Methodist Homes

Laurel Court (Didsbury)

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 14 September 2015. We last inspected Laurel Court in May 2014, at which time the home was found to be meeting all standards we reviewed.

Laurel Court is in Didsbury, Manchester and is owned by Methodist Homes. It provides residential and nursing care as well as care for people living with Dementia. The home provides single occupancy rooms with en-suite facilities and is registered with the Care Quality Commission (CQC) to provide care for up to 91 people.

There are four units at the home, known internally as Wilmslow (Privately funded Dementia), Burton (Dementia), Palatine (Nursing and General Residential) and Broadway (General Nursing Unit). At the time of the inspection there were 88 people living at the home, across the four units.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing and Safe Care and Treatment. The breach of Safe Care and Treatment was with regards to Safe Administration of Medication.

Summary of findings

At the time of our inspection, the home manager was not yet registered with CQC and was going through the application process. The manager had worked at the home since November 2014. 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 staff told us they did not think there were sufficient numbers of staff on shift to meet people's needs in a timely way. We were told this by staff working on each unit of the home. In addition some people who lived at the home told us there were not enough staff which meant they had to wait for support at times. Following the inspection, the manager sent us a 'Staffing Guideline' tool which described the ratios of staff required to care for people at the home on each unit. However, this did not consider peoples individual care needs and how many staff were needed as a result.

We looked at how the home ensured people received their medication safely. One person who lived on the Palatine Unit, ran out of their morning medication, which did not arrive at the home until approximately 4pm. This could have placed this person at risk. The morning medication rounds on both Palatine and Broadway did not conclude until approximately 12pm, with staff encountering interruptions on the unit at regular intervals, mainly due to having to provide support to other staff. This meant could have affected people's medication requirements later in the day and placed them at risk.

People living at Laurel Court told us they felt safe. Staff we spoke with were aware of safeguarding procedures and had received training in safeguarding of vulnerable adults. We looked at recruitment records and saw that checks had been carried out to help ensure staff were of suitable character to work with vulnerable people. This included undertaking DBS checks and seeking two written references from previous employers.

The service carried out risk assessments in relation to people's health and care needs and measures were identified to reduce risk wherever possible.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service had made DoLS applications as required. Several of the staff we spoke with felt that more in-depth training in this area would be beneficial to them.

Staff supervision was not always consistent at the home. Some of the staff we spoke with said they had not received supervision for some time. The manager told us they aimed to complete staff supervision every six to eight weeks; however the records we were shown did not demonstrate these had taken place consistently.

The staff we spoke with were able to provide examples of how they sought consent from people who lived at the home. However, on the Wilmslow Unit we observed several instances where people were not always asked for their consent before tasks were carried out by staff. We saw people were not offered the choice of refusal and were spoken to by staff as if they did not have a choice.

Two of the units at the home (Wilmslow and Burton) catered for people living with Dementia and we checked to see what adaptations had been made to make these units more 'dementia friendly' for people. We saw people had specific 'memory boxes' outside their bedrooms to remind them of past life events. However, there were few adaptations to the environment to make it dementia friendly or that would support these people to retain independence within the home. Signage around these units was limited. This meant people could have difficulty finding their way to areas such as the lounge areas, the dining room and bathrooms/toilet areas. People told us they had enough to eat and drink. We saw information was available to help ensure any special dietary requirements were catered for. There was evidence in people's care plans that referrals were made and advice sought from other health professionals as required.

We observed staff interacting with people in a positive, respectful and friendly manner. People told us the staff were kind and caring. Staff were able to describe how they would support people to retain independence.

Summary of findings

However we observed two separate instances where people's independence was not promoted because they did not have their walking frames close to them in order to mobilise Independently.

The service sought feedback from people using the service through surveys and resident and relatives meetings. The last minutes of a staff and relatives/ residents that we were shown were from March 2015. Another residents meeting had been scheduled for the end of September 2015. The manager told us they were looking to introduce a 'You said, we did' system, which would clearly identify how issues that were raised had been responded to.

Activities and stimulation were limited on the day of the inspection. The only activity we saw taking place was baking which was done by the activities co-ordinator. Some of the people living at Laurel Court told us there was not always enough for them to do and staff said that due to current staffing levels at the home, they did not have sufficient time to spend with people and engage in regular conversation.

