Orchard Care Homes.Com (2) Limited

Sutton Hall and Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on 28 September 2015 and was unannounced. The last inspection at this service on 7 November 2013 had found no breaches of regulations.

Sutton Hall and Lodge is registered as a care home, which also provides nursing care. It is owned and managed by Orchard Care Homes.com (2) limited. The home is registered to accommodate up to sixty adults and is set in private grounds. There is car parking to the front of the premises. Accommodation is over two floors and there is a passenger lift, as well as staircases available, to access upper floors. The home is split into four units; each unit has fifteen bedrooms, with quiet and communal areas available. Two units, which are on the ground floor, have been set up specifically to care for the needs of people living with a dementia type illness. The home employs carers, nurses and ancillary staff.

There was a newly appointed manager at the service, who is working through the process of registering with the Care Quality Commission (CQC). The previous registered manager had left the employment of the company on 21

Summary of findings

September 2015, after a handover period with the new manager. This service needs to have a registered manager in place as part of the conditions of registration. A registered manager is a person who like registered providers, 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 they felt safe and we saw that risks had been identified within the service and actions taken to ensure peoples safety. Overall medicines were managed safely, however some improvements were needed in two of the four units to make sure people received their medication as prescribed and in accordance with their medical conditions.

Staff understood how to protect people from abuse and had received training. They were supported through the use of supervision and regular staff meetings.

The majority of people who used the service had personalised care and support plans and had been involved in their development . They were involved in all aspects of their care.

People knew who to complain to and complaints were being dealt with as described in the providers procedures.

There was an effective quality assurance system in place at this service.

This service was safe in most areas but improvements were needed in the management of the infection control practices and the deployment and use of domestic on two of the four units. The infection control practices were not adequate in some parts of the service, and the deployment of domestic staff meant that some areas were not being cleaned regularly due to staff shortages.

Staff understood what it meant to safeguard someone and they had been trained to do so.

Health and safety risks had been considered and actions had been taken to minimise them.

Overall care plans were personalised and any risks had been identified. However, in small number of records we reviewed we found some information was contradictory and lacked sufficient detail.

There was a strong emphasis on community involvement. People had access to a wide range of activities and relatives had formed a 'Friends of Orchard' group who worked together in the best interests of the service.

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?
This service was safe in most areas.

Improvements were needed in the management of medication, the infection control practices and the deployment and use of domestic staff on two of the four units.

People told us they felt safe.

Staff understood what it meant to safeguard someone and they had been trained to do so.

Health and safety risks had been considered and actions had been taken to minimise them.

Requires improvement

Is the service effective?
This service was effective.

On the whole people were given choices. However, we discussed ways this could be improved for people living with a dementia type illness.

Staff were trained in subjects that were relevant to people who used the service. They were supported through training and the use of supervision.

Food was described as good overall by people who could give us their views about the meals provided.

Good

Is the service caring?
This service was caring.

We could see interactions were friendly and respectful between staff and the people they were supporting and caring for. We noted staff were engaging overall and knew people very well and how best to care for them.

Peoples privacy and dignity was respected.

People were involved in their care and were given information.

Good

Is the service responsive?
The service was responsive.

Overall care plans were personalised and any risks had been identified. However, in some of the records we reviewed we found some information was contradictory and lacked sufficient detail.

There was a strong emphasis on community involvement. People had access to a wide range of activities and relatives had formed a 'Friends of Orchard' group who worked together in the best interests of the service.

Good

Summary of findings

There was a complaints policy and procedure and people who used the service knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

It was being managed by a newly appointed manager who was working through the process to become registered with CQC.

We noted some unrest in the staff team which would benefit from positive engagement with the management team to address any concerns staff had about the running of the service.

There was an effective quality assurance system in place to ensure the quality of the service was maintained and that improvements could be made.

Maintenance of mains services and equipment was completed and up to date.

Sutton Hall and Lodge

Detailed findings

Background to this inspection

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

The inspection took place on the 28 September 2015 and was unannounced.

