Care UK Community Partnerships Ltd

Harry Sotnick House

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

Overall summary

We carried out a focused inspection of this service on the 5, 6 and 12 May 2015. Repeated breaches of the legal requirements were found in relation to the standards of care and welfare for people who used the service, lack of robust quality assurance, unsafe management of medicines and the failure to manage complaints effectively. After this focused inspection the service was placed into special measures and a condition was placed on the registration of the service prohibiting admissions to the service without the express permission of the Commission.

We undertook this unannounced comprehensive inspection on the 23, 24 and 29 September 2015 to check the service had made improvements and met legal requirements. The service had demonstrated sufficient improvement to be taken out of special measures.

The home provides accommodation and nursing care for up to 92 older people including those who live with dementia. At the time of our inspection 58 people lived at the home.

A manager in place had submitted an application to the Commission to become the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the registered provider and manager had met all the requirements of the Regulations to meet the fundamental standards, however further work was required to embed this practice in the home.

Medicines were administered, stored and ordered in a safe and effective way. Some work was required to embed this good practice in the home.

Staffing numbers were sufficient to meet the needs of people, however staff were not always very visible to people or their relatives.

Risk assessments in place informed plans of care for people to ensure their safety and welfare, and staff had a good awareness of these. External health and social care professionals were involved in the care of people, especially those with enhanced needs; care plans reflected this.

Staff had a good understanding of how to keep people safe, identify signs of abuse and report these appropriately. Processes to recruit staff were in place which ensured people were cared for by staff who had the appropriate checks and skills to meet their needs.

Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Further work was required to record the needs of people whose ability to consent to care may fluctuate. Where people were legally deprived of their liberty to ensure their safety, appropriate guidance had been followed, however some records required further information on the reasons for these restrictions.

People's nutritional needs were met in line with their preferences and needs. People who required specific dietary requirements for a health need were supported to manage these.

Care plans in place for people reflected their identified needs and the associated risks. Staff were aware of these and understood people's needs well. Staff were caring and compassionate and knew people in the home very well.

Complaints had been responded to in an effective and timely manner and this work needed to be sustained.

The service had effective leadership which provided good support, guidance and stability for people, staff and their relatives; however, this needed to be sustained. Audits and systems were in place to ensure the safety and welfare of people. People, their relatives and staff felt positive in the recent changes in the service however, these needed to be sustained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was safe. Further work was required to embed this safety in the service.

Whilst medicines were managed in a safe and effective manner,new processes which had been implemented at the home required time to become embedded in staff practice.

Risk assessments were in place and informed plans of care for people.

Staff had been assessed during recruitment as to their suitability to work with people and they knew how to keep people safe.

Health and social care professionals were involved in the care and support of people to ensure the care they received was safe and in line with their needs.

Is the service effective?

Requires improvement 

The service was effective. Further work was required to embed this effectiveness in the service.

Where people could not consent to their care the provider was guided by the Mental Capacity Act 2005; however, for people whose capacity fluctuated records required further clarity on how they could be supported to make decisions.

Staff knew people well and could demonstrate how to meet people's individual needs.

There were sufficient staff on duty to meet the needs of people.

All care records held nutritional risk assessments for people. These included information on specific diets required for health conditions and preferences.

Is the service caring?

Good 

The service was caring.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people.

People and their relatives were involved in the planning of their care

Staff showed an empathetic and caring approach to the care of people who were close to the end of life. Care plans in place to support this care were thorough and informed staff of the person's wishes.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Summary of findings

Some areas of care required further review to eliminate task orientated practices by staff.

Activities available for people had improved however, some people remained isolated and lacking in stimulation throughout the day.

Care plans reflected the identified needs of people and the risks associated with these needs.

People felt able to express any concerns and complaints were responded to in a timely way.

Is the service well-led?

Requires improvement

The service was well led but this needed to be sustained.

The home required further time to ensure sustained leadership and to embed the improvements which had been made in the home.

The manager had developed robust audits and systems to ensure the safety and welfare of people in the home. People, their relatives and staff were positive the service was improving to meet people's needs.

Harry Sotnick House

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 was 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.

