Akari Care Limited

Dene Park House

Inspection report

Killingsworth Road
South Gosforth
Newcastle upon Tyne
Tyne & Wear
NE3 1SY
Tel: 0191 2132722
Website:

Date of inspection visit: 16 and 20 February 2015
Date of publication: 10/07/2015

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?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection was carried out over two days on 16 and 20 February 2015 and was unannounced. We last inspected this service in February 2014, when we found a breach of the regulation regarding the recruitment of workers. We carried out a desk-based inspection (that is, without visiting the service) in October 2015, when we found the service to be no longer in breach of this regulation.

Dene Park House is a care home providing accommodation and general nursing or personal care to older people. It has 50 beds over three floors. There were 35 people living in the home at the time of this inspection.

The service had a registered manager who had been in post for one year. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 living in the home, and relatives and other visitors we spoke with confirmed this. Appropriate policies and procedures were in place for the safeguarding of people using the service. Staff were knowledgeable about their responsibilities to recognise and report any abusive situation. Risks to people had been assessed and managed.

Staffing shortages and the regular use of agency nurse and care staff meant the needs of people who needed two staff to provide their care safely were not always receiving that care in a timely manner.

Staff used appropriate aids and equipment to provide people's care in a safe way. Accidents and other issues affecting people's safety were monitored carefully and appropriate actions were taken. Fire systems were checked regularly.

People's medicines were managed safely.

As Dene Park House Nursing Home is registered as a care home, CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for a DoLS. However, we found applications to deprive people of their liberty had not been submitted in a timely fashion. At the time of the inspection no-one living in the home was subject to a deprivation of liberty safeguard.

People said they felt their needs were met effectively by the staff team, and this was confirmed by relatives and other visitors. Staff were given appropriate induction to their work and received appropriate ongoing training to enable them to meet people's needs. We noted effective communication between people and the staff team. Where appropriate, checks had been carried out of the competency of individual staff members, for example, in the management of medicines.

Staff received regular supervision of their performance, and a programme of annual appraisals was arranged.

People received a varied and nutritious diet, and told us they were very happy with the quality and quantity of their meals. Any special dietary needs were met.

People told us they were always asked for their consent before any care was carried out.

We found the service to be very caring. People gave us many examples of the kindness, courtesy and caring approach by all staff. Their comments included, "I'm happy with the care. I am treated with kindness and respect"; and, "The staff are very nice. They are lovely." Relatives were also very complimentary regarding the quality of the care. They spoke of the home being a "warm and welcoming place."

People told us the staff were good at keeping them informed and giving them any information they might need.

People were involved in the assessment of their needs and the planning of their care. They told us staff responded positively to any changes in their needs and wishes, and were alert to any changes in their health or well-being. Care records showed that staff took a person-centred approach to people's care.

People told us they were given choices about their daily living routines. They told us, however, that the levels of social activities in the service had decreased from their usual frequency due to the recent unavailability of the home's activities co-ordinator.

The service worked in conjunction with other health and social care professionals to meet people's needs.

We found the service lacked a cohesive staff team. The registered manager was robust in driving up standards in the home, but we noted that a significant number of staff did not feel their contribution was always valued and acknowledged. These factors were hampering the development of the service.

Systems were in place for checking the quality of the service, and issues identified were included in the service's development plan. The registered manager received regular support from his line manager.

We found breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010 in relation to

Summary of findings

staffing and the protection of people against the risk of unlawful deprivation of their liberty. You can see what action we told the provider to take at the back of the full version of this report.

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?

The service was not always safe. There were not always sufficient staff to meet people's needs in a timely way.

People told us they felt safe. Procedures were in place for reporting safeguarding incidents.

Risks to people were assessed and actions taken to minimise such risks.

People's medicines were safely and appropriately handled.

Requires Improvement

Is the service effective?

The service was not always effective. Safeguards against depriving people of their liberty had not been implemented.

People said their needs were met effectively by the staff team.

Staff had been given the training and supervision necessary to enable them to meet people's needs.

