Gainford Care Homes Limited

Lindisfarne Hartlepool

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Lindisfarne Hartlepool is a nursing and residential home, although at the time of the inspection it was not providing nursing care. It is registered to provide care for 54 people. At the time of our inspection there were 46 people living at Lindisfarne Hartlepool.

At the last inspection of the home in February 2016, we asked the provider to take action to make improvements. This was because we found the provider had breached a number of regulations.

We found the provider had not ensured staff received appropriate training and development to enable them to carry out the duties they were employed to perform. The registered manager failed to identify and take appropriate action in regard to safeguarding concerns. The provider had not ensured equipment was in place to ensure the safety of people who used the service and to meet their needs. Care records did not reflect people's needs and preferences. People were not always treated with dignity and respect. People's confidential information was not held securely. We also found that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

This inspection took place on 28 June 2016 and was unannounced. This meant the provider did not know we would be visiting.

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider had made a number of improvements since the last inspection. We found the provider had reported safeguarding issues to the relevant local authorities and had notified CQC of these. However, we noted in one of the seven referrals there was no record of any investigation into allegations made by a person who used the service.

There were enough staff on duty to support the people who lived there. The provider carried out checks to make sure only suitable staff were employed. Staff now had suitable training and supervision to carry out their roles.

Potential risks to people and the premises were assessed and managed.

The provider followed the principles of the Mental Capacity Act 2005 (MCA). This meant safeguards were in place for people who did not have capacity to make some significant decisions.

There had been improvements to the dining arrangements and this supported people with their nutritional

needs.

Quality assurance processes used to monitor the quality and safety of the home had been completed and the registered manager had used this information to drive improvement.

A full-time activities coordinator had been employed and the activities room was utilised daily.

Whilst improvements had been made there were still areas for development including people's care records and the protection of people's confidential information. The registered manager recognised that the consistency and quality of care records was an area that required further work.

Medicines records we viewed were complete and up to date. This included records for the receipt, return and administration of medicines.

Relatives and people told us staff were kind and caring. Staff had a sound knowledge of the people they supported, their likes and dislikes.

Relatives were made welcome and were involved in their relatives care planning.

The home worked with external professionals to support and maintain people's health. We saw evidence in care plans of cooperation between care staff and healthcare professionals including, occupational therapists, podiatrists and GPs.

The provider sought feedback from people, relatives and staff in order to develop and improve the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The home's safeguarding logs did not always include details of investigations and the outcomes.

Accidents and incidents were analysed to identify trends.

Medicines were managed in a safe way.

Is the service effective?

Good

The service was effective.

The provider had a training programme to ensure staff had the appropriate skills to support people.

People were supported with their nutrition needs.

People had access to health care professionals to ensure they received effective care and treatment.

Is the service caring?

Good

The service was caring.

Staff were able to describe the likes, dislikes and preferences of people who used the service.

People were treated with dignity and respect.

Staff addressed relatives in a friendly manner and were on first name terms.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care records varied in detail.

People were supported to engage in activities and interests of their choice.

People had information about how to make a complaint or raise a concern

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager recognised the areas requiring improvement and developed an action plan to ensure this was achieved.

People and relatives told us the registered manager was approachable.

Statutory notifications had been sent to CQC in a timely manner.

Lindisfarne Hartlepool

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 28 June 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor in nursing care 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.

Prior to the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

Before we visited the service we contacted the local authority commissioners, local authority safeguarding, and clinical commissioning group.

During this inspection we spoke to 12 people who lived at Lindisfarne Hartlepool, nine relatives, two external care professionals, the registered manager, the area manager, two senior care workers, five care workers and support staff.

We looked at seven people's care records and reviewed people's medicines records. We examined staff files including recruitment, supervision and training records. We also looked at other records relating to the management of the home.

We carried out an observation using 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 undertook general observations of how staff interacted with people as they went about their work.