We undertook this unannounced comprehensive inspection of Harry Sotnick House on 23, 24 and 29 September 2015. At the last focused inspection in May 2015 this provider was placed into special measures by CQC and a condition placed on the registration of the service prohibiting admissions to the service without the prior permission of the Commission.

The inspection team consisted of three inspectors, a pharmacist inspector, a specialist advisor in the nursing care of older people and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and service improvement plans. We reviewed notifications of incidents the manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

It was not always possible to establish people's views due to the nature of their conditions. We spoke with 5 people who lived at the home and ten relatives to gain their views of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the manager and 17 members of staff including; the deputy manager, two clinical lead nurses, four registered nurses, a nutritional lead, care staff and activities coordinators. We spoke with the regional director and a member of the registered provider's clinical governance team.

We looked at the care plans and associated records for 17 people and the medicines administration records for 11 people. We looked at records relating to the management of the service including six staff recruitment records, records of complaints, investigation records, quality assurance documents including medicines and care record audits.

Requires improvement

Is the service safe?

Our findings

Relatives told us they felt their loved ones were safe at the home although they were not sure there were sufficient staff available at all times. They said staff knew people well and understood their needs to ensure their safety. One said, "They know [relative] very well and I know they always lookout for her. She is safe." However, another told us, "Sometimes I just can't find anyone or they are very busy. I am sure [relative] is safe, but they could do with a few more people [staff] around." Health and social care professionals we spoke with said people were safe in the service although they would require reassurances from the home of how they would manage people's safety when the number of people who lived at the home increased.

In our inspection in May 2015 we found, whilst systems to audit and monitor the management of medicines had been put in place, medicines were not always administered when required. The provider had not always identified learning from incidents of missed medicines. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in the management and administration of medicines.

There were clear and effective systems and processes in place to administer, order and receive medicines, however these required time to become embedded in staff practice at the home and would need to be developed further when more people were admitted to the home.

All medicines were administered by a registered nurse. Medicine administration records (MAR) held information to identify people including photographs and dates of birth; they also held information on any known allergies. Administration of medicines were recorded clearly on MAR sheets and there were no gaps in these records, however two did not identify the times medicines were administered which may have led to people being offered medicines without an appropriate time delay between doses. Medicines that were applied as patches were recorded on separate charts; one patch had been administered however the positioning of this had been inaccurately recorded. Topical medicines charts were in place, however these did not always reflect that medicines were being administered correctly. For example, for one person a topical medicine had been prescribed for a specific area of their body. This was being applied in a different manner by staff and this was reflected in care records. The manager told us these issues would be addressed immediately.

We had received notifications from the home of two cases where the balance of medicines in administration records was incorrect and medicines were deemed to have been missing. These incidents had been identified and investigated by a pharmacist employed by the provider to review the management of medicines in the home. Systems had been put in place to monitor the balance of medicines kept at the home for people. However, in two cases the balances of medicines recorded by the home did not correlate with the administration records. This was reviewed by a member of the provider's corporate team at the time of our visit who identified further work was required to ensure stock balances of medicines were accurately recorded.

Protocols were in place for the administration of most 'as required' medicines. These protocols provide guidance as to when it is appropriate to administer an 'as required' medicine and ensure that people receive their medicines in a consistent manner. However, two protocols were missing and two protocols did not contain important information about how to give medicines appropriately. These issues were addressed at the time of our visit.

Medicines were stored safely and securely, in locked medicine trolleys, cupboards or fridges within a secure treatment room. Medicines that require additional controls because of their potential for abuse (Controlled drugs) were handled appropriately and stored securely.

Staff confirmed they had undergone recent training with regards to medicines administration and their responsibilities and accountabilities for this. Improvements had been made to the management of medicines. However, further work was needed to embed this work and ensure all staff were aware of their responsibilities in relation to the management and administration of medicines. We spoke with the manager and they agreed there were areas which required further work to embed the practice in the service.

People and their relatives told us they often could not find staff when they required them. One person told us, "They are very busy so I don't really see much of them [staff]". Staff rotas and daily allocation sheets showed there was

Is the service safe?

sufficient staff available to keep people safe and meet their needs; however, it was often difficult to find staff around the home or for staff to be seen by people as they carried out their duties. Staff told us the numbers of staff working at the home had improved and was usually consistent however, they were concerned as to how they would manage when numbers of people who lived at the home increased.

