Saffronland Homes

Glen Rose

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

Glen Rose is a care home with nursing. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Glen Rose provides accommodation for up to 47 older people. The accommodation is arranged over two floors. At the time of the inspection there were 19 people using the service. Many of these people were living with dementia.

The service had a registered manager. 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 and associated Regulations about how the service is run.

Our last inspection had identified concerns regarding the deployment of staff, the management of risks to people and of medicines. People's dignity had not always been respected and care had not always been designed to meet people's individual needs. The quality assurance systems were not being effective at assessing and monitoring the quality and safety of care. Due to the nature of our concerns and the provider's poor track record with compliance with the Regulations, we took enforcement action and placed conditions on the provider's registration. We required them to submit a range of information to the Care Quality Commission (CQC) on a weekly and monthly basis. We used this information to monitor how the service was performing. In addition, the local authority and clinical commissioning group began to support the service via their quality improvement frameworks. The provider also voluntarily agreed to not take any new admissions to the home to support this process. This continued until May 2018, when due to increasing concerns about the safety and effectiveness of care provided, the local authority placed the service under their safeguarding framework and initiated a large-scale enquiry into the service. Two specific incidents are part of an ongoing safeguarding investigation by the local safeguarding team.

This inspection continued to find some areas where the service was not meeting the fundamental standards.

Staff were not always following risk management plans or guidance. Calls bells had not always been left in reach. Pressure relieving mattresses had not always been set correctly limited their effectiveness as a pressure relieving aid.

Whilst systems were in place to assess and monitor the safety of the service, these were not being fully effective as we continued to find instances where the safety and quality of the service provided had been compromised.

Insufficient action had been taken to monitor people's nutritional needs.

Despite being made available; the registered nurses were not undertaking additional training relevant to

their role and to enhance their clinical skills.

Some local health and social care professionals continued to express concerns about the clinical care provided. They lacked confidence in the leadership team to drive improvements. However, the provider had introduced measures to try and address these concerns and to improve partnership working.

Improvements were needed to ensure that following incidents and accidents, post falls protocols were always followed. In one case, the records did not provide a satisfactory explanation as to how the incident of unexplained bruising had occurred.

Whilst there were still some aspects of the dining experience that needed to improve, where people needed support to eat and drink, this was provided in a way that was dignified and respectful of the individual.

Improvements had been made to ensure the safety of the premises and of some of the equipment within it.

Improvements had been made to ensure that staff were deployed in a manner that helped to ensure people's safety.

Improvements were needed to ensure that people cared for in their rooms had regular opportunities for meaningful interaction. Despite the home only having 19 people, their needs were very diverse and we were concerned that the provision of 21 hours of dedicated activity time was not sufficient to ensure that each person received regular and meaningful activities.

Overall medicines were being managed safely, although further improvements were needed to ensure that the application of topical creams was documented effectively. Individualised risk assessment and care planning was needed to identify and protect people from accidentally ingesting thickener.

Staff were receiving more regular supervision and felt generally well supported.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

Overall the home was clean and we did not find any malodours. We observed that staff used appropriate personal protective equipment (PPE) and they were aware of how to appropriately handle and dispose of infectious waste.

Where there was doubt about a person's capacity to make decisions regarding their care and treatment, staff had completed mental capacity assessments which were well documented.

The premises were generally suitable to people's needs, although we have made a recommendation that the provider continue to explore evidence based practice guidance on how environments can be designed effectively to meet the needs of people living with dementia.

Staff referred to people in a respectful and dignified way and care was provided in a discreet manner.

Staff spoke fondly about the people they supported and it was clear that the permanent staff and longer-term agency staff had developed meaningful relationships with people.

People were encouraged and supported to make decisions about their care and support.

Care plans had improved and now recorded people's individual preferences about how they liked their care to be delivered. There remained some areas where care plans could be developed further to ensure that staff were able to be responsive to people's individual needs.

Staff were observed to be attentive to people and engaged with them in a person centred rather than neutral manner.

Information about how to complain was available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to.

We have made a recommendation that the service consider ways in which information about people's end of life needs and wishes are assessed and documented.

The registered manager was passionate about their role and to driving improvements within the service. Staff were generally positive about the registered manager and most felt supported in their roles. They told us morale was improving.

This is the third consecutive time the service has been rated Requires Improvement. The service is not yet consistently providing good care. We will meet with the provider to discuss the findings of this report and consider the most appropriate regulatory response. We will publish actions we have taken at a later date.

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 were not always following risk management plans or guidance. Calls bells had not always been left in reach. pressure relieving mattresses had not always been set correctly limited their effectiveness as a pressure relieving aid.

Further improvements were needed to how incidents and accidents were managed and documented.

Improvements had been made to ensure the safety of the premises and of some of the equipment within it.

Improvements had been made to ensure that staff were deployed in a manner that helped to ensure people's safety.

Overall medicines were being managed safely, but we identified that further improvements could be made to the documentation of topical creams and to ensure that individualised risk assessment and care planning was in place to identify and protect people from accidentally ingesting thickener.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

Overall the home was clean and we did not find any malodours. We observed that staff used appropriate personal protective equipment (PPE) and they were aware of how to appropriately handle and dispose of infectious waste.

Is the service effective?

Requires Improvement

The service was not always effective.

Local health and social care professionals lacked confidence in the clinical care provided and we also identified areas where the clinical care provided had been compromised. For example, insufficient action had been taken to monitor people's

nutritional needs.

Staff were receiving more regular supervision and felt generally well supported.

Where there was doubt about a person's capacity to make decisions regarding their care and treatment, staff had completed mental capacity assessments which were well documented.

The premises were generally suitable to people's needs.

Is the service caring?

Good

The service was caring.

Staff referred to people in a respectful and dignified way and care was provided in a discreet manner.

Staff spoke fondly about the people they supported and it was clear that the permanent staff and longer-term agency staff had developed meaningful relationships with people.

People were encouraged and supported to make decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had improved and recorded people's individual preferences about how they liked their care to be delivered. There remained some areas where care plans could be developed further to ensure that staff were able to be responsive to people's individual needs.

