Bupa Care Homes (AKW) Limited

Ardenlea Grove Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 February 2016. It was unannounced. At our previous inspection on 6 November 2014, there was a breach in one of the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to improve their care planning and record keeping. We found during this inspection that improvements had been made.

Ardenlea Grove nursing home provides nursing and residential care to a maximum of 60 people. On the day of our visit 52 people lived at the home. The home has three floors. The Emerald Unit (ground floor) provides care to people who live with dementia. The Pearl Unit (first floor) provides care to people who have been discharged from hospital and whose needs were being assessed to determine what their next steps would be. The Ruby unit (first floor) provides care to people with nursing and palliative care needs; and the Sapphire unit (second floor) provides care to people with physical nursing needs.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People told us that staff were not always available at the times they needed them. We were concerned that staffing levels during the evening and night time meant some people's care needs were not responded to quickly. Some people told us their care needs were not always met in a timely way at busy times of the day. The recruitment process checked that staff were suitable to work in a care service.

Suitable arrangements were in place for ordering, storing and returning medicines. Medicines were mostly managed safely and securely.

Risks related to people's care were mostly managed appropriately. Staff mostly had a good understanding of how to manage risks related to people's health and welfare. The registered manager and staff understood the principles of the Mental Capacity Act and the registered manager had applied for Deprivation of Liberty safeguards for people whose freedoms were restricted.

People told us they felt safe at the home, and staff understood policies and procedures designed to protect people from the risk of abuse.

People received food and drink which met their nutritional needs. There were mixed opinions about the quality of the meals, and the meal time experience did not cater sufficiently to meet the needs of people who lived with dementia.

Staff sought the advice and guidance of other healthcare professionals to support people's healthcare

needs. These included the GP, dietician, tissue viability nurses and speech and language therapists.

Most people felt cared for by staff. Some people felt that staff did not spend enough time talking with them and engaging with them, and we observed this during our visit. Staff had received sufficient training and support to meet people's care and nursing needs, but had not received training to provide a 'specialist' dementia care service.

Some organised activities and individual activities were available to people who lived at Ardenlea Grove. People enjoyed the activities but did not think there were sufficient to keep them occupied. The registered manager had recruited a new activity worker who would provide a further 20 hours of activity work per week. People who lived with dementia had very little stimulation or activities available to them.

There were systems in place to capture feedback from people and relatives who used the service. This included a formal complaints policy and procedure, customer feedback boxes, relatives meetings, and quality assurance questionnaires. Friends and relatives were able to visit the home when they wished.

People and their relatives felt the home was managed well. The registered manager worked with staff on the floor, and staff felt they were approachable and supportive. Not all the people we spoke with knew who the manager was, or felt comfortable in approaching them. The provider had quality assurance systems in place to support the registered manager in running the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

Most people felt there were sufficient staff available to meet their care and support needs safely during the day, but people expressed concerns about staffing at night. Risks to people were mostly managed well, and medicines were mostly administered safely. People told us they felt safe at the home, and staff understood procedures to protect people from abuse.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff had received basic training. However staff had not received more specialised training to meet specific care needs. People received food and drink which met their needs, and had access to healthcare when required. Staff understood the principles of the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff were mostly warm, caring and engaging with people. Most people felt their privacy and dignity was respected by staff. People's friends and relations were able to visit the home when they wished.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Care plans provided detailed information about people's needs, likes and dislikes. These were regularly reviewed. People enjoyed the social activities available but felt there were not enough to occupy their time. People who lived with dementia were not provided with sufficient activities to meet their needs. Complaints were responded to appropriately.

Is the service well-led?

Good

The home was well-led

The registered manager strove to have an open and transparent culture, where people learned from mistakes. The provider supported the registered manager with regular visits and checks to make sure people's needs were being met.

Ardenlea Grove 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 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 24 February 2016 and was unannounced.