The registered provider used a recognised dependency tool to measure the needs of people in the home and ensure adequate numbers of staffing were available to meet these. This was reviewed by the manager as required when people's needs changed. They had used this to identify staffing levels at the home could not meet the need for some people to have one to one care and support; subsequent funds had the been applied for with the local authority to provide additional staff to meet these people's needs. The home had an on-going recruitment drive to ensure sufficient staff, particularly registered nurses, were available at all times to meet the needs of people.

Registered nurses completed risk assessments on the provider's computerised records system and copies of these documents were available for all staff. These provided clear information on identified risks for people and how these could be minimised. For people who displayed behaviours that might present a risk to the person or others, the behaviours and triggers to these had been identified. Staff knew people very well and demonstrated a good understanding of their needs and how to support them. Care records reflected actions staff had taken to support people should they become distressed or agitated and care plans had been updated when required to reflect changes in people's needs.

For people who were at risk of isolation or being unable to summon help with the use of the services call bell system, risk assessments were in place to ensure they were monitored and supported to maintain their own safety on an hourly basis.

For people who were at risk of a breakdown in their skin integrity, risk assessments and care plans identified the use of appropriate equipment, such as pressure relieving mattresses and cushions and suitable equipment to support people to move whilst in bed. Care plans reflected the need for people to be supported to change their position regularly and ensure their hygiene needs were met. This was completed. Most of these mattresses were automated to accommodate the weight of the person. However of the three which required staff to set these manually in accordance with a person's weight; we found these were not set correctly. This meant these people may have been at risk of break down in their skin integrity. We spoke with a clinical lead nurse who addressed this immediately.

For people who were at risk of falls, risk assessments had been completed and these informed care plans of their mobility and risks of falling around the home. All incidents of falls were recorded in care records and learning had been identified from these, care plans and risk assessments had been updated to reflect the change in needs. For example, a falls mat alarm had been placed in the room of one person who was prone to falls. This would be triggered if the person should attempt to mobilise independently from their bed and prompt staff to ensure their safety. This mat had subsequently been identified as a trip hazard and removed with additional actions in place to monitor the safety of the person.

Safeguarding policies and procedures were in place to protect people from abuse and avoidable harm. The manager held clear information on any concerns raised and how these had been addressed and learning identified from these. Staff had received training on safeguarding and had a good understanding of these policies, types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC. Staff were aware of the registered provider's whistleblowing policy and how they could also report any concerns they may have to their immediate line manager or other manager in the service.

Personal evacuation plans were in place and up to date for each person. A system was in place to identify those people who would require assistance in the event of an emergency and all staff were aware of this.

The registered provider had safe and efficient methods of recruiting staff. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. The registered provider had established a management structure for staff

Requires improvement

Is the service safe?

in the home. This ensured a senior member of staff was always available to provide guidance and support for staff, ensuring safer working practices to meet the needs of people.

Requires improvement

Is the service effective?

Our findings

Staff knew people well and could demonstrate how to meet people's individual needs. They interacted with people in a calm, encouraging and positive manner. Relatives spoke highly of the staff and the way in which they supported their loved ones. One said, "They have looked after my [relative] so well and I can't thank them enough for that." Health and social care professionals we spoke with felt the care people received was effective and met their needs.

The manager had a management and staffing structure in place which provided clear roles and responsibilities for all staff. The clinical lead and other registered nurses provided clinical leadership roles each day, taking charge of each daily shift, providing support and guidance for all staff. Care staff were encouraged and supported through direction from the clinical lead nurses, nursing staff and training to take on enhanced skills such as medicines administration and nutritional support. Staff said they felt supported by their peers and senior staff.

A program of supervision sessions, induction, training, and meetings for staff ensured people received care and support from staff with the appropriate training and skills to meet their needs. Staff felt supported through these sessions to provide safe and effective care for people. All staff were encouraged to develop their skills through the use of external qualifications such as national vocational qualifications (NVQ). These are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability to carry out their job to the required standard.

