Donisthorpe Hall

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Inspection report

Donisthorpe Hall
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 19 and 24 April 2017. Day one was unannounced and day two was announced. At the three previous inspections in June 2015, March and August 2016 we rated the service as inadequate. At the inspection in August 2016 we found the provider was in breach of six regulations which related to safe care and treatment, staffing, person centred care, governance, consent to care and nutrition.

At this inspection we found the provider had improved the service sufficiently to meet three of the regulations. They needed to make further improvements to ensure the service was consistently safe, effective, caring, responsive and well-led. The provider was still in breach of three regulations relating to safe care and treatment, consent to care and good governance.

Donisthorpe Hall is registered to provide residential and nursing care for a maximum of 189 people. Care was provided in four units. The management team told us there were 83 people using the service when we inspected. The home has a longstanding association with the Jewish community in Leeds and also offers care to people of other faiths or beliefs.

At the time of the inspection the service did not have a registered manager although the home manager had submitted an application and this was being assessed. 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.

At this inspection we found medicines were better organised and the provider had reintroduced a paper based system which staff found easier to use, however, medicines were still not being managed safely. Staffing arrangements had improved; there was a more regular team of workers and a big reduction in agency workers which meant people received care from staff they knew. The provider told us they were actively looking at reviewing the staffing levels and increasing where possible. Risks to people were identified, assessed and usually managed although we found some examples where management of risk was not effective. People lived in a safe, comfortable, clean and pleasant environment.

Systems for assisting people to make decisions in line with the requirements of the Mental Capacity Act 2005 had improved but not sufficiently to meet regulation. Consent records and care plans did not consistently evidence people or their representatives were in agreement. We found the process for managing Deprivation of Liberty Safeguards was not effective.

Staff told us they received more opportunities to receive training and better support, including regular supervision. Staff told us the quality of training was good and it had helped them understand how to do their job well. We observed meal times and observed people had a pleasant experience. People told us they enjoyed the food and were offered a varied menu. People received appropriate support to make sure their

health needs were met.

During the inspection we saw many examples of good care practice. Staff were observed to be caring and kind in their interactions with people. Stakeholders told us the service was caring. People who used the service and visitors were complimentary about staff. People looked well cared for, with hair styled and clean clothes. Although feedback was positive we received some comments from people that further improvements were required, for example around support at meal times.

We saw staff worked as a team. They communicated with each other and checked who had eaten and who needed assistance. Staff knew the people they were supporting and referred to them by name. When we looked around the service we saw there was information available which helped to keep people informed. For example, there were leaflets and notices around promoting dignity, data protection, safeguarding and hygiene.

The provider had improved their care planning system. A standard format was used which helped staff understand the process and aided access to information wherever they worked within the service. Care plans were written for a range of needs, however, the quality of information varied. This included details around people's preferences, likes and dislikes, and guidance for staff to follow. Some lacked person centred information. People were encouraged to engage in different group and individual activity sessions.

People who used the service, their relatives, staff and stakeholders told us the service had improved. The provider continued to develop the service, however, they had failed to establish and operate effectively systems and processes to assess, monitor and improve the service or assess, monitor and mitigate risk. Further changes in management had impacted on the service delivery. Information was gathered around incidents and complaints but the provider did not have effective systems to identify trends or how they could learn lessons and prevent repeat events. Opportunities for people who used the service to share views were limited although more regular meetings were held with staff which had improved communication so they felt better informed.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. These related to management of medicines, how people consented to care and governance arrangements. You can see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Requires improvement'. However, the service will remain in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had improved staffing arrangements and how they managed risk although the systems needed to be operated more effectively to make sure people received consistently safe care.

Medicines were better organised and staff found a new system easier to use, however, medicines were still not being managed safely.

People felt safe and staff understood how to safeguard people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems for assisting people to make decisions in line with the requirements of the MCA had improved but not sufficient to meet regulation. The provider had improved how they met people's nutritional needs.

Staff were supported to do their job well; training arrangements continued to be developed.

People received appropriate support to make sure their health needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service and visitors we spoke with were complimentary about staff and told us the service was caring.

Staff were observed to be caring and kind in their interactions with people. They worked as a team and knew the people they supported and referred to them by name.

The quality of information in care plans around individual preferences, likes and dislikes was varied. Some were detailed

whereas others lacked person centred information.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider had improved their care planning system sufficient to meet regulation but we found they still needed to develop this further to ensure people received care consistently to meet their needs .

People were encouraged to engage in different group and individual activity sessions.

A system was in place to record and respond to complaints. Investigations of complaints were carried out although not robustly.

Is the service well-led?

Inadequate

The service was not well led.

At the last three inspections we have rated the well led section and the overall service as inadequate. At this inspection we found the provider had improved the service in a number of areas, however, similar issues were found around the governance arrangements.

Information was gathered around incidents that had occurred but the provider did not have effective systems to identify trends or how they could learn lessons and prevent untoward events from recurring.

Opportunities for people who used the service to share views were limited. Communication with staff had improved and continued to be developed.

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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 19 and 24 April 2017. Day one was unannounced. Day two was announced because we wanted to make sure senior managers could attend the feedback session. Four adult social care inspectors, two pharmacist inspectors, two experts-by-experience and two specialist advisors carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisors covered governance and nursing care.

Before the inspection we reviewed all the information we held about the service including statutory notifications. We contacted the local clinical commissioning group, Healthwatch, the local contracting and safeguarding authority, and NHS England. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. In the report we have referred to these agencies as 'stakeholders'. 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, what the service does well and improvements they plan to make.

