HC-One Limited

Chaseview Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 9 February 2017 and was unannounced. Following our last inspection on 26 October 2016 we issued the provider with warning notices to improve the level of staffing and meet the legal requirements regarding consent. The provider sent us an action plan which detailed the improvements they would make within the timescale we had specified. At our inspection we found that the level of staffing was still not adequate to protect people from harm and poor care. The provider had made improvements in gaining consent and supporting people who were unable to make decisions for themselves.

Chaseview Nursing home provides accommodation, personal and nursing care for up to 60, some of whom may be living with dementia.

There was no registered manager. A new manager had been appointed and was completing the process to register with us. This manager has since left the service. 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

People were not protected for harm because there were an insufficient number of staff to meet their needs and keep them safe. We had to alert the provider on three occasions because of our concerns for people's safety relating to specialist nutritional care, a fall and the failure by staff to respond to a call bell which had been activated for 45 minutes. Staffing levels were based on an assessment of people's individual needs but we saw this had not been completed correctly to reflect their requirements. Staff who should only have been shadowing experienced staff were left alone with people, including a person who presented with behaviours that challenged their safety and that of others, particularly staff. The way people's medicines were managed required improvement. Some medicines had been refused but staff had not taken action to ensure the person's wellbeing was not affected.

When people were seen by healthcare professionals their requests for investigation were not always done. People's dignity was not supported because staff were delayed in providing personal care in a timely manner. The provider was using agency (temporary) staff but they did not know people or show an active interest in them or their welfare. Communication arrangements for agency staff were insufficient as they did not know about people's long term conditions and behaviours.

People's access to activities was limited because the activity co-ordinator was also fulfilling a care role. There was a complaints procedure however people were not always aware who to speak with to raise their concerns. People and relatives were provided with opportunities to share their views on the service but when shortfalls were identified there was no analysis or feedback to them.

The provider had improved the support they gave to people who were unable to make decisions for themselves. Staff were supported to attend training and gain nationally recognised qualifications. People were provided with a choice of food but there were no arrangements to support people who were living with dementia to pick their meals by using visual aids.
People had been asked about their likes and dislikes so that staff could provide care in the way they preferred. The provider had displayed their poster in a prominent position for relatives and visitors to see.

We found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The service was not consistently safe. There were an insufficient number of staff to provide people with safe care and protect them from harm. Specialist nutritional systems were not managed safely which increased people's risk of choking. People's medicines management required improvement to ensure they were supported correctly.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff did not follow instruction from a healthcare professional. Staff were not aware of the process to support people who were drinking insufficient amounts to maintain their health. Staff understood how to support people to make choices and decisions about their care. Staff had access to training and support to gain nationally recognised qualifications.

Is the service caring?

Requires Improvement

The service was not consistently caring. The low staffing numbers had an impact on promoting people's dignity. Temporary staff did not engage with people. Relatives were able to visit whenever they chose.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. The arrangements for staff handover were not providing sufficient information about people's care needs. The activity co-ordinator was providing care which impacted on the time they spent supporting people. Some people were not aware how to raise a concern or complaint.

Is the service well-led?

Inadequate

The service was not consistently well-led. The provider had not taken a consistent approach to staffing. The dependency tool used to plan staffing was not completed correctly. The provider was unable to monitor the call bell response times. There was an audit programme in place but action was not recorded when shortfalls were identified.

Chaseview Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 February 2017and was unannounced. The inspection was completed by three inspectors, an inspection manager 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. The expert-by-experience supporting this inspection had experience of supporting people living with dementia.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant. When we were planning the inspection we contacted colleagues at the local authority and care commissioners to discuss their views on the home. We looked at the information we held including safeguarding referrals, comments from relatives and healthcare professionals and the statutory notification the provider has to inform us about. We receive statutory notification about any important information which affects the care of people and the way the service is operated.

We spoke with eight people who used the service and 11 relatives. We observed the care provided in the communal areas of the home to understand people's experience of living in Chaseview Nursing Home. We spoke with nine members of staff, the manager, a turnaround manager, the area director and the managing director for the provider.

We looked at eight care plans to see if people were receiving the care planned for them. We also looked at documents relating to the management of the home and three recruitment files to check these were suitable.

Inadequate

Is the service safe?

Our findings

At our last inspection on 26 October 2016 we remained concerned that improvements had not been made to provide a sufficient number of staff to care for people. We issued the provider with a warning notice and told them they must improve by 30 November 2016. When we inspected again on 9 February 2017 we found that the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not made appropriate improvements and there were still insufficient staff available for people. We identified that the staffing levels impacted on the care and safety of people who used the service.

