Crabwall Claremont Limited

Claremont Parkway

Inspection report

Holdenby
Kettering
Northamptonshire
NN15 6XE

Tel: 01536484494
Website: www.brighterkind.com/claremontparkway

Date of inspection visit:
24 July 2017
25 July 2017
27 July 2017

Date of publication:
30 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Claremont Parkway provides care for up to 66 people who require nursing and residential care. The home provides a permanent home for up to 22 people. The home also works in partnership with the local NHS hospital (Kettering General Hospital) to provide care for up to 46 people who are waiting for discharge from hospital. Medical and therapy staff from the hospital work in the home alongside nursing and care staff from Claremont Parkway to provide all care. The home consists of two floors, communal areas and gardens in the town of Kettering, Northamptonshire.

At the last full comprehensive inspection in January 2016, the service was rated Good. At this inspection we found there were areas that required improvement.

The service had 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.

There had been a change to the purpose of the home since the last inspection. Alongside the people living at Claremont Parkway there were continual admissions and discharges for two thirds of people residing at the home. The provider and registered manager worked closely with NHS staff to assess, plan and evaluate people's care to manage their discharge to their home or another care provider.

There were not enough managers or clinical leads to provide the oversight required to continue to maintain people's safety. There were not always enough staff deployed to ensure that people always received their personal care or meals in a timely way. We have made a recommendation about the deployment of staff. The registered manager was in the process of building a management team and actively recruiting nursing and care staff.

Some people were at risk of not receiving food that met their needs as staff were not always well informed of people's nutritional needs or had time to read people's plans of care.

Overall people were happy with the care they received and said that staff were kind and compassionate.

Staff had been recruited using safe recruitment practices. Staff understood their responsibilities for safeguarding people from harm and followed the provider's policies to provide people's prescribed medicines safely. Care plans were updated regularly and people and their relatives were involved in their care planning where possible.

People received care from staff that had received training to meet people's specific needs. Staff were compassionate and helped to build positive relationships with people living at the home and those in transition between services.

People were treated with respect and helped to maintain their dignity. Staff were respectful of people's wishes.

People were supported to access healthcare professionals and staff were prompt in referring people to health services when required.

Staff sought people's consent before providing care and people's mental capacity was assessed in line with the Mental Capacity Act 2005. The registered manager understood their responsibilities and referred people appropriately for assessment under the Deprivation of Liberty Safeguarding.

The provider and registered manager continually assessed, monitored and evaluated the quality of the service to identify areas for improvement, and implement change where required.

We identified that the provider was in breach of one of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3). The action we have asked the provider to take is detailed at the end of the main report.

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.

Staffing levels and clinical oversight were not always consistent enough to ensure that people's care and support needs were always safely met.

People were protected from unsuitable staff through safe recruitment procedures.

People were protected by staff who were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were reviewed regularly.

There were systems in place to manage medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not consistently supported to maintain their nutrition and hydration as staff did not always follow the plans of care.

Staff received the supervision, support and training that they needed to provide effective care and support to people.

People's health needs were monitored and responded to appropriately.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and people's consent was sought appropriately.

Is the service caring?

Good

The service was caring.

People's privacy and dignity were protected and promoted.

There were positive interactions between people using the

service and staff.

Staff had a good understanding of people's needs and preferences.

People had access to an advocacy service.

Is the service responsive?

Good

The service was responsive.

People receive their care as planned.

People were involved in the planning of their care which was updated regularly.

People using the service and their relatives knew how to raise a concern or make a complaint. There was a complaints system in place and people were confident that any complaints would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management and clinical lead within the home was not fully established.

A registered manager was in post who understood their role and responsibilities.

The provider offered regular support and guidance to staff.

People, relatives and staff were encouraged to provide feedback about the service and it was used to drive continuous improvement.

Quality assurance systems were in place to review the quality of the service.