At the time of our inspection there were 83 people using the service. During our visit we spoke with 22 people who used the service, ten visiting relatives, 19 members of staff and eight members of the management team. This included the manager who has applied to register with the Care Quality Commission and the general manager who is the provider's accountable person. We also spoke with the Chairman of the board. During the inspection we observed how people were being cared for and looked around areas of the home, which included some people's bedrooms and communal rooms. We checked equipment was in working order such as bed rails, wheelchairs and hoists, and spent time looking at documents and records that related to people's care and the management of the home. We looked at ten people's care plans and 24 medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the provider was not providing safe care and treatment because they were not managing medicines properly and were not managing risks to the health and safety of people who used the service. They did not have sufficient numbers of suitably qualified, competent and skilled workers. At this inspection we found improvements had been made around staffing arrangements and how the provider assessed risks to people who used the service. They had made some improvements with the way they managed medicines but this was not sufficient to meet the regulation. Although staffing arrangements and risk management had improved they still needed to develop their systems further to ensure the service was consistently safe.

In the PIR the provider told us they had recognised the need to move away from the electronic medication administration recording system and reintroduce paper records so that 'they are more accessible and transparent' and 'to aid compliance and audit'. Management and staff we spoke with said the changes had improved how medicines were managed. We found the medication system was more organised and staff were more confident when they administered medicines.

At this inspection we checked quantities and stocks of medicines for 12 people on four units and found the stock balances to be incorrect for two of them. This meant we were unable to determine if medicines had been given when they were signed for. One person was prescribed two different strengths of the same medicine used to a treat thyroid hormone deficiency. Incorrect stock levels were found for both strengths of this medicine. Staff confirmed that on two occasions the wrong strength had been administered. Therefore, it was not possible to demonstrate that this medicine was being managed safely.

We found guidance to enable staff to safely administer medicines prescribed to be given only as and when people required them, known as "when required" or 'PRN'. However, in six out of the 24 records we checked guidance was not available. Staff did not always record whether one or two tablets were given when variable doses of pain medicines had been prescribed. This meant that records did not accurately reflect the treatment people had received. Documentation was available to support staff to give people their medicines according to their preferences.

Medicine administration records (MARs) contained photographs of service users to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. Handwritten MARs were not always signed by the person writing the chart. Those that were signed had not been checked by a second member of staff in line with national guidance.

Instructions for medicines which should be given at specific times were not always available. For example, one person was prescribed a medicine to be taken with food and another person was prescribed a medicine which should be taken 30 minutes before breakfast when the stomach is empty. However, these instructions were not recorded on the handwritten MARs. Not administering medicines as directed by the prescriber increases the risk of the person experiencing adverse effects from the medicine, or the medicine not working

as intended.

We saw the use of patch charts on each unit for people who were prescribed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical MARs were also in use, these detailed where creams should be applied and documented the administration.

Records of thickeners used to thicken fluids for people with swallowing problems were not always recorded when they had been used. Information was available to staff about how to use them for individual people but the records did not always demonstrate when they were given. This meant we could not be sure they were being administered safely

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the provider's policy.

Room temperatures where medicines were stored were recorded daily, and these were within recommended limits. We checked medicines which required cold storage and found temperatures recorded in one unit had been outside the recommended range on five occasions in February 2017. Records were not always completed in accordance with national guidance because they were not recorded daily, for example, temperatures had not been recorded on four days in February 2017 and one day in March 2017 in one unit. This meant we could not be assured that medicines requiring refrigeration were safe for use.

Medicines audits had been developed since the last inspection, however the audit tool was limited in detail and had failed to identify the shortfalls we found during the inspection. Action plans were not always produced following an audit. Those which had been produced were often duplicated from week to week and not finalised or acted upon. We concluded although improvements were noted the registered person was still not managing medicines safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

A review of records and discussions with staff and stakeholders confirmed the staffing arrangements had improved. Staff we spoke with told us there was a more regular team of workers and a big reduction in agency workers. Staff said the improvements ensured people received care from staff they knew. Staff also told us the unit management arrangements worked well and the introduction of deputy care managers to assist the care managers had provided additional management support at unit level. A stakeholder who had worked with the service told us they previously had concerns about the lack of leadership and responsibility on the units. They said, "If the unit manager was not present it was unclear who was in charge or who could readily give information to professionals visiting. Also who would give direction to staff 'on the floor'. This has now changed with the addition of deputies on the units and less reliance on agency staff."

We received a mixed response when we asked people who used the service and visitors about staffing arrangements. Some people told us there were enough staff whereas others said staff were always busy. Comments included, "I feel content and happy here. Yes I think there are enough staff here; the staff are very kind and come when I need them even in the night", "Yes staffing is ok", "I think there is enough. No one grumbles", "I think there are not enough staff at weekends and at meal times; there are so many people needing help to eat they can't manage. They are taking trays to people in bed. Definitely not enough to cope with meal times, they are all busy then." A visiting relative told us they had raised concerns the previous

weekend and was told they 'were understaffed'. Three people said they sometimes had to wait a long time for someone to respond to their call bell. One person gave an example which occurred in the last two weeks, where they said they had to wait up to two hours. We asked the provider how they monitored call bell response times but were told they did not carry out routine audits and monitoring was only undertaken when it was relevant to a complaint or other type of investigation. A member of the management team agreed to review call bell monitoring.

Care managers told us the staffing arrangements had improved although one care manager said there had recently been high sickness levels and two staff were absent for other reasons, and they had not been able to cover some shifts on one unit. We reviewed rotas and saw staffing was provided to meet the minimum requirements identified on most occasions and often staffed above the recommendations of the dependency tool which was used to establish the staffing requirements. However, there were four occasions when the staffing levels fell below this on one unit over a three week period. A care manager said they had identified the need to increase staffing from the minimum levels in order to fully meet people's needs. We saw rotas indicated the staffing levels had increased in the last month; with additional care workers in place most days

Care managers and the home manager told us they did not find the staffing dependency tool effective and they only used it as a guide. Care managers said the dependency tool assessed people's needs in terms of the support they required such as moving and handling but did not take into account people's social needs. We spoke with the home manager and general manager about staffing. They were confident staffing arrangements were better but recognised they needed to improve further. The general manager said they were exploring alternative dependency tools and 'actively looking at reviewing the staffing and increasing where possible'.

A stakeholder told us, "The management team has implemented a wide ranging plan of action which has resulted in major changes in documentation, medicines management and improvements in staffing. In our opinion, these changes will support the provision of a safer service than previously identified."