Staff were observed to be attentive to people and engaged with them in a person centred rather than neutral manner.

Improvements were needed to ensure that people cared for in their rooms had regular opportunities for meaningful interaction.

Information about how to complain was available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Whilst systems were in place to assess and monitor the safety of the service, these were not being fully effective as we continued to find instances where the safety and quality of the service provided had been compromised.

Whilst some improvements had been made, risks were not always reduced as much as possible. Some of the concerns raised during previous inspection visits remained and new breaches of the Regulation were identified.

Some Health and social care professionals lacked confidence in the leadership team to drive improvements. However, the provider had introduced measures to try and address these concerns and to improve partnership working.

The registered manager was passionate about their role and to driving improvements within the service. Staff were generally positive about the registered manager and most felt supported in their roles. They told us morale was improving.

Glen Rose

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 checked 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. We also checked to see if the improvements required following our last inspection had been made.

This was an unannounced inspection which took place over three days on 10, 13 and 24 September 2018. On the first two days, the inspection team consisted of two inspectors and a specialist nurse advisor. On the third day the inspection was completed by a one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We also reviewed the information that had been provided to us by the service over the past year. This included information such as staffing rotas and the nature and number of incidents which had occurred within the service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with four people who used the service and nine relatives. 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 spoke with the registered manager, the director of operations, three registered nurses, seven care workers, the activities lead, the maintenance person, cook and laundry person. We reviewed the care records of eleven people. We also looked at the records for three staff that had been recruited since our last inspection and other records relating to the management of the service such as audits, policies and staff rotas.

Prior to the inspection, we sought feedback from five health and social care professionals about the care provided at Glen Rose and from a further three following the inspection.

Requires Improvement

Is the service safe?

Our findings

Most people were unable to share with us their experiences of living at Glen Rose. Those that were able told us they felt safe living at Glen Rose. One person said, "I'm ok here". A relative told us, "Yes [person] is safe here".

Whilst people told us they felt safe living at Glen Rose, we continued to find that some improvements were needed. Staff were not always following risk management plans or guidance about how to meet people's needs safely. One person's care records included an assessment from a speech and language therapist (SALT). This stated that staff should use a tea spoon when assisting the person to eat and drink. This was to slow down the pace with which they ate, reducing the risk of choking. At lunchtime on the first day of our inspection, we saw staff using a dessert spoon when assisting this person to eat. This increased the risk of them choking. Before we could intervene, the care worker was heard to say, "I'll change to a tea spoon as you seem to be coughing". They did this and were later heard to say, "That's better isn't it".

We observed one staff member leading a person to their room where they assisted them with personal care. We heard the person shouting loudly. We spoke with the registered manager about this as the person's care plan said that the person should have the 'Assistance of two carers for personal hygiene, one to do the care and one to help divert [person's] attention so that she doesn't get all worked up and start shouting'. The registered manager told us, one experienced care worker who knew the person well could manage her personal care and that this helped to prevent her becoming overwhelmed. This was not however, what the person's care plan stated.

A second person's care records also contained a SALT assessment providing recommendations that the person have grade two thickened fluids. Three staff told us they were now giving this person grade three fluids and this is what we observed the person to be having on the first day of our inspection. Staff also told us the person was not tolerating grade two fluids and they were concerned for his wellbeing. However, despite this well-meaning rationale, we were concerned that staff had decided to diverge from the person's care plan without first bringing their concerns to the attention of the registered nurses or manager so that further specialist advice could be sought. Whilst their actions were well intentioned, this could have impacted upon the person's safety and we were concerned that staff lacked understanding of the accountability for decision making.

We found that two people who could use their call bells, did not have their call bell in reach. Neither we, or staff, could find the call bell in one person's room. Staff had not long before brought this person their breakfast but had left without checking that their call bell was in reach. This meant the person was not able to call for assistance if they needed it.

One person had been assessed by staff as being 'very high risk of pressure damage' using a nationally recognised tool. The risk assessment stated that an action plan must be in place to prevent development of any pressure sores, however, their records did not include a skin integrity plan. Their repositioning/ food and fluid booklet stated 'you should check on page 3 what the planned regime for this resident is'. When we

checked this, it was blank. The clinical lead told us this person was being repositioned every three hours, however, neither their records, or the handover sheet, reflected this was happening. Care staff told us the person did not need turning. The person did not have any skin damage but omissions in care planning and lack of communication about the person's needs could have placed them at risk of harm.

There were similar gaps and concerns noted in a second person's records. This person had a pressure ulcer which was healing and this would be indicative that appropriate care was being given, however a check of their records did not always provide assurances that they were being repositioned in line with their care plan. Staff were sometimes recording repositioning in the daily records and sometimes in another booklet which included charts for repositioning and food and fluid intake. Both had to be cross referenced to be able to see if the care had been provided as planned. This limited the effectiveness of the documents as a monitoring tool. When we checked both records, we still found periods where the person had not been repositioned for six hours. Sometimes staff had noted that personal care had been given and the registered manager felt confident this would have included a change of position, but as care workers had not noted whether the person had been repositioned onto their back, left or right side, we could not be confident that the correct repositioning regime was being followed.

A number of people required an air mattress to help prevent pressure ulcers. Three of the ten mattresses checked were set incorrectly, despite staff having signed a chart earlier that day to say they were at the correct setting. It is important these mattresses are set correctly to ensure they are providing effective pressure relief.

The above concerns indicate a continuing failure to assess and mitigate risks. This is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records included clear and comprehensive information about risks for people. A range of assessment tools and care plans were being used to assess and mitigate risk. These included, risk assessments regarding the use of bed rails, continence management, falls and skin care. Chair alarms were being used to alert staff that people were standing so that they could attend and check their safety. Choking risk assessments were in place and staff were able to tell us about the action they would take should a person choke. Overall, improvements had been made to documentation which ensured that staff were aware who was for, and was not for, resuscitation. This information was readily available. We did note that in one person's records, information about their resuscitation status was confusing. We brought this to the attention of the registered manager who has acted to clarify this.