The inspection was undertaken by two inspectors, a specialist nursing advisor and an expert by experience. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported the inspection had experience and knowledge in general and mental health nursing care. An expert by experience is person who has personal experience of using or caring for someone who uses this type of care service

We reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with commissioners of the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS. The commissioners had no concerns about the service.

We spoke with 14 people who lived at the home, one relative, and 13 staff members. This included the cook, and nursing and care staff. We also spoke with two senior managers who were working at the home on the day of our visit, and the registered manager.

A number of people were living with dementia and were unable to share their experiences of the care and support provided. We therefore spent time observing care in the lounge and other communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experiences of people who could not talk with us.

We reviewed six people's care plans to see how their care and support was planned and delivered and looked at the medicine administration records of 19 people. We looked at other supplementary records related to people's care and how the service operated. This included checks the management team took to assure themselves that people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were mostly safe, and staff had the skills and knowledge to provide safe care. On the day of our visit we saw staff kept people safe. However people expressed concerns about continuity of care. People and staff told us staff did not always work in the same area of the home. The registered manager informed us that they had employed agency nurses because they did not have enough permanent nursing staff available. They told us they used the provider's preferred agency nursing staff who were familiar with people who lived in the home to try to ensure consistency of care, however this was not always possible. One person told us, "If staff are on one floor one day a week, they don't have the commitment to the floor. I think continuity is a great thing as they get to know you and the floor." A member of staff told us, "If you stay on a floor you get to know people."

On the day of our visit two agency nurses worked at the home, one who had not previously worked on the floor they were assigned to, were doing the best they could to understood the needs of people. The registered manager told us they had two nurses on long term absences and they had to cover their nursing hours with agency nurses. They told us they felt the situation was improving as they had recruited to fill many of the vacant hours. They were waiting for checks to be completed before staff commenced working at the home. There were no agency care workers used.

Some people expressed concerns that there were not enough staff on duty. For example a person told us, "I don't feel there is enough staff, they do their best but I feel they are always in a rush with dressing, washing and when they put you to bed at night." Other people told us they felt there were not enough staff in the morning. Some staff told us at certain times during the day and night, there were not enough staff. For example, one member of staff told us it could be a struggle to provide care to people in a timely manner when there were only two care staff on the unit. This was because some people on the unit required two staff to support them moving, and this left no care staff available to support other people's needs.

We checked whether people had access to call bells and asked whether staff responded to them in a timely way. One person said, "If I ring needing the toilet desperately and one staff is on a break, I have to wait. I could be left half an hour." They told us there was often only one care worker on Pearl unit and one care worker on Ruby unit at night, with a shared nurse. Another person told us, "The night nurse said that I can call them at any time, when I call them sometimes they don't come at all." "When I press the buzzer at night, it varies to how long they take to come; it could be three minutes or half an hour." Another person told us, "Sometimes at night it takes a while to get someone, and they can be a bit 'off', especially when they are busy."

We discussed our concerns with the registered manager who told us they regularly monitored call bell response times to ensure people's call bells were answered within appropriate time scales. They were not aware people had experienced these issues, and agreed to look into the specific concerns expressed by people. On the day of our inspection most call bells were in reach of people, and they were responded to quickly. They also told us that staffing levels were set according to people's assessed needs and would be increased if extra staff support was required.

People were protected by the provider's recruitment practices. The registered manager checked staff were of good character before they started working at the home. We looked at the recruitment records of two staff, and spoke with staff about their recruitment experience. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to work alone until the recruitment checks had been completed.

We checked the administration of medicines to see if they were managed safely and whether People received the medicines prescribed to them. One person told us, "I get my medication on time and they make sure that I take it." We observed medicines being administered to people, and spoke with the nursing staff responsible for medicine administration. The nurses ensured each person had taken their medicines before attending to the next person. However, one of the agency nurses on duty left the medicine trolley unlocked with the cabinet keys in the lock, whilst they went into the person's bedroom to give them their medicine. This meant the trolley was not secure.