Staff we spoke with who had recently commenced employment told us they had attended an interview and employment checks were completed to ensure they were suitable. We reviewed the recruitment records for five members of staff which confirmed the provider's recruitment process was robust.

We reviewed people's care records and saw formal assessments of risk, including those for falls, skin integrity and risks associated with nutrition were in place. Care plans for each aspect of people's care and support needs included a description of risk and guidance for staff to follow to show how risk could be minimised. We saw some risks were being managed appropriately. For example, where people required assistance to change position to protect their skin integrity, we saw records which showed they were being assisted to turn at the intervals specified in their care plan, and staff were recording the position to ensure the person did not keep returning to the same position. One person's care plan said after a four hour period they needed to go to bed for pressure ulcer relief. Staff were fully aware and we saw they followed this guidance.

We saw some guidance for staff was generalised and did not evidence robust risk management strategies were in place. For example, two care plans we looked at referred to the need for the person to be wearing 'appropriate footwear' to help keep them safe, however no detail to identify what this might be was included. One person's 'communication' care plan, showed the person experienced hallucinations and became 'anxious and agitated' when these occurred. The guidance stated staff should be aware of this and 'offer support and reassurance when [name of person] becomes distressed or agitated.' There was no

guidance to explain how the hallucinations presented, or what support or reassurance strategies to attempt.

We saw one example where staff did not follow Speech and Language Therapist (SALT) guidance. They had been advised to, 'avoid mixing food and drink in [name of person]'s mouth.' We observed staff giving the person a piece of cake and a drink, which was left with them. Staff we spoke with were not aware of this risk. Staff also told us the person was assisted to eat sandwiches but their care plan stated they were at risk from choking and had a pureed diet to help manage this risk. One person had a bed rail in situ but there was no associated risk assessment. The concerns we identified at the inspection around risk management were shared with members of the management team; they agreed to take action straightaway to ensure appropriate risk minimisation measures were in place.

Prior to the inspection we noted there were two incidents where people were harmed due to the unsafe use of bed rails. The provider had identified two actions to help make sure similar incidents did not recur. They said they had to ensure bumpers were well fastened and individual training would be provided to staff around the safe use of bed rails and bumpers. At the inspection we checked a number of rooms and saw bumpers were fastened and training records confirmed moving and handling training covered bed rails.

Following the inspection, the provider sent us an independent health and safety visit summary report. This identified that the standards of housekeeping were generally very good throughout the service with minimal trip or slip hazards. They reported record keeping of temperature checks and other checks in the kitchen was good. Staff had also checked the person who was carrying out the health and safety check was authorised to walk around the service. Plans to continue to develop the risk assessment and training programme were evident.

We looked around the premises as part of our inspection and saw people lived in a pleasant, spacious, clean and well maintained service. Maintenance documents such as fire alarm checks, fire drills, an electrical certificate and water hygiene solution records confirmed this. We saw personal protective equipment such as gloves and aprons, alcohol hand gel and liquid soap was readily available and staff used these at appropriate times.

People we spoke with told us they felt safe living at Donisthorpe Hall. One person said, "Yes I feel safe nothing has happened." Another person said, "I feel safe, and don't think anything about it really. I'm getting used to living here." One person said they didn't feel safe but this was because they were unsure what would happen to the home in the future.

Staff we spoke with understood their responsibility to protect people from abuse and harm, and were confident if they raised any concerns the management team would respond appropriately and promptly. Training records showed staff had received safeguarding training.

Information about staying safe and reporting concerns was displayed in reception and other areas of the service. This included sharing concerns with the local safeguarding authority and an external whistleblowing service. Whistleblowing is when an employee raises a concern about a wrong doing within an organisation. In the PIR the provider told us, 'We use a dedicated safeguarding email address which is monitored by the home manager and the general manager'. During the inspection we saw a notice informing people the email was confidential.

The provider maintained a safeguarding database, which included reporting incidents to the local safeguarding authority and the Care Quality Commission. A stakeholder who had worked with the service

around safeguarding told us, "The information reported now is of a much higher standard. They have appropriately raised alerts when there have been concerns about another source, for example, in relation to hospital care, or safeguarding concerns about a family member or another professional."

Before the inspection we received information of concern about the arrangements for keeping people's valuables safe. We saw that people had inventory lists held in their personal files which included valuables and some had photographs of items kept at the service. We were informed that one person's inventory list had been misplaced. The service had a central register, however, we found an accurate record was not always maintained so people could not be confident their valuables were kept safe. The provider told us following the inspection they would be reviewing their arrangements and introducing a much more robust system.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and did not have suitable arrangements in place to make sure people's nutritional needs were met. At this inspection we found they had improved their systems around meeting people's nutritional needs sufficient to meet regulation. They were developing systems for meeting the requirements of the MCA but had not made sufficient progress to meet regulation.

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

We looked at people's care plans and found assessments were carried out when people lacked mental capacity to take particular decisions although we saw examples where best interest decisions did not follow best practice guidance. One person's care records showed in August 2016 a review around remaining at Donisthorpe Hall was completed but the records indicated family members were not involved. It stated a further review should take place 'When the DoLS expires'. The person's DoLS expired in October 2016 but no review was held. Another person's care records stated 'Does not have capacity'. We saw best interest decisions were recorded but there was no evidence that any other professional or appropriate other was involved.

Consent records and care plans did not consistently evidence people or their representatives were in agreement. Three members of the inspection team reviewed care records and all found unsigned documents. One member of the team looked at two people's care plans and spoke with both; their care records were unsigned but it was evident from discussions they had capacity to consent to their care.

One person's care plan stated they could no longer choose food preferences so staff were asked to do this in the person's best interests. A food preference sheet was completed by staff but did not match that completed by a relative. Another person's care plan stated they did not like chicken or porridge. The person's eating and drinking care plan review in March 2017 stated, 'Staff to make appropriate choices of food based on known preferences.' We saw the person had been given porridge for breakfast each day for a fortnight, up to and including the day of our inspection.