Claremont Parkway

Detailed findings

Background to this inspection

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

This unannounced comprehensive inspection took place on 24, 25 and 27 July 2017 by two inspectors from the adult social care team, one inspection manager from the hospitals team, a nurse specialist advisor and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both of the experts by experience had experience in using care homes and hospital services for their relative.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, to detail what the service does well and improvements they plan to make. We also checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted and met the health and social care commissioners who monitor the care and support of people living in the home and those receiving care whilst being assessed for discharge from the hospital.

During this inspection we spoke with and observed care for 36 people residing in the home. We observed the care and interaction between staff and people who could not speak for themselves due to their medical conditions. We also spoke with five visiting relatives and friends. We spoke with 25 Claremont Parkway staff including 10 care staff, two nurses, one senior care practitioner, the clinical lead nurse, three kitchen staff, one maintenance staff, two activities co-ordinators and the discharge co-ordinator. We also spoke with four members of senior management including the registered manager, the regional manager, the regional support manager and the operations director. We spoke with thirteen members of NHS staff deployed to the home including one doctor, two pharmacy staff, physiotherapists, occupational therapists and nurses. We reviewed the care records of 24 people that used the service and the recruitment records for five members of staff. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Claremont Parkway. One person told us "I do feel safe. The staff are good here and I've got a bell if I need anything." Another person told us "I do feel very safe here, I can't fault it."

However, we found there were areas that required improvement within the home to maintain people's safety.

There was not always enough experienced staff to keep people safe and to meet their needs. Although people's dependency needs had been assessed and staffing had been allocated to meet their needs, we found that the skill mix and staffing levels were not always consistent. The provider told us and the rota showed that three nursing staff were required during the day to meet people's needs. The provider also used senior care staff with additional nursing skills in place of a nurse which could also meet people's needs. We found that the nursing staff did not always have the skills and experience required to meet people's needs.

During the first day of the inspection there was only one nurse at the home who had the skills and experience to provide the nursing care required to meet people's needs. Another less experienced nurse was also on duty; they were on probation and were being supervised by the experienced nurse. There was also a senior care assistant assisting with nursing duties. This had led to some people not receiving their medicines until late morning. For example at 9.45am one person told us "My tablets are later than normal, they are usually given at 7am." Although there was one experienced nurse on duty there was a lack of clinical oversight or support for the nurse as the manager and clinical lead were not in the home. We brought our concerns to the attention of the provider who told us that the nurses had telephone access to a senior clinical person within the organisation if required; however, this did not support people to receive their medicines at the correct time. The manager later told us that the senior care assistant would normally only be allocated when two experienced nurses were on duty and could not explain why the clinical lead was not in the home when they were allocated to be on duty. The home had enough nursing staff to meet people's needs on the subsequent days of inspection. The manager also demonstrated how they had employed more nursing staff who were due to start their induction in the next two weeks. The lack of consistent nursing and clinical oversight was a concern, however, the manager had taken action to mitigate the risks in future by deploying the clinical lead from the night shifts onto days, although we have not been able to test the effectiveness of their actions.

Although most people received their regular pressure area care by being assisted to change their position in bed there was not always enough staff deployed to provide people with their personal care and meals in a timely way. During the first day of inspection, on the first floor, care staff were allocated to make and provide breakfasts to people in their rooms; we observed that some people had to wait until 10am to receive their hot drinks and breakfast and some people had to wait later than this for their personal care needs to be met. People told us they often had to wait for care; one person told us "'I often have to wait a long time to go to the toilet." We observed that the call bells were continually sounding with people requiring assistance and staff rushing to provide care. One person told us "If I buzz, and they are busy they generally pop a head in and say 'back in few minutes' and they generally are. It takes two staff to move me with the hoist." We

saw that people's care was delayed where staff had to wait for a second member of staff to be available to use equipment such as a hoist. However, on the ground floor catering staff provided the breakfasts and care staff were able to meet people's care needs in a timely way. We brought this to the attention of the provider who arranged for catering staff to assist care staff on the first floor at meal times. We observed on the second day of inspection that care staff were able to meet people's care needs as required. We brought this to the attention of the registered manager who told us that they were adopting an increase in the catering staff allocation on the first floor permanently in order that care staff would be available to provide for people's personal care needs. We recommend that the provider reviews the way in which all staff are deployed in the home during busy periods of the day.