We checked that staff accurately recorded medicines given. Most medicines were recorded correctly on the medicine administration records (MARs), however a medication used to treat Parkinson's Disease, which had been administered to the person, had not been recorded as administered. We found the procedure to record one person's 'as required' (PRN) medicines was not clear. The nurse told us they would amend this immediately. There were a few instances where staff had not recorded the opening dates of medicines. This is good practice because it ensures that medicines are not administered past their opening expiry date.

People we spoke with told us they felt safe living at Ardenlea Grove. One person told us, "I feel safe as I normally live on my own, there is someone here if I get poorly."

People were safe and protected from the risks of abuse because staff understood their responsibilities and the actions they should take if they had any concerns about people's safety. One member of staff told us, "If I saw any staff speak to, or abuse a resident in any way, I would be the first to report it." Other staff gave us examples of possible abuse and told us they would report any concerns to the nurse. They knew what action to take if the nurse did not act on the information they had given. They told us the provider had a whistleblowing policy and a 'speak-up' number they could contact.

The registered manager notified us when there had been any concerns raised about the safety of people. This included concerns about pressure sores, and allegations of abuse or poor practice. They also notified us of the outcome of any investigations.

People's individual risks were mostly minimised because their risks had been assessed, and detailed plans told staff how to reduce the risks. However, we saw one member of staff walked behind the person with an armchair in case the person fell back to minimise the risks of the person falling. The care worker was clearly doing this in the best interest of the person, but had not considered this was potentially dangerous as the person may have fallen into the armchair in a position which might have hurt them. The care plan for the person's movement had since been re-assessed to inform staff of a safer way of supporting the person.

One person at risk of skin damage told us, "If I need repositioning they [staff] do that and the night lady comes every night." We checked the person's repositioning records and saw staff were repositioning them in accordance with the risk assessment and care plan.

Where people had been identified as being at risk, there had been referrals to the appropriate service. This included the tissue viability service, the dietician and diabetic services. One person told us they had bed rails

on their bed. They said they didn't mind having the rails because it reduced the risks of them falling out of bed. Where people needed equipment to help them move, we found moving plans were in place which identified the type of hoist and sling required. This minimised the risks of accidents occurring when people were moved as it ensured staff used the correct sling and hoist. A person told us about hoisting, "I don't mind it, I like the ride!"

The provider undertook monthly reviews of accidents, incidents and pressure sores. Where incidents had occurred, these had been investigated and action taken to reduce the risk of them happening again.

Emergency and contingency plans were in place for staff to use in the event of the home requiring evacuation or other emergency situation. Each person who lived at Ardenlea Grove had a personal emergency evacuation plan (PEEP) which informed staff how they should be supported to evacuate the premises. For example, one person who was immobile, was to be supported to use a ski pad to evacuate (A ski pad is a mat with straps to keep the person secure, which can be used to bring a person down a flight of stairs when the lift is out of action). The contingency plan provided staff with the names and telephone numbers of people to contact should there be any other emergency or unforeseen event, such as water or gas leakage. This meant the emergency could be resolved more quickly as they had contact details to hand.

Requires Improvement

Is the service effective?

Our findings

Most people told us that staff had been trained to meet their needs, however one person told us, "Staff don't seem to have a great understanding of Parkinson's". We asked two staff whether they had received training to support people with Parkinson's disease. They told us they had not received formal training, but had spoken with the nursing staff to find out more about the condition. The care plans also informed staff how to support people who lived with Parkinson's disease. Another person said, "They don't know how to clean my hands without trying to prize open my fingers, when they do that it is too painful."

We asked staff what training and support they had received to carry out their roles. A member of staff told us they had attended a five day induction. This involved training and familiarising themselves with the provider's policies and procedures. They told us when they started work at Ardenlea Grove; they initially worked alongside more experienced staff until they were familiar with the home and the people they supported.

