to long waits from community teams, they were addressing this appropriately.

Good

Is the service caring?

Our findings

People living in the home said that the staff were caring, and one person said, "Yes, they're always calling me by my name, and they're polite". A visitor to the home told us, "All the care staff are lovely, it's just the way they do things, they just get on with it". This was echoed by another visitor, "The care here is excellent, first class, the whole experience, just the way everyone is very caring, nothing is too much trouble". Visitors felt that most staff enjoyed their job and engaged well with people. One member of staff said, "I have a very good relationship with [people], they tell me things".

There was some inconsistency in the feedback we received regarding the staff. One person living in the home said, "I feel happy, most of the carers are very good". We observed that most staff, when assisting someone in the hoist to move, talked them through what they were doing and reassured the person, chatting to them along the way. Another visitor said, "[Staff] seems to really like their job, seeing how [staff] engages with people and enjoys what they're doing". We found that the majority of people found the staff caring despite the occasions where they perceived that they were rushing.

People's independence was respected and encouraged. One person visiting their relative said, "[Relative] has done really well since they've been here, now [relative] can walk on the ground floor with their walker". A member of staff told us how they supported people to do as much as they could by themselves. People living in the home reported that they usually had the same member of staff to support them to have a bath, and this was reassuring. Where there had been problems with this, they had been resolved effectively, for example with one staff member staying on late in order to assist someone to have a bath. One member of staff reflected that this could provide a good opportunity to chat and really get to know people.

One person described how staff assisted them to make daily decisions, "They ask me what I want to wear, and if it's not clean they tell me and find something different". Staff told us that they offered people choices regarding personal care, and that if they had difficulties with communication, they would show them options to help them to choose. We observed people being given choices during the inspection, and staff supporting people to communicate. One key worker described how they bought their key person some flowers and went to introduce themselves and get to know them

People were involved in planning their care and signed their care plans when they were able. Other family members told us that they had received care plans to look over and comment on where their relative had not been able to.

A visitor to the home said, "Everybody is treated with respect." Staff were able to tell us how they promoted people's privacy when providing care for them , for example making sure that people were covered up and doors were closed when providing personal care. They ensured that they knocked on people's doors. People were supported to maintain their family lives and receive visitors. One person living in the home told us, "[Relatives] come here and have a meal with me, they tell the staff the day before". People were able to receive their pets visiting in the home when they wanted.

Requires Improvement

Is the service responsive?

Our findings

There were sixteen hours a week of activities in the home at the time of the inspection. One person said, "If I didn't have a paper and my word search I'd go mad". People living in the home confirmed that there was a church service on Mondays once a month. A visitor to the home said, "We don't get anything to tell us what's going on – I don't like to think of [relative] sitting there on their own". Other visitors and the staff confirmed that they felt the provision of activities was not enough.

One member of staff said, "People don't get anybody to talk to". We spoke with an activities coordinator who gave examples of crafts and games they played with people and we saw that people were bowling on the day of our visit, which people enjoyed. There was some visiting entertainment, including an orchestra twice a year and a travelling zoo. The home had recently begun a visiting exercise programme and held yearly events such as a strawberry tea. The activities coordinator told us how they chatted to people to get to know what sort of things they liked and what they used to do in order to decide what to do with people. The registered manager confirmed that they agreed that there were not enough hours dedicated to the provision of activities. Following a meeting with the providers the manager had advertised for a further member of staff to support activities daily.

People did not always get a choice about gender specific care. One person said, "They don't ask me, but I don't mind really". One person using the service said, "Sometimes I get a man – I'd rather it was a woman but I don't mind really". A visitor to the service confirmed that their relative would rather have a female carer and did not like having male staff, but that they had not been asked.

Some people living in the home stated how they had to fit in with other people living in the home, one person saying that although there's always a member of staff available, they chose to have the same people, "There's certain carers that get me up – it's my choice, although I have to fit in with others along the corridor". Another person living in the home told us that they would prefer to get up slightly later than they did, "I get up at six but I'd prefer to get up at seven, but [staff] have always got work". One member of staff said that at times people had to wait for a long time in the morning to have their showers because staff were attending to other people.

People living in the home reported that they had to wait at times up to half an hour when they rang their call bell. One person visiting their relative said, "[Relative] has to wait so long when they press the call bell, [relative] gets so frustrated and anxious. The worst time is in the morning, after their cup of tea". Another visitor said, "There's always staff about, the call bells go off all the time, but you always see the staff respond". We observed during the inspection that a person waited for thirteen minutes mid-morning for staff to come to them. This meant that at some times staff were more responsive than others, as there were some particularly busy times, and this had a negative impact on people increasing their anxiety and decreasing their choices.

Each person in the home had a key worker who met regularly with the person they worked with to talk and see if there was anything they wanted to change. One person living in the home said that staff were flexible

and explained, "They tell the staff the day before and they'll have me all ready to go out". In order to further support someone to continue making their own drinks independently, when changes to the building were made the manager had ensured that a kitchen area was replaced. One member of staff said, "I know how [people] like things and their routines, and what makes them anxious". The staff were able to tell us about each individual's changes in needs. The home was responsive to people's changing health needs and staff we spoke we knew people well.