The inspection team was made up of two inspectors, a specialist advisor 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. On this occasion our expert was experienced in the care of older people and those living with dementia. Prior to the inspection we looked at information we held about the service including any statutory notifications. These are notifications that the provider makes to CQC when they need to report specific events. We contacted the local commissioners and they shared information with us following their quality audit from May 2014 which identified a number of recommendations which the provider needed to address to comply with their local authority funding. We also contacted Healthwatch which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch did not raise any issues with us about Sutton Hall and Lodge.

We requested and received a Provider Information return (PIR) for the service. 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. We used this information to help plan our inspection and we checked out what the provider had told us during the course of our visit.

During the inspection we looked at ten care plans, associated care records, monitoring tools and medication records. We also looked at employment and training files for four staff and other records relating to the running of the service including policies and procedures and service records. We spoke with nineteen people who used the service and spent time observing people in the communal areas as some people had complex needs and were not able to express their views about the service. We met and spoke with five relatives, twelve staff members – including four care workers, an agency carer, the chef, the administrator, a domestic, two nurses, the manager and the operations manager. We also spoke with two visiting healthcare professional, one who was a district nurse.

Requires improvement

Is the service safe?

Our findings

When asked about the care being delivered and if people were safe, one relative told us, "I think it's brilliant to be honest; they are in safe hands. I can't speak highly enough of them." The relative went on to say that another of their relatives was familiar with how care homes ran and that they were also happy with Sutton Hall and Lodge. One person using the service said, "Yes, I feel safe; I'm alright here." Another person told us, "I've never seen anything to upset me. Staff always seem pleasant when you walk past rooms."

People, who could walk around indendently or with a walking aid, were seen moving around the building freely. Some people told us they liked to visit other people in their own rooms to have a talk and socialise. Staff were keen to make sure that people, who were being nursed in bed, were not isolated and where appropriate their bedroom doors were left open. People told us they locked their bedroom doors when not using them and this helped them to be confident their room was private and their belongings kept safe.

A number of people told us they thought the service was short of staff. One person told us their relative spent most of their time in their bedroom because of that. We explored this during our inspection and received the following responses. One person told us, "They need more staff sometimes; a lot have left." They went on to say that the staffing seemed less at weekends and that staff were "run off their feet." One person told us, "There used to be more [staff]. They are very, very busy, that's why I get myself up and washed." We asked about night time and the person went on to say, "It's difficult at night; sometimes they've got to have these agency workers; they are good; they've all got their own ideas. The nurses I liked are gone." Another person told us, "They are often short- staffed. It puts a strain on staff and care; they can't fully engage with the clients. The girls are lovely and they work flat out." In contrast one person told us, "They are very busy but if I want anything, they get me it but I'm very independent." We also asked people about the response times when they used their alarm calls to summon help. Those who were able to give a view told us that their buzzers were answered quickly and there was always someone on hand should they need attention. They understood if they had to wait if staff were busy with others but they had not been left too long before getting attention.

The manager told us that the staffing arrangements were planned according to the dependency levels and that the service used a dependency tool which they said gave them a good indication of when to increase staffing levels on both the nursing and care worker roster. It was acknowledged that there were vacancies throughout the service but that new staff had been appointed and were awaiting pre employment checks before starting work. Further interviews were also planned to cover the shortfall in nursing hours at night time. To avoid a shortfall in the roster, until new staff started, the service used agency staff. To protect people and ensure the proper level of care was given, regular staff from the agency were used for consistency. We did not find any evidence during our inspection that the staffing arrangements were not sufficient to safely meet the needs of those using the service. However, some people using the services and their relatives were concerned about the current situation and felt that more should be done to keep them updated.

We recommend the provider reviews and monitors staffing levels across the home, including ancillary staff, to ensure that the care people receive and the hygiene levels in the service are not compromised.

We looked at the employment files for staff and saw that they contained all the required information including evidence of criminal records checks obtained through the Disclosure and Barring service(DBS). The DBS assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. This meant that those staff who worked at the service were deemed suitable to work with this client group which in turn safeguarded the welfare of people who used the service.