Staff told us they had received training considered essential to meet people's health and social care needs. This included training to move people safely (with equipment such as hoists), infection control, first aid, and nutrition and hydration. This was confirmed by the provider's records which showed training had been undertaken by over 95% of staff. We saw staff used their training when they moved people safely. The registered manager told us the first aid training had enabled staff to provide cardiopulmonary resuscitation (CPR) to a visitor who had become unwell whilst visiting the home, whilst waiting for the paramedics. The CPR was partly responsible for ensuring the person stayed alive.

During our observations of the Emerald Unit we saw instances where staff did not engage well with people who lived with dementia. For example, in the morning, we saw very little staff engagement with people once they were placed in the dining room. We were told staff completed basic dementia awareness training as part of their induction and once they were confirmed in post, they started to work through the provider's more advanced dementia training called 'Person First'. This was comprehensive training which consisted of a work book of 13 modules, with a total of 50 hours learning. Staff we spoke with said they had started this training, however of the three staff we spoke with, none had completed it. The registered manager informed us that 95% of staff had completed five or more of the modules. After the inspection, the registered manager told us they had contacted the provider's dementia trainer, who had agreed to schedule more sessions for staff to support them in completing their more advanced training.

Staff told us they had received individual supervision to support them in their work, and the registered manager told us each member of staff had just received a 'growth plan' to complete, prior to their annual appraisal meeting. This was to help staff identify what they did well and any areas the organisation could support them to improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw people were supported to make daily decisions about how they wanted to live their lives. For example, people chose whether they wanted to stay in their bedrooms or go to the communal lounges, what they wanted to wear, the time they got up and went to bed, and the meals they wanted to eat. Staff understood the importance of receiving people's consent before they undertook a task; however they also understood that sometimes a decision had to be taken in a person's best interest if the person refused to consent to care. For example, a member of staff told us if a person did not want to have their continence pad changed, they would try different ways to get the person to agree to this, but ultimately they would have to take a best interest decision to change the pad because the person might be at risk of skin damage if left too long.

Records showed each person's capacity had been assessed to determine the level of ability they had to make decisions about their care. Where people had been assessed as not having capacity to make decisions, we saw consultation with the relevant people had taken place to determine what decisions were to be taken in their best interest. Where people did not have capacity, family members who had the legal authority to make best interest decisions about the person's health and welfare (Power of Attorney) were involved.

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). We saw that appropriate applications had been made to the supervisory body, and staff were aware of applications that had been authorised.

We checked to see if people received food and drink which met their needs. We received mixed responses from people about whether they liked the food provided. Some said they enjoyed it and there was sufficient to meet their needs, for example, one person said, "The food is very good", whereas others said, "The food is alright I suppose. They do their best. They will change it if you don't like it", and, "The food is terrible, there is always lots of potatoes and the veg is soggy."

The chef told us there was a four weekly menu that was seasonal, and set by head office. They knew people's dietary needs, which included gluten free, diabetic, and soft food or pureed diets.

We saw breakfast and the lunchtime meal served. We saw people had a choice of breakfast and people enjoyed cereals, porridge and toast, or a cooked breakfast. At lunchtime people had a choice of main meals and dessert. We observed lunch provided in each area of the home. We saw people who required assistance with eating were provided with assistance at their pace; and people had adapted cutlery and crockery to support them to retain independence with eating and drinking.

People were assessed to check whether they were at risk of dehydration or malnutrition. Food and fluid monitoring was in place where assessments had determined people were at risk; and weight checks undertaken to see whether weight was increasing. People were also referred to the GP, dietician, or speech and language therapist for further advice.

People received support to maintain their health and wellbeing. We saw people had access to other health and social care professionals for physical and social needs. People had seen the dentist, tissue viability nurse, physiotherapists, and chiropodists. Staff had acted on the advice given by professionals who supported people's health care needs.

Requires Improvement

Is the service caring?