In most cases a record had been maintained of incidents and accidents that had occurred within the service and there was evidence that improvements had, in most cases, been made to monitoring and escalation of unexplained bruising. However, we continued to identify that in a small number of cases, incident records were incomplete or did not provide evidence that post falls protocols had been followed. For example, following unwitnessed falls or falls resulting in head injuries, neurological observations had not always been completed for the recommended period without there being an explanation as to why. Following a fall, some people had post falls huddles, others did not. Post falls huddles are a tool used to help staff examine the circumstances of the fall, what might have caused this and considered how further falls might be prevented. The registered manager, told us these had been stopped when the new care planning system had been introduced, however, they have advised that these have now been reimplemented. In the case of one person, bruising had been attributed to a fall, but there was no documented evidence that a fall had occurred. As staff were not able to firmly link this bruising to a fall, this should have been classed as unexplained bruising and escalated by the registered manager to the local safeguarding adults team. We have asked the registered manager to report this retrospectively. The registered manager monitored

incidents and accidents and undertook a monthly analysis of these. They also maintained a log of falls and incidents of aggressive behaviour which occurred within the service again to assist with identifying any themes and trends that might require remedial action.

Our last inspection found that improvements were needed to the safety of the premises and of some of the equipment within it. This inspection found that improvements had been made. The suction machines, used to remove substances from people's airways, were now in working order and regularly checked. Wardrobes had been fixed to the walls to prevent them from toppling over. Regular checks were being made of the temperature of water to prevent the risk of scalding.

In additional a range of other environmental checks were routinely undertaken. These included checks to detect the presence of legionella in the water system and checks of the safety of the gas and electrical systems within the home. The home's fire risk assessment had been reviewed in January 2018 and an action plan was in place to address the areas identified for improvement. People had personal emergency evacuation plans (PEEPS) and a grab pack containing copies of the PEEPS, and other emergency supplies such as torches and blankets, was now in place. A business continuity plan set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies.

At our last inspection, the service was in breach of the Regulation regarding the deployment of staff. This was because, we had had identified concerns regarding people being left unsupervised in the communal areas and the lack of available staff to support people to have a positive dining experience. Leaving the communal areas unsupervised was a concern as some people could display unpredictable behaviour that could present risks to themselves or others and some people were at high risk of falls. Since our last inspection, we had been monitoring the staffing arrangements within the service. Weekly rotas showed that planned staffing levels were usually being maintained, albeit this be through the regular use of agency staff, some of whom were regularly seconded to the service. Staff told us they worked flexibly across floors to provide cover when there were staffing shortages due to sickness or staffing vacancies, including at weekends and a 'Staff Daily Deployment' sheet was being used to allocate staff to specific tasks so that they were clear about their role and responsibilities and when to take their breaks.

Whilst we noted that there had been two complaints, since our last inspection, raising ongoing concerns about lack of staff supervision in communal areas, we did not find this to be a concern during our inspection. A member of staff was allocated to supervise the lounge and should they need to leave for some reason, they ensured a colleague was available to replace them. We also noted that there were sufficient staff deployed to support people in a person-centred manner with care needs and their meals. Staff were busy, but despite this, sat with people and helped them to eat and drink in a non-hurried manner.

People were only able to provide limited feedback about the staffing levels. One person told us, "If I press the alarm they come quickly". Feedback from relatives was generally positive. One relative told us, "Yes things have improved, the lounge hasn't been left unsupervised for a long time". This was confirmed by a second relative who said, "There is always a member of staff in the lounge as some of the residents are very vulnerable".

Staff feedback remained mixed. One staff member said, "Yes there have been enough staff but it can depend upon who is on. If there are agency who have never been here before, you could do with more staff". Another staff member said, they could be left on the top floor on their own to support the six people as the second worker was sent downstairs to help. We asked them about the impact of this on people, they said, "It doesn't impact on the residents, more on us…we work really well as a team to care, no [people] suffer, we all do a really good job".

Both the registered manager and provider were confident that the current staffing levels were safe and they used a tool to review these on a regular basis. Since the inspection and due to a reduction in the numbers of people living at the service, the provider has decided to reduce the numbers of staff available each shift. Moving forward there was to be one less care worker on day shifts and a reduction from two to one registered nurses on late shifts. We have asked that this be kept under close review to ensure that this does not impact on staff being able to care for people safely.

Improvements were needed to ensure that all the required recruitment checks were undertaken. Identity checks and Disclosure and Barring Service checks and been completed. Checks were also made to ensure that the nurses were registered with the body responsible for the regulation of health care professionals. However, in the case of two of the records viewed, staff had not provided a full employment history and one person's reference gave differing information about their dates of employment with a previous employer. This had not been identified by the service. The registered manager acted during the inspection to ensure that this information was obtained/ clarified.

Our last inspection found that the provider had failed to ensure that there was an effective system in place to manage people's medicines. This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act. This inspection found improvements had been made and the legal requirements were being met. Medicines were managed by staff who had received the relevant training and who underwent annual assessments of their competency. Medicines were kept securely in locked trolleys, or the clinical room, and administered by trained staff.

Medicine administration records (MARs) contained photographs and information about any allergies the person might have. This helped to ensure the safe administration of medicines. MAR sheets were completed accurately and the medicines stocks we checked tallied with the balances recorded. Care records detailed the support each person required to take their medicines. Staff followed the guidance in place for managing 'when required' or 'PRN' medicines and documented the reasons why they had administered these medicines. The clinical lead told us that they planned to update PRN protocols to ensure they included all the relevant information.

We observed staff administering people's medicines and this was managed in a person-centred manner. People's relatives told us they had confidence that staff would manage their family members medicines safely. One relative said, "The staff always give my husband his medicine".

We did note some areas where further improvements were needed. Our last inspection had found that topical medicines administration records (TMAR's) did not include sufficient information about where and when topical creams should be applied. Whilst the TMARS now included clearer written and visual instructions about the site the creams should be applied to, the TMARS still did not include information about the frequency with which the creams should be applied. This meant we could not be assured that topical creams were being applied as prescribed. The registered manager told us that staff checked with the registered nurse if unsure about how often to apply creams. However, staff told us, they checked the label on the topical cream. The topical cream labels we viewed did not include specific information and referred to the need to 'apply as directed'. We have asked that action be taken to include information on each TMAR about the frequency with which each cream is to be applied.

