Parkfields Nursing Home Limited

Parkfields Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 and 29 June 2016. The inspection was unannounced.

At our previous inspection of the service on 18, 19 November 2015 and 12 January 2016 we identified two breaches of legal requirements. This was because the provider's systems for minimising and mitigating risk had not been effective, and systems were not robust enough to ensure risks relating to the health, safety and welfare of people were responded to. The overall rating after the previous inspection was inadequate and the location had been in Special Measures since August 2015. We found the provider had met the regulations at this latest inspection, and the overall rating had changed to Requires Improvement this meaning we have taken the decision to take the service out of Special Measures.

Parkfields Nursing Home provides care and treatment for up to 49 older people that may have a physical disability. The home provides nursing care, which means qualified nursing staff are always available. There were 25 people living at Parkfields Nursing Home when we inspected.

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

Staff knew how to protect people and reduce risks but this information was not always reflected in people's assessments. Staff were confident in escalating any allegations of abuse, so these would be investigated, and people protected. People said there was sufficient staff to ensure they were safe and received assistance when required. People were satisfied with how their medicines were managed. There were not always records in place to show pre-employment checks for new staff were carried out.

People's consent was sought, but assessments to establish if people had capacity to make decisions were not always accurate and did not show how staff gained people's consent in accordance with their rights. People felt staff were skilled and competent. The training staff needed had been identified and was been prioritised, so that more important areas of learning were provided first. People had a choice of food and drink available to them and said they enjoyed these. People's health care was promoted, and risks to their health escalated to appropriate external health care professionals.

People said they were treated well by staff who were kind and caring. People's privacy was respected and they were able to make choices before and during the care staff provided to them. People's independence was promoted.

People did not always have access to pastimes they enjoyed and found meaningful. People had involvement in the care and support they received. Staff were knowledgeable about people's individual likes and dislikes, although this information not always captured in people's records. People felt able to complain

and were confident any issues would be addressed.

People had confidence the provider was improving the service they received. The provider had made improvements to ensure risks to people's safety were identified and minimised. The registered manager recognised further improvements were required to improve people's experiences. People were able to approach staff and felt listened to. Staff were well supported and happy in their work.

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.

Staff knew how to protect people and reduce risks but risk assessments were not always up to date. Pre-employment checks for staff were not consistently completed. Staff could identify signs of abuse and any concerns were escalated appropriately. People said there was enough staff available to ensure they were safe and had timely assistance when needed. People told us they were happy with how their medicines were given to them, and we saw medicines management was continuing to improve.

Is the service effective?

Requires Improvement

The service was not always effective

People told us they were able to make decisions, but assessments of people's capacity did not always show how people's rights would be promoted and their best interests considered. People said staff were skilled and competent. People had a choice of, and enjoyed the food and drinks that were available to them. People's health care needs were promoted.

Is the service caring?

Good

The service was caring

People told us staff were kind and caring. People said staff treated them respectfully. People's privacy was consistently promoted by staff. People had choices given to them before and during the care and assistance staff provided to them. People's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were not always supported to pursue pastimes that they enjoyed and found meaningful. People were involved in the care and support they received. Staff were knowledgeable about people's individual preferences, although this knowledge was

not always captured in people's records. People were able to complain and were confident issues raised would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were confident that the provider was improving the service they received but recognised there was still further scope for improvement. We found the provider had made improvements to ensure risks to people's safety were identified and minimised. Systems to capture and respond to people's experiences and monitor the quality of the service were improving. People's views were listened and responded to. Staff felt supported to do their jobs well.

Parkfields Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 28 and 29 June 2016 and was unannounced. The inspection team consisted of one inspector, one specialist advisor (who was an occupational therapist) 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.

We reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also reviewed notifications of incidents the provider had sent us since the last inspection. The provider is required to tell us about certain types of incidents such as serious injuries to people who live at the service. We also heard the views of local commissioners about the service prior to our inspection. We considered this information when we planned our inspection.

We spoke with nine people who lived at the home, five visitors, the manager, deputy manager, three nurses, one team leader, six care staff, and one maintenance person. We also spent time looking to see how people were cared for and supported by staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at eight people's care records (including six people's medicine administration records) and other records related to the management of the service for example audits of medicines, action plans and staff meeting records. We looked at records relating to the assessment of risks relating to the safe movement of people with equipment. We also looked at records for the servicing of equipment used to assist with people's movement.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 18, 19 November 2015 and 12 January 2016 we found the provider was not meeting regulations as the risks to people's health and safety had not been assessed robustly, and staff moving and handling practices had the potential to cause injury to people. The provider's systems for minimising and mitigating risk also needed improvement. The provider sent us an action plan telling us about improvements they were making to address these issues. We found the provider had made sufficient improvements and met the regulation at this inspection.