Our findings

Most people we spoke with told us they were happy living at Ardenlea Grove; however we had mixed responses from people about staff. Some said, "I receive good care but sometimes some [staff] get irritable and are a bit sharp," or "Some [staff] seem caring, but some just do the job at hand," and, "Most of the staff are nice but some can be really grumpy." Some people told us that staff did not speak with them when providing care. Whereas other people told us staff were caring. They said, "The staff are excellent; they are first class", "It is very nice here, the care is lovely," and, "The girls are lovely and thoughtful."

We observed similar themes during our visit. We saw times when care workers did not speak with people whilst supporting them with their care, and showed little interest or engagement with them. For example, we saw a care worker move a chair which a person was sitting in, to turn the person towards them to help them to eat. They did not inform the person they were going to be moved and it took them by surprise. The care worker then went on to support them to eat without talking to them. We also saw good care provided by most staff where they were fully engaged with people, and were warm and caring in their approach with people. For example, we saw one staff member check whether a person was feeling okay by saying, "Do you feel a little bit better now? " At the same time another person held out their hand to the care worker. The care worker took the person's hand and gave them a hug, and the person looked very happy that this had happened.

Permanent staff we spoke with had a good understanding of people's needs. Many had worked at the home for a number of years and knew people well. Care plans were thorough, informed of people's individual wants and needs, and were reviewed regularly.

During our inspection we saw two occasions where people's dignity was not fully considered by staff before they took practical action. On the first occasion, we found a person had been given their pureed meal in a cup to drink. We asked the staff why the person was going to be drinking their meal. They told us it was because the person did not like lumps in their food, and they could have their meal independently by drinking it. We spoke with the manager about this who investigated further. They told us the care staff had thought this promoted the person's independence and had not considered the implications of this being an undignified way of eating a meal. The person's cutlery and crockery were re-assessed to support them to eat their meal with dignity, and their care plan was revised to reflect this.

We were made aware that another person who lived in the home had their meals in a cup, but this was because the registered manager and staff had agreed this with the dietician and SALT team because no other option was available to maintain the person's health and wellbeing.

On the second occasion we saw a person was walking around the lounge area. The worker was concerned that the person might fall, and walked behind the person with an armchair in case the person fell back. The care worker had not considered how undignified it was to be followed by a person with an armchair when walking.

Staff told us they supported people's privacy by knocking on their room door before entering, and by making sure curtains and doors were closed before they undertook personal care. During our inspection we saw staff mostly knocked on people's doors and waited for a response before entering the person's room. However when we attended the morning staff handover meeting, we observed a nurse going into each room without knocking – this may have been because some people were still asleep and a knock may have woke them up. Again, we had mixed opinions from people as to whether staff respected their privacy. One person said, "When administering personal care, I am treated with respect. The staff normally close the door and if the curtains are open they would close them." However, another person said, "They do not always knock before entering my room."

During our visit we saw staff being respectful towards people in the way they spoke with them and behaved towards them. However one person told us they knew staff did not like the person in the room next to them because they overheard staff moaning about the person when they walked past their room. We spoke with the registered manager about this, who told us they would ensure that the next supervisions with staff would cover confidentiality and privacy.

Permanent staff we spoke with had a good understanding of people's needs. Many had worked at the home for a number of years and knew people well. Care plans were thorough, informed of people's individual wants and needs, and were reviewed regularly.

We saw people visiting the home at different times during the day and evening. Relations and friends could stay as long as they wished. We saw staff being very supportive of one family whose relation was very ill on the day of our visit.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 6 November 2014, we found there was a lack of information in people's care records about their preferences for care, which meant their preferences might not have always been met. The provider was not keeping accurate and up to date care records in respect of each person. This was a breach of Regulation 20, Records.

During this inspection we found care planning documentation was person centred, and there had been regular reviews of care to ensure staff were responsive to the person's needs. One person told us, "My needs have increased since coming in here. I know this is updated in my care plan." A relative told us, "I remember the care plan when we first came, and I have been involved in reviews." We saw staff had tried to identify peoples' past history, likes, dislikes, wishes and aspirations to support them in providing care for people.