Thickening agents are used to modify the texture of liquids to make these safer for people to swallow when they have swallowing problems. These are individually prescribed and should only be used by the person for whom they are prescribed. We saw staff using one person's thickener to modify the drinks of another person. This is not best practice and we have asked that action is taken to ensure this does not happen.

An NHS national alert has previously been issued due to a thickening agent being accidentally ingested by a person living in a care home. At Glen Rose, we found thickening agents in two unlocked cupboards. Whilst it is important that thickening agents are readily accessible, we recommend that in line with a NHS patient safety alert, that Individualised risk assessment and care planning is put in place to ensure that people at risk of accidentally ingesting thickener are identified and protected.

Medicines audits were undertaken and action plans produced as a result. Where medicines errors or omissions had occurred, there was evidence, these had been investigated and remedial actions taken. The service had been experiencing ongoing problems with the supply of people's medicines by their pharmacy. To address this, action had been taken to change the pharmacy supplying people's medicine and staff were adjusting to this new system at the time of our inspection.

The permanent staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and were confident that concerns would be acted upon by the registered manager to ensure people's safety. One staff member told us, "If I thought for a minute that a carer was not kind and caring, I would let someone know" and another said, "The safety of the resident and their wellbeing is my main priority, I look after them the best I can". Staff were aware of what was meant by 'whistle-blowing', the reporting of poor practice, and were aware of which other agencies they could share concerns with should this be needed. One staff member told us, "I know my residents and I would have no problem whistleblowing if I saw something wrong".

Feedback from relatives about the cleanliness of the home was mostly positive. One relative told us, "[person's] room has usually been cleaned when I visit". However, another relative told us, they had on two occasions found the water jug in their family members room had a dirty lid". Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE) and they were aware of how to appropriately handle and dispose of infectious waste. Suitable cleaning schedules were in place and followed in practice. Staff reported that mattresses and bed rails were also cleaned on a regular basis. The kitchen was clean and the catering team were completing appropriate food hygiene record.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with, told us they received effective care. For example, one person told us, "It's clean here. The food is good…. I don't like baths; they give me a strip wash most days. They are very good. I don't have any broken skin". Relatives gave us mixed feedback as to whether their family member received effective care. One relative said, "I have no concerns about the care that [person] receives" and another said, "They keep [family member] clean and fed, they seem quite happy and settled". A third relative said, "I have not met a bad carer, a couple are brilliant, the others are good". However, another relative was less satisfied, they said, "They [staff] just don't dot the I's and cross the t's, they say they don't know when you ask them questions, they have just not got their act together".

Prior to the inspection, a number of local health care professionals had expressed concerns about the clinical care provided by Glen Rose. They reported concerns about the skills and knowledge of the registered nurses. For example, one health care professional said, "During the time I have worked in Glen Rose there has been a number of staff changes and a high use of agency staff, it has been very difficult to get information on residents as often we were told I'm agency and don't know. There was evidence that when a resident was unwell the nurse had to go and check if the resident had a DNACPR [A do not resuscitate order] this is concerning as the nurses should be aware of who has a DNACPR". Concerns were expressed that registered nurses had not always identified when people were becoming unwell or dehydrated and about the effectiveness of the care of pressure areas. Local health care professionals also raised concerns that their advice was not always being followed and that communication within the service was not always effective. A community mental health professional told us, "Staff appear to have limited knowledge around mental health medications, especially side effects. This became evident when they liaised with a GP to increase Risperidone for restless legs".

In light of these concerns, our inspection focussed on aspects of the clinical care being provided. Our specialist advisor spent time with the clinical staff assessing their knowledge and expertise. The registered nurses were, overall found to be informed about people's healthcare needs. We found that the registered nurses were taking people's observations monthly. They could describe how they used these readings to help identify changes in a person's condition and the actions they would take in response. Care staff were able to tell us the signs that someone might be dehydrated and how they used a repositioning regime and barrier creams to maintain good skin integrity.

We did however, identify some concerns about aspects of the clinical care provided. People's weight was being monitored, but we could not consistently see that timely action was being taken when weight loss was identified. For example, one person's weight was noted to have dropped by 7.2kgs when weighed on the 3 June 2018 however records show that this was not brought to the attention of the person's GP until 20 July 2018 when a fax was sent to the surgery. A response to this fax was not chased until 14 September 2018. This person's weight loss has now stabilised, but we were concerned about the timeliness with which medical advice was sought.

Records, including the handover sheet, did not accurately record which people were diabetic. The chef told us they referred to their whiteboard in the kitchen to remain updated about people's specific dietary needs. We found that the white board did not accurately reflect people's dietary needs. Staff could tell us the signs which might indicate a person was dehydrated and there was evidence that people's food and fluid intake

was being monitored but we were concerned that records did not always indicate a proactive approach to encouraging food and fluids. For example, one person's records indicated a poor dietary intake as they often declined food and drink. Whilst staff had referred the person to their GP on the 5 September 2018, their intake continued to be poor, but a response from the GP was not chased until eight days later. On 5 and 9 September, the person's dietary intake was particularly poor, but there was no evidence that they were offered any food or fluids after 5pm. This person has now been reviewed by the GP and has been prescribed dietary supplements and their weight is currently stable.

People were weighed on a monthly or weekly basis; however, this information was not then being used to update the person's MUST assessment. MUST assessments are a screening tool used to identify adults, who are malnourished or at risk of malnutrition. Fluctuations in weight were not being used to inform the settings on pressure relieving mattresses. This is important to help ensure the mattresses provide effective pressure relief.

Insufficient action had been taken to monitor people's nutritional needs. The above concerns indicate a breach of Regulation 14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Feedback about the food provided was mixed. One relative said, "At lunchtime mum usually has something like corned beef hash or soup and a salad, I don't know about evenings. The food looks appetising, there is enough of it but mum says there is too much and she can't eat it all". Another relative said, "The food is good, they do it well". However, a third relative felt that the food provided was often a "Strange concoction such as cauliflower cheese with baked beans or hot dogs and tinned tomatoes". They were concerned about the nutritional value of such meals.