The provider sent us an action plan following our last inspection detailing how they would ensure they had a sufficient number of staff available to support people. The action plan concentrated on re-deployment of staff within the home. On the day of our inspection there were seven members of staff supporting 27 people on the first floor of the home which is a nursing care unit. The staffing levels included one nurse, a nursing assistant and five carers, one of whom was responsible for hospitality. The manager told us that the staffing levels were calculated according to people's care needs and dependency. We saw, that on the first floor of the home 22 people required two staff working together using equipment to move them, and five people had specialist feeding systems in place which required care by a trained nurse. The dependency information we were shown rated these people's dependency needs as medium which did not reflect the level of care we were told they required. A member of staff told us, "It's hard. People's needs have changed. You want to give the best care you can but sometimes you just can't do it". The manager told us that staff were not completing the dependency tool accurately and needed to be trained to do so correctly. The manager told us they did not feel there were an adequate number of staff available and had raised their concerns with the provider.

People told us they waited for staff to respond to their calls for support. One person told us, "I always wait a long time when I press my buzzer". We observed the access people had to staff in the communal areas of the home and when they were in their bedrooms. We saw, despite assertions by the manager that staff were present in communal areas at all times when people were using them, that a staff presence was not always maintained. For example, we saw two people sitting in a communal lounge for 45 minutes, without a member of staff to support them. . A member of staff told us that one of the people could demonstrate behaviours that may challenge and should not be left unsupervised with others. People were also sitting in two of the dining rooms on the first floor without a member of staff. We heard one person say, "Please help me, I'm hungry and we've been waiting for breakfast for ages".

We saw that staff did not always respond to calls for assistance from people. One person had activated their call bell. We could see the person was safe so we monitored the time it took for staff to respond to them. When the call bell remained unanswered after 45 minutes we alerted staff and asked them to check the person. The manager told us the call bell sound volume in the home had been de-activated and staff were provided with pagers to alert them when call bells were activated. We saw that two pagers had been left in the office which was not occupied by staff on a permanent basis. One pager in the office was turned on and the other was off. We were told by staff carrying the remaining pagers that they were in working order but

they did not think they had activated to alert them to the unanswered call bell. One member of staff told us, "It was better when we could hear the call bells".

A new member of staff had started working at the home the day before our inspection. This member of staff told us they were shadowing an experienced staff member and was not included in the number of staff available to support people. We saw this member of staff was left alone and unsupported by other staff with people for up to half an hour because staff were busy elsewhere. This included a person who presented with behaviours that challenged their own safety and that of others. There was no behaviour management plan in place for this person. A behaviour management plan is used to ensure staff support people in the most effective and consistent manner when their behaviours become complex or challenging.

These are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People with risks associated with their care were not supported safely. Risk assessments had been completed however there were not always processes in place to ensure people received their care as planned. When we were planning our inspection we received information from the local authority safeguarding team. A visiting healthcare professional had raised concerns about the care of people who were receiving their nutrition via a system referred to as percutaneous endoscopic gastrostomy (PEG). This system is used for people who have difficulty swallowing which increases their risk of choking. We discussed the concerns with the manager at the beginning of the inspection and were told all the required improvements had been made. We saw that one person was receiving their nutritional feed whilst lying in their bed. The person's risk assessment stated that they should receive their feed whilst supported to sit at a 45 degree angle. This was to ensure they were protected from the risk of choking. We saw that despite staff going into the person's bedroom they did not re-position the person and we had to alert the manager to ensure the person's safety. A relative told us, "My relation shouldn't be lying flat and I come in everyday because I worry about them. I always find they're flat in bed. I'm sick of telling them".

Another relative asked us to look at their relations PEG site because they were worried about some inflammation and discharge. The relative told us they had highlighted this to staff the previous evening but we saw no action had been taken. The person's relative confirmed to us that their relations top had not been changed since the previous evening. We saw that the PEG site was inflamed and discharging. The last entry on the person's PEG care chart had been during the morning of the previous day which meant staff had not acted on their relations concerns. We alerted the manager who arranged for the care to be provided as required.

We heard a person coughing in their bedroom. On investigation we found they were lying flat in bed drinking a cup of thickened fluid. The person had been prescribed thickened fluids as they were at risk of choking. We alerted a member of staff as we were concerned the person should not have been lying flat and they were starting to choke. A member of staff attended the person's bedroom but left them, with the drink, whilst they went to find a colleague to help them sit the person up. We saw the person's risk assessments said, 'Ensure that [name of person] is sat upright and supervised when eating and drinking'. This meant the person was not receiving the care that was planned to keep them safe.