People could be assured that the provider's recruitment practices helped to protect them from unsuitable staff; checks had been made to establish that staff were of a suitable character to provide people with care and support. There was a system in place to check and monitor the registration status of the nursing staff. Records showed that staff had the appropriate checks and references in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

There were appropriate arrangements in place for the management of medicines. Nursing staff and trained senior care staff provided safe administration, storage and disposal of medicines and they were knowledgeable about how to safely administer medicines to people. During the first day of the inspection one of the medicine rounds was taking longer than usual, however, people told us that they usually received their medicines on time which we observed to be the case on the second day of inspection. We also saw that the medicine records confirmed that people usually received their medicines in a timely way. One person provided an example of how staff gave their medicines at exact times throughout the day including 6am, they explained they were happy with this as it was the time the doctor had set and they always went back to sleep afterwards.

People were supported by staff that demonstrated they understood their responsibilities to safeguard people from the risk of harm. One member of staff told us "I would have no problem whistleblowing if I saw something wrong". Staff knew what to do to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us "I would report any suspected abuse to the manager or to CQC." Another member of staff told us they had confidence that their concerns would be acted upon, they told us "I would absolutely bring someone up if I didn't like what they were doing. I know that it would be taken seriously by management." The registered manager had submitted safeguarding referrals where necessary and investigated concerns where required by the local safeguarding authority.

Risk relating to people's care needs were assessed and reviewed regularly or when their needs changed; for example the risk of acquiring pressure ulcers or the risk of falling. Staff were provided with clear instructions in care plans to mitigate the assessed risks, such as how to support people to mobilise safely using the right equipment. Staff told us they were happy that people's assessments were comprehensive and they felt safe to support people.

During our inspection the home experienced an outbreak of nausea and vomiting. Staff immediately implemented their plan to contain the outbreak; they informed NHS England and collected the necessary samples for diagnosis of the outbreak. They closed the home to admissions and reduced the numbers of people coming to the home by informing and deterring visitors. The staff that usually provided discharge planning from the local NHS hospital did not attend the service during this time, although the doctors continued to provide medical cover. The registered manager arranged for refresher training for all staff in

hand washing to help prevent the spread of the infection. Staff also had access to all the equipment they required to help prevent the spread of the infection and carried out the necessary procedures with cleaning and safe disposal of soiled linen as detailed in their policy.

People lived in an environment that was safe. There was a system in place to ensure the safety of the premises including fire safety checks. The registered manager and staff kept fire exits clear and tested the fire alarms. Records showed that the fire alarm system had been carried out regularly. Staff had received annual fire safety awareness training and understood their role in the event of a fire. Staff had ready access to people's specific emergency evacuation plans to ensure each person could be safely evacuated in a fire. There were systems in place to check the safety of the water.

Requires Improvement

Is the service effective?

Our findings

People could not always be sure that they would receive food that met their individual needs. People were assessed for their risk of not having enough to eat or drink. People were weighed at regular intervals; where people were identified as at risk, they had been referred to their GP, dietitians or a speech and language therapist (SALT) for further assessment. These health professionals advised staff on the types of diet people required to meet their needs, for example a pureed diet. The staff in the kitchens had detailed information about people's needs, likes and dislikes and prepared their meals accordingly. People's care records stated the type of diet people required. However, we observed that there was some confusion amongst staff about some people's dietary needs. For example, we observed staff discussing whether they could give a sponge pudding to someone on a pureed diet which would have been unsafe as they were at risk of choking.

Staff told us they did not always have time to check people's records for the type of diet they required; one member of staff told us "It gets so busy sometimes we don't have the time to look at people's notes." People's records did not always give clear instructions to staff, for example one person's records stated they were on a normal diet and a pureed diet, a member of staff told us "Sometimes we just get busy and don't transfer the updated information." We brought this to the attention of the registered manager who told us they were taking action to ensure that staff had the information they required. Although we received these assurances, people continued to be at risk of choking or receiving meals that do not met their dietary needs; the provider must ensure that staff have access to up to date records relating to people's dietary needs.