A relative expressed concern to us that their family member was not always offered appropriate support to eat and drink. They told us, "I quite often find food untouched in her room cold and dried up". They raised concerns about finding their family members drinks out of reach on their visits. They told us that on one occasion during the hot weather, they had visited to find their mother's drinks out of reach. They were concerned that their mother was thirsty as with their assistance, she had immediately drank two full cups. We did not see similar concerns during our inspection. We saw staff offering people regular drinks and mid-morning and afternoon a trolley serving a selection of hot and cold drinks, cakes and fruit was provided which people appeared to enjoy. For example, we observed a registered nurse helping one person to drink a fortified milkshake. They also asked the person if they would like some fruit and gave the person a choice of fruit. The person told us, "We don't usually get strawberries, so why not have them! We do get cups of tea and drinks regularly".

We observed that people were offered a choice of meal. We were assured that people who required pureed diets were offered the same menu as everybody else unless the meal was not suitable for pureeing in which case they were offered an alternative. Some people would have benefitted from being shown pictorial representations of the menu or show plates to assist them with making a choice of meal. Since the inspection, the registered manager had informed us that there is a pictorial menu folder already available. We did not, however, see this in use during the inspection to assist people with making their dietary choices.

Where people needed support to eat and drink, this was provided in a way that was dignified and respectful of the individual. For example, we saw one care worker ask a person, if it was ok that they wiped their face. People were praised for eating well and alternatives were offered if people declined their meal.

There were some areas that could improve. Staff were unable to tell people what flavour the soup was on the first day of our inspection as they did not know. At lunch on the second day, those that finished their meal last were not able to have a choice of pudding as one of the options had all gone. We saw staff give one person a meal of liver and bacon but then tell them that lunch was a "Lovely beef casserole".

We observed a family member supported their relative to eat in an unsafe position. They told us they had not been provided with guidance about appropriate positioning for eating and drinking. We brought this to the attention of the clinical lead who took prompt action to discuss this with the relative. Whilst we were aware that another relative told us they had received guidance on positioning. We recommend that action is taken to identify all people for whom this might be a risk so that action can be taken to mitigate this.

It was the provider's policy that new staff receive a 'First day at work' induction. We looked at the induction records for three staff. One staff member did not have a record of induction and the records for a second member of staff indicated that their induction had been completed several months after they started to work in the service. We discussed this with the registered manager, they told us both staff had completed an induction when they first started to work at the service, but that the records for these had gone missing. They told us this was why they were now being completed retrospectively.

We noted that the induction covered areas such as the member of staffs' role and responsibilities, fire procedures and moving and handling. We were told that new staff also underwent shadow shifts where they were able to work alongside more experienced staff. However, the induction process did not include an opportunity for the new staff member to have dedicated time to read people's care plans and we recommend that this is included in future inductions to ensure that staff are fully informed about people's needs and preferences. There was evidence that new staff were supported to complete the Care Certificate. The Care Certificate standards cover a range of essential skills and knowledge that care workers need to perform their role effectively. It was the provider's policy that staff should aim to have completed the Care Certificate within the first 12 weeks of their employment. Records indicated this was not always happening. For example, one staff member had started their employment at Glen Rose in March 2018, but had still not fully completed the Care Certificate at the time of our inspection.

Staff could complete a range of training. Some of this was required to be completed on an annual basis and included subjects such as moving and handing, first aid, health and safety, safeguarding people from harm and fire training. Every three years staff were required to complete training in additional subjects which included equality and diversity, nutrition, person centred care, infection control and food hygiene. Records showed that this training was largely up to date or had been assigned to new staff to complete.

However, we were not assured that, despite being made available, the registered nurses were undertaking additional training relevant to people's needs and to enhance their clinical skills. For example, training on diet and nutrition and falls prevention had been assigned to the four registered nurses and the registered manager in June 2018, but only one registered nurse had so far completed this. Only two of the registered nurses had completed training in epilepsy and none had completed the provider's training in dysphagia, despite there being people living with epilepsy and at risk of choking, using the service. Only two of the seven registered nurses, either directly employed by, or seconded to, the service had training in resuscitation and only one had training in the use of syringe drivers. Syringe drivers are machines used to manage people's pain at the end of their life. We have asked the registered manager to ensure that priority is given to staff competing the dysphagia and epilepsy training and we will check to see that this has been done.

Our last inspection had identified that the systems in place for providing regular and meaningful supervision

and appraisal needed to be further embedded. This inspection found that improvements had been made. Supervision and appraisals are processes by which an organisation provides guidance and support to staff and assesses their learning and development needs. Records viewed at this inspection showed that most staff had received an appraisal and were receiving periodic supervision. Staff told us they felt generally well supported and could approach the registered manager for advice or guidance and found their supervision sessions useful.

We looked at how the service was implementing the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where there was doubt about a person's capacity to make decisions regarding their care and treatment, staff had completed mental capacity assessments which were well documented. For example, we saw people had mental capacity assessments in relation to the use of alarm mats and bed rails. We continued to observe that best interest's consultations needed to be more clearly documented and demonstrate how external professionals and family members had been involved in reaching decisions about how people's care and support should be provided when they lacked the capacity to decide this for themselves.

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). Relevant applications had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

Glen Rose was not a purpose-built care home. The accommodation was arranged over two floors with both a lift and stairs available to access these. There were a range of lounges where people could spend time or enjoy visits from their friends and families. Staff told us they had access to sufficient equipment such as hoists, stand aids, specialist baths/ showers and chairs in order to meet people's needs. There was evidence that people's rooms had been personalised with their own furniture and possessions. No one was currently sharing a room, although the home did have some shared rooms. Some of the corridors had been decorated with artwork and reminiscence material to provide opportunities for interaction and stimulus. Environmental audits took place and demonstrated that repairs were generally completed in a timely manner. Records showed that there was a planned programme of ongoing decoration and improvement to the premises. As part of this we recommend that the provider continue to explore evidence based practice guidance on how environments can be designed effectively to meet the needs of people living with dementia.

Good

Is the service caring?