These are breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one person was sitting alone in a communal lounge. We saw this person stand and fall forwards onto the floor. We activated the emergency call bell but when we received no response from staff, we made

the person safe and went to find a member of staff to support them. The first member of staff said they did not know the person and took no immediate action to reassure this person or to check for potential injuries. We read in this person's care plan that they had a history of falls and a recent entry stated, 'remains at high risk of falls when left'. We read in another person's care plan that they should have a sensor mat in place to alert staff when they were moving but we saw this was not in position. A member of staff told us, "They have crash mats to stop them falling. Don't know why they didn't have this morning". The member of staff did not put the mats in place to ensure the person had their safety equipment in place. This demonstrated that staff were not following the risk assessments in place for people to keep them safe and protect them from harm.

The management of people's medicines required improvement. We saw one person had not received one of their essential medicines on five occasions because they had been sleeping. Staff had not offered the person their medicine during the remainder of the day. We read that one person had been prescribed a medicine, one tablet up to twice a day if required. We saw this person had been offered the medicine up to four times a day which is more frequently than had been prescribed for them. When people refused their prescribed medicines action was not always taken to respond to this. For example we read in two people's medicine administration record that they had refused one of their medicines for the ten days prior to our inspection. We received information from a healthcare professional informing us that a relative had told them that another person had not received their essential medicines. There was nothing recorded in the people's care plans to indicate what affect this could have on the person or what action staff had taken, for example inform the people's doctor. We received information from a healthcare professional informing us that a relative had told them that another person had not received their essential medicines. We conducted a stock control spot check on the medicines in use and found the actual stock did not tally with the expected amount. This would indicate that staff had either failed to administer medicines or had not recorded the administration correctly.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw when people were moved using equipment they did not have individual slings to use with the hoist. People's risk assessments for safe moving did not specify the size and type of sling that should be used to ensure people were moved according to their individual requirements and to protect them from cross infection. The manager told us individual slings had been ordered and would be in use shortly.

There was a recruitment process in place. Newly recruited staff told us they had completed checks before they were able to start working in the home. One member of staff told us, "I had an interview and I had to provide references. I had to wait for my references and my DBS to come back before I could start". The Disclosure and Barring Service (DBS) is a national agency which holds information on members of the public's past police history and convictions. We looked at [number] of staff recruitment files and saw that checks were completed before staff were able to start working with people.

Staff understood their responsibility and had received training to ensure people were protected from abuse. Staff could describe how people could be abused and the actions they would take in response to any concerns they identified. For example one member of staff told us, "I've reported concerns in the past. We have a choice to walk in here, people don't. We have to act appropriately". We saw that safeguarding referrals were made when necessary, to protect people.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 26 October 2016 we found that the provider was in breach of Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice because the provider had not made appropriate assessments when people lacked capacity or ensured that decisions made were in their best interest. At this inspection we found that the required improvements had been made. We found that the provider had completed assessments and applications for people who needed support with their decision making to ensure they were working within the principles of the MCA.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that mental capacity assessments had been completed for people who needed them. Decisions made on behalf of people were demonstrated to be in their best interests. This demonstrated the provider understood their responsibility to comply with the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had identified that some people were being deprived of their liberty and had made applications on their behalf for a DoLS assessment. A member of staff told us, "People have DoLS because they don't realise they wouldn't be safe if they went out on their own". The provider had completed risk assessments for each person to ensure that whilst they waited for formal assessment they had limited restrictions in place to keep them safe. This demonstrated that the provider had met the requirements of the MCA.

We saw that people were referred to other health care professionals but their advice was not always followed. We read in one person's care plan that they had been treated for a bacterial infection during a recent hospital stay. A healthcare professional who was visiting the person in the home, was concerned that this may have returned and requested that a swab was taken. The request was made four weeks before our inspection. There was no record in their care plan or daily records to confirm that the swab had been taken and the manager confirmed with us that it hadn't been done. We read in the person's daily records that they were displaying signs that the infection was still present which could present a risk to them and other people in the home.