There were policies and procedures in place in relation to abuse and whistleblowing procedures. Records showed that staff had received training in safeguarding adults and staff could explain to us what they would do to alert people if they witnessed any abuse.This helped to ensure that staff were confident in the use of safeguarding procedures

Requires improvement

Is the service safe?

which protected people who used the service. There had been four safeguarding notifications relating to people who lived at this service received by CQC and each had been dealt with appropriately.

People were protected from the risk of unsafe premises. Health and safety risk assessments had been completed which included a fire risk assessment. Mains services had all been checked within the last twelve months. The risk assessments looked at all areas of the service, any identified issues and actions taken. This meant that the risks to peoples safety were clearly identified and action taken to protect people.

Risk assessments were also carried out as part of the care and support planning process for individuals using the service and these included areas such as personal care, nutrition, behaviours and pressure area care. These were present and sufficiently detailed to help staff address any issues raised in the majority of the care plans we looked at.

Staff had completed training in fire safety awareness, medicine management, food safety and moving and handling. This meant that people who used the service were protected from the risk of unsafe health and safety practices because staff had received up to date training.

The home was clean and tidy overall and we were able to see some of the bedrooms used by people who used the service with their permission. They told us, "They keep it as clean as they can. I am satisfied with the way things are done." We saw that there was an infection control policy and procedure for staff to follow. We talked with one domestic about their work. The service has three domestic posts but one post was being covered by bank staff as a member of the team was on maternity leave. It was evident that this had had an impact on the staff available and although the housekeeper was working hard some of the rountine cleaning tasks, such as deep cleans, were being delayed. We also noted that the laundry skips in use, containing soiled linen and clothing did not have lids, and this was adding to the malodours present and could compromise infection control procedures. We looked at the roster for domestic staff for the months of August and September. We found that there had been twelve occasions when there had only been one domestic for the whole building in August and fifteen occasions in September. When we talked to the operations manager about this he agreed there had been times when the domestic had found it difficult to cover the whole home, but on these occasions the night staff had been asked to do clean some of the communal areas to help. Some areas of the home had 'pockets' where the area was malodourous and would have benefitted from more frequent carpet cleaning but this varied across two of the four units. This lack of inconsistency around the cleaning of communal and individual areas could have an impact on infection control overall.

We recommend that the shampooing of carpets is carried out regularly to address the malodours we noted in three bedrooms and that lidded laundry skips are used when soiled laundry is being transported and stored prior to being washed.

Policies and procedures were comprehensive and covered all areas of medicine management. The medication policy found on site was not up to date but the provider was able to forward the new policy, which had not been made available during the inspection, but which was available to staff on the internal computorised system. Staff had received training in administration of medicines. We examined the records for medicines. We found evidence to show that medicines were managed safely on two of the units, however some improvements were needed to the management of medication in the remaining areas.

The medication was organised using a computerised system, which had been in place for just over two months. Nurses were responsible for administering medication with the support of a senior carer where appropriate. Medication was provided in a pre filled blister pack from Lloyds Pharmacy and once the medication was administered the nurse would tick a box on the computer held record, an 'electronic medication administration record' (EMAR). At the start of medication round a photograph of each person due to receive medication is displayed on the computer screen, once they have received their medication their photograph disappears. This is a useful tool for agency/newer staff as the photographs were up to date and made identifying people easier.

The time the box is ticked is the record of medication being administered. Therefore, it would be an effective system to audit medication timings. However, out of the thirty people checked on two of the four units, we picked up three errors whilst reviewing the medication round. We noted that although the computer record showed medication had been given to three people, their medication was still present in the pre filled blister pack. This had happened on

Requires improvement

Is the service safe?

four separate occasions, on the 16th and 24th September 2015 for one person, on 22nd and 26th September for another person and on the 16th and 22nd September for the third person. Staff on duty could not explain this but the manager agreed to investigate the matter immediately and check who was on duty and if necessary take further action.

We recommend the provider closely monitors the management of medication on the units identified and carry out further training where necessary to make sure all staff are working within the medication policy and providing people with medication as prescribed.