Where people had the mental capacity to consent to their treatment, staff sought their consent before care or treatment was offered and encouraged people to remain independent. People were encouraged to take their time to make a decision and staff supported people patiently whilst they decided. For example, for one person who could not decide which of the offered meals they would like, staff patiently discussed with them the choice and allowed the person time to decide. For another person who was very independently mobile and did not wish to sit for their meal at meal time, staff respected their choice and ensured their meal was available later when they requested it.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. Care records held clear information on the processes which had been followed to ensure the appropriate people were involved in making decisions about people's care and welfare. However, some records required further clarity on how people could be supported to make decisions. All staff had completed training on the MCA and Deprivation of Liberty Safeguards (DoLS) and were able to tell us how people were supported to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect the person from harm. Many people who lived at the home were subject to a DoLS; we found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards, however some care records required further clarity to ensure the reason for these restrictions were fully identified. The manager was aware this information needed to be updated and completed this during our inspection.

People received a variety of homemade meals and fresh fruit and vegetables were available each day. A nutritional link member of staff discussed with us the changes made to meals to accommodate people's preferences and needs such as weight gain, weight loss and diabetic or vegetarian needs. They identified significant improvements they had made in the monitoring and management of people's dietary intake to ensure they received a nutritious, individualised and effective diet. They worked closely with a speech and language therapist and dietician if they had any concerns about people and linked closely to the chef to meet the dietary needs of people.

Care plans identified specific dietary needs, likes and dislikes of people and the chef was aware of these. People's weights were monitored regularly and action taken should any significant changes be noted. For people who were at

risk of choking, information in care records clearly identified the need for staff to thicken fluids to reduce this risk. For those who required pureed meals, the chef had recently had training to accommodate this need in a way which allowed meals to appear more appetising for people.

In most of the units of the home, only a few people used the dining area at meal times. Many people required support to manage their meals whilst they were in their room or in bed; staff did this in a patient and calm way. Dining areas had background music on and the interaction between people and staff was minimal but good. People were assisted to manage a choice of meals in a quiet, dignified and respectful way. Throughout the day a range of snacks and beverages were available for people and their visitors. The kitchen area was clean and well managed.

Records showed people had regular access to external health and social care professionals as they were required. A GP visited on one day of our inspection to support people. The manager told us they regularly worked with community services staff to meet the needs of people. This included a chiropodist, community specialist nurses and therapists, speech and language therapists and the community mental health team. Feedback we received from external health and social care providers was positive. They told us the stable management structure within the home over the past six months had led to clearer lines of communication; staff were more approachable and responsive to suggestions, requesting support when this was required. The manager worked closely with many local surgeries to address the needs of people and was looking to review and refine this process.

Good

Is the service caring?

Our findings

Many people at the home were unable to speak with us and tell us of their experiences. We observed the support and care provided for people. They were treated with dignity and respect. Relatives were happy their loved ones were respected and well cared for. Staff showed kindness and compassion whilst supporting people with their needs and respected people's views. One person told us, "The staff are nice and friendly." A relative said, "The staff are lovely. I can't fault them. They're very patient." Another said, "Oh yes the staff are all very caring and my [relative] loves them all." A visiting health care professional told us staff were always very caring and knew people well.

Staff had worked with people and their representatives to ensure their care reflected their preferences, choices and needs. People and their relatives or representatives had been involved in the planning of their care and monthly review of their care. Care plans reflected people's likes and dislikes.

Staff knew people well and demonstrated a regard for each person as an individual. They addressed people by their preferred name and had a good knowledge of people's previous life history and preferences. For example, staff had shared pictures of a former local landmark with one person and this had supported them to reminisce of their life in the local area. Areas of the home were being developed to support people who lived with dementia to have meaningful interactions with others; such as a sweet shop which allowed a person who had previously worked in retail to use the skills they had learned in life to be put to use. A replica bar area was available to provide an environment where people could relax and interact with each other and their relatives.

People's rooms had been decorated with familiar objects and mementos which reflected their individual preferences and choice. For example two people had mementos of their favourite football club in their rooms and staff were seen to interact with them about their teams recent results. For another person, pictures of their family displayed in their room were important to them as they, "Make them feel nearby." Staff knew this person liked to talk of their family.

