Silver Healthcare Limited

Leahyrst Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 20 May 2016 and was unannounced. This meant people who used the service and staff did not know we were going on this date.

At the last inspection on 12 and 16 November 2015 we found breaches of legal requirements in relation to staffing levels, staff training and supervision. We also found medicines were not managed safely and the systems in place to monitor the service were not effective. We asked the provider to take action to make improvements and this action had been completed.

Leahyrst Care Home is a 41 bed residential care home providing care and support to older people with a range of support needs, including dementia. It is located in a residential area close to Sheffield city centre. On the day of the inspection there were 32 people living in the home.

The service requires a registered manager. 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. On the day of the inspection the registered manager was not working at the service and there was an acting manager in place.

People who used the service told us they felt safe living in the home. Their relatives spoke positively about the standard of care and support their family member received.

Staff knew people well and were aware of their personal needs and preferences.

People who required support with their medicines were given this in a caring and attentive way.

During the day staffing numbers were sufficient to meet people's needs. Additional staff had been employed to work during the night, but had not started as they were awaiting final recruitment checks to be completed.

Staff employed at the home had been recruited in a way that helped to keep people safe because thorough checks were completed prior to them being offered a post.

Staff were receiving regular training and supervision so they were skilled and competent to carry out their role.

People said they enjoyed the meals provided to them and that their was plenty of choice. People could chose to eat their meals either in the dining room or their own room. At lunchtime staff were busy taking meals to people which meant some people had to wait to be assisted to eat.

People and their families were involved in making decisions about their care. A range of healthcare professionals visited the home to offer support and advice to staff about people's varying needs.

Staff and people who used the service were mutually respectful. People were seen enjoying the company of staff and staff spoke with people in a polite and caring way.

Work had started to re-write all care plans. This was to ensure people's needs were recorded and understood by everyone.

The majority of social activities had stopped being provided as no activity worker was in place. A new activity worker was due to start work imminently.

There was a new manager in place who was working in partnership with other professionals to improve the quality of the service. New audit systems were in place which needed to be maintained so that improvements were sustained.

People, relatives and healthcare professionals had confidence in the managers ability to lead the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Appropriate arrangements were in place for the safe administration of medicines.

Staff were aware of their responsibilities in keeping people safe and had a good understanding of adult safeguarding procedures.

Recruitment checks were completed prior to staff being employed which helped make sure staff employed were of good character.

Is the service effective?

Requires Improvement

Improvements were required to make the service effective.

People were supported to eat healthily and maintain an adequate diet. Some people required additional assistance during mealtimes.

People who used the service had access to health and social care professionals to make sure they received effective care and treatment.

Staff received regular training and supervision to ensure they had relevant skills and knowledge to support people they cared for.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and dignity.

Staff were caring and supportive when providing support to people.

Is the service responsive?

Requires Improvement

Improvements were required to make the service responsive.

Care plans were being re-written to ensure they included all aspects of people's care and support.

Activities were not taking place on a regular basis. A new activity worker had been recruited but was not in post.

People and their relatives felt able to report any concerns and said they were confident these would be dealt with.

Is the service well-led?

Requires Improvement

Improvements were required to make the service well led.

New audit processes in place needed to be embedded and robust to ensure risks were identified and quickly rectified.

Staff and relatives said the service was improving and they had confidence in the manager.

People, relatives and staff were encouraged to meet with the manager to question practice and make suggestions for improvements.

Leahyrst Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 May 2016 and was unannounced. Three adult social care inspectors carried out this inspection. Before the inspection we looked at the information sent to us by the provider and other interested parties. This included information from local safeguarding teams, commissioners and Healthwatch (Sheffield). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider 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.

In order to understand what peoples experience was of living in the home we carried out two SOFI's in different areas of the home. SOFI is a way of observing care to help us determine the experience of people who could not talk with us.