We checked how people were assisted to transfer with the use of hoists and slings on a number of occasions and saw this was carried out in a safe way. Staff were careful with the use of equipment. For example we saw they made alterations to the position of lifting slings, on people's request, which considered people's comfort and safety during transfers. Staff said they were confident with use of lifting equipment, and were able to tell us how to use different types of equipment safely. Staff said recent training in moving and handling people had helped them understand how to keep people safe when moving them. We saw appropriate risk assessments were in place that stated how people should be moved safely with equipment, which we saw staff followed. These were completed by senior staff who demonstrated a good understanding of how risks from use of lifting equipment should be assessed. This showed the provider had made improvements so people were transferred safely with the correct lifting equipment.

At our previous inspection equipment needed to protect people, as identified in their risk assessments was not always available. At this inspection we found equipment identified to protect people was available, and reflected risk assessments we saw. For example protective wedges and covers for bedrails were now in place and ensured the risk of injury from exposed bedrails was reduced. We saw the registered manager had identified strategies to minimise some risks to people. For example, one person identified at risk of falls had a falls protection plan in place and we saw that staff were completing actions identified within this. We did see some instances where people's risk assessments lacked clarity however. For example, some people had fragile skin and their risk assessments said they needed repositioning to relieve pressure on their skin between two to four hourly. The registered manager told us they were aware of this and they were going to review these risk assessments and would seek advice from tissue viability nurses. They said they would make sure the risk assessments set out the exact frequency people needed to be repositioned to relieve pressure on their skin. No one who lived at the home had developed pressure ulcers however, and staff were able to tell us how they would identify changes in people's skin and escalate any concerns. This showed the provider's systems for minimising and mitigating risk were more effective, although some further development was needed.

Systems in place for recruitment of staff were not always sufficient to show people living at the home were protected. We looked at the files for three recently employed staff and none carried evidence of a Disclosure and Barring checks (DBS) carried out before they began work at the service. DBS checks include criminal record and barring list checks for persons whose role is to provide any form of care or supervision. Two of the staff had a DBS completed some weeks after commencing work and these did not present any concerns about their safety. We also found other pre employed checks had not been carried out. For example the

provider had not sought past employment/professional references for one of the staff and only one reference for another. We spoke to two of the staff and they told us checks had been completed as required, for example DBS and references despite a lack of recorded evidence in their files. This suggested the provider's recording of recruitment checks needed to be better. We did see there was regular review of all the professional registration numbers for nurses employed, so the provider could be assured nurses were registered with the national body overseeing nurse's professional standards and registration. The registered manager acknowledged the importance of ensuring all necessary checks were carried out before new staff were employed and said these would be put in place.

People told us they felt safe and they were well cared for. One person said, "I always feel safe. I look after myself mainly but it's safe here the staff make sure of that". Another person said, "I feel safe, no worries at all. If I had any I would just say something to one of the staff, or my family if needed to but there has never been any need for that sort of thing". All the visiting relatives we spoke we had no current concerns about people's safety, and said they knew how to raise concerns with external agencies should they feel this was necessary. We saw information about how people could raise concerns with external bodies should they feel unsafe was on display and accessible in public areas. This showed people felt safe and information on escalating concerns was available.

At the previous inspection we had concerns that alleged abuse was not escalated to the appropriate external bodies by the provider. Since this inspection, concerns or allegations about potential abuse had been promptly raised by the registered manager with ourselves and the local safeguarding authority. Staff we spoke with demonstrated a good awareness of their responsibilities in respect of safeguarding people. Staff were able to describe what abuse looked like, when they should escalate concerns and to whom. One member of staff told us there were aware it, "Is our duty to report abuse". This showed staff knew how to raise allegations of abuse so they were investigated and people were protected.

People said there were enough staff available to ensure they were safe. Some people told us staff were more responsive to calls for assistance than they had been in the past. One person said, "If I need help there's always (staff) there". Another person told us, "When I press my bell I sometimes have to wait a bit. There is an emergency bell and if you press that they come straight away". Relatives we spoke with had no concerns in respect of staffing levels. Staff told us how their deployment by senior staff had improved which meant staffing was better as there was, "More teamwork and more communication". Another member of staff said, "While we can't always respond immediately, overall there is no problem with staffing". This showed staff were deployed in a way that ensured people were safe, and received a timely response to requests for assistance.