In the remaining units the medication was being managed safely.

Despite the shortfalls found we also noted some good practices around the management of controlled drugs, the storage and disposal of medication and the monitoring of peoples conditions for example those living with diabetes, parkinsons disease and pain relief management.

Good

Is the service effective?

Our findings

When we asked people if they were involved in making decisions about their care one person who used the service told us they were consulted but that they preferred their relative to be involved too as they knew them well.

A visiting healthcare professional told us they thought staff were attentive and that they had been impressed by the way staff wanted to embrace new ways of working to enhance their awareness of different medical conditions. People told us they had access to a wide range of healthcare professionals and we could see from peoples records that they had been referred to specialists and medical services as required.

On the whole the building was well maintained. Corridors, reception areas, communal areas and bathrooms were spacious with plenty of light coming in through the windows. Furnishings and floorcoverings were appropriate with a good level of signage and pictorial prompts to support people who were living with a dementia type illness. However there were certain pockets in the home which needed attention to make sure that these standards were maintained throughout the building. For example, in some areas we saw skirting boards were missing, wallpaper and paintwork was chipped and the general décor was looking tired and in need of a refresh. It was acknowledged that on the day of our visit the decorators were in attendance working through some of the communal areas. In contrast to this, we also noted that there was a lot of art work on display around the service, which had been completed by people using the service. Visual prompts re season 'autumn leaves' displayed and pictorial signage to support people living with dementia to be orientated.

We noted that the dining experiences throughout the service was varied depending on which unit people were living. We observed the breakfast being served in one unit and the lunchtime meal on three of the four units. (One dining room was closed as access was difficult due to refurbishment in the corridor area, so two groups of people were being served in one of the dining areas.) Whilst we observed some isolated examples of concern regarding the meals service, overall the dining experience was good. For example, on Sutton Hall, one person who required assistance with their meal, fell asleep during their meal and although they were encouraged to wake up and finish what was on their plate, the member of staff walked away after a short interaction. The member of staff proceeded to rinse the plates already used by those who had finished their meal and had left the table. This meant that the person needing assistance and prompting was left without being supported to finish their meal. Staff rinsed plates before sending them to the kitchen using the 'dumb waiter' a lift used to transport items to and from the kitchen, on the lower floor. Staff confirmed to us that there were eight people on Sutton Hall who required assistance with their meals and that sometimes it was difficult to get round everyone in a timely way.

On the Lodge, one staff member was observed to move a person in their wheelchair from one dining table to another by pulling the chair backwards without any explanation or warning to the person to ensure they knew what was happening. This meant that the person was not informed or given the opportunity to consent to being moved. This was a missed opportunity of the member of staff to engage with the person.

In one of the three areas staff were not treating people appropriately when preparing for the lunchtime meal. For example, some people were offered a blue plastic apron to protect their clothing from spills. However, not everyone was given an explanation about why the apron should be worn and invited to decline the offer. In contrast on the remaining units, this was done in a more inclusive way and people were offered a tabard to wear and staff respected the views of those who declined.

The lack of attention whilst preparing for the meal in one of the areas continued during the meal service. For example, staff offered people a choice of omelette or jacket potato. There was no description of any fillings or other options that were available to tempt them. For example, when the meal was brought to the tables the plate contained either a jacket potato or an omelette, but also had two sandwiches and a cup of something. On asking staff informed us that it was vegetable soup served in the cup, however people were not told what was in the cup, or what was on the sandwiches.

One person was served cauliflower cheese. Staff explained this was because they were on a soft diet. However, this meant that person's choice may have been restricted to what was on offer for soft diet, and other people may have preferred to have opted for the cauliflower cheese if they had been offered this as an alternative.

Good

Is the service effective?

One person refused the meal they were served saying : "I don't like that." The staff member attempted to encourage the person to try it but they refused. The staff member offered the person some cherry pie and custard which they readily accepted and ate it all independently and seemed to enjoy it. When they had finished a staff member removed their dish. They did not offer any second helpings even though the person had only eaten one course of their meal and had clearly enjoyed their pudding.