There was effective communication between people and the staff team.

Requires Improvement

Is the service caring?

The service was caring. People, their relatives, visitors and professionals all spoke highly of the caring nature of the service.

People told us they were treated with respect at all times, and that their privacy and dignity were protected.

Good

Is the service responsive?

The service was responsive. People told us they and their families were involved in assessing their needs and in planning their care.

There was a person-focussed approach to people's care, and the service responded positively and flexibly to changing needs.

The service worked well with other professionals in meeting people's needs.

Good

Is the service well-led?

The service was not always well-led. The management of the service had yet to develop a fully cohesive staff team.

Systems were in place to monitor the quality of the service and any areas for improvement identified were included in the service's development plan.

Requires Improvement

Dene Park 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 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 16 and 20 February 2015 and it was unannounced.

This inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the home. We reviewed the notifications of significant incidents the provider had sent us since the last inspection. We contacted local commissioners of the service, Healthwatch, and local authority safeguarding adult team to obtain their views about the delivery of care. We have included their views in this report.

During the inspection we spoke with ten people who lived in the home, eight visiting relatives and friends; a GP; the registered manager; deputy manager; line manager; three nurses; three ancillary staff; two senior care assistants; and six care assistants.

We looked at the care records for eight people living in the home and the personnel records of four staff members. We looked at records related to the management and operation of the service.

Is the service safe?

Our findings

People told us they had no concerns about living in the home. One person told us, "I feel very safe, here."

We looked at the staff rotas for the previous three months. The registered manager had calculated minimum staffing levels following the use of a dependency assessment tool. This was to identify the staffing levels required to meet the needs of people. We asked the registered manager about the staffing levels in the home. They told us there were problems with providing sufficient cover from the current staff establishment and that they regularly had to use agency nurses and care assistants. Wherever possible, the registered manager told us they requested the same agency care assistants and nurses. This was to try to maintain consistency of care.

We asked five members of care and nursing staff about the impact of agency staff. One told us there was never a problem with the quality of agency staff and said they felt staffing levels had not impacted on people's safety. However, other staff felt the use of agency staff impacted on their ability to meet people's needs effectively. One told us, "It takes a lot of time to help them [the agency staff] to understand people's needs and how the home runs." Other staff comments about agency staff included "I know we are short staffed and we need to use agency carers sometimes, but the quality and their attitude is inconsistent" and, "They are of variable quality."

We observed people in the communal areas of the second floor. We saw that individual staff were usually quick to respond to anyone's requests. However, some people needed two care staff to assist them with tasks such as toileting or bathing and this meant that there was sometimes a delay in other people being cared for promptly on request.

One person told us they had been trying to attract attention to be helped to the toilet by shouting for staff but they had waited some time before help arrived. We saw their call bell was out of reach. We looked at the 'maintaining a safe environment' risk assessment for this person. It stated staff should make sure the person was within reach of their call bell at all times and that staff were to monitor this on an hourly basis. We tested the response times of staff by using a call bell. Staff were unable to deal with the call quickly as both care assistants were helping a person to move with a hoist.

Another person, who needed the support of two people for their care needs, told us, "There are not enough staff to carry out the job." This person told us when care tasks were allocated they were left till last, because they needed two staff. This person said their preference was to be assisted to get up at a certain time in the mornings, but it was often more than two hours after their preferred time before staff got round to them. The person told us, "It affects me. I need to be active. There are not enough staff to get me out of the home."

We found the staffing levels, combined with the reliance on agency staff did not always allow for people's needs to be met in a timely way, and that some people's independence, dignity and choice were being compromised. This meant there was a lack of suitably qualified, skilled and experienced staff. This was a breach of Regulation 22 of the Health and Social Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found appropriate policies and procedures in place for the safeguarding of people using the service. Staff were knowledgeable about their responsibilities to recognise and report any abusive situation. We noted from our records the registered manager responded appropriately to safeguarding issues, contacting the local authority safeguarding adult team and notifying the Care Quality Commission.