People told us they were happy with how their medicines were managed. "One person said, "I've never missed any and they always make sure I take them". Another person said, "I always get my medicines, they give me the pills in a little pot and tell me what they are. They give me a drink and make sure I have them as I'm a little forgetful". We saw nurses administer medicines, these given to people in a safe way. For example, a nurse checked people's medicine administration records (MARS) before giving people their medicine, this to check they the right person had the right medicine, and only signed MARs when they had given the medicine. We looked at six people's MARs, and found two occasions where medicines had not been signed out. A nurse was explained the gaps related to occasions where a person had refused their medicines, this not recorded. The registered manager told us people's MARs records were audited weekly and these MARs would have been checked and the expectation was that the gaps would have been identified, as we saw was the case with previous audits. We found medicines were stored safely, and in a way that ensure they would be effective, for example at a safe temperatures. We saw two people were given their medicines, and were given the choice of taking these when they wished. These people understood the importance of taking their

medicines and were seen to do so safely but there were no assessments completed to show how any potential risks to the person of self – medicating had been considered. The registered manager told us these would be completed. We saw the provider had received reviews of their medicines management systems by a National Health Service (NHS) pharmacist. We saw the more recent check by the NHS showed the provider had made improvements, and we found that these improvements were continuing. This showed the provider was improving their systems for the safe management of people's medicines.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and saw people's capacity was not consistently assessed. Where people's capacity had been assessed the information in the assessment did not reflect what staff told us about people's capacity and their ability to make decisions. For example one person's MCA assessment said they did not have capacity. Staff, and the person's relative told us the person, with support, could make some decisions. This showed assessment of people's capacity was on occasion inaccurate and did not reflect staff knowledge about how they would support people to make decisions. The registered manager told us people's MCA assessments would be reviewed, or completed where not in place, so they were accurate and detailed how staff supported people to make specific decisions where able.

We saw staff gained people's consent before they supported people with care. We saw staff ask people for their consent before providing support and throughout the task. For example, before people were transferred with a hoist their consent was sought. One person we spoke with told us, "They always listen to me and respect my decisions". A relative told us a person was supported, "To make their own decisions". Staff we spoke with understood they must gain people's consent, although some staff had a better understanding of their responsibilities under the MCA and how this should inform their practice. For example they did not always understand when relatives had the legal right to make decisions about a person's care and welfare, and when this was not permissible. The registered manager told us some staff needed to have training in MCA to assist their understanding of the law. This showed people's consent was sought before people had care or support although there was scope to improve staff understanding of the MCA.

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 are called the Deprivation of Liberty Safeguards (DoLS). There was one person who was subject to a DoLS at the time of our inspection which had been reviewed by the local authority. We were told by the registered manager that an application had been made for a DoLS authorisation for a second person, this yet to be approved. The registered manager said they had only made DoLS applications to the local authority when people had no capacity to make decisions. This showed they had an understanding of DoLS and when applications were appropriate.

People told us they experienced positive outcomes regarding their health and this was promoted in partnership with community healthcare professionals. One person said, "If I'm not feeling well the staff will say to me stay in bed, I will get the doctor". Other people we spoke with said they would see their doctor on a regular basis but staff would call them if they felt unwell. They also told us they saw other health care professionals, for example they said the chiropodist came on a regular basis to cut their toe nails and cream

their feet. A visiting relative said the staff, "Always ensure they see the doctor when needed". Another visitor said when their relative was ill the staff, "Had done everything they had to". We saw staff were observant of one person looking unwell at lunch time. A member of staff told them they would contact their doctor, and came back to tell the person they had done so. We saw people's records showed regular contact with external health professionals, with any health concerns identified escalated to people's doctors or other appropriate health care professionals as and when needed. For example, we found risks to people's health due to weight loss were monitored, with staff recording people's weight, diet and fluid intake when this was identified as needed. We saw referrals were made to the person's doctor when a person had recent weight loss with dietary supplements prescribed when needed. This showed people's healthcare was promoted with the support of external health care services.