Staff told us some people had their food and drink intake monitored and recorded. However, staff were unable to tell us how much fluid each person should receive each day to maintain their health and wellbeing. The provider had a system in place to ensure if people's assessed fluid intake was not achieved, that they should be encouraged to have fluid rich foods, for example, soups and custard to increase the volume of fluid. Staff we spoke with were not aware of this. One member of staff told us, "If people weren't drinking enough we just push the amounts up", but the member of staff was unable to tell us how they would achieve this if the person was reluctant to drink. This meant staff were not always aware of the best

way to improve people's fluid intake to support their health.

People were asked for their meal preference. One person said, "I chose my own breakfast, I had poached eggs. We have a choice of two things for lunch". For people living with dementia staff did not use alternative aids to support their ability to choose. For example, there were no pictorial format cards to help people pick what they wanted. During lunch we saw people who needed it were supported patiently by staff to eat their meals. This meant people were provided with an unhurried mealtime.

Staff received in house training which they could access online or face to face. Staff told us they were supported to gain nationally recognised qualifications including the care certificate. One member of staff said, "We get some training online and some by practical sessions. I prefer the practical sessions; it makes more sense to me. I've recently done the safe moving and handling. I didn't use the equipment like the hoist until I'd been trained". This meant staff were supported to gain the skills and knowledge to care for people.

Requires Improvement

Is the service caring?

Our findings

People's care and support was not provided in a consistent manner in the home. People and relatives told us, and we saw that people were not always supported to maintain their dignity. One person told us, "I'm sitting in a wet bed. I've been waiting for them for 15 minutes now. If I ring my bell there's no guarantee that someone will come. I often say to them that I could have died waiting for them". A relative said, "My relation was soaked on one occasion, even the chair they were sitting on was wet. I had to speak with the manager to sort it out". We saw one person was sitting in wet clothing. A member of staff transferred this person into a wheelchair to go for their breakfast. The member of staff did not notice the person required personal care support until we pointed it out to them.

We saw that some agency staff did not display an interest or caring approach to people. For example, we were informed by a member of staff shortly after we arrived for our inspection, that one person who had been lying on the floor, had been ignored by a member staff. The member of staff had walked past them because they said, they didn't know them. We saw another member of staff staring into the garden and ignoring the nine people sitting in the lounge. The member of staff made no attempt to interact with people or display an interest in what they were doing. Relatives told us the use of agency staff was impacting on care. One relative told us, "They've been through a bad patch with staffing so they've filled in with agency. It's not always been great".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the staff had limited time to spend with people. Relatives told us that the staff were kind but did not have time to spend much time interacting with people. One person told us, "The staff give their all here, they are wonderful". A relative said, "They're rushed off their feet but they are very kind and caring". We saw that staff spoke kindly and politely with people and people responded with pleasure from their attention. One member of staff told us, We would like more time to spend with people".

People's privacy was respected by staff. One person told us, "The staff don't just walk into my room, they knock on the door first". We saw staff knocking before entering people's rooms or going into bathrooms to check they weren't occupied.

People were supported to maintain relationships which were important to them. We saw that families and friends were frequent visitors to the home. One relative told us, "I come every day to visit my relation and stay for about an hour". We heard staff offering visitors a drink and greeting them with familiarity. This demonstrated that staff knew people's families and friends.

Requires Improvement

Is the service responsive?

Our findings

A lack of effective communication in the home put people and staff at risk. People and relatives we spoke with expressed concern that temporary [agency] staff did not know people or understand how to provide their care. We saw there was an agency member of staff leading the care on the nursing care floor. This member of staff was working at the home for the first time in five months. The nurse had received a handover from another member of staff supplied by an agency. The nurse was unable to provide us with information about people's health and support needs. For example, the nurse was not aware how many people in the home had chronic long term conditions such as diabetes. We read in the staff handover book that the behaviour of one person the previous day had been described as 'violent' however no further explanation had been provided. The member of staff told us this information had not been communicated to them at the handover and they did not know what had occurred. The lack of information sharing could put people and staff at risk.

There was an activity co-ordinator in the home who supported people to spend their time doing activities which they enjoyed and were meaningful to them. During our inspection we saw some people were making valentine cards to give to their loved ones. However, we saw the activity co-ordinator was also fulfilling a carer role as they sat for part of the day with a person who needed to be observed. A member of staff told us, "I would like to see more one-to-one activity time for people. The care staff have to do people's care monitoring and support with activities but we can't do everything. This needs improving". Another member of staff said, "There used to be more on offer for people. Day trips and things like that but not anymore".