We found risk assessments had been conducted in the best interests of people and helped them to be cared for safely. Risk assessments had been updated monthly, or more frequently where staff had noted a change in a person's condition. We found people had been risk assessed for falls, moving and handling, skin integrity and the use of bed rails. During our observations, we saw staff advising a person the tea was very hot and offering people drinks in safety cups, where appropriate.

Is the service safe?

A visitor told us, "I've noticed that staff are particularly good at keeping people safe when they provide personal care. For instance, [our friend] needed some help to use the bathroom and we were pleased that the staff took such care over their safety."

Care assistants told us they had been trained in the safe use of hoists and moving and handling and this included practical exercises to help them to put their skills into practice.

Staff had also been trained in the use of evacuation slides, used to move people quickly and safely down stairs in an emergency. We saw these were positioned in each stairwell.

Accident and incident records were detailed, and were signed and dated by the registered manager or delegated member of staff. This showed us they were aware of accidents and incidents and could therefore take appropriate steps to review risks and take action to reduce their re-occurrence. We looked at the fire safety arrangements. We saw fortnightly fire drills had been completed and areas for improvement or action had been taken immediately by the registered manager. Weekly fire safety checks were carried out. Staff members gave us consistent and detailed information about the home's fire procedures. A nurse said, "We have plenty of fire drills here that are unexpected. I think we're very safe – I'm always happy that staff respond well to the alarm."

We found staff had a good understanding of equality and we found no evidence that people were discriminated against. A visitor told us, "[Our friend] has [a sensory deprivation] and staff adapt their approach to care very well. I've never felt that they're being discriminated against or being treated differently."

We looked at the Medicine Administration Records (MARs) of all people who were cared for on the second floor. Each person's MAR records were labelled with a recent photograph, for safe identification purposes, along with details of their preferences for taking medicines and any allergies. This meant staff could quickly obtain information about a person if they needed to and ensure their medicines were given accurately. We saw there were no gaps in recording for the month prior to our visit and all medicines had been signed for appropriately. This meant people had received their medicines as prescribed.

Is the service effective?

Our findings

We spoke with two care assistants about their understanding of capacity and consent to care. Both members of staff said they had been trained in safeguarding, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act. They are a legal process followed to ensure people are looked after in a way that does not inappropriately restrict their freedom. We noted from our records the service had not notified us of any applications made under DoLS.

We asked the registered manager about this. He told us one application had been made to the local authority, to date, and this had not been accepted. We noted in the care records of a second person, their social worker had communicated the need for the service to complete a DoLS application for that person, as the person had clearly indicated a wish to leave the home. An 'urgent' application document was on the person's care record, but this had not been completed. This meant the person was being unlawfully deprived of their liberty as a DoLS authorisation had not been sought and granted by the supervisory authority (Newcastle City Council). We noted less than half of the people living in the home had been assessed as to whether they required DoLS application in respect to their residing in the service. The registered manager accepted the service had been slow in meeting its obligations under DoLS, but told us an assessment of every person's mental capacity was currently being undertaken, and that appropriate DoLS applications would then be made, where appropriate.

This was a breach of Regulation 11(2) (a) of the Health and Social Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us their needs were effectively met the majority of the time. Relatives and visitors of people in the home confirmed this. Comments included, "The staff seem to know exactly what is going on and communication is really good;" and, "I'm confident they know what they're doing and their professionalism is really obvious. They're not just behaving this way because you're here; it's always this good."

We observed staff and people in the communal areas in the home. We saw staff communicated effectively with each other and with people and were able to tailor their communication to the needs of the individual. A person who became upset whilst watching a TV programme was approached by staff who understood their disposition and were able to sit with them and reassure them. This demonstrated permanent staff had a good understanding of people and had developed skills in providing flexible support. Where people were not able to communicate verbally, staff responded well to non-verbal cues, such as a person who indicated with their eyes and body language that they were uncomfortable.