People and their relatives, where appropriate, had been involved in planning their care. One visitor confirmed, "They normally send me a copy of [relative's] care plan, I think it was January". We could see that other people had signed their care records in order to confirm that they had looked through them. The care records we looked at contained some relevant information about people's personal histories, and the manager told us that this would be improved with the activities coordinator going over people's histories with them. Other records such as people's nutritional information and daily needs were recorded in daily information folders. Records confirmed that repositioning charts and recommendations were in place and adhered to by staff. Care records contained detailed information relating to people's basic needs in important areas such as mobility and nutrition and how they preferred personal care. However, the care plans were not well detailed with people's individual continence needs and emotional and psychological requirements. The manager informed us that these care records were still in the process of being improved following the development of new care plans. Staff told us that they knew where to look for information about people's care.

One person told us how the manager had been able to resolve a problem they had. There was a 'concerns' book for when people had feedback or any issues which needed resolving, but had chosen not to go down the formal complaints route. These were recorded in detail and the manager had acted upon them to resolve them. No formal complaints had been received within the last six months by the home. The manager had been responsive to feedback and concerns in order to improve the service. There were resident's meetings which were held, however three people told us that they hadn't been able to understand what was being said. One person said, "I didn't really know what it was about, I couldn't turn round to see them". The person had not been supported by staff to sit somewhere that helped them to see and hear what was going on. People said that they had not fed this back to the manager.

The manager told us that there were some people living in the home with dementia. The staff told us that they had received some training specific to dementia and the manager said they wanted to expand on this. The manager told us that the improvements in the provision of activities were especially important for people living with dementia. The home was having environmental changes and building work done at the time of the inspection to better meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

Staff told us that they felt the team was largely effective and that staff worked and communicated well together. Some staff reported that although the majority of staff worked well as a team, at times there was tension. Five out of eight people living in the home we spoke with raised concerns around the staff having lot of other people to care for. People living in the home told us that they felt the home was short-staffed and staff sometimes rushed about or looked unhappy. This impacted on people negatively as they said they often had to fit around the staff. There had been recent changes to the management team, as well as the environment and staff team and way of working. Staff were able to tell us about the provider's shared vision and values, but some members of staff were experiencing difficulty with the recent restructuring that had taken place.

Team leaders had been given certain areas to champion, such as continence, medicines and infection control. This meant that some staff had more accountability for ensuring that improvements in specific areas were made, and supervising and advising in the areas. The manager told us that identifying champions would make it manageable for people to focus on certain areas of people's care. The continence lead was in the process of gathering information to develop associated plans and risk assessments to go in people's records. However, it had not been identified that improvements in people's catheter care were needed. The manager told us that they would look into training for this as soon as possible. The medicines champion had taken the lead to reiterate the importance of medicines administration and said that they would talk to staff about any mistakes they made. Team leaders were also responsible for checking new staff's competencies and reporting back to the manager if there were any concerns.

The registered manager understood their responsibilities and had made numerous improvements in the home, including increasing accountability for staff. This included increasing staff's understanding of what was expected of them under the provider's core values, and improvements were still underway. The manager told us that they understood this and were in the process of changing the culture following recent staff turnover. Staff told us they felt that feelings in the team were becoming more positive since the present manager had been there.

The manager was visible throughout the home and engaged with everybody living there. A member of staff confirmed that the manager had returned to the home in the evening to support staff during a difficult situation. Another staff member said, "We need leadership, and [manager] is extremely supportive". Other staff reiterated that the manager was always available to be contacted and very approachable. Visitors and people living in the home told us that they felt comfortable to go to the manager with any concerns should they have any. One relative told us they would like to have specific relatives meetings to share ideas.

The deputy manager had been at the home for a week, and had become familiar with some people living in the home and planned to get to know people very soon. They said that they felt people and staff had accepted them well and were supportive. They said that a priority was to support the staff in their roles.

The manager said that they and the deputy manager were happy to help staff during busy times if it was

needed, such as mealtimes. They confirmed that there had been a lot of changes recently and that staff were adapting to changes and new ways of working. The manager told us that they felt well-supported by the regional manager. They were able to hold meetings when they requested with the regional manager. These meetings were used to discuss any concerns such as the home previously having been short-staffed, and requiring more hours for activities. The meetings were effective in resolving these concerns and reaching solutions.

The manager had carried out audits in dignity and medicines and fed the results back to staff. The medicines administration had improved and was still undergoing improvements, including improvements with regard to staff signing for medicines and recording surplus medicines. We saw in records from meeting minutes that progress had been discussed with the team, as well as further improvements needed.

The manager had written an action plan when they started in the home six months ago, and had recorded how many of the actions, or how far along, had been achieved so far. They had developed care plans and increased staffing levels. They were implementing new ways of obtaining feedback from people using the service, for example regarding the food.

The home carried out meetings for people living in the home, however several people said that they could not always fully take part in these. This was either because they had not been supported to sit in a position where they could hear and see everything, or because the speaker had not been loud and clear enough. The manager told us that a new activities person would be included in gaining people's views on the service. The resolutions from concerns raised by people were well documented and the manager had learned from these. An example of this was the allocation of staff at mealtimes, which had been improved.