We found the process for managing DoLS was not effective. The provider had collated information relating to people who required a DoLS, and this showed some applications were submitted in a timely way, however others were not. We saw four cases had been identified where a deprivation of liberty safeguard authorisation should be applied for but these had not been submitted. At least nine DoLS had been applied for a long time before the inspection; one went back as far as May 2015 and others were between January

and April 2016, however there was no information available to show the provider had followed these applications up with the local authority. When we reviewed care records we found at least two people's DoLS had expired and a new application had not been submitted.

We received different explanations from members of the management team as to why the process for managing DoLS was not effective. One member of staff told us, "We have let some DoLS expire, then we can do the capacity assessment and best interests, and start the process again." Another member of staff told us the provider had been asked by the authorising authority not to chase applications. We asked the home manager what oversight there was at management level. They told us, "It should be with me in the future, but at the moment there isn't any." The provider forwarded an email from the local authority which acknowledged delays in the DoLS authorisation process but stressed they could be phoned at any time and 'we can tell you where we are in the process with each of them.'

The provider had not made sufficient improvement to meet regulation, however, it was evident they were improving the systems around MCA. In the PIR the provider told us, 'We have completed MCA training for over 90% of staff however, having changed the care plans it is evident that staff were struggling to embed this into good practice therefore we have employed the services of a specialist to support the home and ensure residents are being supported effectively in the area of mental capacity.' At the inspection we spoke with the person who had been employed to take the lead on MCA and DoLS. They told us, "The training is on-going. We have identified two 'champions' and we are also running training with staff groups."

Staff we spoke with said they had received MCA training and it was evident from discussions they understood people's right to make decisions and that the MCA protected people who lacked capacity to make decisions. We spoke to a senior member of staff who had commenced the role of 'MCA champion'. They told us they had received very good support and individual training over a period of sessions to ensure they were equipped with the knowledge and understanding to guide other staff. They had completed a 'couple' of assessments with the MCA lead and involved the person and their family members. We saw MCA information displayed around the home which kept people informed about their rights.

The provider was improving the systems for complying with the MCA but as yet this was not sufficient to ensure staff were acting in accordance with the legal framework for making particular decisions. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need to consent.

People who used the service and visitors we spoke with said staff understood how to look after people appropriately and encouraged people to make decisions. One person said, "They know what they are doing." Another person said, "I can choose when I get up and if I feel unwell I can stay in bed if I want to." A visiting relative told us staff understood what their mum needed and said, "The staff are good. We have a good laugh and they know her memory is not very good when she says to them that she hasn't had something when they know she has. They have a laugh with her and that's nice because she likes that."

Staff told us they received more opportunities to receive training and better support, including regular supervision. Staff told us the quality of training was good and it had helped them understand how to do their job well. We saw staff who had attended 'in-house training' had completed post training quizzes which had been devised to test the knowledge of attendees. A care manager who spoke highly of the organisation's commitment to future training told us they had received training on person centred care and end of life training for managers and nurses delivered by a local hospice. They described this as 'invaluable in ensuring good and dignified deaths'. A stakeholder told us, "The home has employed a training co-ordinator who has implemented a programme of training and a clear system for monitoring training

compliance of all staff. A focused programme of training has taken place including falls and safeguarding training. Significant improvement has been noted in staff training compliance."

We looked at the provider's training matrix which showed staff completed a range of training including health and safety, infection control, safeguarding, equality and diversity and information governance. The training matrix indicated staff had completed the majority of sessions although there were some gaps and highlights which indicated training sessions were incomplete or refresher training was overdue. Following the inspection the provider sent us a more up to date training matrix and told us they were developing electronic systems which in future would flag up staff training requirements. They said, 'From August 2016 the home needed to provide a high amount of training to meet compliance' and 'this has been largely achieved'. The revised training matrix confirmed this.

In the PIR the provider told us staff had completed the care certificate which is a set of standards that care workers adhere to in their daily working life. The training co-ordinator confirmed this applied to existing staff and new starters. However, when we asked to see records which confirmed staff had completed the relevant modules we were told the care certificate was not included on the training matrix and an overview was only available for new starters. We reviewed this record which indicated some staff had been in post for more than six months but had still not completed the care certificate. The provider told us the training co-ordinator would be concentrating more on timely completion of care certificates.

We saw from the records we reviewed that staff had received supervision sessions to discuss their work and development, and an annual appraisal. We also saw a weekly key performance indicator report was completed to show how many staff had received supervision each week. A care manager told us they reported on this to keep senior managers informed of progress with supervisions.

People told us they enjoyed the meals. One person said, "The food is very good here. I've no complaints." Another person said, "I always look forward to meal times; there is always something on the menu I like." A visiting relative said, "I think the food's good here, like a hotel." Two people commented that there was a lack of choice. One person said they didn't enjoy the food. Another person told us they were diabetic and sometimes needed a sweet drink in the morning. They said they didn't get this so their relative had brought in some biscuits in 'so that I have something if I should need it'.

We spoke to the catering manager about how menus were planned. They told us there was a four weekly rolling menu in place, and this was changed four times per year. We saw the menus reflected the food served and offered people choice. For example, day one of the inspection we saw people were offered parsnip and carrot soup, BBQ chicken, lamb burgers, mashed potato, peas, swede and gravy, apple pie or muffins.

The catering manager told us they had information about people's specific dietary requirements, which was also in their care plan. People were consulted through regular conversations with catering staff, to ensure people could contribute to meal ideas. The catering manager told us, "I find it more useful to speak to people in person rather than in meetings. You get better feedback. People told us they liked traditional, simple meals, and they really like their greens. That was very important to people. As were smaller portion sizes. We have plenty of spring vegetables and cabbage at the moment." The catering manager told us some foods were fortified as a matter of routine, for example with use of butter and cream. Staff we spoke with also said they provided people who were at risk of low weight with milkshakes. We observed fruit was available in the units.