In total contrast two of the three areas being used were well organised with staff making time to engage with people. There was also a difference in the way tables were prepared on each of the units and what people had access to, for example some tables were set with table clothes, condiments, cutlery with jugs and glasses.

People who could express a view told us the food was generally good and that they had a choice of meals most of the time. However, we noted that those who were unable to make a verbal choice were not always supported to make an informed choice about what they wished to eat. For example, good practice would be to offer choice by showing what is available by plating up the choices so people could see the options. We noted that where people were at risk of losing weight or becoming malnourished they were monitored and when their weight fell below an acceptable threshold, they were referred to a dietician. Most of the records we reviewed relating to this area of care had been completed, however, this varied in standard depending on the staff on duty, with some showing gaps in recording.

We recommend the provider reviews the whole of the dining experience across the two units identified to them and acts on areas which fall short of the expected standards. It is also of importance that all staff are trained in the recording of food and fluid monitoring to make sure records accurately reflect the amounts being offered and taken.

When asked if staff were trained properly, those who could share their views agreed that staff were skilled and competent. One person told us, "Oh, yes, they are very good. They see to the helpless; Oh yes; very nice that way." One person who used the service told us, "The staff know exactly what they are doing." Staff had the skills and knowledge required to carry out their roles and had completed training in subjects such as moving and handling, fire safety, dementia care and safeguarding. We saw that all the staff had completed this training and when we looked at training files they confirmed when the training had been completed.

Staff files we looked at contained supervision records. The most recent record showed that staff had supervision in August and September 2015. These supervision meetings enabled staff to discuss their performance, training needs and achievements to date.

We saw that the service had used the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty safeguards (DoLS) to support those people who lacked capacity. The MCA sets out the legal requirements and guidance around how staff should ascertain people's capacity to make decisions. The Deprivation of Liberty Safeguards protects people liberties and freedoms lawfully when they are unable to make their own decisions. MCA assessments and Best Interest decision documentation was completed well. A copy of the DoLS application, confirmation date and date of review were in the care records detailing all relevant information. This meant that staff were having regard to the appropriate safeguards and were acting within the law and generally understood the principles of the MCA.

Good

Is the service caring?

Our findings

Throughout the inspection we saw that interactions between people who used the service and staff were friendly and respectful. It was clear that people knew each other well and people told us they were well cared for. One person told us, "The staff are really good and they care about me." Another person told us, "The staff are nice." One person remarked on the kindness of staff and told us, "They have always been very patient and they have always been nice with me."

A visiting healthcare professional told us, "Staff seem to go above and beyond. It seems like one big happy family. There always seems to be a member of staff there in minutes if someone shouts. It's a nice atmosphere; it's one of the good homes."

A relative we spoke with commented on the overall care provided. They told us, "Yes, they treat them differently. It's amazing how they [the staff] adapt to the individual needs; they treat them as individuals. I have peace of mind when I'm not here." They went on to describe how staff dealt with a particular medical condition and that the way they did it meant everyone benefitted. They also described how staff used familiar prompts and items of interest to stimulate their relatives memory and how much enjoyment their relative got out of this time with staff. A relative told us they were, "Very happy with the home and all of the staff." They said their relative received good care and they were satisfied they had made the right choice of home for their relative. They told us the food available was good, and said their relative had put weight on since moving into the home.

People also reflected on how other people they knew had been dealt with during their end of life care and how this had been done in a sensitive way which they had found comforting.

Staff were seen to be attentive and responded well when people were showing signs of distress or needed reassurance. We noted many good examples of compassionate, patient, calm and responsive care from all of the staff on duty.

A couple of people talked about staff who had left the service and that they were worried about the impact this could have on the service. One member of staff reflected on the way they had to prompt staff to carry out basic grooming but thought this had improved as the staffing numbers had increased.

Staff ensured that people's dignity and privacy was respected. When we were taken to look at people's bedroom or into bathrooms and toilets staff knocked on the door before entering and asked permission for us to enter. When we spoke to people they confirmed to us that this was normal practice.