There was a complaints procedure in place for people who wanted to raise their concerns or a more formal complaint, which was displayed in the reception area. People we spoke with were not always confident about how they would raise concerns. One person told us, "If I had a complaint I wouldn't know who to talk to". We saw when people had made a complaint a response was provided to them within a timely period.

People's care plans contained personal information about their past lives, social history and family relationships. People had been asked for their likes and dislikes, for example their favourite foods and if they had particular preferences about their bedtime. We saw the care plans had been reviewed on a regular basis to reflect when changes had been made.

Inadequate

Is the service well-led?

Our findings

We have inspected Chaseview Nursing Home on 24 March 2016, 26 October 2016 and 9 February 2017. Over this timeframe, we have raised our concerns regarding the number of staff provided to meet people's needs and keep them safe. When we were planning the inspection we spoke with colleagues at the local authority, the commissioners of people's care and reviewed safeguarding concerns that had been reported to us. We found these were predominantly related to the number of staff available to care for people and the affect this had on their care. For example, people who had sustained injuries after a fall which had not been witnessed by staff.

At this inspection we were not reassured that the provider had developed a consistent approach to the management of staffing. We found that there was not an adequate number of staff available to maintain a safe environment for people. There was a lack of permanent nurses and the arrangements for communication, as documented in the responsive section of this report, could lead to poor outcomes for people. We saw that following our previous inspections the provider had taken reactive actions to our concerns and had not demonstrated a longer term solution to improve staffing levels. For example, we found that when we highlighted staffing concerns on one floor this was addressed at the next inspection to the detriment to the other floor. The provider used a dependency assessment tool to plan staffing however the manager confirmed that staff did not know how to complete this correctly. The manager told us one person had a dependency score indicating medium care needs when in fact, their needs were very high. This meant that basing staffing levels on this tool was not always effective.

Because we identified immediate shortfalls with people's care on the day of our inspection we requested an urgent meeting with the provider to share our concerns. We told the manager and the area manager that we could not leave the home until immediate action was taken. We said they must provide us with assurances that people would be provided with care that was consistently safe, effective, caring and responsive to their needs. The managing director for the provider joined us at the home and was present for our feedback on the inspection findings. The managing director told us they had increased the staffing levels during the afternoon and would maintain the increased level. They would also introduce further processes to improve staff training and monitor their competency particularly in respect of PEG feeding and supporting people to maintain an adequate fluid intake. We told the provider they must confirm their intentions to improve care to us within a week. We have advised the provider that they must not accept further admissions into the home without providing us with assurances about their care and safety.

During our inspection we highlighted a delay in answering call bells, as we documented in the safe section of this report. We asked the manager to provide us with a report on call bell response times but they were unable to do this. The area director told us, "The system in place here will not provide us with a report". There was no audit in place to gauge, despite the inability to run a report, to monitor how long it took for staff to respond to people's calls for support and ensure this was not prolonged.
Some people's records were not up to date. We saw, that the daily record sheets for staff to record people's daily care were not always in place at the beginning of the day. A member of staff told us, "I don't know why there aren't any in, the night staff usually do that. I'll get some and fill them all in for everyone". This meant

the member of staff was not recording people's care as they received it which could provide an inaccurate record.
The provider had an audit process in place to monitor the quality of the service however when shortfalls where identified we could not see that action had always been taken. For example, we saw a food audit which recorded people's satisfaction with the food they were provide with. We read three comments which provided negative feedback however we could not see the results had been evaluated. Another survey recorded the concerns relatives had about the staffing levels in the home. There was no evidence that this audit had been analysed. This demonstrated that although there was an audit process in place there was no analysis in place or arrangements to feedback information to people who had raised concerns.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff raised concerns with the inspection team about the care and support some people received. One member of staff told us they did not feel able or supported to share this information with the manager. The member of staff was unaware of external contacts with whom they could raise concerns. We provided the member of staff with our details and the local safeguarding authority.

Relatives told us they were provided with meetings and had met the new manager. One relative told us, "They put notices up about the meetings and ask what we think about the home". Another relative said, "We've had relatives meetings and I've had my say about my concerns". One relative expressed concerns that the manager did not have an open door policy and were asked to put a note under their door instead. The manager told us they were unable to provide this type of access as they were working on the improvements they needed to make in the home.

The registered manager had left their post before our inspection. Another manager had been appointed who was completing the process to register with us. This manager has now left the service. During our inspection we saw that the ratings poster from the previous inspection had been displayed in a prominent position. The display of the poster is required by us to ensure the provider is open and transparent with people who use the services, their relatives and visitors to the home.