During the first day of the inspection we observed that although people on the ground floor received all of their meals as planned, people on the first floor did not receive their breakfast or lunch at the times they expected. People told us they were unhappy that they could not have a hot drink in the morning and some people told us they were hungry. One person said "They are very under-staffed, here we are at 9.45am and I've not had a cup of tea or breakfast yet." We also observed that one person had refused breakfast and was not provided with any alternatives; this person told us "I am hungry; I would love Weetabix with cold milk and tea." They did not receive any food that day until 1pm when staff supported them to have their lunch. Staff arriving for the afternoon shift were surprised to find people had not had their lunches and told us that this was unusual. We brought this to the attention of the registered manager who told us they were increasing the number of catering staff on the first floor to assist care staff with providing meals.

People had access to cold drinks and where necessary were supported to drink regularly. Some people had specific needs whereby staff were required to record how much they drank every day. However, there were not always clear instructions to staff to state how much people needed to drink daily to maintain their health and welfare or consistent clinical oversight of whether people had had sufficient to drink. We brought this to the attention of the manager who told us they would put in a system to inform staff of people's daily fluid requirements and have oversight of these. We have not been able to assess these actions.

The provider failed to ensure that all people received the diet and fluids they needed to maintain their health and welfare. This is a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Where people received their nutrition via Percutaneous endoscopic gastrostomy (PEG) feeding tube we saw that staff helped to support people into a position which was safe for them to receive their feed. Staff followed the regime set by the dietitian and flushed the tubes at regular intervals to maintain their hydration. Staff recorded and monitored what they gave people via their PEG feeding tube to ensure that people received their set recommended daily amount.

People received care from staff that had undergone an induction and training to prepare them to meet people's needs. One member of staff told us "My induction was all the in house mandatory training like safeguarding, moving and handling, health and safety, medication. I then shadowed staff for several shifts before properly starting work."

Staff received updates to their training and records showed this included fire, mental capacity assessments, dementia awareness and managing challenging behaviour. We observed staff using safe moving and handling techniques when transferring people; one member of staff told us "I always transfer with two people and I have been trained.''

Staff received supervision which helped them to carry out their roles. Records showed that staff received regular supervision and appraisals. Staff told us that they felt supported and they valued the supervisions they received. One member of staff told us "The clinical support is good, and the nurses are reliable. We can get help from them when we need it." Staff had opportunities to develop their skills and knowledge through additional vocational training. Nursing staff were supported to maintain their registration with systems in place to manage their re-validation.

People said that staff asked for their consent before carrying out care and support. One person told us "Staff always gain my consent over everything; they know that I am still able to make my own decisions and are respectful of that." We observed staff asking people for their consent before providing care. One member of staff told us "Where possible we try and help people to make their own decisions and they are helped to do so when required." Records showed that people had been involved in planning their care and were able to make their own decisions.

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 authorisation 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 registered manager and staff understood their roles in ensuring people's capacity to make decisions was assessed and staff ensured they received people's consent before delivering care. The registered manager had made DoLS applications to the local authorities as required.

People who lived at Claremont Parkway permanently were supported to access health professionals for assessments, appointments and care. People who were under the care the local NHS hospital had regular access to doctors and had a consultant led ward round twice a week. There was an effective level of clinical oversight provided by the local hospital and people's records clearly detailed the input from the doctors and allied healthcare professionals.

Good

Is the service caring?

Our findings

People received care from staff that showed compassion and care in their interactions. People told us "Staff are kind and caring." We observed that staff communicated with people in a warm and friendly manner. Staff referred to people by their preferred names, one person told us "I like that the staff know me as [preferred name]."

People who lived at the home permanently told us "The care here is good, I'm well looked after." And "Staff listen and are very kind. I don't know what I'd do without them." Staff knew people who lived at the service well; they had built up positive relationships and spoke with people about their interests and family life. One person provided a daily motivational quote that was displayed every day in the main entrance. They had also created a positivity tree to share with other people living in the home. The tree contained positive messages for people to read and talk about. Although this used to be in a prominent position by the front entrance, it kept being knocked by people so this had been moved to the dining area where people could continue to see it. Staff knew people who lived at the service well; they had built up positive relationships and spoke with people about their interests and family life.