Accurate records were not always maintained by staff. These related to records for two people who were required to be weighed weekly and one person who was required to be re-positioned through the night. Although these recording systems were in place, we found inconsistencies on certain days.

A range of audits and checks were undertaken by the manager to monitor the quality and safety of the service. The manager also conducted a 'Monthly Watch' which consisted of observations around each unit, to ensure that good practice was prominent within the home. Some of the staff we spoke with said that they did not see the manager enough and that an increased presence on the units was required.

People and staff told us they felt able to approach the manager with any concerns. However, some staff we spoke with felt that staffing levels at the home had been a concern for some time and that nothing was being done to improve the situation.

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?

Inadequate

Not all aspects of the service were safe. Staff told us they thought there were not enough staff available to meet people's needs. They said this could have an impact on the safety and wellbeing of people at the home.

One person who lived on the Palatine Unit, ran out of their morning medication, which did not arrive at the home until approximately 4pm. This could have placed this person at risk due to adequate ordering systems in place. The morning medication rounds on both Palatine and Broadway did not conclude until approximately 12pm, with staff encountering interruptions on the unit at regular intervals. This could have affected peoples medication requirements later in the day and placed them at risk.

Safe recruitment procedures were followed when recruiting staff such as undertaking disclosure and barring service (DBS) checks and seeking references.

Is the service effective?

Requires improvement

Not all aspects of the service were effective. There were few adaptations to the environment to make it more dementia friendly or that would support people to retain independence within the home.

Staff supervision was not consistent. Some of the staff we spoke with said they felt that supervisions were not regular enough. The records we looked at also confirmed that supervision did not always take place on a regular basis.

The staff were able to identify ways in which they sought consent from people. However we observed three separate instances on the Wilmslow Unit where people were not given the choice of refusal around certain aspects of the care.

Is the service caring?

Good

The service was caring. The people living at the home made positive comments about their care.

People who lived at the home and their relatives said that staff treated them with dignity and respect. Staff also showed understanding of how they aimed to do this.

Staff were aware of how to support people's independence. However we observed two instances where people did not have their zimmer frames in close proximity in order for them to mobilise on their own.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive. Accurate records were not always maintained in relation to people who needed to be weighed weekly and re-positioned through the night.

Summary of findings

People living at the home said there was not always enough for them to do. The only activity we saw during the inspection was a baking activity which on two of the units, was done very early in the day.

Both people who lived at the home and staff said that meetings were not regular enough, in order for them to voice their opinion or raise concerns. The last meeting minutes we saw were from March 2015.

We did not see any evidence that people who lived at the home were involved in the reviews of their care plans or had been able to contribute towards the content.

Is the service well-led?

Requires improvement

Not all aspects of the service were well-led. This was because at the time of our inspection, the home manager was not yet registered with CQC and was going through the application process. They had been in post since November 2014.

Overall, staff said that they could raise concerns with the manager, but that issues relating to staffing levels had been ongoing for some time and nothing had changed.

There were a range of audits in place to monitor standards being provided within the home. We saw they described any necessary action that needed to be taken.

Laurel Court (Didsbury)

Detailed findings

Background to this inspection

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

This inspection took place on 14 September 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and a specialist advisor. The specialist advisor was a registered nurse.

Before the inspection we reviewed information we held about the service. This included previous inspection reports, details of any notifications that the service had sent us about safeguarding or other important events and any feedback that had been sent to us about the service. We also contacted Manchester Council and asked for their feedback about the service.

During the inspection we spoke with 10 people living at the home, although not all of these people were able to clearly express their views to us. We also spoke with eight relatives who were visiting at the time of our inspection and 18 members of staff, including night staff, day staff, nurses, the cook and the home manager. We also spoke with two visiting professionals.

We looked at documents relating to people's care including nine care plans and six staff recruitment records. We also looked at other documents related to the running of the care home including policies and procedures, medication records and quality assurance audits.

Inadequate

Is the service safe?