We looked around the home, visited people's bedrooms with their permission and spent time with people in the communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this home in February 2016 we found the service was not safe for the people who lived there. This was because safeguarding concerns had not always been reported or investigated. The provider did not have robust emergency plans in place to make sure staff knew how to support individual people in the event of an emergency and infection control measures were inadequate.

During this inspection we found that the provider had made some improvements. Safeguarding issues were now reported to the local authority and the Care Quality Commission was notified of these. The registered manager had a safeguarding file that logged each concern and included the referrals to the safeguarding team at Hartlepool Borough Council. In some cases the registered manager had also included a report of any lessons learnt and the actions that would be taken to minimise any further reoccurrence of incidents. There had been seven safeguarding referrals since the last inspection.

However, we noted that in one of the seven referrals there was no record of any investigation into allegations made by a person who used the service. There was also no detail of the nature of allegations or of the staff members involved, and no record of an outcome. In discussions the registered manager stated that actions had been taken and other agencies had been involved, including the person's social worker, but acknowledged there was no written record of this in the safeguarding file.

At the last inspection we found emergency plans were not sufficiently robust to make sure staff knew how to support individual people in the event of a fire. During this inspection the registered manager advised staff were reviewing individual 'fire safety' care plans for each person to outline what support or guidance they would need in the event of a fire. This was on-going work while people's care plans were still being re-written.

Previously we found the evacuation list, which categorised the people living at the home depending upon the support they required, was out of date. This had now been revised and was up to date. This was kept in the hallway and identified at a glance those people who were nursed in bed, those who required a wheelchair and two staff to transfer, and people who walked with aids or walked with staff support.

At the last inspection the registered manager had not made sure fire drills were carried out in line with the provider's policy or the fire service's recommendation, that is six-monthly for day staff and three-monthly for night staff. During this inspection the fire drill records indicated that all except two day staff had been involved in at least one drill in the past four months. There were arrangements in place for the remaining two staff to take part in a drill in the next few days. There had been monthly fire drills for night staff so all night staff had taken part in at least one drill within the past three months. The home also had a current fire risk assessment in place.

In our February 2016 inspection we found infection control measures were not adequate. For example, soiled bedding was being stored in bathrooms before being taken to the laundry area. This meant there was the potential for cross contamination. It also meant odour control was poor in these rooms so it would not

have been a pleasant environment for people to bathe. During this inspection we saw soiled items were now collected in laundry trolleys and taken to a sluice room until they were transported to the laundry. There was good odour control in bathrooms and toilets and there were no unpleasant smells in any area of the home throughout the day and evening of this visit.

However we saw that sluice doors were open for periods during the day because the laundry trolleys were too big to allow the doors to close. We told the registered manager about this because this could cause a hazard for people who may enter these rooms mistakenly.

Certificates in regard to the safety of the premises were up to date, such as gas and fire safety. The provider had arrangements in place with specialist contractors to check equipment in the home, for example fire systems and call alarms. The six monthly check of hoisting equipment was now overdue but the home had contacted the engineer about their delay and arranged for this to be carried out the following day. Staff carried out monthly health and safety checks. There were contingency arrangements for dealing with emergency situations.

Risks to people's safety and health were assessed, managed and reviewed. People's care records included individual risk assessments which provided staff with information about identified risks and the action they needed to take. For example, some people had mobility needs and used specialist mobility equipment to support them, such as hoists. There were moving and assisting risk assessments which identified the number of staff and equipment required to support those people. These were reviewed on a monthly basis. There were also risk assessments about people's risk of choking and falls. These were also reviewed monthly.

Following the last inspection the registered manager now carried out a monthly analysis of accidents. This meant it was now possible to check any trends and show the actions taken to minimise further accidents. For example, the analysis had identified that one person had experienced several falls over one month. As a result, staff had contacted health professionals including the Falls Team and an occupational therapist. The person was offered a motion-sensor for their bedroom which they declined. The person was found to have a short-term illness that affected their balance and the number of falls they experienced had since reduced.