During the visit we spoke with six people who used the service, four relatives, the acting manager, five care workers, the chef, kitchen assistant, a domestic assistant and two visiting healthcare professionals. We also looked at four care plans, three staff files and records associated with the running and monitoring of the service.

Good

Is the service safe?

Our findings

At the last inspection we found the service had not managed individual risks presented by people, to ensure their safety. This was because where a risk to a person was identified their care plan did not include actions which could be taken to reduce the risk. We also found some people were not receiving their medicines in a safe way or at the correct times or intervals. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment. The provider sent an action plan detailing how they were going to make improvements. We checked and found improvements had been made, sufficient to meet regulations.

People we spoke with told us they felt safe living in the home. One person said, "I feel more than safe." Another person said, "There's always plenty of people around and that makes me feel safe." Relatives we spoke with said they had no concerns about their family member's safety. One relative said, "My mum has had three falls recently and the staff were very good. They did everything they should and now she's stopped falling." Another relative told us, "I am trained in moving and handling people and I've watched the staff handle my relative. They always do this correctly. There's always two staff which is what it says is needed in the care plan and risk assessment."

We saw staff were aware of people's individual demeanour and behaviour and of the potential risks associated with this. For example, one person was very keen to walk with their hot drink. We saw staff encouraging this person to sit down whilst they had finished their drink, explaining to them they might spill their drink, which could cause a burn or slipping risk.

We looked at four care plans and found each had individual risk assessments. These included risk assessments regarding falling, burns and scalds, poor nutrition and mobility. Risk assessments were reviewed every three months or sooner if the person had any changes to their health or support needs.

Since the last inspection the manager with the support of the GP and pharmacist, had introduced a new system for medicines. All medicines in the home had been returned to the pharmacist and a new supply delivered. The GP had reviewed each person's medicines and supplied the appropriate prescriptions for medicines required. This was because the manager was not confident medicines were being managed in a safe way. We looked at the new system in place. All medicines were safely kept in a locked room in a locked medicine trolley. There were two medicine trolleys and the manager said they planned to purchase another so each floor would have their own. The medicine trolleys were not attached to the wall when not in use. We spoke with the manager about this and following the inspection we received confirmation the trolleys had been fitted with locks attaching them to the wall of the medicine room.

We saw medicines were administered to people at the correct time and intervals. Medicines were administered either prior to meals or after meals depending on their instructions. We saw staff using protective gloves, placing medicines in pots and offering people a drink. Staff stayed with people until they were sure they had taken it. The Medication Administration Record (MAR) showed all medicines had been signed for at the time of administration. Where someone hadn't taken their medicine there was a code to

explain the reason for this. MAR charts had a photograph of each person and showed if anyone had any allergies.

Two people who used the service were prescribed Controlled Drugs (CD's), which we checked. These were kept in a recognised CD cabinet and recorded in a CD register. Two staff member's had signed to confirm any CD medicines given and a running tally was recorded. We checked the number of medicines in the CD cabinet and found this tallied with the record in the CD register.

At the last inspection we found staffing levels were not adequate to provide safe, person centred, interactive and stimulating care which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. The provider sent an action plan detailing how they were going to make improvements. We checked and found improvements had been made, sufficient to meet regulations.

On the day of the inspection there were 32 people living in the home. The manager, deputy manager, one senior care worker and three care workers were on duty. Other staff included a chef, kitchen assistant, three domestic assistants and an administrator. The manager told us there was usually another care worker also on duty but this person had not been able to work on the day and the manager had not been able to replace them. The manager said they did not use a 'tool' to assess staffing numbers. They said they were aware of people's individual dependency needs and was able to assess adequate staffing numbers required from their knowledge of people. Our observations were that staffing numbers were sufficient for people to be provided with care and support as needed.