Our findings

Our last inspection had judged the service to be in breach of the Regulation regarding dignity and respect. Overall, this inspection found the required improvements had been made. We observed that staff referred to people in a respectful and dignified way and most of our observations indicated that care was provided in a discreet manner and that staff were mindful of people's privacy and dignity when providing care. For example, we saw staff draw curtains in the person's room prior to providing personal care. We did on one occasion, see a staff member enter the lounge holding a continence pad and asking where a particular person was. This compromised that person's dignity. We also noted that in the laundry there were storage boxes marked 'mixed socks' and 'ladies' socks, tights'. Staff told us these contained spare socks which were used for people who didn't have any of their own socks and didn't have family to purchase new socks for them. It is not dignified for people to be wearing other people's clothing and have asked that alternative options are found to ensure that people have access to their own clothing.

Relatives were positive about the kind and caring nature of the staff team. One relative said, "Yes, [people are] definitely well cared for, the care is good and staff are friendly" and another said, "They [staff] are very kind and caring, mum has been here a long time, they feel like my family". A third relative told us, "[family member] hugs the carers, they feel they do a good job". A health care professional told us, "I observed the carers to be both caring and kind to the residents that I saw".

Staff spoke fondly about the people they supported and it was clear that the permanent staff and longer-term agency staff had developed meaningful relationships with people. For example, we saw one person put their arm around a staff member and hug them as they were chatting about meal choices for the day. The care worker hugged the person back and they both enjoyed some conversation and banter. We observed one person say to a staff member, 'Come and see nanny [person's name]. They started to chat about the staff members family. They clearly valued the interaction and the person's face became more animate that it had previously been. A third person was returning to their own home from Glen Rose after a period of respite. Upon leaving, the person became tearful and hugged staff. We saw that staff bent down to speak with people at their level and spoke in a calm and reassuring manner. Staff used humour to interact with some people. In turn people seemed relaxed with the staff caring for them. Staff, including the ancillary staff, appeared to be enjoying their work and readily engaged with people when passing or going about their tasks such as cleaning people's rooms. One staff member said, "I know the residents well and would treat them like my nan". This was echoed by a second care worker who said, "The residents are my main priority and making their lives a lot better".

People were encouraged and supported to make decisions about their care and support. For example, people were asked which chair they would like to sit in and encouraged to make decisions about what they ate and drank. People's consent was sought before care was provided and before clothes protectors were placed upon them at meal times. Where able, people had signed consent forms in relation to their care plans and sharing information with other agencies. We saw evidence of people being involved in reviews of their care plans and changes being made in response to their comments. This evidenced they had been involved in drafting their care plans and reviewing these on a regular basis.

Staff told us how they tried to promote people's independence wherever possible. We observed a staff member clearly talking a person through the process of standing from a seated position. The care worker gave clear instructions, did not rush the person and then praised them for successfully completed the task.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection had found that the service was not consistently providing person centred care. This inspection found that some improvements had been made. We observed many examples of staff caring for people in an individual manner. Staff were observed to be attentive to people and engaged with them in a person centred rather than neutral manner.

People's care plans contained sufficient detail about their individual preferences. For example, we saw that one person liked watching football, rugby and tennis and that another person was a 'free spirit who used to move around a lot', so staff were reminded of the importance of not preventing this where possible. One person was noted to like the use of fiddle mats which we saw they had access to during the inspection. Plans described the names people liked to be called and how they preferred their hot drinks and preferences regarding foods. Some of the care plans, although not all, included information about the person's life before coming to live at the home and about how they liked to spend their time. The staff we spoke with demonstrated that they were aware of this information and we observed staff interacting with people in a manner which demonstrated that they knew people well. Overall relatives felt that the permanent staff knew their family members well and were responsive to their needs. For example, one relative said, "They know [family member's] quirks".

We observed some examples of staff recognising the triggers that could lead to agitation between people and intervening in a positive manner to manage and de-escalate the situation. This was also commented on by a relative who told us, "They [staff] do a wonderful job, they handle [family members] behaviour really well". Where people were unable to express pain, the registered nurses were using a pain assessment tool to help interpret body language and other aspects of the person's behaviour to assess whether they might be in pain. Many of the care plans viewed were suitably detailed and provided appropriate guidance for staff about people's care needs and how these should be met. For example, one person was living with diabetes. Their diabetic care plan gave clear information about how staff might identify that the person was experiencing either a hypoglycaemic or hyperglycaemic episode. The person also had a clear plan in place for the care of their stoma.

There remained some areas where further improvements could be made to people's care plans which would help to ensure that staff were able to be responsive to people's individual needs. For example, one person was living with a mental health condition, but there was no care plan in place which provided guidance for staff on how this condition affected the person and impacted upon their needs. Many of the care plans described people as living with dementia, but did not describe what type of dementia this was and how this affected them. We asked for further information about this and were told that one person had 'senile dementia'. We were concerned this showed a lack of knowledge regarding dementia. Another person was living with a restless legs condition, but staff did not demonstrate an understanding of how this condition might impact upon the person.

We were concerned about the lack of evidence of people receiving baths or showers. We have asked the registered manager to monitor this and provide a report to us providing assurances that people are being

offered the choice of having a bath or shower.

Handovers took place each day. Handovers provide information about changes in people's needs and the support that has been given. We attended handover on the first day of our inspection. The registered nurse leading the handover shared whether people had slept well and their fluid intake for the previous 24 hours. The handover was not interactive. The nurse leading the handover did not ask the oncoming shift when they were last on duty. This meant they did not know how much information to share about people's needs or significant changes since they had last been on duty. As reported elsewhere, the inspection also noted that the handover sheet was not up to date and did not accurately reflect each person's needs. This is of concern as the service does use agency staff. Following the first two days of our inspection, the provider confirmed that the handover sheet had been fully reviewed and was now accurate. However, on the third day of our inspection, we found another error on the handover sheet. Some of the staff we spoke with felt that communication within the service could at times be better and we were able to see that the registered manager had implemented systems to try and assist this. These included a daily meeting at 11.30am and a 'weekend report' from the nursing staff summarising significant events or issues that had occurred.