People and relatives we spoke with felt there were enough staff on duty to support people in a timely way. During this visit there was a timely response to call bells, although there were very few occasions when they rang. We saw staff supported people in a calm and unhurried way.

The staffing rota for a four week period showed there were usually nine care staff on duty through the day, including a senior care worker, for the 46 people who lived here. Night time staffing levels were typically five care staff including one senior care worker. The registered manager told us staffing levels were calculated by the provider's Head Office and took into account people's dependency levels as well as the number of people living there. The registered manager stated that staffing levels could be increased at any time if people's dependency levels increased.

There had been few changes to personnel since the last inspection and relatives said this was an important aspect of their family member's care. One relative commented, "It's always the same staff, it's very stable. It means the staff are very familiar with people's needs."

The registered manager told us there was a continuous recruitment drive for care workers. This was intended to make sure there was sufficient cover for holidays, sickness and training. The home had two relief staff who were used to cover gaps in the rota. The home did not use external agency staff.

There had been two new care workers appointed since the last inspection. Recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the Disclosure and Barring Service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure prospective staff were suitable to work with vulnerable people.

When we arrived at the home at 5.30am we found two locked medicine trolleys were on the first floor corridor and two in the ground floor dining room. The registered manager told us, "The trolleys are stored in the treatment room and brought up in the morning before the first round." We advised the registered manager of our observations. They advised they intended to introduce a secure locking system on each floor.

People's medicine administration records (MARs) showed no gaps or discrepancies. However topical cream charts we viewed had numerous gaps. We spoke to the registered manager who advised they had identified the issue and recently discussed the matter at a staff meeting. Minutes meeting confirmed this.

Systems were in place to ensure medicines had been ordered, stored, administered, and audited. We saw monthly medicines audits were completed regularly.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Fridge and treatment room temperatures were monitored and recorded to make sure medicines were stored within the recommended temperature ranges.

Good

Is the service effective?

Our findings

At the last inspection of this service in February 2016 we found the provider had not made sure staff had sufficient support with their professional development. For example at that time most staff had not had an annual appraisal of their performance during 2015. Also, only two staff members had received a supervision bi-monthly as per the provider's action plan. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role.

During this inspection we found staff members who had been employed for over one year had taken part in an annual appraisal. We saw staff had taken part in supervision sessions with either a senior care staff member or a manager. The staff records we looked at showed those staff members had been involved in two supervisions sessions over the past four months, which was in line with the provider's policy and action plan.

Training records showed staff members received training in mandatory subjects such as moving and assisting, fire safety, food hygiene and first aid. Two-thirds of the care staff team had achieved a care qualification and most of the remaining staff members were currently working towards this. Since the last inspection staff had completed computer-based training in dementia awareness, data protection and equality and diversity.

At the last inspection in February 2016 we found 31 staff members had not attended training in mental capacity and deprivation of liberty. During this inspection we saw this had improved. The regional manager was a trained trainer and had provided group training for some of the staff group in the Mental Capacity Act 2005 and the remaining staff had completed computer-based training.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

On our inspection in February 2016 we found the home had not taken action in a timely way to apply for new DoLS where these had expired (standard DoLS are authorised for a maximum period of 12 months). This meant that, during the interim, people had been deprived of their liberty without the necessary authorisation.

During this inspection we found improvements had been made. There were 31 people in the home who had

DoLS authorisations in place and these were all in date. There was a DoLS register that included the date the DoLS was applied for and the date the authorisation was valid until. This meant the service could plan for any future requests for DoLS to be made in advance of the end date of their current authorisation.

There were records of 'best interest' decisions involving other agencies or advocates for decisions where people did not have the capacity to consent to these. These included, for example, the use of safety bedrails or making mealtimes choices on the person's behalf. This meant people's best interests were protected without compromising their rights.

People who were able to express their views told us they made their own choices over their own daily lifestyle. We heard staff ask people for permission before carrying out care tasks, such as supporting people to eat and drink and when offering medicines. In this way each person's consent was sought and awaited before providing care.