We arrived at the home at 7am and found there were three care workers on duty. The manager was also 'sleeping in' so they could be called upon quickly if needed. Some people required 'turning' in bed and others needed drinks throughout the night. We looked at the positioning and fluid charts in three people's rooms and saw they had been completed during the night. Some people were up and others were in bed. People in bed looked clean and comfortable. People who were up were dressed, awake and enjoying a drink. The provider told us in their action plan that staff numbers on nights had been increased by one. The manager showed us confirmation of new staff employed to work on nights but had not started work as they were finalising recruitment checks. So that the service can be confident they are keeping people safe at night the increase of night staff from three to four is necessary. In the meantime the manager told us they would continue to 'sleep in' to provide extra cover.

We spoke with 10 staff. They were able to describe their responsibilities for keeping people safe. Staff had received training in adult safeguarding and were able to describe what abuse was and the types of abuse people could be subject to. Staff told us, "We've had the training [safeguarding] and I understand what I need to do" and "We can always ask the manager if we're unsure if something needs reporting to safeguarding." The manager was aware of their duty to report any concerns to ourselves and Sheffield local authority and we were aware this was done as required.

The provider had a policy and procedure for the safe recruitment of staff. We looked at three staff files. We saw checks had been carried out, prior to people being offered posts. These included identity checks, past employment history, references from previous employers and Disclosure and Barring Services (DBS) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have.

The provider had a policy and procedure in relation to supporting people who used the service with their personal finances. The home managed money for some people. We saw the provider had a system in place to manage each person's money and a sample of documentation was reviewed. We saw finance sheets for

money put into and taken out of people's accounts had been electronically recorded and verified by the home's administrator. A company auditor carried out regular on-line checks of finances and made an unannounced visit to the service once a year to check to accuracy of the records inputted onto the electronic system at the home.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found staff who had not received training or their training was invalid in subjects such as medicine administration and dementia. We also identified gaps in supervision for some staff, particularly night staff. Supervisions are accountable, two-way meetings that support, motivate and enable the development of good practice for individual staff members. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. The provider sent an action plan detailing how they were going to make improvements. We checked and found improvements had been made, sufficient to meet regulations.

Staff told us the training provided them with the skills needed to do their job well. Their comments included, "I've been booked onto things to make sure I'm fully up to date with my training," "All we need to do is ask and the manager will try to get us trained in things that are useful to us, like writing care plans."

The manager showed us the staff training matrix. This evidenced there was a rolling programme of training for all staff. The majority of staff were up to date with their mandatory training. The manager had identified where staff were due a refresher or update in a particular subject and sessions with the training provider had been arranged.

Staff that administered medicines had received training in the new medicines management system and were booked onto a distance learning medicines Level 2 training course. The manager told us the new medicine system had only been in place for one month and they planned to check staff competency of medicine administration over the following month. The manager was confident staff were administrating medicines as instructed during their training because during medicine rounds they were visible around the home and carrying out medicine rounds.

New staff employed at the home were signed up to complete an induction programme that met the requirements of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Prior to starting work staff completed a programme of learning which included sessions on person centred planning, safeguarding adults, health and safety and moving and assisting safely. After five days of classroom based training staff were observed in the workplace by the training provider for two days. When staff and the training provider were confident the person was competent to carry out their role they were given shifts working alongside other more experienced staff. The manager told us staff that were working at the home prior to them starting had been booked to complete the induction programme over a number of weeks so they would also be awarded the Care Certificate. One staff told us, "The new induction looks really good. Even though I've been here a while I'm going to complete it over the next few weeks."

The manager had a supervision matrix which showed the majority of staff (with the exception of eight) had received supervision in May 2016. The remaining staff were booked in for June 2016. The manager had also worked during the evening to complete supervisions for staff working the night shift. The provider's policy was that staff would receive supervision at least four times per year one of these being an appraisal. Staff

who had worked at the home for over a year told us they had been given their pre-appraisal questionnaire to complete and had been told they would be meeting with the manager for their appraisal in June 2016. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had applied to the supervisory body [Sheffield city council] for 17 people to be allocated a best interest assessor (BIA). This was because the home had key pads fitted to doors which could restrict people's freedom and deprive them of their liberty. We saw a letter dated 27 April 2016 from the supervisory body stating they were in the process of prioritising allocation of BIA's and they would be contacting the home as soon as possible. This showed appropriate steps had been taken in line with the MCA and DoL'S legislation.