Our findings

As part of the inspection we checked to see that there were sufficient staff working at the home, in order to meet people's needs in a timely manner. The general nursing unit (Broadway) was staffed by a nurse and five care staff. The nursing and general residential unit (Palatine) was staffed by a nurse, a senior carer and three care assistants. The first floor dementia unit (Burton) was staffed by a senior carer and four care assistants. The ground floor private dementia unit (Wilmslow) was staffed by two senior care assistants and one care assistant. We spoke with the manager about the current staffing levels at the home. The manager said they were currently in the process of recruiting '10% over' the assessed staffing levels to ensure more staff were available to care for people at the home. Following the inspection, the manager sent us a 'Staffing Guideline' tool which described the ratios of staff required to care for people at the home on each unit. However, this did not consider peoples individual care needs and how many staff were needed as a result.

Across the four floors of the home, the staff we spoke with raised concerns about the homes current staffing levels. One member of staff said; "The staffing levels are rubbish to be honest. We just don't have time to interact with people. People are capable of going out for walks and to the shops but we just can't do it". Another member of staff said; "Staffing levels are poor. They are not safe as they are. There are three of us today but that is not always the case. Sometimes, on this unit there is only one member of staff at night. They can ask for help from other floors but it isn't right". Another member of staff said; "We work well together but there just aren't enough of us". A further member of staff added; "The home is not well staffed I have to be honest". One person who lived at the home also said; "These girls are very good but there just aren't enough of them". Another person told us how they had been looking forward to going to the gym and post office but had been told they couldn't go because there were no staff available to take them.

We observed one person during the day, whose care plan referred to several instances of inappropriate behaviour towards staff, as well as other incidents involving aggression towards other residents on the unit. Their care plan also referred to the need for them to be observed by staff. However, we saw this person moved freely around the unit at regular intervals and was not being observed by staff as identified in their care plan. This person was also at risk of trips and falls because they could not judge how close certain objects were. Another person had fallen several times and their care plan also stated they should be observed. One member of staff said; "We should really observe these people but we can't because of the staffing levels and needing to look after other people".

On both the Palatine and Broadway Units, the morning medication rounds were still in progress at 12pm. We saw this was because the staff undertaking the medication rounds had to provide support to other care staff, when people required assistance. On several occasions we saw that staff undertaking the medicines round had to lock the cabinet and provide assistance to people. Breakfast was also still in progress at 11.30 am. Whilst this meant people had the flexibility to eat when they wanted, staff told us there was a delay because there weren't enough staff to support people in a timely manner. At approximately 7.20am, we saw that there was only one member of staff who was a nurse, on the Broadway unit to provide care to 24 people. A member of staff who had been working on the night shift had left early unexplained. This placed people at risk, as many of the people on this unit had been judged to be of high dependency. Several staff also told us that there was often only one nurse working between both the Palatine and Broadway units. They described this as 'An accident waiting to happen'. The manager told us they often worked the night shift on the nursing unit due to staff shortages.

These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We checked to see that staff who worked at the home, had been recruited safely. During the inspection we looked at a sample of six staff recruitment records and saw that application forms had been completed, interviews had been carried out and DBS (Disclosure Barring Service) checks had been undertaken. The files we looked at also contained evidence that references had been sought from previous employers before staff began working with vulnerable adults.

We checked to see if medication was handled safely within the home. We saw medication was administered by either nurses or senior care staff within the home. When we checked the training matrix, we saw that they had received

Is the service safe?

appropriate training. People's medication was stored in secure trolleys which we saw were not left unattended when not being used. We saw that there was a medicines fridge for medicines which needed to be kept cool and at a certain temperature. We saw staff maintained an accurate record of these checks. One person on the Palatine Unit had run out of 'Haloperidol liquid' which is a prescribed antipsychotic medicine to be administered 'morning and night'. The nurse on this floor contacted the GP to request an urgent prescription. This was not delivered to the home until approximately 4pm meaning the person did not receive their morning medication. Staff said this person had not displayed any challenging behaviour as a result. This could have placed this person at risk, due to appropriate ordering systems not being in place for this person.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to Safe Care and Treatment.

Also on the Palatine Unit, we saw that a store room door was left unlocked which contained 'thickening powder' which is used to add to people's drinks. We saw this door was open between approximately 9am and 9.55am, before eventually being closed by the deputy manager. This meant people on the unit could have accessed these products and consumed them, placing them at risk.

People we spoke with told us they felt safe. The staff we spoke with were aware of potential indicators of abuse or neglect, and were aware of how to report any concerns appropriately. One member of staff said to us; "In terms of how I would spot potential abuse, I would look for changes in behaviour or if they were being quiet and reclusive which was out of character". Another member of staff said; "Initially I would speak with my manager and raise my concerns. I would notice if people were withdrawn or if they were just not their usual self". A further member of staff said to us; "If I saw somebody not being treated very nicely, I would stop them immediately and tell the manager".