However we did observe one interaction when a person's choice was disregarded. A person was asked what they wished for their evening meal and given a choice of chicken nuggets or fish pie. The person replied nuggets and a care worker intervened and said, "No [Person] will have fish pie." We enquired why the person was unable to have what they requested and were informed the person was having problems with a new set of dentures. We discussed the matter with the area manager and the person was provided with their first meal choice with the option of the alternative available.

At the last inspection we found the dining arrangements and support were not adequate for the people who lived there. At that time the upstairs dining room was too small to accommodate all the people living on that floor if they all wished to sit at a table to eat their meal. Tables did not have condiments and each place setting had a plastic apron on the table without people being asked if they wanted one. Meals were not served in a timely way and people who needed physical assistance did not receive one-to-one support with their meal.

During this inspection we found improvements had been made. We joined people for a lunchtime meal. The activities lounge on the lower ground floor now provided additional dining space. Throughout the meal there was a good staff presence in the dining room. People who needed physical assistance to eat their meals and were provided with one-to-one support by staff. People told us meal times were a pleasant, social occasion and they looked forward to their meals. This helped to set an engaging atmosphere that encouraged people with their nutritional intake.

People were offered two choices of main meal and dessert. Although people were asked in the morning what they would like for lunch, they were able to change their minds and at lunchtime some people opted for the alternative dish. People were served to their individual choice, for example one person who enjoyed their meals was offered a larger portion. There were pictures of the day's menu options in the dining room which were intended to support people to make informed choices. Condiments were offered to each table people as meals were served.

Where people had nutritional needs there were care plans about how they should be supported. In newer care files these included a nutritional risk assessment and regular weight records. If people were identified as at risk of poor nutrition staff monitored and recorded their daily food and fluid intake. Diet notification forms were completed for each person. The forms included details of any special dietary requirements, for example whether people had diabetes or needed their food to be soft texture if they had swallowing difficulties. The form also included the likes and dislikes of each person. Copies of the diet notification form were kept in the kitchen by catering staff and also in each person's care file.

Relatives felt people were supported with their health care needs. One relative told us, "I trust the staff to look after [relative's] health and they do." They told us they were contacted by Lindisfarne Hartlepool staff about any changes in their relative's well-being. They also confirmed they had been involved in discussions about their family member's health. One relative commented, "They keep us informed all the time, so I always know how [relative] has been. If anything has happened they always go with them to the hospital. "

People's care records showed when other health professionals had input into people's care. These included, for example, GPs, dietitian, occupational therapist and community nurses.

There were some design features in the home to support people living with dementia. For example, bathroom and toilet doors were painted green and had large picture signs to help people recognise these rooms. On bedroom doors there were people's name and a current photograph.

The home had purchased memory boxes for outside bedrooms doors. The boxes could be filled with items that were familiar and personalised to each person, but this had not yet been done. Since the last inspection the staff had begun to provide more themed areas to help people find their way around. For example, one corridor now had a seaside theme and tactile pictures on the walls that people could touch as they walked past.

Good

Is the service caring?

Our findings

At the last inspection in February 2016 we found people were not always treated with dignity and respect.

During this inspection we found improvements had been made. We attended the home at 5.30am and saw one person was dressed and sat in the upstairs lounge. A care worker advised this was on the request of the person. The person told us they liked to get up early on a morning. The care worker ensured the person had a cup of tea and asked if they wished to have some cornflakes or wait for breakfast.

The home provided care for several people who were living with dementia. Two staff had recently trained to provide 'resident experience' training to the staff group and six staff members had completed this so far. The training gave individual staff members the chance to feel what it was like to be a resident for a few hours, for example by spending the day in a wheelchair and being fully reliant on staff for support. One care worker told us, "It really makes you think, how would I like to be looked after?"

People we spoke with told us they were happy living at Lindisfarne Hartlepool. One person said, "I am very happy here." A relative said, "My mother only came for three days and she did not want to leave, she has been here six years now." Another relative told us, "The staff are very caring they treat everyone the same the manager knows everyone by name. It's very friendly in here and I can visit anytime."