Whilst care plans provided a lot of information about people, we did not always see this being used effectively. During the morning in Emerald unit, we observed people who had been brought into the communal dining area to have their breakfast, sat at the table with little to do, and had little staff engagement until the lunchtime meal came to the table.

We observed meal time on this unit. Staff told us the people on Emerald unit, as with the other units, were asked about their menu choices the day before the meal was served. If people could not inform staff of their choices, staff would either ask relatives or make the decision for them based on their knowledge of the person's likes or dislikes. On the day of our visit, we saw their meals were served to them, already plated, without staff informing them of what was on their plate. This meant people might not know what they were eating because they might not remember, or, know what had been chosen for them on their behalf.

Where people could express their choices, we saw staff mostly worked with people to ensure their choices were respected, and people confirmed this was the case. For example, one person told us, "I organise myself, I choose when I get up and I go to bed when I want." Another said they preferred to have a bed bath instead of a shower or bath; and another told us it was their choice to have the TV or radio on. However one person told us "I told the staff that I did not want a male nurse to look after my personal care. I was told that I had no choice."

We saw some organised activities taking place. For example, in the morning on Sapphire unit four people participated in a group game of 'Countdown' and appeared to really enjoy this activity. Later in the day, some people who lived on Emerald Unit enjoyed a balloon game with two of the care staff.

People who could communicate with us had mixed views about their social needs being met. One said, "We have stimulating activities," but most people felt there was not enough to do, and that staff did not have time to sit and talk with them. For example, one person said, "There is no personal touch. Staff do not stop for a chat. I just sit here [in their room]." Some staff echoed this view. One member of staff told us, "If there were more staff on the floor we could do activities with them." Another staff member said, "The activity person will do 'one to one' chats with people, but if we had more staff we would be able to chat too."

People told us of some of the activities provided. They explained that animals had been brought into the home, and how the animal handler had brought a Shetland pony in the lift to see a person on one of the floors who was too unwell to get out of bed. Another told us a person brought in knitting for them to do. Staff confirmed that other activities included 'Mr Motivator' and bingo. One person was unhappy because there used to be a trolley which would come around the home twice a week with items they could buy such as wine or sherry. They told us this had been reduced to once a week, and now not at all. They said they enjoyed this because it gave a chance to speak with staff. They told us, "There is no compassion or caring towards people. They don't realise the impact on residents. It makes a big difference to a day." Another person told us, "We are often wheeled into the lounge and just left there with no-one about."

People told us there had been another activity worker but they had left the home a month or two ago. The registered manager confirmed this, and told us they had recruited to fill the position. They told us this had not impacted on the activity programme of the home and they felt there were sufficient individual and group activities to meet people's needs.

People and their relatives understood how to complain about the service. People either told us they had no complaints, or that they knew who they would complain to. For example one person said, "If I had any concerns I would call head office." And another said, "If I had any concerns I would let them know." Information about how to make a complaint or make suggestions was available throughout the home, including in the foyer of the reception area. We saw there had been two suggestions posted in the suggestion box in the home. The suggestions and the provider's response to these were available on the notice board in the lobby for people to see.

We saw there had been six formal complaints raised since our last visit. These had been investigated in line with the provider's complaint policy and procedure. Two of the complaints had been upheld by the provider. We asked the registered manager what systems they had in place to learn from informal complaints or grumbles. They told us these were recorded in the person's individual care file. We were concerned this meant potential trends or issues would not be identified by the provider. The registered manager told us after our visit, they were putting a 'concerns' book on each unit for staff to record any concerns raised, and action taken to address the concerns.

The registered manager had monthly relatives meetings which provided relatives with an opportunity to get together with the registered manager and share their views about the home. There were different themes for each meeting, for example, in December 2015 relatives discussed maintenance issues in the home.