People's care plans contained risk assessments with detailed control measures about how to keep people safe. These covered areas such as mobility, nutrition, pressure sores and maintaining a safe environment.

Requires improvement

Is the service effective?

Our findings

There was an induction programme in place which staff were expected to undertake when they first began working at the home. This enabled staff to gain an understanding of the expectations to undertake the role, to meet the people they would be caring for and to familiarise themselves with policies and procedures. Each member of staff we spoke with told us they undertook the induction when they first began working at the home. One member of staff said; "I was able to shadow more senior members of staff first. I also did my moving and handling training and fire safety. I did the main courses before I began working with people". Another member of staff said; "I hadn't worked in care previously so the induction was beneficial to me".

We looked at what training staff had available to them in order to support them in their role. We looked at the training matrix which showed staff had received training in areas such as moving and handling, safeguarding, medication, infection control, fire safety, health and safety and COSHH (Control of Substances Hazardous to Health). The staff we spoke with were positive about the training they received, although some staff working within the dementia units of the home felt that more in-depth training in this area would be beneficial to them. One member of staff said; "They are on point with training here". Another member of staff said; "I am happy with the training so far".

Staff supervision was not always consistent at the home. Some of the staff we spoke with said they had not received supervision for some time. The manager told us they aimed to complete staff supervision every six to eight weeks; however the records we were shown did not demonstrate these had taken place consistently. The home manager told us they would try to ensure that staff supervision was conducted more regularly.

Two of the units at the home (Wilmslow and Burton) catered for people living with dementia and we checked to see what adaptations had been made to make these units more 'dementia friendly' for people. We saw people had specific 'memory boxes' outside their bedrooms to remind them of past life events. Signage around these units however was limited. This meant people could have difficulty finding their way to areas such as the lounge areas, the dining room and bathrooms/toilet areas. Additionally, we saw there was nothing tactile along the corridors for people to feel and touch as they walked around. We also noted that clocks on both the Wilmslow and Palatine unit were not showing the correct time, which could prove confusing for people. We spoke with the manager about this who said that this was something they were looking to develop on the units.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

We checked to see if people living at the home received enough to eat and drink and observed parts of both the breakfast and lunchtime meals on each of the units. At the time of the inspection the home did not have a permanent chef and instead, used a chef from an agency. Staff on the Wilmslow unit felt that there were not enough staff to support people appropriately at meal times. This was because five people required assistance to eat their meals and there were only three members of staff working on the unit. We observed that although staff worked well during the observed period, support was not personalised and staff were unable to provide one to one support due to needing to assist other people at the same time. The lunch time meal looked appetising and consisted of mushroom soup, quiche and chips with a selection of sandwiches also available. We saw that people were offered more food if they were still hungry and were also offered a dessert. If people did not like a certain food, we saw they were provided with a different option. For instance, one person did not like mashed potatoes and was given roast potatoes instead on one particular day. One person told us; "The food is good here I love it".

The staff we spoke with were able to provide examples of how they sought consent from people who lived at the home. One member of staff said; "I would ask what people wanted first. For instance if they did not have capacity I would offer them a choice of two outfits to wear that day and then look at their facial expressions to see what they wanted". We also spent time observing staff to see if they sought peoples consent before carrying out a particular care task. On the Wilmslow Unit we observed several occasions where people were not always asked for their consent before tasks were carried out by staff. We saw people were not offered the choice of refusal and were spoken to by staff as if they did not have a choice. For example one member of staff said to a person; "Stand up then" when they were assisting them to stand from their chair. On another occasion a member of staff said; "Take

Requires improvement

Is the service effective?

this will you" when they approached them to give them their medication. On a third occasion a member of staff said; "Drink this for me will you" when they offered them a cup of tea.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service had made DoLS applications as required and the care plans we looked at contained Mental Capacity Assessments. Several of the staff we spoke with felt that more in-depth training in this area would be beneficial to them.

We saw that people had access to relevant health professionals as required and any involvement around this was recorded in their care plans. This included the falls service, district nurses, opticians, physios, chiropodists and GP's (General Practitioners).