People's daily records indicated they were treated with kindness and respect. For example we noted that one person had been found in their room awake, sat in their chair and fully dressed at 02.00am. Staff had encouraged the person to change into their nightclothes and had assisted them back to bed. During our visit this person was trying to find their room and we observed a member of staff treating them with respect and they reminded them of their room number.

At mealtimes, staff were seen to engage positively and cheerfully with people. They offered support with managing meals, cutting up food and offering drinks to people.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. For example, staff ensured doors were closed when providing people with support with their personal care.

Care was taken to ensure people's wishes were respected as they moved toward the end of their life. Care plans gave clear information and direction for staff on people's wishes and who they chose to have with them at this time. Advanced directives and care plans were in place for people who had specific wishes at the end of their life and we saw staff followed these. Staff supported people in the end stages of life in a dignified and caring way.

Requires improvement

Is the service responsive?

Our findings

Relatives thought staff were helpful and always aimed to address the needs of their loved ones. They were able to raise any concerns they may have with the manager or staff and felt sure these would be addressed. Health and social care professionals we spoke with felt confident people's needs were met at the home.

Care plans reflected the identified needs of people. Preadmission assessments and information from families and friends were available on file and had fully informed people's care plans. People had discussed their care with staff and agreed with this, where they were able. A system called, 'Resident of the day' was used to ensure people and their families and representatives had the opportunity to discuss and agree their care. During a designated day every month each person had a full review of their care to include; an update of all care plans, records were audited and checked for accuracy, monitoring of their weight and other specific health needs (such as blood sugar monitoring). A review of their room was completed by maintenance staff and their catering needs were reviewed by kitchen staff. We saw that this system had been embedded in the daily working of staff, with all records which required review having been completed and updated.

All care records were held on a computerised system to which all staff had access. Staff were aware that all information with regard to people's care needs could be found in their care plans on the computer and in files at each nursing office.

Care plans were individualised and held information on people's likes and dislikes, how they required support and what they could do independently. Care records held clear information regarding specific health conditions such as dementia, diabetes, epilepsy and Parkinson's disease, the impact these had on the person and how staff should support them with these needs.

Whilst staff were very caring of people and provided care for people in a supportive and empathetic way, care was sometimes seen to be provided in a way which was task orientated and lacked an individualised approach, or did not encourage people to remain independent. For example, one person who was sat with their relative during a meal, wished to use the toilet. However, they were aware they could not do so during a meal as staff were busy serving food for people and would support people to the toilet only after the meal. Their relative was also aware this was the usual routine. Staff sometimes used phrases such as , "They will be next to be done [supported]", and, "I will get to them next," indicating a rote of work which required completing through a shift, rather than individualised needs being met as required. Some staff needed to be encouraged to remove task orientated care from their working practices.

During our inspection 24 of 58 people remained in bed throughout one day. Whilst some care records identified the need for the person to remain in bed following advice from health care professionals, there was no information to suggest other people should not be encouraged to spend time in their room or communal areas of the home. When we asked staff why so many people were in bed, they told us this was often people's choice and they respected this. Some people who remained in bed had minimal interaction with staff and were at risk of isolation. The manager acknowledged that some people may need to be encouraged to participate more actively in their care, out of bed.

At our inspection in May 2015, activities which were coordinated in the home lacked direction for many people and were focused on very small numbers of people. At this inspection three activities coordinators were available to support people with a wide range of activities throughout the week and this included one to one sessions for every person during the week. The home was working towards being a centre of excellence for those who live with dementia. Decoration and development of several projects including a sweet shop and reminiscence area were under way and the manager had encouraged staff to develop a themed approach to each unit in the home to motivate and stimulate people. People represented each unit of the home and took part in a competitive interaction with various games and activities including 'dog racing' and 'family fortunes'. Activities were advertised in various areas around the home including people's rooms.

For people who remained in their rooms throughout the day their main activities were watching television or listening to the radio. A central ground floor communal area was well used by a small number of people who attended all activities and appeared to enjoy these. A karaoke event was well attended and people enjoyed this.

Requires improvement

Is the service responsive?

A drama session was also well received. However, for people who could not reach these events, further work was required to use other communal areas of the home, which had good facilities to support and motivate people, to ensure people were not isolated and had access to suitable activities to meet their needs.