People said they received a choice of good food and drink. One person told us, "I'm not a fussy eater but it's really nice homely food here. We have some lovely soups, and bacon sandwiches, I love a good bacon sandwich". People said they had two meal options for every meal, including a cooked breakfast. People also said if they changed their minds the cook made them whatever they liked. We saw lunch being served and staff supported people in a way that ensured it was a pleasurable experience. We saw people offered meal choices, with ready access to condiments and a choice as to where they ate their meal. We saw people's specific dietary requirements were catered for. For example, people with swallowing difficulties could have a purred diet presented so the tastes of different foods were preserved. Aids such as plate guards were available for people who needed them. We saw people received appropriate support with eating from staff. For example, we saw staff ensured a person was comfortable before their meal. The member of staff described the meal, assisted the person at their pace and talked to them throughout. The member of staff checked discretely between each spoonful of food to ensure the person's mouth was empty. People had a choice of drinks with their meal, and at other times during the day with a plentiful supply of drinks. Staff asked people if they wanted drinks on numerous occasions. We saw fruit was available and staff encouraged people to have this fruit on a number of occasions between meals. This showed people received a choice of food and drink and were offered support to with their meals and drinks when required.

People said they thought the staff were well trained and were knowledgeable about how to care for them. One person said, "The staff are competent enough to care for me and keep me safe. They have the skill, they have had lots of training you know, the new manager sorted that out". Another person said the staff, "Are good at what they do". One relative told us staff awareness and competence was, "Much improved" recently and felt this was in part due to the newer staff that had been employed. The registered manager told us there were still areas where staff needed further training. They told us how they planned training so staff training needs were addressed in their order of importance. For example, staff training in moving and handling and use of lifting equipment had been prioritised. We saw staff competence in this area was much improved since our previous inspection. The registered manager said they were looking at increasing the number of staff on vocational training so that they had grounding in fundamental standards of care. They also said they had identified a need to improve staff awareness in respect of specific health conditions such as diabetes and sensory impairment. Staff told us they felt well supported with training, and they had received training in a number of areas this year. A staff member told us about recent training had included experiential elements, for example where they were transferred in a hoist. They told us, "I did not like this" but added it allowed them to appreciate what the experience was like for people they cared for. Staff who had recently started work at the service told us they were well supported through their induction. This showed while there were areas where staff needed training the provider had identified this and was providing training in a planned way.

Good

Is the service caring?

Our findings

People and their visitors were positive about the kind and caring attitude of the staff. One person said about the staff, "They are kind, they have always been good to me". Another person said staff, "Are more bothered to care now and they are good staff, especially the new ones they have brought in, they talk to me and include me". Relatives also told us staff were polite, kind and caring. One relative said, "Staff are friendly and have always looked after [the person]". Another relative told us the staff were more caring now than they had been in the past. We saw staff approached people in a caring way, for example they were friendly, respectful and polite whenever they spoke with people.

People were consistently given choices by staff, for example we saw staff helped people to make choices by explaining these to them. We saw a person asked by staff about having their medicines. The person expressed some discomfort through facial expression. The member of staff sat with them and kindly acknowledged the person's dislike of taking their medicine. They offered the person reassurance by touch which was well received and ensured they were happy to have their medicines. The person's privacy was promoted by the member of staff using privacy screens before the medicine was administered. We saw another occasion where a member of staff offered a person a drink. The person was offered choice of four drinks and given time to make their choice. The member of staff then checked they were happy with their choice before giving them the drink.

We saw there were good relationships between staff and people that they cared for. We saw staff promoted people's dignity and consistently showed them respect when providing care and support. For example, one person used signs and facial expressions to communicate and we could see staff knew the person well. We saw staff responded appropriately to people's non-verbal language on a number of occasions. On another occasion we saw a member of staff bring a person's meal to their room and join in song with them to some of their favourite music. Where people's first language was not English, staff were available who could communicate with them. We saw when one person who did not speak English expressed some anxiety staff responded quickly. A member of staff spoke to them in their first language discreetly, and addressed them in a culturally appropriate way. We saw the person became more relaxed.

We saw staff promoted people's privacy. Some people told us their preference was to stay in their bedrooms and they were able to do so, but knew they could choose to sit in the communal areas if they wished. One person told us they had discussed with staff where they could keep their money, not wanting to use the provider's safe storage as they wanted ready access. They said they were offered a key to their room which they were satisfied with. We saw staff were aware of the need for privacy when people were transferred with a hoist, with use of privacy screens. Staff were able to tell us how they promoted people's privacy and dignity, for example by closing doors and asking people how they wanted their care provided. We saw staff knocked on people's doors and asked if they could enter, and people's bedroom doors were closed when this was the person's choice.