Overall care plans contained information about peoples likes and dislikes. We saw evidence of people being involved in their care planning and one person said, "I am involved in my care and staff support me to make choices."

Good

Is the service responsive?

Our findings

On the whole, people received support which was personalised and met their needs. The manager told us that people were assessed prior to moving in to make sure the service was the right place for them and that they could meet their presenting needs.

We saw that people got the right level of support overall, and they clearly felt comfortable talking to staff about what was important to them. People could express their choices about how they wanted their care to develop. We knew this from the comments that people made to us, one person told us, "We [including the staff] have just updated the care plan, I instigated it." Another person told us that they had been included in discussions about what mattered to their relative and they thought staff had taken notice of this as they had seen their relative being involved in things which were of particular interest to them and staff made sure they wore what they liked.

We spent a lot of time sat in the communal areas so we could observe the care being delivered and how peoples needs were being met. We saw that people who were at times anxious or displaying behaviours which could challenge, were dealt with appropriately and interventions were used when necessary. Often people were distracted by gentle reassurances or by being offered a drink or snack. One person received one to one attention to support their emotional needs at times and staff were skilled at knowing when to intervene or when verbal prompts were enough.

We reviewed care records and saw a range of tools were being used to assess peoples skin condition, their weights and when to refer people to a doctor or dietician and monitoring of food and fluid intake. Most of the records we reviewed relating to this area of care had been completed, however, this varied in standard depending on the staff on duty, with some showing gaps in recording.

Where people preferred to not sleep in a bed, but use a chair for example, staff had used a variety of ways to make sure the person was made comfortable if they resisted encouragement to go to bed. We noted that on some occasions it may have been in the persons best interests to have their feet raised whilst sat in a chair for long periods. The manager acknowledged this. On the whole monitoring care charts were filled in appropriately, however we discussed the need to fill these charts in at the time care interventions were delivered as some charts were not completed at that time and errors could be made around the accuracy of the entries. For example, night sleeping patterns and food intake. Care plans contained information about people's needs and associated risks. These included peoples behaviours and highlighted the risk to themselves or others. They detailed what triggered the behaviour and what staff could do to support the person. The daily notes recorded any incidents and responses by staff.

We also noted that some peoples 'care profiles,' which were a description of key needs, were laminated. This meant that additions or amendments could not be added when their needs changed. Some of the laminated documents were dated 2014.

Not all care plans were being regularly reviewed. The company policy for evaluation of care plan was 'at least monthly', however documented evaluations had been done less frequently in at least six of the care plans we looked at.

We recommend the provider closely monitors the care records being used and introduces better ways of recording which reflect the care and support people are receiving.

Some good practice was noted in relation to the management of agitation during the delivery of personal care. Records were well written and descriptive with a good explanation of triggers and advice to staff to allow. For example if a person became too distressed, staff were to give the person a break and for staff to return later when the person was calm.

We spoke with staff about the people they were caring for and supporting. Staff had a good understanding of each persons needs and clearly knew people well. Staff told us they believed the people who lived in the home were well cared for and their needs were met. They added everything was done, but not in the timescale they would like. Indicating that they were often busy and that they sometimes felt under pressure.

There was a strong emphasis on supporting people to be involved in activities in the service, either as a group or on a one to one basis. We saw people had access to a range of activities which were recorded. One person told us that they had been involved in a variety of activites including painting and papier-mache. People described how they were invited to join coffee mornings, attend a church

Good

Is the service responsive?

service and watch entertainment. Some people reflected on trips they had been on in the summer and some went out with relatives. There was also a strong emphasis on community involvement and relatives had formed a 'Friends of Orchard' group who worked together in the best interests of the service.

People were supported to maintain relationships with family and friends. One person told us they went to their family home to visit sometimes and that this was encouraged and supported by the staff.