There was clear enthusiasm from the activity coordination team and manager to develop further means of providing appropriate and stimulating activities for people, particularly those who lived with dementia. This work required embedding in the home to ensure all staff acknowledged and understood the need for people to have activities which met their needs.

The provider had a complaints policy available for view in the home. We saw one formal complaint had been forwarded to the provider in the period since our inspection in April 2015; this had been actioned, investigated and reviewed in line with this policy. The manager told us they actively encouraged people and their families to approach them with any concerns they may have so that these could be reviewed and addressed appropriately. Relatives told us they would be happy to approach the manager to raise any concerns they may have and were confident these would be addressed promptly and effectively. One relative told us, “She’s [manager] very approachable. We feel we can speak to her with any problem and things get done.”

Requires improvement

Is the service well-led?

Our findings

In our inspection in May 2015 we found the registered provider had failed to establish systems and processes to effectively ensure compliance with the safe administration of medicines. They had failed to learn from and improve the poor practice of medicines following incidents at the home over a sustained period of time. This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in this area and met the requirements of this regulation.

Effective audits were in place to ensure the safety and welfare of people who required medicines to be administered for them. Medicines were audited and managed in accordance with the provider's policies and procedures. Incidents which had occurred during the administration of medicines had been reviewed and learning had been recognised from these and shared within the service. Whilst new processes were in place, the service required time for these to become embedded in staff practice.

The service had not had a registered manager in place since May 2014. A manager had made an application to the Commission to become the registered manager for this service. This manager had been in the service for a period of over six months and people told us this had given the staff and people who lived at the home stability in support and development for the home. One relative told us, "It is great that she [manager] is staying as she is the right person to take the home forward." Another said, "She has really made a difference." Health and social care professionals spoke highly of the manager and their dedication to moving the service forward to improve the lives of everyone who worked and lived there.

A staffing structure in place at the home provided a strong support network for staff. The manager, deputy manager and two clinical lead nurses provided a stable senior management team in the home. Staff told us they felt able to speak with their line manager or senior managers about any concerns they may have and these would be addressed promptly and effectively. Staff felt supported through supervision and team meetings were used effectively to encourage staff to take ownership of new projects in the home such as the development of memory boxes for people and themed areas of the home. Staff were reminded of their accountability in these meetings and were also encouraged to bring new ideas and ways of working to the meeting. One member of staff told us, "Having lead members of staff has made such a difference," and another said, "We really can make a difference now 'cause anything we suggest to make things better is considered." Staff felt empowered to improve the service whilst being supported by the manager; one told us "They [management] are great they are really taking notice of what we are saying- it makes it really worthwhile and people are getting a better service because of it."

People and their relatives met with the manager to discuss ideas and new developments within the service. Minutes from these meetings showed people had been involved in the development of themed areas within the home, new activity ideas and feedback about meals. Following a recent meeting one relative said, "A lot of people came and voiced they would like the present manager to stay." Relatives told us the meeting was very open and honest and helped them to understand why the changes in the home were required.

Audits were in place to review and monitor the effectiveness of care plans and records. The computerised system of records supported a programme of monitoring reviews of care and identifying the need for records to be reviewed in a timely way. This work was up to date and a programme in place to ensure this was sustained. Staff knew how to access care plans and records available to them. They were aware of people's needs and how to have these amended on the system if they identified a new or changed need.

Care records were reviewed monthly or more frequently as required by the clinical lead nurses and the deputy manager. Some daily records for people including fluid monitoring charts and topical medicine charts were not always completed thoroughly and this was an area the clinical lead nurses were looking to develop and improve. However, standards of documentation had improved from our previous inspections and the manager told us this work was being addressed and staff had a clearer understanding of the need to ensure care records held accurate information to reflect the work they did to support people in the home. This work required further embedding in the home.

The provider had completed a regulatory governance audit at the home in September 2015 and identified the need for

Requires improvement

Is the service well-led?

the system for action plans to be completed following all audits in the home. This had been addressed. Audits to ensure the safety and welfare of people were completed and monitored centrally by the provider. These included audits on; incidents and accidents, kitchen working, night time care and health and safety in the home.

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.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.