People whose faith or allergies required them to have a specialised diet were catered for, with appropriate

suppliers and ingredients available at all times. Kitchen staff prepared snack items which staff could give to people outside mealtimes, such as cakes and sandwiches.

We observed at meal times people had a pleasant experience and received appropriate support to eat and drink, however, two people we spoke with said this was not always the case. We saw examples where staff provided good individual support, for example, a member of staff spent dedicated time to make sure one person received plenty of fluid. However, we also observed over a two hour period staff did not prompt a person to drink even though their oral risk assessment stated they needed to be encouraged to take regular sips of fluid.

We saw from the care plans we reviewed that people accessed health and social care professionals, for example GPs, opticians and tissue viability nurses. Each person had a section in their care records for visiting professionals to make entries. A senior member of staff said district nurses frequently attended the service although when they visited they could not always find a senior member of staff so information and updates about treatment might not be communicated face to face. We saw short term care plans had been written for specific conditions, for example, an infection and a person having a plaster cast.

One visiting relative discussed their recent experience which had been positive. They said their relative received appropriate healthcare support and pain relief. Another relative told us they were concerned that some checks were not carried out properly. They said they had to chase up health checks because they were not done and said, "Things like that are frustrating." They also told us they had seen on the day of the inspection that at 11.30am an observation chart had been signed for in advance.

We saw in one unit staff were being reminded about their responsibilities to complete charts such as food and fluid charts and re-positioning charts. Staff were also allocated responsibilities each day which included topical creams application, catheter care and food and fluid charts.

A stakeholder told us, "Staff speak with health and social care professionals, such as GPs, and take the right action at the right time to keep residents in good health. We suggested that a more robust system be introduced to log professional visits/outcomes to inform changes to care plans etc in a more timely way. A concerted effort was being made to review and update care plans and to re-educate staff of the importance of fluid and food charts – accuracy and completion." Another stakeholder said, "Weight, food and fluid charts in general have been completed appropriately and in a timely manner, although work continues to ensure that these are completed accurately and consistently."

Requires Improvement

Is the service caring?

Our findings

During the inspection we saw many examples of good care practice. Staff were observed to be caring and kind in their interactions with people. Staff were respectful and offered support where people needed assistance; people were encouraged to be independent where appropriate. On a number of occasions we saw staff sat chatting with people in their rooms and in communal areas in the dementia units. One person was not eating their lunch. They were asked if they would like an alternative and staff returned with a plate of sandwiches. One person spent time in a busy area of the service; staff chatted as they passed and it was evident from the person's response they enjoyed the interactions. We saw one care worker assist a person to drink; they adjusted the person's glasses so they could see the cup coming towards them and waited for them to swallow in between sips.

A stakeholder told us, "During quality assurance visits staff have been noted to be kind and attentive to residents, treating them with dignity and compassion. Overall the home has a friendly atmosphere and all staff whether clinical or non-clinical are noted to be welcoming and helpful to residents and visitors. Mealtimes observed have been calm and orderly, and residents requiring assistance have observed to have been given attention and support. Care plans and assessments reflect individual's needs."

Another stakeholder told us, "We witnessed several examples of good practice during our visit where staff were kind and caring in their approach. We visited all the units and saw people comfortable in their environment, free to walk around the unit, spend time in their room or communal areas (including the coffee shop). We also visited the 'Beach Bar' communal area which offered residents bright light therapy to influence mood." At the inspection we also observed people were comfortable and utilised different areas of the service. We saw people socialised in the reception and café area. One person said, "There is always someone to chat with round here." People's rooms were personalised with items of their choosing such as photographs, ornaments and pictures.

People who used the service and visitors we spoke with were complimentary about staff and told us the service was caring. Comments included, "Staff are second to none. They are brilliant.", "When I walk out of here I know he is well cared for", "Always clean and smart. Everything is special here. It's not an easy job", "If I didn't think dad was being looked after I would move him", "I've been visiting here for years and I can honestly say I've never met any staff member that isn't a lovely person", "Now it's the best it has been. They always treat mum with respect she seems happier now."

We saw people looked well cared for, with hair styled and pressed, clean clothes. We concluded people's personal care had been attended to, and we saw records in people's care plans which showed people were offered regular baths or showers. Staff also recorded when people declined. One visiting relative raised a concern about the appearance of their relative. They said when they arrived their relative had food on their face which had dried and drink was spilt on their clothes.

We saw staff worked as a team. They communicated with each other and checked who had eaten and who needed assistance. Staff knew the people they were supporting and referred to them by name. Although we

saw many examples of good care practice and received positive feedback the service still needed to make improvements to ensure the service was consistently safe. For example, one visitor who assisted their relative to eat at meal times told us they were concerned their relative 'would not get enough to eat' if they relied on staff. We observed one person was struggling with phlegm in their mouth, and they had used several napkins to try and clear it but became distressed. Staff were not present and were not aware the person was distressed until it was brought to their attention by a member of the inspection team. Once made aware staff provided support.

In the PIR the provider told us, 'We have implemented a 'this is me' document in the individual care plans which highlights individuals likes and dislikes and preferences in order to identify specific needs and wishes'. When we reviewed care plans we saw the level of information recorded about people individual preferences was varied. Some contained good detail whereas others were lacking in person centred information. In one unit we reviewed 'what matters to me' documents but these were incomplete. This is information which helps staff develop meaningful relationships with people, especially where people may find it difficult to engage with conversation, for example for people living with dementia. Members of the management team said they continued to develop this part of the care plan.

When we looked around the service we saw there was information available throughout the service which helped to keep people informed. For example, there were leaflets and notices around promoting dignity, data protection, safeguarding and hygiene. Menus and activities were displayed and these were updated when options changed. The provider displayed information about the previous inspection near the entrance of the service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the care and treatment of people who used the service was not always assessed and planned in a way that ensured their needs were met. At this inspection we found the care planning system had improved sufficiently to meet regulation but the provider needed to develop this further to ensure the service was consistently responsive.