We looked at the training records for four care staff and two senior care staff. We found staff training was up to date and appropriate to the needs of the people who lived there. Staff had been trained in safeguarding, equality and diversity, risk assessments, mental capacity awareness, food hygiene and in providing adequate nutrition and hydration. Senior care staff and nurses had been trained appropriately in competencies around the administration, storage and disposal of medicine. A care assistant told us, "The training here is very good. There's lots of it and it's very specialised so we can put it into practice with the people we care for."

Staff told us they had been given a good standard of induction when first employed. An agency care assistant said, "My induction was quite detailed. I was given the tour of the home, told about fire precautions, introduced to the residents, and could ask questions. I will be looking at care plans later."

We looked at the records of staff supervision and appraisal. We saw these were planned in advance, at the rate of five one-to-one supervisions and one annual appraisal for each staff member each year. Supervision was recorded appropriately. Appraisals had been affected by the registered manager's sickness two months previously, but we saw all were planned and staff members had been given the necessary documentation to prepare for their appraisals.

We found staff had a good understanding of people's needs and were clear on their responsibilities to obtain people's consent to provide care. We saw staff knocked on people's bedroom door before entering and let people who were bed-bound know who they were and why they were entering their room. Staff asked permission before

Is the service effective?

providing personal care to people and we observed a confused person being talked to very gently and quietly and coaxed away from a potentially challenging situation. One member of care staff said, "We understand the importance of consent very well and the training helps us understand the legal requirements."

We spoke with a person about the quality of the food in the home. They told us, "It is absolutely fantastic. The roast beef last Sunday was delicious." A visitor said, "We've been really impressed with the food in here. [Friend's name] has told us often how much they enjoy it." A member of care staff said, "Some people are also on soft diets so their food is pureed."

We saw people were offered tea, coffee, juice, water and snacks at frequent intervals during the morning. We observed lunch in the dining room on the second floor. People were told what their meal was before it was served to them and staff were encouraging to support them to eat enough food. For instance, a person who was reluctant to eat by themselves ate a hot meal when a member of staff sat with them and talked to them. We noticed staff were attentive to people's needs, such as offering a spoon to someone who appeared to struggle with a knife and fork and helping a person to sit more comfortably in their chair to eat their meal safely.

We noted staff were very busy at lunchtime. There were two care staff to assist with lunch and three people in the lounge who needed a lot of support to eat. This meant people sometimes did not have the level of support or attention they appeared to need. People were able to be relaxed at lunch and staff did not rush them, instead reminding them to eat when needed. We observed one person who sat alone at lunch who ate very little despite encouragement from staff. We saw staff were encouraging with them and helped them to be comfortable.

We looked at the nutrition and hydration records of four people on the second floor. We found in most cases staff were consistent in using the Malnutrition Universal Screening Tool (MUST) to monitor people for signs of unplanned weight loss or weight gain. We saw where a person's weight dropped consistently for more than one week, staff had been proactive in contacting a GP for further support.

We spoke with a nurse about people's access to healthcare services. They showed us the care plans of three people, which documented the multidisciplinary involvement of medical professionals in their care. We saw staff had been proactive in involving podiatrists, dieticians, mental health professionals and tissue viability specialists where appropriate. People told us they felt comfortable asking staff to see a doctor whenever they needed.

We saw, in daily records, that care staff and nurses liaised and communicated well with health professionals and people had been given information on any diagnostic testing or on any new treatment they needed. We therefore found people were supported to access health services when needed and kept informed about their healthcare needs.

Is the service caring?

Our findings

People told us they were happy with the quality of the care in the home. One person told us, "I'm happy with the care. I am treated with kindness and respect." A second person said, "The quality of care is fine." Other comments included, "There's nothing I don't like about the home. I can't think of any improvements"; "The staff look after my privacy"; and, "I enjoy living here." We were also told people were encouraged to be as independent as possible. One person told us, "I try to do most things myself. We are encouraged to be independent."