Staff had knowledge of people's preferences and were able to describe people's likes and dislikes. We observed staff addressed relatives in a friendly manner and were on first name terms. One relative told us, "The staff are really knowledgeable about my family member's needs and they understand everyone's little foibles." Another said, "The carers don't just carry out care tasks, they understand the differences in a person and know what's worked in the past for them."

Relatives we spoke with told us staff were caring and kind. One relative said, "We've got a very good relationship with the staff – nothing is too much trouble for them." Another said, "All the staff, even the cleaning staff, pop in to see my family member on their breaks. The culture is lovely and caring."

We saw people being treated with respect and their dignity maintained. Staff were seen knocking on people's doors before entering their rooms. We also saw during meal times, staff asking people if they wanted to wear a 'pinnie' to protect their clothes and respecting their wishes if they declined. One relative said, "The dignity they've shown my family member, we couldn't ask for more."

Staff were attentive to people's needs. One person's cooked breakfast had become cold; the care worker contacted the kitchen to obtain a fresh meal. Another person asked for a cup of tea and when the care worker brought it to them they said it was too hot so the care worker took it away and brought it back when it had cooled.

The atmosphere was relaxed and unrushed. Staff engaged with people as they went about their duties. As staff supported people they explained to the person what was happening. For example, when supporting

the person with their meal.

Information was displayed on noticeboards throughout the home promoting the local advocacy service and outlined the support available. The registered manager told us, "We support people to get the support their need."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in February 2016 we found care records did not reflect people's needs and preferences. Care plans contained conflicting information and were not regularly reviewed.

Whilst the home had made improvements the provider and registered manager recognised it was a work in progress. The registered manager told us, "We are in the process of rewriting the care plans and this can take time." A senior care worker had completed care plan training. We found improvements had been made to the care plans they had rewritten, however there were still inconsistencies and variation in the level of detail recorded.

Each person's care records contained a 'This is me' document and a map of life which gave a brief record of the person's employment, childhood memories and family structure. Care plans were in place for areas such as nutrition, moving and handling and personal care. These outlined the person's needs and an objective with an action plan on how to achieve this.

We saw in one person's initial assessment reference was made that the person was living with epilepsy, however there were no care plans in place to support the person or risk assessments to mitigate potential risks. We spoke with the registered manager who asked a senior care worker to review the information and develop a care plan and risk assessment immediately. This was put into place before we ended our inspection.

One person's communication section reported the person was partially sighted; no reference was made to the person requiring spectacles. However within the risk assessment it stated the person had 'glasses'. We asked the registered manager. They checked with a senior care worker and advised, "[Person] does not like to wear them." We noted this was not reflected in the care plan. The registered manager advised, "We are currently going through the care plans, I will work on this one."

Care plans which had been written by the senior care worker who had recently completed the care plan training described how people preferred to be supported in a person centred and safe manner.

Within a moving and handling care plan it outlined how to support the person. Detail included the well-being of the person and the technical use of the hoist and sling. Also within the nutrition care plan it detailed, 'Ensure [Person] meals are given with a teaspoon to prevent overloading [person]'s mouth.'

The registered manager and area manager recognised care plans needed further work and this was reflected in the provider's action plan.

People and relatives we spoke with told us they were involved in the review of the care provided. A relative said, "I attend the reviews of my mam's care." A senior told us, "Family are highly involved with their family member's care".

The provider had a complaints policy. A pictorial complaints process was on display in the entrance of the home. People and relatives we spoke to told us if they had any concerns they would speak to the registered manager. When asked what people would do if they were not happy with the home, one person said, "I would just go to the manager and ask what's happening".

We saw one complaint had been received since our last inspection; an acknowledgement letter was present in the complaint log however no investigation was available. The registered manager advised that the area manager was conducting the investigation and was due to reply to the relative.