Staff had an understanding of the MCA and how to make sure that people who did not have the mental capacity to make decisions for themselves had their legal rights protected. One staff told us, "We always try to involve relatives or friends in decision making as they usually know the person best."

People who used the service told us, "I like the food, I've put on weight," "There's all sorts to eat, whatever you want" and "I love the food here and I don't have to cook it myself."

During the inspection we observed breakfast and lunch being served in the main dining room. The dining room was spacious which allowed people to move around easily and safely. It was pleasantly furnished with matching furniture. Tables were set very nicely with table cloths, napkins, crockery, cutlery and condiments. Specialist aids were seen, for example, high sided plates and easy to grip cutlery. The days menu was displayed on a large board and written in big print so everyone could see what was available. Meals were served from a hatch by the kitchen staff. Care workers and kitchen staff knew people well and were aware of their likes and dislikes. People requiring special diets were provided with these. Breakfast was 'open choice' and included a variety of hot and cold cereals, toast and preserves or cooked options. We saw people being asked what they "fancied to eat" and staff providing this. At lunchtime there were two main options, which most people had. One person chose to have their meal cooked differently and this was catered for.

At breakfast we saw people were assisted where necessary. Staff sat with people and talked to them, encouraging them to eat and engaging them in conversation. At lunchtime we found staff were busier and less visible in the dining room. This meant people had to wait for assistance. We saw one person's meal given to them and it was 10 minutes before they were given assistance and the meal was then cold. We discussed this with the manager who told us there were two people who required assistance with eating and a number of others who chose to eat in their own room. This meant staff were taken away from the dining room for periods of time. She said she would look at staggering the lunchtime meal so staff were able to give people the support they needed.

In between meals people were offered drinks and snacks. During the morning staff took fresh fruit around and people were seen enjoying strawberries, grapes, pears and bananas. One person told us, "It's good for you and I feel better when I've had my pear." During the afternoon homemade cakes were on offer, which we saw were very popular with people. Five people who used the service were being monitored due to concerns about their food and fluid intake. We found records were completed showing what each person had consumed each day. We saw when one person had not eaten very well, they had been referred to a dietician.

Relatives spoken with said their family member's health needs were met and they were involved in discussions about changes in treatments. One relative said, "I come every day and staff tell me exactly what's going on [with relative]. If [relative] needs to see someone they sort it. That's so much better."

Care plans seen confirmed a range of healthcare professionals were involved in people's care and support. These included speech and language therapists, physiotherapists and district nurses. One visiting healthcare professional told us, "I am very pleased with the way people are looked after. Staff know people and can always find what I'm looking for. I am happy with this home."

The home was over three floors. Each floor had a 'theme' and was named and decorated around the theme. For example the 'poppy' floor was furnished in red and had poppy decorations and pictures. The doors to people's rooms were different colours and had a picture of the person on them. This helped people to recognise their own room. Communal areas were well furnished and comfortable. Toilets and bathrooms were spacious and clean, with soap and towels available. One relative told us, "Things are much better around here. The place is much cleaner."

There was an outside area which could be easily accessed. The area needed tidying and grooming to make it more appealing for people to sit out and enjoy the fresh air.

Good

Is the service caring?

Our findings

People and relatives we spoke with said they were happy with the care provided to them or their family member. Comments included, "The staff are really nice, I like them," "Staff seem to be doing a better job. They're all great," "I don't like being here but that's nothing to do with the staff or people" and "Things are much better, staff are more caring and have got to know [relative] better."