At the last inspection care records were stored in different places and it was difficult finding all the relevant information. It took an excessive length of time to review the records and we concluded a new member of staff or agency worker would not have time to sit and look at these to find out how to meet the person's needs. There were inconsistencies in the systems used; some care plans and assessments were on the computer and others were on paper and kept in a care plan folder. At this inspection we saw the provider was no longer using electronic care plans and was using a more consistent system.

In the PIR the provider told us, 'We have reviewed and rewritten care plans in a new paper based format which are far easier for residents to be able to access and read their own information should they choose to' and 'they are more individualised and person centred. We have developed a resident of the day system to ensure that residents care plans are reviewed at least on a monthly basis'.

A stakeholder told us, "A process is underway to standardise the documentation systems across the home. Previously the home had inconsistent standards and processes for assessment, care planning and documentation on (and within) different units. A significant programme of work has been undertaken to review the assessment and care planning processes and to ensure that plans reflect individual needs. All plans are now contained in one place and are paper based. Care plans reviewed by us have shown clear evidence of regular updating that reflect changes in residents' needs." Another stakeholder told us, "There was evidence of improved care planning and more personalised care."

We reviewed care plans and found these were written for a range of needs. A standard care planning format was used which helped staff understand the care planning process and aided access to information wherever they worked within the service. Care plans and associated risk management tools were reviewed at least monthly, and we saw staff recorded reasons why a care plan had changed or remained the same.

Care plans were varied. We saw some clearly identified people's individual needs and guidance was in place around how staff should deliver care. However, we also saw some care plans did not reflect people's current needs. Good examples of care plans we reviewed included details around moving and handling, support with eating and drinking and falls prevention. We observed staff followed care plan guidance. Reviews of daily notes and discussions with staff confirmed people's care needs were identified and met. Examples of less effective care planning included a lack of guidance around meeting specific conditions, such as Charles Bonnet Syndrome and the care plan did not reflect the person's current needs. Some care plan updates were only recorded in the review notes, with no changes made to the main body of the care plan. This meant staff needed to read all sections of the care plans to ensure they had access to the most up to date information about people. Two care files contained a lot of information but some of this was not current;

archived care plans were still in the file and not marked as discontinued which could be confusing for staff.

Daily notes were also of variable quality and did not always provide sufficient detail about people's health and welfare. We saw the provider had introduced a 'good practice example' of a progress note entry for staff to follow. A member of the management team said they were working with the staff team to improve recording and would be offering relevant training.

There was very little evidence to show how people or their representatives had been involved in planning their care. Discussions with people confirmed they were not familiar with their care plans although most said they felt their needs were being met and were happy with how their care was delivered. One person said, "No one asks me about my care plan." Another person said, "I don't get involved in the care plan." We saw documentation had been placed in care plans to use during reviews with people and their families. In two care plans we saw the anticipated date of completion was in October 2017.

Some people told us they enjoyed and looked forward to arranged activities provided at Donisthorpe Hall. Others told us they didn't engage in the activities on offer and some said they were unsure what was happening. During the inspection we saw the activity programme was displayed and we observed activity workers explaining to people what was being provided throughout the day.

On both days of the inspection we saw people enjoyed interactive singalongs, which were facilitated by activity workers working alongside other staff and volunteers. During these sessions there was a lively atmosphere, and people who used the service clearly enjoyed staff interactions. On day one of the inspection we observed a person smiled and sang along with the music throughout. A person who initially looked disinterested was encouraged by staff to sing; they smiled and then joined in. On day one we observed people enjoyed a weekly concert; staff encouraged and assisted people to attend.

We spoke with two activity workers who discussed their programme of activity which included group and individual sessions. They said the programmes were based on people's preferences and through consultation. We saw film, bingo, quiz, art, keep moving and bridge sessions were included. The service had themed weeks which included specific sessions during the week, for example, drink tasting and music. It was 'Yorkshire' week when we visited and previously it had been 'American' week.

We got a mixed response when we talked to people about discussing issues and concerns. Most people who used the service said they would speak to the staff; they were unsure who they would talk to from the management team, and most did not know who the manager of the service was. One person said, "If you did raise a concern. You would not get the person you really need." Another person said, "They listen and that is as far as it goes." A visiting relative said, "I've never had to complain. If I have any concerns I go to them and they sort it out, if they have any problems they come straight to me and let me know."

Since the last inspection two units had closed and some people had been transferred to alternative units because they were assessed as requiring a different type of care. At the inspection some people who used the service and their visiting relatives said they had experienced changes at the home which had been upsetting. One person told us they had not been happy since they transferred to an alternative unit. The home manager discussed the changes which they felt could have been managed differently but said it had been a difficult time for everyone.

We reviewed complaints received in 2017; eight had been logged. We saw a process was in place to record and respond to complaints; everyone received an initial response to their complaint where they were informed their complaint was being investigated and by whom. They were not told when they would receive

further correspondence. We reviewed the investigation records but these were brief and it was difficult to establish if action points or lessons learned were followed up. For example, a response letter stated witness statements were obtained and staff supervisions were undertaken, however, there were no witness statements or details of members of staff involved. The member of staff who was responsible for co-ordinating complaints said they were advised what to include in the response but did not collate any relevant evidence. Members of management team were unable to provide any evidence to support the actions they stated were taken in the response letter.

The provider had collated some data around complaints received, which included the month, relevant unit, how the complaint was received (email, verbal, written etc.) and nature of the complaint, (clinical or non-clinical). However, they didn't carry out any root cause analysis to try and find the cause of complaints. There was no trend analysis to try and establish if there were patterns and common themes.