Visiting friends of a person living in the home told us, "As our friend [has a sensory impairment] but still feels very independent, sometimes they struggle to accept help from staff. But the carers are so patient with them. The carers closed [person's] door to give them some privacy and we could hear them talking on the other side of the door. We were pleased that the carers told [person] exactly what they were about to do and why. This made them feel reassured." Another visitor told us, "The chef last weekend was really kind. [Friend] asked us to tell them how much they'd enjoyed the Sunday roast beef and a little while later a little package of roast beef sandwiches arrived for them to enjoy later. It's the little things like that – it shows staff really care."

We saw, in the 'compliments' file, a relative had made many very complimentary comments. These included, "I could not fault the care and kindness of everyone;" "Warm and welcoming place;" and, "Care and attention from manager and staff is excellent."

An agency care assistant told us they found the quality of care in the home was "really good. The staff all genuinely care for and know their residents – all of them."

Staff members we spoke with told us they took a pride in providing the best care they could to people living in the home. Comments included, "I think the quality of care is fine"; We saw staff were aware of the diverse needs of people and they treated people with respect for their wishes and needs. The nurse administering medicines spoke to people as individuals and with respect. In all cases the nurse told people what their medicine was for and made sure they were happy to take it. Where a person needed some encouragement, the nurse provided this with positive support and kindness. For example, one person did not like the taste of their medicine. A care assistant told us, "We have helped them to understand how important it is. So instead of just taking the pills with water, [the person] takes them with a piece of cake, which we're happy with and so are they."

At the meal times, we saw staff were kind and demonstrated their understanding of each person's needs. For instance, they knew one person often felt upset at mealtimes and they were able to anticipate this and provide them with encouragement to eat their lunch. Another person was feeling unwell and the nurse had recommended they try and eat a small portion. Staff supported them in this by sitting with them and saying, "You'll make me happy if you have some of this mashed potato. I know you can do it, it will help you to feel better." We observed this informal approach and familiar communication helped the person to feel relaxed and they enjoyed their meal.

People told us staff were good at protecting their privacy. Several people told us staff were careful to knock on their doors before entering, and would always make sure the door was shut before carrying out any personal care. One person told us, "They look after my privacy and dignity."

We saw, in the minutes of staff meetings, a clear emphasis was placed by the registered manager on ensuring people in the home were always suitably dressed and men were to be offered a shave when being assisted with their washing and dressing.

Meetings were also held with people living in the home and their relatives, to involve them and to get their views and ideas. There was evidence that staff responded to people's comments, with examples of improvements to the décor in the home, and different activities having been introduced.

A daily diary was used to communicate important information about people's care needs, including their health and well-being, and any appointments they might have on the following staff shift.

We saw there were no independent advocacy services advertised in the home. We asked the registered manager about this. They accepted such services were not advertised but said they were made available to people on request. They agreed this information would be displayed in the future.

Is the service caring?

We saw people's end of life care was planned with sensitivity, and with the involvement of the person, where possible, and their relatives. Any existing advanced decisions the person might have made about their future care were complied with. One care assistant told us, "We take pride in people's end of life care, and I think it is very good."

Is the service responsive?

Our findings

People told us they found the service to be responsive to their needs. One person told us, "They give me my care in the ways that I want." People said they had "lots of choice." One person said, "I'm a picky eater, but they give me what I want to eat. I can get up and go to bed when I want to – stay up all night, if I want to." Another person said, "I decide when I want a bath." People were happy with the social activities available to them. One commented, "I do some activities. The range of activities isn't bad."

Visiting relatives told us, "[Our relative] is given lots of choices, about the food, the bed, whether to walk or use a wheelchair, and how they want their hair done." A second relative commented, "Staff are very helpful and friendly." Another relative said, "Our [relative] has not been here very long, but we were made to feel welcome. All the family were involved in the assessment."

Visiting friends of a person in the home told us, "We were happy that they had been able to decide whether or not to get up early or have a lie in and that staff always give them choices about things like that."