Throughout our SOFI observations we saw staff treat people with respect and dignity. Staff took time to explain things to people, for example, when they were choosing what to eat staff showed them the options and explained what it was. We also saw staff provided care to people privately. Bedroom doors were closed when personal care was being met and curtains and blinds were positioned so that people outside could not see into rooms. People were dressed cleanly and appropriately. Ladies had their hair set and styled and were wearing their favourite jewellery. Gentleman were shaven and smartly dressed.

The ambience in the home was calm and friendly. People were able to move around freely and stopped to chat with staff, who in turn took time to respond to people in a kind and supportive way. Staff were well organised which meant they had time to spend with people that were more dependent. We saw people responded well to the staff and felt at ease with them.

Staff had received training in confidentiality and privacy and dignity. They were aware of their responsibilities of not speaking about people in front of others. One member of staff was the 'dignity champion'. Their role was to promote good practice around dignity. We saw when a healthcare professional tried to engage a staff member in a discussion about a person in the lounge, the staff member politely asked them to go with them to a private room so that the person's privacy and dignity was not compromised.

We saw information was provided to people about how to access local advocacy services. An advocate is a person who would support and speak up for a person who doesn't have any family members or friends that can act on their behalf. There was also information on display about visiting arrangements, their 'dignity challenge' [statement] and the last inspection report.

The manager said no one in the home was receiving end of life care. They said they had identified this as a training need for staff so they would be prepared when they were called upon to provide end of life care.

The service user guide had information on protected mealtimes. This stated that people were welcome to visit at any time but were requested to avoid mealtimes as a show of respect to people who used the service. Relatives we spoke with said they were happy to visit outside of mealtimes and did not have a problem with this. We spoke with the manager about this as it can often be the case that relatives like to visit during mealtimes so they can support the staff to assist their family member to eat. The manager said they were considering changing this arrangement so that people were free to visit at a time to suit themselves if this was in agreement with people who used the service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the system and processes for auditing had not identified a lack of responsive action by staff, which could have placed people at risk of not receiving appropriate care and support to meet their needs. This was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance. The provider sent an action plan detailing how they were going to make improvements. We checked and found improvements had been made, sufficient to meet regulations.

The manager showed us the plan in place to re-write all care plans. This plan was agreed with Sheffield local authority contract and commissioning. The plan was compiled on 24 April 2016 and stated, "Care plans will be completed in an order that recognises high risk service users for priority completion. The overall plan requires that all care plans will be re-written and set in a structured format that is easier to understand and refer to. Completion is intended in a twelve week period, which will allow for three fully completed care plans a week." This was the responsibility of the manager, deputy manager and senior care workers. The manager told us three care plans had been re-written and another seven were currently in the process of being re-written.

We saw new care plans were being written in a format that was person centred and addressed all areas of risk, including risk associated with the environment, nutrition, weight loss, skin integrity and falls. New care plans were being completed in conjunction with people who used the service, their families and healthcare professionals. For people that didn't have family, advocacy services were involved. When the care plans had been re-written the manager had a plan in place to audit and monitor them each month. The manager told us, "We are lucky that we have a dedicated GP who is assisting to ensure all medication and health care reviews are taking place. As we are progressing through the care plans people have been seen for eye tests, hearing tests and dental examinations." We spoke with Sheffield contracts and commissioning and they told us they were confident the manager would ensure the care plans were re-written as per their agreement and within the timescale set.

There was no activity worker employed at the home. One relative we spoke with said, "It's very disappointing. We thought someone would be in place by now." The manager showed us confirmation they had recruited to this position and were awaiting a recruitment check to be finalised. The activity worker had already completed an induction at the service and would therefore be able to commence work as soon as the recruitment check was completed. Our observations were that staff spent time with people on a one to one basis, talking to them and reminiscing, which people clearly enjoyed, but we did not see any organised social activity taking place. One person told us, "We have a sing and dance and someone came to play a musical instrument. That was great." The manager said a full programme of activities would be introduced as a matter of urgency as soon as the activity worker was in place.