Good

Is the service caring?

Our findings

During the inspection we received positive comments from people who lived at the home and their relatives about the care they received. One person said; “It is the best move I ever made coming here. I’m very happy here. The staff are better than good, they are excellent. I can have a laugh with them and it helps to break up the day”. A visiting relative also said; “I think it is excellent here. The care is good, as is the quality of the staff. I visit fairly regularly and mum is always clean and well presented. We are very lucky. I think it is very good”. Another person added; “The staff are good I can’t complain”. A further relative added; “The staff are very caring. No problems. I think it is brilliant”.

The people we spoke with and their relatives said that they felt staff were caring people and that they got on with them well. One person said to us; "I like the staff. We get on well together and can have a laugh". Another person said; "I've here for a year or so now and have gotten to know the staff quite well". A relative also said; "The staff seem to treat my mum pretty well. They speak with other like friends and seem to have bonded well".

The staff we spoke with displayed a good understanding about how to treat people with privacy, dignity and respect. One member of staff said; “I would always deliver personal care in a private place. I think if people can do something for themselves then we should let them. That shows respect”. Another member of staff said; “We always knock on doors before going into bedrooms. If we are talking to people about personal things then that should always be done in private”.

Whilst speaking with staff we asked them about how they aimed to promote people’s independence whilst they lived at the home. One member of staff said; “When showering people I let them do as much for themselves as possible first before offering to help them”. Another member of staff said; “I try not to let people use the wheelchair if they are able to walk themselves. Even though some people eat their meals very slowly, I think this is sometimes good because we can let them do it themselves”. During the inspection we observed two separate instances where people’s independence was not promoted because they did not have their walking frames close to them in order to mobilise independently. One of these people’s care plans stated they needed their walking frame in close proximity so that they could go to the toilet on their own, however it was nowhere near them. This did not allow these two people to retain their independence.

We saw that generally, people who lived at the home looked clean and were well presented. Where peoples clothing had become dirty or unclean we saw that staff took them away from the main lounge area and assisted them to change their clothing in private. One visiting relative said ; “I have never had any problems with how mum is presented”. Another visitor commented about how they thought their relative received good personal care. We also saw that staff communicated well with people living at the home. For instance, crouching down at the same level as the people they were speaking to or speaking loudly and clearly so that the person could understand what they were saying.

The service produced a service user guide which included information about the staffing structure, mealtimes, activities and the statement of purpose. This was given to people who may wish to use the service, or their relatives. A copy of the service user guide was also placed in each person’s room for them, or their families, to refer to whenever they wanted to.

Requires improvement

Is the service responsive?

Our findings

We saw several examples of where the home had been responsive to people's needs. For example, staff had requested an assessment from Speech and Language Therapy team (SALT) due to one person having swallowing problems. As a result, this person was then provided with 'Syrup Consistency' fluids in order to make them easier to consume. Another person living at the home needed prompting to consume more fluids and we saw staff encouraging them to drink a bit more during the day and that they had a cup of tea or juice near them. A third person had come to Laurel Court with three pressure sores, of which two had now healed completely.

We saw that before people moved into the home, an initial assessment was undertaken to establish the types of care people required. This covered areas such as mobility, eating and drinking, continence, communication, sleeping and socialising. Staff at the home had also made an effort to establish information about people's past life events such as where they lived, any early memories, hobbies and interests and the school they attended.

During the inspection we looked at the care plans of nine people who lived at the home. The care plans provided guidance for staff about the kinds of care people required. People had care plans for areas such as pressure sores, nutrition, personal care, mobility and communication. The care plans we looked at were detailed and described how many staff people needed assistance from, the types of food they liked or didn't like or if they needed support at meal times and prompting to drink more fluids. In one instance on the Wilmslow unit we saw that one person was given orange cordial and porridge when their care plan clearly stated they would like fresh orange juice and toast for breakfast. We did not see staff asking this person what they wanted before the food was placed in front of them. We saw that the care plans were reviewed at least monthly or when people's needs changed. Despite this we did not see evidence that people were involved in the reviews of their care plans or had been able to contribute towards them.

The service sought feedback from people using the service through surveys and resident and relatives meetings. The last minutes of a staff and relatives/residents that we were shown were from March 2015. Another residents meeting had been scheduled for the end of September 2015. Some of the people who lived at the home that we spoke with told us they would like these meetings to happen a lot more regularly than they had been doing. One person said; "I don't recall there being a recent meeting. I think it would be good to have them more often".