There was a procedure in place for making complaints and people had used this. People we spoke with told us they knew who to complain to if they were unhappy or dissatisfied with the service. Since March 2015, there had been nine complaints raised with the manager. All these were recorded, including the action taken by the provider and there was a copy of the written response sent to the original complainant. All the complaints had been resolved within the policy timescales and to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

We noted, through discussion with the staff on duty on the day of our visit, that there were some areas of their work which needed to be dealt with by the management team, through proactive engagement with staff. All the staff we spoke with told us they enjoyed working at the home, but they also commented that it was becoming increasingly difficult to maintain standards due to the number of staff leaving, which was having an impact on other staff trying to maintain staffing levels and quality of service. There was also a comment about managers paying extra for agency staff, rather than using 'core' staff, who knew the residents. We gained the impression that this was a recent concern and that staff would have welcomed the opportunity to discuss and explore other ways of addressing the problem with the management team. Despite staff telling us they made sure people were well looked after and that their needs were being met, they felt this could be better acknowledged by the management team. Staff told us they thought management could be more approachable and inclusive and praise their efforts rather than critising them. A service with a culture and value which is constantly reinforced through positive leadership, supervision and people's behaviours and attitudes is of benefit to staff.

All the staff were clear about how to report concerns and told us they would not hesitate and felt happy to do so. They told us that some of the senior staff were approachable and that they would always report areas of concern. Despite the feeling of 'unrest' staff told us that they enjoyed their work and worked together as a team 'on the floor.' They also told us they were proud of their work and took a pride in delivering the best care they could. "Nothing is too much trouble," one person told us when talking about the care they received. Records showed that all staff received regular supervision. This meant that staff were clear about what was meant by good practice, what was expected of them and how this would in turn have a beneficial effect on people using the service.

Relative's questionnaires had been sent out at the beginning of September, and three had been returned. The manager was planning to collate the returns once more were received. However, the service also holds regular residents and relatives meetings and felt she had a good understanding of the views of people using the service. One relative had commented, "I cannot praise the staff enough." Some relatives had noted the need for refurbishment, however, there was a refurbishment schedule in place and they had been satisfied with the progress made to date.

During our inspection we spoke with the manager and the staff team and they were able to answer all our questions about the people who used the service. They knew how the home ran, who was responsible for what and the needs of each person living at the service. The senior management team had noted there were some matters which needed addressing around the quality of delivery on each of the units and they had plans to address this. Some work was being done to rotate staff and develop a sub leadership team who would have different areas of responsibility.

The manager and senior staff carried out quality audits every month. We saw audits had been completed for the environment, medicines and care plans. Where any failures were identified actions were set, with a completion date. The manager and provider demonstrated that they were committed to continuous development and improvement of the service.

Records showed that staff recorded all incidents and accidents which occurred at the service. The manager showed us that accidents and incidents were recorded and that these were checked on a daily basis to make sure correct procedures had been followed. Incidents were then followed up according to need.

We saw emergency contingency plans were in place. We saw that there was a fire risk assessment and plan for fire issues and staff were aware of the plans. Safety checks of fire safety equipment and other mains services had been carried out recently and were all up to date.

The manager actively sought advice and guidance from other professionals. For example staff worked with healthcare and mental health professionals in order to reach positive outcomes for the people who used the service.

Regular formal staff meetings were not held but daily discussions with other members of the staff team took place.The manager and senior staff did provide supervision for staff. We also saw a folder evidencing how the manager had maintained and updated their own practice through reading articles and training.

Good

Is the service well-led?

The manager was open and honest throughout the inspection and was able to answer all of our questions and provide any information we requested. The information was clear and easy to follow.

There were effective systems in place to monitor the quality of the service. The manager had captured the views of people who used the service through questioning and recording these in their records. A recent survey had been sent out and the manager was in the process of analysing these and from that she would develop an action plan to address any issues raised.

We saw that servicing of mains services had been carried out which demonstrated that the provider was making every effort to maintain the safety of people who used the service. The wiring of the property had recently been checked.

There was a fire safety folder which showed evidence of weekly fire alarm checks having being carried out. There was a fire risk assessment carried out in the last year and a fire safety policy and procedure available for peoples information.

There were policies and procedures to inform staff relating to first aid, health and safety administration of medicines, missing persons and safeguarding so that when required staff could access the relevant information.