People who were residing in the home whilst their discharge from the local NHS hospital was being planned told us they liked the environment and the staff. One person told us "The difference between being here and being in hospital is huge, it's so much nicer here." Another person commented on the good quality of the staff they told us "I've met a lot of staff and there's loads I would pick to be my home carers….even the cleaners are helpful and thoughtful." A member of staff from the hospital who were based at the home told us "We have observed staff to be caring and have no concerns."

People received support from staff that preserved people's dignity when providing care by ensuring that they were discreet in offering personal care and providing this in the privacy of their rooms or bathrooms. One person told us "The girls [staff] are lovely. My privacy and dignity is respected at all times." People received care from staff that were respectful of people's personal space; we observed that staff were careful to attract a person's attention and seeking consent before providing people's care. One person was using a device to conceal their catheter bag in a discreet way; the manager told us that this had been so successful; they have introduced this to other people living in the home who said they would also like to use it.

People had access to an advocacy service where required. An advocate is a trained professional who can support people to speak up for themselves. People who did not have close relatives or friends were offered the service when they faced making decisions about their care.

People were supported to maintain relationships that were important to them; visitors were encouraged to visit the home. People told us that family and friends visited when they wanted to, they said "My family can visit at any time…but not too late at night." One relative told us they could come in when they wanted to, but they tried to avoid mealtimes out of respect.

Good

Is the service responsive?

Our findings

People who planned to live at Claremont Parkway had been assessed before they had been admitted to ensure that the service could meet their long term needs. People had on-going assessments of their needs and they were involved in the development of their care planning.

People received their care as planned. Where people were at risk of acquiring pressure ulcers they received their regular planned care to assist them to change positions. Where people had been admitted with pressure ulcers nursing staff had provided an organised approach to the planning that led to these pressure ulcers to heal over time.

Staff followed people's care plans to prevent people from falling out of bed. For example some people's beds were placed at the lowest levels with crash mats to prevent injury should they fall out of bed, and others had bed rails. Some people had air mattresses to help prevent pressure ulcers. These air beds were monitored for their effectiveness and adjusted according to people's needs.

People's care plans provided staff with details about their needs and preferences including how they prefer to mobilise or communicate. Staff had access to information about how to support people in the right way and care plans were reviewed and updated regularly or when people's needs changed. Although staff told us they were not always given time to read and contribute to people's care plans, they demonstrated a good knowledge of people's preferences and care needs. One member of staff told us "We rotate often, and I was on leave, but if I do not know something I can look it up. The turnover of NHS patients is also high." All staff were involved in the handover of information which helped staff to understand people's care needs.

People who were temporarily residing at Claremont Parkway under the medical care of the local NHS hospital were assessed for their suitability before they were admitted to the service. One member of staff told us "It's important that we know we can meet a person's needs first." Once in the home people were assessed by a discharge team which included a physiotherapist and occupational therapist to establish the type of care they required in the future. Most people were awaiting either social care packages of care or a return to their own homes. One person told us "It's an excellent place to recuperate."

Most people told us they were waiting for equipment or funding to be put into place in their own homes. One person told us "I can't speak highly enough of the staff, I feel ready to go home now and the staff have helped me put a package together. I have felt involved in everything. I have a hospital bed waiting for me when I get home and all the other equipment I need."

Whilst people waited to go to their respective homes, the activity co-ordinators arranged for a variety of activities. People told us there was "Something for everyone". The weekly timetable demonstrated a selection of activities that could keep people active. Three people told us they were supported to maintain their independence and wanted to remain as active as they could for going home. One person told us "The activities are excellent she [activities coordinator] has so much energy."