People's independence was promoted. People were able to move around the home independently when able. We saw there was access outside to secure gardens and one person used this area regularly and

independently when wished. We saw staff promoted people's independence, for example encouraging people to walk where they were able. We saw staff would encourage people they were assisting to complete tasks for themselves where able, with encouragement and comment to people to acknowledge how well they were doing when being independent. For example we saw people were encouraged to walk with appropriate aids where they were able. Staff were able to tell us how they would encourage people's independence and understood why this was important for people.

Requires Improvement

Is the service responsive?

Our findings

We saw that people sometimes had involvement in pastimes they found meaningful, although there was not a consistent approach by the provider in respect of how people were involved. People told us about pastimes and activities that were available to them. One person told us, "The staff are really kind and bingo's ok but not all the time. There's nothing to do really". Some visitors told us activities for people could be better, although one said their relative had little interest in getting involved, but did enjoy the television.

We saw limited opportunities for people to get involved with activities, although saw a bingo session was held on the one day of the inspection. People were asked if they wished to join in although as held in the lounge everyone in this room had some involvement. Staff supported people to get involved and one person called the numbers, and they presented as enjoying this. We saw some people lost interest after a time which suggested some variety in the activity may have been beneficial to keep people interested. We saw there was not much available in the home that would provide people with items to focus on. For example there were no reminiscence boards, or tactile objects that people may be able to pick up and use. In addition, some information was not presented in a way that would help people with cognitive or sensory difficulties understand it. For example the menu board was only available in writing and not for example a pictorial format that people living with cognitive difficulties may find easier to understand. While we saw the activities programme was illustrated, this was mounted too high on the wall for people in wheelchairs to see easily. We saw people had little other input in day to day hobbies beyond watching the television, listening to the radio or for some seeing visitors. We did see there was a programme of group activities advertised but staff, and the registered manager acknowledged this was an area where improvement was needed. The registered manager told us they were planning to employ a dedicated activities organiser.

We looked at people's care records and found people's needs were assessed. We found people, or their legal representatives had involvement in planning of their care. One relative told us they made decisions on behalf of a person as their legal representative and staff sought their agreement to planned care. Another visitor told us their relative was, "Quite able to share their views". We did find that some important information about people's life histories, that would help staff know people better was not always evident in their care records. For example one relative told us of a person's past hobbies and likes, which they told us the person still found of interest. Some staff we spoke with were not aware of these. There were some people's likes and dislikes staff were aware of however, that were again not used to support how people's care was planned in relation to their day to day care. We did see staff used their knowledge of people in respect of how they provided care however. The registered manager told us how they planned to review people's care records so they reflected the person's likes, needs and preferences more accurately. They told us this would help staff understand what was important for people and provide more of a person centred focus when people's care was planned. We saw that work was commencing on compiling people's life histories based on what people and relatives told staff, this to support care planning. This showed that while people's care plans were not always up to date, the provider had recognised the need to update these with people so as to better involve people in planning their care.

People and their relatives told us that they were satisfied that the care and support they received from staff

reflected their preferences and needs. People told us about preferences they had, for example one person told us, "I have trouble sleeping until quite late at night. I can come down here and let myself in the garden with a code, and come back in without disturbing or annoying anyone. I feel properly at home". We saw another person liked to wear a number of top garments. While we saw staff were aware of them becoming over hot and advising them to remove a top, they let them make this choice and respected their preferences. One person told us their preferences were respected by staff. They told us, "We are supposed to have a bath or a shower every other day. They [staff] remind me. I like a wash though. It's a lot of effort to have a shower". They confirmed their choice was respected by staff. Staff demonstrated they knew people well, for example we saw one person was assisted with their meal, and while doing so the member of staff was singing a gospel song. The person at this point had a big smile on their face. The member of staff told us after this was one of the person's favourite songs. This showed staff had an awareness of people's preferences and considered this in respect of people's daily routines.

People and relatives we spoke with knew how to complain and we saw there was information about complaints clearly on display within the home. No one we spoke with said they had made a complaint, although one relative did say a person had raised some informal concerns. For example they had made comment about some equipment and the relative told us the staff, "Have done everything" to resolve the person's concerns. People did tell us that if they had any comments they felt able to approach staff or managers. We found that complaints the provider received were documented, monitored and follow up action recorded, with feedback given to the complainant. This showed that that people knew how to complain and the service did respond to concerns raised.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 18, 19 November 2015 and 12 January 2016 we found the provider was not meeting regulations as they had not ensured systems were robust enough to ensure risks relating to the health, safety and welfare of people were responded to. The provider sent us an action plan after our inspection in January 2016 telling us about improvements they planned to make. We found the provider had met the regulation at this inspection although there was still scope to improve further.