We looked at the most recent survey which had been sent out in 2014. The 2015 survey was in the process of being sent out. We saw people were asked about being involved in their care, staff availability, complaints and concerns, privacy, food quality, dignity and respect and home safety. Some of these areas had scored lower than others such as food quality (72%) and people being involved in their care (78%) and it was not clear to us what action had been taken in response. The manager told us they were looking to introduce a 'You said, we did' system, which would clearly identify how issues that were raised had been responded to.

Activities and stimulation were limited on the day of the inspection. The only activity we saw taking place was baking which was done by the activities co-ordinator. Some of the people who used the service told us there was not always enough for them to do and staff said that due to current staffing levels at the home, they did not have sufficient time to spend with people and engage in regular conversation. We raised this concern with the manager who told us they were aware of this and that activities was an area they were looking to develop within the home.

We found that accurate records were not always maintained by staff. These related to records for two people who were required to be weighed weekly and one person who was required to be re-positioned through the night. Although these recording systems were in place, we found inconsistencies on certain days. These three instances related to people who lived on the Wilmslow unit. The staff on this unit said that as far as they were aware, these records should have been completed but had not been done so by staff. Despite this, we did not see any evidence of significant weight loss for these people but felt recording systems needed to be improved.

There was a complaints procedure in place. The procedure was clearly displayed in the reception area of the home. We also looked at the complaints which had been made against the home. We saw that there were details about what the complaint had been about and what action had been taken. There was also a copy of the response which was sent to the complainant.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection, the home manager was not yet registered with CQC and was going through the application process. The manager had worked at the home since November 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked staff for their views on leadership at the home. One member of staff said; "You can talk to the manager and can approach her with things. The manager is still fairly new and needs to be given time". Another member of staff said; "I have no concerns about the manager at the minute". Another member of staff told us; "We can approach the manager with further training courses we would like to undertake which is good". A further member of staff told us they felt that nothing seemed to change when concerns were raised about staffing levels and that things stayed as they were. Several other members of staff felt that the manager needed to have more of a presence on the units on a daily basis to ensure that things were being done correctly.

We saw a range of audits and management reports were being completed by the home manager. These covered areas including medication, care plans, infection control and health and safety. We saw that areas for improvement were often identified during these audits such as controlled drugs not always being signed for by two members of staff and accurate records of stock not being maintained. Each area was given an overall score along with any action that needed to be taken. In addition to this, the manager also completed a 'Monthly watch' which included observations and a general walk around the building to see that standards were being adhered to. Some of the observations included people wearing dirty clothing and waste bags which needed to be disposed of. Some of the observations were actioned at the time or given a timescale for completion.

There was a system in place to monitor accidents, incidents or safeguarding concerns within the home. The manager maintained a monthly record about the incidents which had occurred and what had been done in response. Additionally, there was a record of what the outcome was and any 'lessons learned' to help prevent future re-occurrences. We found that when safeguarding concerns/alerts or significant incidents had occurred at the home, appropriate notifications were sent to the Care Quality Commission.

The last meeting minutes from a staff meeting we were shown were from December 2014. The staff we spoke with told us that they would like more regular staff meetings where they could voice their opinion about how the home is run or if they had concerns. Staff also told us that team meetings used to be held monthly but had recently not been as regular. We found improvements were needed in this area.

There was a system in place to ensure that staff were competent to administer medication safely. We saw that these had been completed as recently as September 2015. These checks covered administration, side effects, refusals, communication with residents and safe disposal. Following these checks, staff were then either 'passed' or 'failed' based on what the findings had been.

We saw that staff took part in a handover at approximately 8am when different staff came in who would be working during the day. We saw that keys for the medication trolley were exchanged between senior staff and that staff had discussed each resident and whether they were already awake or were still in bed. Staff also spoke about a resident who had some swallowing difficulties and had seen the GP the previous week. Staff spoke in detail about this person and to 'Keep an eye on him', to ensure his safety. This demonstrated that staff had considered people' s care needs and mood on the day and informed other members of staff to ensure they were aware of this information.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient staffing levels at the home to look after people safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Appropriate systems were not in place to ensure people received their medicines safely.**