Activities staff provided activities that related to people's lives and hobbies. One of the coordinators told us "We have a resident who used to make perfume so we had a day with her making perfume with some rose petals. She has little communication but from eye contact it was evident she enjoyed it." They told us "We communicate with the families and work out what would be best for the resident." One person told us "The activities are good, we get to go out and about sometimes, we went to the pub the other day." The registered manager recognised that people living at Claremont could access and make more use of more of the provider's resources such as the Wishing Well scheme, where people could request specific activities that would have an impact on the quality of their lives; they had allocated specific staff to implement the scheme.

People said they knew how to complain or had been given information on how to make a complaint. People told us they felt confident that their concerns would be listened to. One person told us they had made a complaint and was happy with the outcome. Another person told us "If I wasn't treated with respect I would say, or I'd tell my daughter, she'd complain straight away, but I've nothing to complain about." There was a log of the complaints that had been received and the actions that had been taken in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had managed the home since December 2016 and registered in May 2017. 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. The registered manager understood their responsibilities and provided the necessary notifications of incidents to CQC; from the information provided we were able to see that appropriate actions had been taken. They also ensured that the rating from previous CQC inspection was on display both in the home and on their website.

The management structure at Claremont Parkway was not fully established. During the inspection the registered manager was on annual leave for the first two days and there was no clinical lead for the first day. Although the provider had placed an area manager in the home to cover for the registered manager, there was no management within the home that knew the people that resided there. The registered manager was in the process of employing a deputy manager and re-deploying a clinical lead from the night staff. Although the provider and registered manager had taken action to build a management team, progress had been slow to find the right people and the team was still in its infancy.

The registered manager was continuing to build their care team. Some of the existing nursing staff were still under probation and had not taken up their complete role. Staffing levels had been enhanced with the use of agency staff until recently; however, the provider had stopped using agency staff as they had assessed the staffing levels and found that agency staff were no longer required. The provider needs to ensure that there are enough skilled and experienced staff on every shift to meet people's needs. The numbers of nursing and care staff were being increased with new nurses starting in August 2017 and care staff being actively recruited in the next few months.

There had been a great deal of change within the home over the last year which led to people living in the home only accounting for a third of people residing in the home. Staff told us that they knew the people living at the home well and the change had not had a negative impact on everyone. One member of staff told us "I don't think having the people from the hospital for short stays has affected the residents. I've not heard any complaints but one person did tell me she is pleased to have more people to talk to. She likes to chat so she enjoys meeting new people." The registered manager recognised that the permanent residents required an advocate to represent their views in the home. Their plan was to give this role to the new deputy manager when they were appointed.

The registered manager was friendly and accessible to staff. One member of staff told us "The registered manager is very good, we see her regularly and she is very approachable." The registered manager held daily meetings with key staff to understand the needs of the service. The staff also attended regular meetings where they discussed their ideas for improving the service. For example the registered manager had changed the shift patterns and handover times following suggestions from staff which staff told us had been effective at ensuring that all staff received a full handover. Further improvement is required to ensure that

all staff have access to the records relating to people's changing needs and dietary requirements.

The provider and registered manager regularly assessed, monitored and evaluated the quality of the care provided. The regular audits provided a clear indication of the areas that required improvement. The registered manager had action plans to take the appropriate and timely action for each of the areas identified such as the recording of care and staffing levels.

The provider carried out regular surveys to gather the feedback of people who used the service and their relatives. The results in 2017 showed there had been an improvement in people's experiences of the care and relationships with staff from the survey in 2016. The registered manager had responded to the results of the 2016 survey by improving the communication between people using the service and staff, which was reflected in the improvement seen in the 2017 survey. The provider compared the results to other homes within their organisation and prepared an action plan to improve any areas of concern.

There were policies and procedures for staff to refer to, that guided them to carry out their roles. However, the provider did not have a procedure to repeat the Disclosure and Barring Service (DBS) check at any time after staff commenced employment; instead staff were asked to sign a form to declare that they continued to be of good character. The provider is required to take further steps to improve their policy to incorporate a suitable timescale for DBS checks for all staff once employed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure that all people received the diet and fluids they needed to maintain their health and welfare.