We saw staff talked to people as individuals, and showed a good knowledge of their history, such as a person who used to be a nurse and liked to remain involved in their care. An agency care assistant told us, "There's attention to detail; the staff know what the person wants." A nurse told us, "We have a good awareness of people's nutritional needs and everyone has been assessed for their required nutritional intake. It means we can be responsive to them, for instance if someone makes a special request we can work with the catering staff to have both their likes and their needs met."

An assessment of each person's needs was undertaken before they were admitted to the home. This covered the person's physical and mental health needs, their social and leisure needs and preferences, maintaining their safety and personal care and hygiene needs. Where possible, the person was included fully in their own assessment, and the views of family members were taken into account where this was not possible. Information from any involved health or social care professionals was taken into consideration. Assessments were reviewed monthly and updated as necessary.

The information regarding the person's needs and wishes about their care was used to draw up individual care plans which staff followed to ensure those needs were met. We saw care plans were of good quality, sufficiently detailed to guide staff and appropriately person-centred. Examples seen included, 'X prefers hot chocolate to coffee', and, 'Y uses one pillow, only, and likes warm blankets.' Food likes and dislikes were also recorded and shared with kitchen staff.

Staff members told us they worked in conjunction with other professionals. A care assistant told us, "When people have complex needs, we work with doctors and the nurses to put together special approaches to care for them." People's care records confirmed this.

Regular reviews of each person's care were carried out to ensure their assessments and care plans still fully reflected their needs. The person and their relatives were encouraged to take an active part in these reviews.

The service had an activities co-ordinator, but this person was on extended leave of absence. This had resulted in the regular daily programme of social activities having lapsed. Other than a weekly visit by the hairdresser, and some exercise sessions and sing-alongs, we found little evidence of social stimulation. Daily records were kept of each person's social activities, but these showed many gaps and in many cases we saw the activity was "not offered" because the person was asleep or bed-bound. This meant there was a risk of social isolation. Staff members told us the activity co-ordinator worked hard when she was in post, but that other staff were not routinely involved in delivering activities. A relative told us, "There's not enough activities at the moment." This relative said they had offered to help with activities, but this offer had not been taken up. There were fortnightly visits by members of local churches. The registered manager told us the activities co-ordinator was due to resume work two days after this inspection, and that the full activities programme would be resumed immediately.

People we spoke with felt they were given choice in their daily activities and routines. They were able to make choices regarding their sleeping patterns, clothing, movement within the home, activities (when available) and meals. A member of care staff told us that people always have two menu choices for each hot meal and staff ask for people's choices every morning. They said, "There's a good

Is the service responsive?

choice of food and menus are planned a week in advance so people know what to expect. Of course we always have extra options and people can ask for snacks such as fruit or sandwiches at any time of day or night."

We looked at how the service handled any complaints. We saw the provider's complaints policy was displayed in the entrance to the home. This policy included people's rights to take a complaint to the provider's operations director, or to external agencies such as the Ombudsman, social services department or to the Care Quality Commission. We saw three complaints had been recorded in the previous twelve months, about care-related issues such as weight loss, missing clothing and lack of activities. Complaints had been recorded in good detail; investigated; and the findings reported back to the complainant or their representative. Where appropriate remedial actions, such as reimbursing a person for missing clothing, were taken.

Is the service well-led?

Our findings

The service had a registered manager in post.

Most of the people we spoke with were happy with the way the home was managed. One person, however, felt the registered manager was not visible on the floors and did not personally check they were satisfied with their care. The registered manager said they would speak with the person.

A visitor told us, "When we came to visit for the first time, the manager was really welcoming and told us what the culture of the home was, that people are supported in whatever way they want." Other visitors confirmed they felt welcome in the home. One told us there was a "good vibe" in the home, and another said the registered manager was "down to earth and approachable."

The registered manager demonstrated a commitment to improving the quality of care in all areas. This was evident in discussions and in the minutes of staff meetings. A visiting GP told us they felt the quality of care had improved and the registered manager was effective in driving this improvement.