We discussed the analysis and trend monitoring in relation to complaints with the general manager and home manager. They both acknowledged the systems needed to further develop to ensure lessons were learned and patterns and trends were identified to prevent reoccurrence. We concluded that investigations into complaints were carried although the quality of investigation needed to improve. However, the provider was not using learning from complaints to improve the quality and safety of the service. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

In the PIR the provider told us they had received compliments about the service. They said the 'compliment' themes related to changes in the home, which were described as 'very different to a year ago, better staffing, improvement in atmosphere and end of life care praised'. They said several comments were received from relatives 'about how well looked after their relative has been'. Comments included, 'Carers on the unit are wonderful', 'Impressed with the changes on Maple', 'Can see a marked improvement', 'Very positive changes in the home and the staffing on Maple', 'How lovely Beech is and how much the atmosphere has improved'. The compliments described by the provider reflected compliments shared with us during the inspection visit.

Inadequate

Is the service well-led?

Our findings

At the last three inspections we have rated the well led key question and the overall service as inadequate. At each of the inspections we identified the provider was in breach of multiple regulations which included the regulation that relates to good governance. At each inspection we reported that quality assurance systems were not effective and a lack of consistency in how the service was being monitored. At the inspection in August 2016 we reported there had been a number of changes in the management arrangements and this had impacted on the progress made. At this inspection we found the provider had improved the service in a number of areas, however, similar issues around the governance arrangements remained because systems and processes were not operated effectively. This was demonstrated by the continued breaches of three regulations. There had also been recent management changes which, again, had impacted on the service.

At the time of the inspection the home manager had submitted an application to be registered with the Care Quality Commission. We spoke in depth to the home manager and general manager who was the provider's 'accountable person'. The general manager had only been in post for a few weeks although had been working at the service for several months in an alternative role. Both told us the systems for monitoring the service and driving improvement were not effective. They said significant events were not always communicated accurately to senior management and learning from incidents was not identified and cascaded to frontline staff. They gave examples of systems that were in place but said they needed to be embedded and developed further.

We looked at a range of audits and monitoring records which showed although information was gathered there was very little evidence the provider had systems to identify trends and patterns or learned lessons or took effective action to help prevent untoward events from recurring. A system was in place to monitor key performance indicators (KPI) across each unit. Weekly reports detailed areas such as numbers of pressure sores, issues with weight loss, accidents and incidents, falls, hospital admissions, infections, medication issues/errors, complaints, compliments, safeguarding concerns, recruitment and staff sickness.

We looked at some of the completed KPI reports and saw they were a mechanism for reporting concerns. Some areas reported were supported by action plans. However, this was often not the case. For example, falls were reported by number with nothing documented on actions taken to prevent re-occurrence. Medication errors were noted but again did not have actions identified to prevent the errors occurring again. The home manager who oversaw the KPI process said they did not have a formal action plan or system for identifying trends linked to the KPIs as this was being developed.

Falls audits (checks) were completed on a weekly basis. These gave details of the number of falls and a brief description of what had happened. All the audits we looked at had the same action plan in place; identifying a number of on-going actions such as the falls assessment tool to be updated monthly and new falls risk assessments to be implemented. The management team told us mattress and bed rail audits were completed and retained in people's individual files. They said they did not have a system to check the outcome and if any issues were acted upon.

Dining with dignity audits were completed on a weekly basis to assess the dining experience for people. We saw these audits were completed each week and we reviewed a period of six weeks. The care manager told us the completed audits were sent to the home manager and catering manager. The audits did not generate an action plan to show what action was taken to address any concerns raised or how this was fed back to staff to ensure people's dining experience improved. We concluded the auditing processes we reviewed were ineffective to manage risk and ensure improvements in the service.

Although it was evident from the records we reviewed and discussions with management the quality management systems were not effective, we did see examples where some learning from audits had been cascaded to staff. At team meetings staff had been given feedback on practice issues such as moving and handling techniques, the need for improved communication, gaps in supplementary charts and the need to record people's consent to care interventions. The need to improve fluid balance charts had been identified through an audit of the actual records and consent to care interventions had been identified through care record audits.

An overview of incidents had been produced each month and listed dates and times, which resident was involved and the nature of incident (i.e. witnessed fall, unwitnessed fall, aggression, spilled hot drink, fractured wrist). However they did not identify key themes, for example, trends or how many falls each person had. There was no root cause analysis or action plans to prevent reoccurrence.

In one unit a daily communications meeting had been introduced at the end of the morning handover to communicate learning from incidents, re-iterate care needs, encourage best practice and prompt staff on their responsibilities to complete charts such as food and fluid charts and positioning charts. We saw these were documented each day to show what had been discussed. We also saw in the same unit a staff allocation sheet had been introduced which gave staff clear direction on their responsibilities each day. We looked at some records of these and saw these included overview information and reminders for staff on care needs such as creams application, catheter care and food and fluid charts to be completed.

At previous inspections we reported the provider had not always notified us about important events and issued a fixed penalty notice for failure to notify us of notifiable incidents. Since the last inspection we have received regular notifications and these have been more detailed. However, we found there were still some notifiable incidents that had not been reported. In September 2016 we wrote to the provider and informed them we had not received two safeguarding notifications; these were subsequently reported to us. At this inspection we also received information about another safeguarding case from January 2017; we checked our records and found we had not been notified. After the inspection the provider sent us information to show they had requested for the safeguarding to be reported at the time but this had not happened. They also confirmed they had reported the incident to safeguarding straight after the inspection.

We saw some incidents had not been dealt with appropriately and the lack of systems and processes did not alert key members of the management team and records were not available to show action was taken. For example, a concern was raised that staff should have requested more urgent assistance when a person was unwell; we asked to look at the investigation record but were told by a member of the management team, as it was a clinical issue, under the current system it was not reported. This meant when things went wrong with the clinical care there was no system to assess, monitor and mitigate risk. A member of staff told us about an incident involving members of staff that had taken place in February 2017. We asked to look at the relevant records but could not find out what had actually occurred. Several members of staff attended a meeting but the notes from this were brief. Disciplinary action was taken against one member of staff. The home manager told us they were unaware of the incident. We concluded the provider was not evaluating and improving their practice sufficiently to meet regulation. They did not operate effectively systems and

processes, and the systems and processes did not enable the provider to assess, monitor and improve the service or assess, monitor and mitigate risk. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The home manager said since the inspection in August 2016 they had prioritised changes to the service (reconfiguration) which they had identified needed to happen before they could ensure the care provision was safe, effective, responsive and well led. The home manager said, "Where we are now is requires improvement across the board." As part of the reconfiguration the provider had closed two further units so care was only being provided in four units. They had also identified some people were not appropriately placed so had reviewed where people were accommodated and supported people to move to an alternative unit or care service. A stakeholder who visited the service during the changes told us, "Residents who had moved units were receiving assistance from unit and estate staff to transfer all of their belongings/update the asset register and were assured that their belongings were safe and secure during this period of transition. It was the home's focus to settle the residents involved in the moves into their new accommodation as a priority."