We saw a range of internal quality audits were undertaken to monitor the service. There were systems in place to identify, assess and manage risks to the health, safety and welfare of the people using the service. We found these systems had ensured people's moving and handling risk assessments were reviewed, for example these had been used to identify the equipment needed to move people safely and ensure staff were aware of how to use this equipment. We saw incidents, accidents, safeguarding and complaints were recorded and monitored for trends and patterns, to inform how risks were managed. This ensured the registered manager was aware of any concerns, for example allegations of abuse, so they could ensure they were acted upon. We did however find some discrepancies in some people's records and care plans in respect of the accuracy of information. For example, one risk assessment was not clear as to how many staff should assist a person to stand, although we saw staff understood how to assist the person in an appropriate and safe way. We also found assessments had not identified at what frequency people should be repositioned to protect their skin from pressure ulcers, although this had not resulted in people developing any pressure ulcers. This indicated risks to people were communicated to staff, but inaccuracies in record keeping were not always captured through the provider's auditing systems. The registered manager was aware of this issue and we saw audits of people's care records had been commenced to identify shortfalls in record keeping.

We looked at other audits and these we saw were used to inform action plans where the provider and registered manager identified areas where they still needed to improve, how they would do this and by when. We saw that a number of the improvements identified within the provider's action plan had been addressed although there was recognition by the registered manager and senior staff there was still scope to improve further and maintain the improvements that had been made. For example, in relation to ensuring staff received training that would help them keep people safe. The registered manager talked to us about training they had planned, but this was progressed in a way that ensured staff had training in areas of knowledge that related to greater risk such as moving and handling people safely. We saw this training had been prioritised and staff now had a good understanding of the principals of moving and handling people safely.

The service had a registered manager at the time of our inspection, following their application to register with CQC since the last inspection. The registered manager as a 'registered person' has a legal responsibility for meeting requirements. The registered manager acknowledged they had learnt much since taking up their position and they were more knowledgeable about areas of management that had raised concerns at our previous inspection, for example escalating and managing concerns. Their understanding of their responsibilities in law had also improved. The registered manager was supported by a deputy who also

demonstrated a good awareness of their responsibilities as a professional and a nurse.

People told us they found managers accessible, they knew who they were and they were able to share their views. One person said, "The new manager comes round most days to ask how I am. She's nice". One relative told us the registered manager was, "Very visible compared to the last manager, almost comes and meets you at the door, knows who you are and who you have come to see". People were happy living at the home. Relatives told us there had been improvements. One relative said they were, "Pleased with how the home's improving now" and another, "Come in any time and find the standard the same, It's heading in the right direction". People did not recall any meetings to discuss the service but relatives did tell us of a recent meeting they attended where they shared their views. Some people said they could share their views, one person telling us, "They (staff) talk to us, ask us what we like and all that". This showed people's views about the service they received from the provider were sought.

Staff expressed confidence in the way the service was managed and said they were feeling better supported by managers. Staff said they received supervision (one to one meetings with their line manager) and they were well supported and listened to. One staff member said, "I feel supported" and the one to one supervision meetings, "Were useful". Another member of staff said, "I have a lot of support, I feel I can come into work and get the support I need". A third member of staff said, "Every time we have a meeting we are asked are you treated well?" Staff said they were kept informed of developments, for example through daily handover and general staff meetings, and these kept them up to date on people's current care needs. Staff felt they were managed better knew what their responsibilities were on a day to day basis, which they said had improved teamwork between staff. This showed staff were positive about their jobs and well supported.

Staff said they were able to raise concerns and said they would feel able to contact the provider or external agencies and 'whistle blow' if needed. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, dishonest, or not correct within an organisation that is either private or public. One member of staff said if they whistle blew they, "Would be supported 110%" by the registered manager.

We found the provider had met their legal obligations around submitting notifications to CQC and the local safeguarding authority. The provider was aware they were required to notify us and the local authority of certain significant events by law, and had done so. We also saw that the provider had ensured information about the service's inspection rating was displayed prominently as required by the law.