There was evidence that care plans were being reviewed monthly, but some of the reviews seen led us to be concerned about the effectiveness of this. For example, on the 6 August 2018, a staff member had recorded that they had reviewed one person's palliative care plan and that it 'remained relevant'. This person, however did not have a palliative care plan.

We looked at the activities provision within the home. The service employed an activities coordinator who currently worked 21 hours a week. They were also referred to as the lounge assistant as it was also their responsibility to supervise the lounge to ensure people's safety. On days when the activities staff were not present, a care worker was assigned to provide activities and stimulation. On the first day of our inspection, a care worker was observed to be engaging people in the communal lounge in puzzles and later put on a film for people to watch. On the second day, the activities lead was on duty and was engaging people with making seasonal bingo cards and enjoying an interactive session with a hedgehog. The atmosphere was lively and there was music playing. One person was seen to be dancing to the music. On the third day, there was an external entertainer singing for people. A programme of planned activities was displayed and the advertised activities for August 2018 had included, picnics, keep fit exercises, crafts and games. On one occasion, the home had been visited by a local farm who brought a range of animals along. One of the relatives had commented on this event, saying it had been good. The activities coordinator told us how they got people involved in baking and making green tomato chutney. The relatives we spoke with were generally quite positive about the activities provided. Records showed that people had been assisted into the garden to pick flowers or to catch up on the news by reading the newspapers. One relative said, "It is always quite upbeat here with everything that happens".

There was however limited evidence that people cared for in their rooms had regular opportunities for meaningful interaction. For example, during one week in September 2018, records showed that one person spent four days in their room and did not visit the lounge. There was no evidence on any of these four days that they received any meaningful activity. The only contact recorded with staff was the provision of support with personal care or meals. A second person's records showed that during the same period, they were also cared for in bed for four of the seven days. Their records referred to them 'watching tv' or being 'left with teddy and fiddle mat'. We looked at a third person's records for the same period. They did often spend more time in the lounge throughout the day. These, however, also did not reflect they had been engaged in regular and meaningful activities. On one of the days, the records noted that the person had 'interacted in the staff meeting' and on a second day had chatted with staff and had been looking at photos. We spoke with this person during the evening meal on the first day of our inspection. They did not appear to be eating

and so we had had asked them if they were hungry, they told us, "There is not enough to do here to get your hunger up".

Health care professionals also raised concerns about the lack of activities for people cared for in their rooms. One said, "Activities seem to be offered to the same residents on a regular basis.... I observed no stimulation for those residents being nursed in bed in their rooms and tried to encourage staff to ensure that they are being offered some form of activity before they left i.e. at least put some music on for them/turn on a television/talk to them". A second professional said, "On several occasions the residents were sat in the lounge area listening to inappropriate music while staff sat in the dining area. There was always very limited interaction with residents and staff. I never experienced residents whom resided in their rooms throughout the day having any interaction that was not a pad change or help with meals".

The activities coordinator told us they did try and visit each person every morning and offer activities such as nail care or a hand massage or aromatherapy. They told us how they aimed to provide each person with at least a ten-minute session on the days that they worked, although they were not sure what happened on the other days. Our observations indicated that despite the home only having 19 residents, their needs were very diverse and we were concerned that the provision of 21 hours of dedicated activity time was not sufficient to ensure that each person received regular and meaningful activities. The registered manager told us that a second activities staff member had recently been employed on a bank basis and they were hopeful that this would have an impact on the quality and quantity of the activities. We were not, therefore, fully assured that each person was having sufficient access to regular and meaningful activities and this is an area where further improvements are needed.

We looked at how the service was meeting the accessible information standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager told us that where necessary information would be provided in a format according to people's needs. They told us how picture boards had been made to assist one person to communicate and that another person liked information to be written down before they made a decision. Mental capacity assessments demonstrated that the registered manager had used a variety of ways to help people understand potential risks relating to their care and support.

Information about how to complain was available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to. There were also systems in place to monitor complaints to look for themes or trends over time. Most of the relatives we spoke to were confident that they could raise concerns with the registered manager and that they would act upon these. For example, one relative said, "I complained about [person's] clothes being untidy in their drawers, [the registered manager] sorted this out for me and it has stopped".

Residents and relative's meetings had been held in May and September 2018. The minutes showed that no relatives had attended the latter meeting and the minutes of the first meeting did not include the details of who had attended, therefore we could not certain about people's and their representative's involvement in these. The meetings were chaired by the activities coordinator and the minutes indicated that these were used to remind people about how they might raise a concern and an opportunity to hear about, and comment upon, developments and changes within the service. Feedback about the quality of the service had been sought from visiting healthcare professionals in June 2018, but there had only been one response to this. An action plan had been developed and included objectives of making the service more dementia friendly, achieving more consistent staff and better communication. The action plan did not however, include details of how these aims were to be achieved or timescales for these to be completed. We

recommend that the service review the way in which it is seeking feedback both from people, their relatives and professionals in order to make this effective and achieve a better response rate.

People's wishes in relation to how their end of life care should be provided was currently recorded in a number of places. People had a 'Palliative Care Plan' on the electronic care planning system and a paper document called 'Wishes and Preferences' kept in another folder. In many cases this document had been completed by a relative, without it being clear that they had the legal authority to direct their family members advanced care planning or that the information had been gathered as part of a best interest's consultation for people who lacked capacity. Many people also had a 'Do not resuscitate' (DNACPR) form or an advanced care plan document created by their GP or other healthcare professional. Whilst these documents evidenced that staff were trying to involve the person, and/or their families in discussions around how they would like their care to be provided in their final days, they were variable in terms of detail and content. To develop these further, we recommend that the provider consider ways in which this information might be coordinated and combined to provide a comprehensive, multi-disciplinary and holistic care plan which encompasses all aspects of end of life care planning in line with best practice guidance such as NICE quality standard QS13 End of life Care for Adults.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2017, Glen Rose was rated as Requires improvement. We found multiple breaches of the fundamental standards including those relating to safe care and treatment and good governance. Following the last inspection, we took enforcement action and imposed a condition on the provider's registration. This condition required them to provide us with both weekly and monthly reports keeping us up to date with concerns or improvements being made within the service. This allowed us to monitor the service but was also aimed at supporting the service to improve.