Staff views on the management of the home were mixed. Some staff were very positive and told us the home was "well-managed." One staff member said, "You couldn't wish for a better relationship with a manager." Other staff we spoke with told us they felt they did not always get recognition from the registered manager for the work they did, and did not always feel supported. One staff member told us, "[registered manager] walks past you eight or nine times a day and doesn't even acknowledge you."

We saw minutes of occasional staff meetings (three in 2014). A regular agenda item was 'ideas for improvement' with suggestions by staff being considered and sometimes implemented. We saw the registered manager employed some positive reinforcement in staff meetings (for example, "well done to all staff for their work and commitment" was minuted) but was also robust in challenging shortcomings (for example, "the attitude of staff is sometimes terrible and should remain professional at all times.")

We found there was not a consistent culture in the service. Feedback from staff differed markedly. For example, four staff members we spoke with told us there was low morale within the staff team. An agency care assistant told us they had noticed this when they first came to the home, and felt it was caused by the high use of agency staff which caused extra work for permanent staff. One person living in the home commented, unprompted, on the low morale of staff. However, other staff members said morale was "good" or "OK", and said they felt well-supported. Comments included, "I get good support and supervision from the nurse and the manager."

Some staff told us they did not feel they were listened to by the management of the service. Three staff members told us, independently, that there were episodes of, as one staff member described it, "shouting at staff in the corridor" by the registered manager. One staff member reported they had been loudly reprimanded in front of other staff and people in the home in the course of this inspection.

We discussed these issues with the registered manager and his line manager. They told us their perceptions differed from those of these staff, and said they felt the registered manager's style was assertive rather confrontational. However, we felt the registered manager needed to be aware of the way their conduct was perceived by some staff.

We found no evidence these issues materially affected the well-being of people living in the home, and saw that all staff were committed to their good care. However, we felt these potential tensions within the service detracted from the ability of the staff team to achieve its full potential.

We were told by some staff the process for raising concerns or grievances was not clear or well-advertised. An example given that the provider's 'whistle-blowing' hot line phone number was not displayed in the home. One staff member said they had written to the registered manager with concerns, but felt the response was slow and the issues remained unresolved for many weeks. We raised these issues with the registered manager and their line manager. They told us they always attempted to obtain an informal reconciliation of staff concerns, but that formal grievances were escalated to head office and then handled by a manager external to the service.

The registered manager described a range of tools used to audit the quality of the service provided. These included an occasional 'quality impact assessment', carried out by a senior manager outside the service's line management. The most recent quality impact assessment had taken place in April 2014. It identified there had been

Is the service well-led?

improvement in all ten areas assessed. However, it also identified the need for improvement in the areas of management, medicines management, human resources, infection control and individualised care and treatment. A quarterly monitoring report was also carried out by the registered manager's line manager. This covered listening to the views of people and staff; complaints; accidents; nutrition; and significant issues. These tools were used to update the home development plan.

Within the service the registered manager and delegated staff carried out audits of areas such as any monies held for people, health and safety, hand hygiene, and the kitchen. Monthly medication audits were conducted. We saw evidence that the audits identified areas for improvement and these were addressed. For example, the replacement of intumescent door seals, as a fire precaution, and fitting radiator thermostats to allow people to safely control their bedroom heating.

The provider had engaged an independent company to canvas the views of people using the service in October 2014, but the results were not available for us to view at the time of this inspection. The provider had also sent out questionnaires to people, but the closing date for their responses was one month after this inspection.

We met and talked with the registered manager's line manager. They told us they visited the home at least weekly, and on request, as well as contacting the home by phone daily to give support and guidance. The registered manager received supervision every two months from his line manager. We were told there were monthly meetings for the locally-based registered managers, to give and receive peer support. The registered manager told us they felt well-supported and confirmed the levels of contact with their line manager.

We concluded that there were some elements of the management style that were positive and effective. However, we found that the failure to build a cohesive staff team and ensure effective communication with the team was hampering the development of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11(2) (a) of the Health and Social Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not suitable arrangements in place to protect people against the risk of unlawful restriction of their liberty. Regulation 11(2)(a)