Good

Is the service well-led?

Our findings

People and their relatives felt the home was well managed, but some did not feel the registered manager was sufficiently visible. One person said, "I think that it is well led. If you have a problem they will sort it out for you." Most people we spoke with told us they were happy living at the home, however one person said, "I know who the manager is but I don't see her much, I'm a little scared of her, she's not approachable." Another told us, "They don't come and ask how you are. They never came to see if I had settled after moving rooms." One person told us they didn't know who the registered manager was.

The registered manager told us they were a 'hands on', approachable manager and was surprised to find that some people felt differently. They told us they wanted to reassure people to feel safe to come and speak with them, and were often on the floors helping with care. They told us they spent a lot of time on the floors talking with people and staff, and chairing resident meetings. They also worked on occasion as a nurse and so had direct contact with people when nursing. They thought that people might see them as a nurse and not the manager.

Staff confirmed the manager was hands on. They said, "The registered manager is quite approachable, she does listen." Staff told us they received support from senior staff and management to undertake their roles. In the last staff survey undertaken by the home, 71% of staff said they felt the registered manager had invested time and effort in their growth and development and 79% also said they felt they had the training they needed to do their job well.

Some of the observations we made and concerns raised, had been previously identified by the organisation. They had been working with staff to engage more fully with people who lived with dementia. After our visit, the registered manager contacted the organisation's dementia trainer to make sure staff received additional training to support specialist dementia care provision.

The registered manager was furthering their own knowledge and using this to support staff understanding of the MCA and DoLS. They told us they were in the process of completing a Best Interest Assessor course. This meant they would have the skills and knowledge to assess whether a deprivation of liberty safeguard was in the person's best interest. However, they would still have to apply to the local authority to make any decision as they remained the 'supervisory body' for authorisations.

There were regular staff meetings held at the home. These provided staff with an opportunity to discuss issues, and to receive information to support them with their work. For example, during the staff meetings in December, the Mental Capacity Act and best interest decisions were discussed to increase staff awareness.

At our last inspection, the registered manager told us their deputy manager had just left the service and they were actively recruiting for a new deputy manager. During this inspection there was again no deputy manager. The registered manager told us it had taken six months to recruit to the deputy manager position; however the person who had been recruited had left the service the week before the inspection, having worked at the home for six months.

The registered manager had recently set up 'staff engagement sessions'. These were dedicated times where the manager was available for staff to come and discuss any issues or concerns they were facing. This was in response to the provider's staff survey where staff requested more time with their registered manager. The registered manager explained that whilst they had an open door policy, the engagement sessions ensured there was uninterrupted time for staff without the distractions of people knocking on the door or phone calls.

The provider had been supporting the registered manager. The area manager had regularly visited the home to provide support and was visiting the home on the day of our visit. They had helped the registered manager implement the new care plans and ensured that quality standards were maintained. This was through monthly home review audits which covered a range of areas such as analysis of falls and incidents, checks on medication administration and checks to ensure people who had lost weight were being referred to the appropriate healthcare professional.

The provider sent out a yearly quality assurance survey to people and their relatives. In their last survey, people were much more positive about the care provided than some of those we spoke with during our visit. In the survey comments included, "Excellent care, friendly and helpful staff"; and "I am very happy living here, carers and nurses are so kind to me and always listening to my concerns."

The registered manager had been proactive in using the information as learning points for themselves and for staff in supervision sessions and in training. This included supervisions in confidentiality, and dignity in care.

The registered manager has a legal obligation to notify us of any incidents, accidents or deaths which occur at the home. They were meeting their legal requirements. The provider has a legal requirement to inform the public of the home's rating. They had informed the public on their website that they had previously been rated as overall 'Requires Improvement', and a poster with their ratings was displayed in the reception area of the home.

The commissioners of health and social care services told us they had no concerns about the care provided to people at the home.