Whilst this inspection found that some improvements had been made, some risks were not always reduced as much as possible. We found two continuing breaches of the Regulations and one new breach which an effective governance system should have helped the registered manager identified and addressed. For example, whilst a range of audits were being undertaken on a regular basis, this inspection continued to find examples where the safety and quality of the service had been compromised. We found evidence that some staff were diverging from risk management plans which led us to be concerned that they did not always understand their role and responsibilities and where accountability for decision making laid. These concerns have been described in the 'Is the service safe' part of this report.

Audits were undertaken to check that topical creams were being applied, that mattress settings were correct and fluid charts completed fully. An audit on the 28 August 2018 showed widespread gaps in this documentation. Whilst there was evidence that the registered manager was discussing the need for improvements with regards to documentation with staff, our inspection continued to find similar concerns.

The provider had completed a general audit on the 29 August 2018. This had noted a container of thickening agent not secured away in the upstairs lounge. On the 10 September 2018, we noted similar concerns and brought this to the attention of the clinical lead.

A new 'Audit Check Book' had been introduced and was mapped to the key lines of enquiry that CQC inspect against. Its purpose was to assess compliance with the Regulations. Over a four-week period, the senior management team audited aspects of the service and then analysed the findings to identify either compliance or non-compliance with the Regulations. The August 2018 check book noted that the target set from the previous month for all staff to have completed their safeguarding training by the end of July 2018 had not been met. There was no explanation as to why, or what might need to be done to achieve this, rather a new date for completion had been set as the end of September 2018. This audit looked at accidents and incidents and had noted, 'completed and in file in managers office' and had confirmed that all additional information had been recorded. However, we had found some examples where incident forms did not include all the appropriate supplementary checks such as observations. We also found one example where paperwork was not available to clearly evidence how a judgement about causality of an incident of bruising had been made. Recruitment was one of the areas this audit checked. The tool reported that evidence was on file of recruitment and induction checks. We found gaps in both of these records. The audit tool stated the 'Kitchen have a board in place and are aware of any specialist diets'. We found this board did not accurately reflect people's diets.

During the inspection, it took some time, before records were made available which showed a comprehensive picture of the training that staff had completed. A system of on line training had been introduced in the spring of 2018 which staff were now completing, but records did not show a combined picture of the completion rates of this online training and the previous training staff had completed. This meant that it was difficult for us to have a clear picture of overall compliance with training targets. We were concerned that this would mean that the registered manager could also not have a clear picture of the overall compliance of staff with their training targets and be able to monitor this effectively. The Audit check book appeared to be only used to monitor compliance with safeguarding training.

The governance systems currently in place were not yet being effective at identifying where improvements were needed. Audits whilst undertaken, were not sufficiently inquisitive or probing and did not achieve the required level of scrutiny needed to drive improvements. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We did note some improvements since our last inspection. The feedback from people and their relatives about the care provided and the leadership of the service was largely positive. One relative said, "Yes, it is well led, she is a good manager, we see her around, she gets quite a few visits in her office, but her door is always open". Another relative said, "Several times, I have been to [registered manager] and she has dealt with it, I've got no complaints whatsoever". Improvements had been made to ensure that staff were deployed safely and medicines were being managed more safely and environmental risks has largely been addressed.

Supervision and appraisal systems were more embedded. Staff told us the registered manager was working hard to foster cooperative and supportive relationships among the staff team. One staff member said, "[Registered manager] is a very good manager, you can talk to her, she tries to make sure that she knows what goes on, she worries about the residents". Another staff member told us, "[registered manager] is the manager for us. She does tell us what we should be doing. We've had staff meetings recently, there's another one today at 2.30pm. They are useful".

Staff told us morale was improving and that they generally worked well as a team to meet people's needs. One staff member told us, "It has picked up, we get a lot more support and advice when in the past it was fragmented…. everybody is more aware of what they need to do, I think it shows, the clients are happier". There was evidence that staff meetings were being held and used as an opportunity to discuss issues such as the importance of completing documentation correctly. Staff told us they were not always informed in good time of the dates of staff meetings and others said information from meetings was not effectively disseminated to staff that were not on shift. A staff representatives group had been formed and along with the registered manager were looking at how the different staff groups within the home could work together more effectively to ensure the smooth running of the home.

Feedback from visiting health and social care professionals was less positive. Many felt their advice was not always understood, listened to or acted upon in a timely manner. Comments included, "Myself and my team attempted to give the most support we could to the home to enable better practice, this, I feel, was not respected and therefore no action was taken at multiple occasions" and "Often when we visited the home we did not see the manager and her office door was often closed, it makes it very difficult that the manager is not clinical as she does not have an understanding of the issues we have raised".

The registered manager strongly disputed this feedback. They felt that the visits from local health and social care professionals as part of the quality improvement framework, had been too frequent and had had a disruptive impact on the service and on staff morale and had prevented the service from implementing

improvements in a timelier manner.

There was evidence the service was acting to improve partnership working. For example, to improve communication, the service had implemented a feedback form. The registered manager felt that the implementation of this form had been positive and would continue to help evidence that the recommendations of visiting healthcare professionals were being acted upon. The Director of Operations was confident that the registered manager was suitably skilled to drive improvements within the service. We saw that a further clinical lead had been appointed to support the registered manager and our specialist advisor felt their clinical knowledge was good'.

Throughout the inspection, the registered manager demonstrated a passion for her role and to the service. They were proud of the staff team who they said had engaged with the programme of improvement and all "Loved their jobs". They were open and transparent during our conversations with them and were receptive to recommendations made and expressed a commitment to tap into sources of support to help drive improvements within the service wherever these were offered. The registered manager demonstrated an understanding of the ongoing challenges within the service and expressed a commitment to their role and to driving improvements within the service. They acknowledged that there was more to do to and agreed that the areas of concern noted during our inspection were a cause for concern and needed to be addressed as a priority.

The registered manager kept up to date with best practice in the health and care sector and had recently completed a nationally recognised qualification in health and social care.