There was a complaints policy and procedure which was on display in the home. This guided people in how and who to raise any concerns they may have. Relatives we spoke with said, "We feel we can talk to the manager and we would if anything was wrong," "All the staff will listen if I've got something to say" and "I

feel I can approach staff to complain and they'll put it right." The manager told us they were not aware of any outstanding complaints about the service. We saw the complaints log which showed any complaints received had been investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found there was a falls/accident record in place to identify the number of falls each month and by whom. We found this had been ineffective in practice as the section to identify any patterns was not completed as intended, for example, times, places and type of fall/accident. We also found there was a lack of monitoring that the staffing levels were sufficient to meet the needs of the service and meet people's needs in a person-centred way. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: good governance. We checked and found improvements had been made, sufficient to meet regulations.

The registered manager was not working at the home at the time of our inspection and the provider had recruited an acting manager to take charge. The manager had been in post for five weeks. They told us they had prioritised actions to be taken according to the risk posed to people. Medicine management had been dealt with as a matter of urgency. They had also recruited new staff to work on nights and activities and these staff were to commence work as soon as their DBS checks were returned.

New auditing systems put in place by the manager had been introduced but were not yet fully operational. We looked at the system for recording and monitoring accidents and falls. We found (with the exception of one) all had been recorded in the person's care plan, the falls risk assessment and the accident record. From this information the manager had carried out a monthly analysis of accidents which showed the action taken and outcome resulting from any accident. Actions taken included medication reviews, referral to falls prevention team, reported to safeguarding and involvement of other healthcare professionals.

A relative told us, "[name] has had three falls recently. I'm very impressed with the action taken by the staff. They did all sorts and now [name] is so much better, even eating better and so much steadier on their feet." When we looked at the record of this person's falls we found one fall had not been added to the analysis form. This was because staff had verbally passed this information to the manager but not recorded it on the falls assessment. We pointed this out to the manager who immediately reviewed how they carried out the auditing so that this would not happen again. We saw confirmation that after the person's first fall they were referred to the falls team, had been reassessed for a more suitable mobility aid, had seen the GP about their medicine and had involvement with a dietician to improve their diet.

People, relatives and staff said the manager had worked hard to improve the service since they started. Their comments included, "Keep up the good work, you're doing a good job," "Things are so much better," "There's a big change for the better," "We get things done now. They [acting manager] cracks the whip but that was needed. We get what we ask for like continence wear. Staff morale is so much better" and "[The acting manager] is absolutely lovely and we're so glad [acting manager] is staying, nothing is to much trouble." One visiting healthcare professional said, "I have faith in the new manager, I'm sure they will be fine."

We found there were recording systems in place to aid communication between the manager and staff. Shift handovers were recorded and showed actions that needed to be taken during the shift. For example a

person being weighed and a person needing a visit from the district nurse. Who was responsible for this was also decided and recorded. Staff were also responsible for transferring this information into the relevant sections of the care plan.

The last staff meeting was held on 26 April 2016 and was attended by six staff. A further meeting was arranged for 29 April 2016 to allow other staff to attend. Staff unable to attend either meeting where then provided with a copy of the meeting minutes and asked to sign them. We saw 15 staff had signed to confirm they had read and understood the minutes. Further staff meeting were planned, initially monthly and then to be reviewed.

A letter had been sent to all families inviting them to attend resident and relative meetings to be held bi-monthly. They were provided with the dates of the meetings for the remainder of the year. Refreshments were also provided. Relatives had also been informed of an' open door surgery' held by the manager, 6pm until 8pm twice monthly. This was to give relatives who couldn't visit in the day the opportunity to meet with the manager and discuss their family member's care at a time more convenient to them.

The provider had policies and procedures in place which covered all aspects of the service. The policies were due to be reviewed in June 2016. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.

The registered manager and senior staff were aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008 and evidence we gathered prior to the inspection confirmed this.