In the PIR, which was completed in March 2017, the provider clearly identified that many systems and processes were new. They stated through their PIR submission that they needed to make sure the systems and processes were working and change when things could be improved. They told us external partners and various consultants had taken the lead role on auditing but the home manager would be taking a more active role. They provided examples in the PIR of what they were doing to make sure the service was well led. They said, 'We have reviewed the management structure within the home and have identified that each unit needs a care manager and a deputy care manager to support the staff and residents particularly through a period of such change which there has been over recent months.' At the inspection we received feedback from members of staff that told us the new unit management arrangements were working well.

We also saw in the PIR the provider had not always accurately reflected their systems and processes. For example, they said they introduced very recently a post falls analysis tool. Staff and members of the management team we spoke with said they did not use this. The provider said in the PIR, 'We have implemented a weekly staffing tool to ensure we have adequate staffing numbers in all the units.' Members of the management team told us and we found from reviewing records the staffing tool did not ensure adequate staffing numbers were provided.

People we spoke with, their relatives and staff told us the service had improved since the last inspection. When we asked if people would recommend the home to others they told us they would. One person said, "It went through a tricky patch in the last few months but it's getting better." Another person said, "It's well managed now its run better." A visitor said, "Things seem better; it seems to have settled down, I can go away now and know that [name of relative] is being looked after." People told us the service had improved although they did not feel they had opportunities to speak with senior managers and were unsure who the home manager was.

We got a mixed response when we asked people about opportunities to share views about the service. Some people told us they had completed surveys and attended meetings; others said they had not. We looked at recent surveys and meetings. These showed the provider had asked people for their views but only a small number of people had engaged. Return dates of 10 April 2017 were given for 'resident and relative' surveys; two relative and four resident surveys were returned. We reviewed 'resident and relative' meeting minutes and saw topics around catering, environment, staffing and communication were discussed. The frequency of meetings varied; one unit had the last meeting in November 2016; other units held meetings in January 2017.

A stakeholder who had worked with the management team told us they had 'seen an improving pattern since September 2016. There is better recording of incidents, better identification for referrals to safeguarding and good consultation. There has been openness and willing to learn and make improvements'. Another stakeholder told us, "We have recognised improvement across the home, some of which has been significant. The management team have been prepared to make changes to support the changes necessary to provide safe care for residents, including the closure of its nursing unit which was a major undertaking for residents and staff. We recognise that whilst there are still some areas where further work is required, the home is on a continued trajectory of improvement and change. Changes in management continue however, and it is as yet unclear as to the impact." Another stakeholder told us, "It was felt that the home had made a number of changes and improvements against the action plan and supporting evidence, although it was acknowledged that there is still further work to do to fully embed and sustain the changes."

We received feedback from staff that the service had improved. Several commented that staffing arrangements, care planning, communication including more regular team meetings, training, supervision and general organisation had improved. One member of staff said, "We're climbing the hill." Another member of staff said, "It's changing for the better. There has been a gradual introduction of change in the last six months." Another member of staff said, "There's been lot of changes. Training has increased, there is better recording. A lot more communication; emails and staff meetings where we can give our views. We are listened to now; we didn't feel we could say things before." Staff told us the management team were visible although some said the frequent change in management was unsettling. Five members of staff raised concerns about the approach and attitude of some members of the senior management team. One member of staff said, "I don't find them approachable. One of them is very rude to staff." Another member of staff said, "You feel as though you're getting a telling off." Another said, "I've lost trust in management. It's about three years since I can say it was a lovely home. There have been lots of changes. You need to feel safe in your job."

Staff surveys were returned in April 2017 and results were being collated at the time of the inspection; we saw 21 staff had responded. We were told the results would be discussed at a senior management meeting and an action plan would be developed.

Since the last inspection more regular team meetings had been held. Staff we spoke with said these were positive and helped them understand their responsibilities and developed the unit teams. We reviewed the minutes of unit meetings that had taken place recently and saw discussions relating to care delivery were held and staff were given opportunity to 'speak up' on the running of the service. We saw issues discussed at these meetings included; the need for good teamwork and communication in order to create improvements in the service, the importance of completing charts such as food and fluid charts and ensuring good hydration and reminders to ensure MAR charts were signed and checked. Staff were given positive feedback gained from people who used the service and relatives and were given updates on new systems in place such as how mattress audits were to be completed. In March 2017 staff had expressed concerns that they were struggling to meet people's needs at meal times due to the time it took to assist people and not having sufficient staff to do this. The care manager told us action had been taken to rectify this as the activities staff were also now available to assist at meal times. We observed activity workers assisting people with their meals.

At a meeting in February 2017 we saw from the minutes staff had expressed concerns at the lack of communication from management about the reconfiguration which had taken place. An action was identified to promote staff 'drop in sessions'. The home manager told us these were held weekly but attendance was poor. When we asked staff about the 'drop in sessions' only one member of staff said they

were aware these were held. Some said 'drop in sessions' were previously held but thought these had stopped.

Since the last inspection a daily meeting with heads of department had been introduced; this was known as the '10@10' meeting and priorities for the day and support that may be needed were discussed. We sat in on this meeting on the first day of our inspection. Heads of department spoke about their key tasks for the day and exchanged information such as the introduction of the summer menu. Important information such as the need to increase security of the building in response to an incident with a person who used the service was brought to the attention of the head of department for estates.