During our inspection in February 2016 we noted a lack of activities for people living with dementia. The registered manager showed us sensory items they had developed including aprons and cushions with tactile texture items attached and rummage boxes. The registered manager said, "We recognised we don't have things for the men so we are collecting things for a male rummage box. We have also bought a doll for doll therapy but no-one has taken an interest"

Since the last inspection the home had employed a full time activities coordinator. They had been in place for three months and had started collating information about people to ensure their previous and current interests were considered in future creation of activities.

We observed people taking part in craft activities in the activities room and enjoying a chat and cup of tea together. One person said, "It's nice here they make a canny cup of tea and there is plenty of biscuits". A reminiscence video of Hartlepool was playing in the background. We saw one person was making a necklace with beads. The activity coordinator told us, "[Person] loves painting." They showed us a book of the person's creations gathered together into an album.

An activities notice was on display in the entrance of the home. Activities included knitting, artwork and card games. The registered manager told us, "Mr Motivator comes once a week and everyone does the exercises they all enjoy it. [Person] gets up to help the instructor." Whilst we did see a number of people taking part in activities in the downstairs activities room no other activities were taking place in the two lounge areas.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in February 2016 we found the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support. We also saw people's confidential information was not held securely.

Whilst some improvements had been made following the last inspection, the registered manager acknowledged work was still to be done in a number of areas. An action plan was in place to monitor and drive the improvement.

We found the provider had a quality assurance system which included the monitoring of areas such as care plans, accidents, incidents, MCA, daily walk rounds, safeguarding and health and safety. We saw these had been completed regularly since the last inspection. All contained detailed findings and actions if required.

The registered manager produced a 'Monthly remedial Action plan' which captured any issues identified from the individual monthly audits. We saw it clearly outlined the action to be taken with a timeline for completion. For example within the action plan it described the introduction of rummage boxes for the men and recorded when this should be completed by.

We noted a number of issues relating to the protection of people's confidential information had been resolved; we saw people's MARs were held securely and the white boards displaying people's personal information removed. However on the morning of our inspection we did find people's fluid and food and topical cream charts unattended in the dining room. We brought this to the attention of the registered manager who advised they would look into the matter.

A deputy manager role had been introduced since the last inspection. The registered manager told us, "I delegate work and we all work together as a team. In meetings we talk about all the roles' from kitchen to carers and the impact on each other."

We observed care workers worked well together and there was a good camaraderie with staff. Staff we spoke to told us they enjoyed working at Lindisfarne. One care worker said, "Its brilliant working here, I would not change a thing about my job." Another said, "I can see the improvements, we all work together now."

People and relatives we spoke to told us the registered manager was approachable. One person said, "The manager is a very nice lady." A relative told us," I see the manager I have nothing but praise for her."

We asked the registered manager what they did to seek people's views about the quality of the service. They told us, "We send out a survey to relatives and residents. We have sent one recently."

We saw 51 relatives were provided with a survey in April 2016, with 13 surveys returned. Relatives were given a series of questions with the following options available, 'excellent, good, average, below average and not

answered.'

To the question 'How effectively do you feel the staff work as a team?' Three relatives answered excellent, six answered good, four answered average. One comment recorded stated, 'Some staff seem to be working as a team, others just don't seem to care.'

For the question, 'How do you rate the level of care provided?' Two relatives answered excellent, five answered good, four answered average, one answered below average and one did not answer. We saw the home was open and transparent and displayed the outcome of the survey and actions it was implementing. For example an increase in activities.

Staff had structured opportunities to share information and give their views about the service people were receiving. We saw the registered manager held quarterly staff meetings and had introduced flash meetings. The registered manager told us, "If there are any issues we call a flash meeting, getting all staff together." They explained that flash meetings gave them the opportunity to address staff immediately and put actions in place to resolve issues quickly. Staff confirmed flash meetings were held regularly. One care worker told us, "With flash meetings we get to know straight away."

The registered manager has notified the Care Quality Commission of all significant events which have occurred. We saw the last inspection rating was displayed in the entrance of the home in line with the legal requirement.