HC-One Limited

Milliner House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 18, 19 and 20 January 2017 and was unannounced. When we last inspected the service in March 2015, we rated the service as 'good'. We carried out this inspection in response to an increase in safeguarding referrals being made in relation to this service.

Milliner House provides accommodation, personal and nursing care for up to 40 people, some of whom may be living with dementia or physical disabilities. The service also supports people who require palliative and end of life care. At the time of our inspection, there were 35 people using the service.

There was a registered manager in post. 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.

During our inspection we found the service was in breach of several regulations. You can see what action we've asked the provider to take at the end of the report.

There were systems in place to keep people safe, although we were consistently told that staffing levels were too low and that people's needs could not always be met. Staffing dependency had been assessed but at the time of our inspection there was additional staffing required to ensure that people were receiving a good standard of care and support. The service had recently had a number of safeguarding referrals and we saw that appropriate action was being taken in response to these. Risk assessments were up to date and reflective of people's changing needs, and there were robust systems in place to record and analyse data in respect of falls, accidents or incidents.

People's dietary requirements were identified and the service were able to meet people's specific dietary needs. However the menu had not been developed with people's individual choices and preferences in mind, and we received poor feedback in relation to the quality and consistency of food. People's medicines were managed safely although some people told us that the use of agency staff meant that there was sometimes a lack of consistency with the way in which they were administered. People's healthcare needs were identified and they were supported to attend appointments and access healthcare professionals as required. People had care plans in place which were detailed, person-centred and responsive to their changing needs.

People were cared by staff who knew and understood their needs and demonstrated a kind, compassionate and patient approach. However a high turnover of staff and use of agency staff meant that people did not always receive a consistent quality of care. Pressures on time meant that people were not always supported to have their choices upheld or their views heard. There was an activity co-ordinator in post and people had access to activities, however on the day of the inspection we observed a lack of structured activity or stimulation for people.

Staff received a variety of training that enabled them to carry out their duties effectively, and were supported through on-going supervisions and appraisals. New staff were provided with a thorough induction into the service when they started. The service had a robust recruitment policy in place to ensure that staff recruited to work in the service were suitable.

There was a new registered manager in post and most staff were positive about them, although some expressed concerns about the decline in quality of the service. The service was subject to a number of quality audits which identified areas for improvement and suggested remedial actions to be taken. Staff were able to contribute to the development of the service through team meetings and understood the visions and values of 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?

Requires Improvement

The service was not always safe.

There were not enough staff deployed to consistently meet people's needs.

Medicines were managed safely although the use of agency staff led to some inconsistency in their administration.

People had detailed risk assessments in place which detailed ways in which risks could be safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always given food and drink in accordance with their individual choices and preferences.

Staff received a range of training which enabled them to carry out their duties effectively.

The principles of the Mental Capacity Act 2005 were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind, caring and compassionate but staffing pressures impacted on the quality of care they were able to provide.

People were treated with dignity and respect, but did not always have opportunities to have their choices and views heard.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a programme of activities available, but people were not stimulated or engaged during our inspection.

Care plans were robust, person-centred and responsive to

people's changing needs.

There was a complaints policy in place although we were unable to see the resolution to some complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We received generally favourable feedback about the new registered manager, although they would have benefitted from further support during their induction.

Quality assurance was robust and detailed but some issues were not always identified.

Staff had the opportunity to contribute to the development of the service.

Milliner House

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 the 18, 19 and 20 January 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and asked for feedback from nine professionals involved with the service.

During the inspection we spoke with six people who used the service and six of their relatives to gain their feedback. We spoke with the registered manager and eight members of the care staff. We also spoke with one professional visiting the service.

We observed the interactions between members of staff and people who used the service including their routines and mealtimes. We reviewed the care records and risk assessments for six people who used the service. We checked medicines administration records, and looked at staff recruitment and training records. We looked at complaints and compliments received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

We received mixed responses when we asked people and their relatives whether they were safe. One person said, "Of course I feel safe here, the [staff] are wonderful and look after me." Another person said, "Yes I feel safe, some of the carers are very kind."

However the majority of people, staff and relatives we spoke to did not feel that there were sufficient numbers of staff deployed to meet people's needs and keep them safe. One person said, "No I don't think there's enough staff. I have to wait and sometimes they forget that I've asked them for something because they're so busy." Another person said, "Night time is awful, I shut myself away in my room. I can go to bed when I want that is my choice but there's not a soul in sight if you need anything. One night a [person using the service] was crying for help for ages in the end I had to get out of bed and try and find someone to help [them]." A relative told us, "I think they are quite stretched and I think they're understaffed." Another relative said, "I am not happy with the facilities here, the [care staff] do their best but they are always short staffed."

Staff expressed similar concerns when we asked them about staffing levels. One member of staff said, "There are not enough staff and we have tried to tell [the provider] this. We have good staff here but it's not enough. If somebody needs to go to hospital, if there's a hiccup or somebody's needs change then it's difficult. Some people need double-up care and we just don't have the available hands." Another member of staff said, "There should be two carers and one senior staff on the top floor and the people's needs have changed, people need hoisting and help with more than they used to and there just aren't enough of us to meet people's needs safely. I feel like it's dangerous at the moment to be honest."

The registered manager agreed that there was a need for extra staffing to meet people's needs safely and had completed a dependency assessment which determined the number of support hours needed for people. However the first initial tool we were given was completed in December and only listed one person as 'very high dependency' whereas we noted that in three of the six care plans we looked at, people's dependency had been assessed as 'very high'. The registered manager had determined that the total required hours for 37 people was 103.5 based on dependency. With six members of staff working during the day and four members of staff at night, the service were delivering 120 hours of care. This had therefore demonstrated the need for a reduction in staffing rather than an increase, which would have placed people at further risk of failing to have their needs met.

Sixteen of the people using the service required two carers for either transfers or personal care. This meant that with three members of staff working on the floor, only one member of staff was available to meet the needs of the remaining people on the floor. One member of staff explained the impact saying, "People get up late and some people are just left in bed all day." During the inspection we noted that people were left in communal areas of the home for long periods without the presence of any staff. For people who may have been unable to use a call bell or communicate for assistance, this presented a risk of neglect. One person explained the impact upon them and told us, "I can't always have a shower if there is not enough staff. And that bothers me because I like to be dressed for my breakfast." Another person also told us they would like to shower more regularly but could not do so because of short staffing.

We reviewed the service rotas for the two months prior to our inspection. We noted that staffing levels had remained consistent as per the dependency assessment, although there were two occasions when staffing levels had dropped to five members of staff due to sickness. We also noted a high use of agency staff, which was also bought to our attention by staff. One member of staff said, "When you have agency workers in it makes things difficult because we're short-staffed. I think we could do with more staff and we need a little bit more help because people do wander around and we can't be everywhere at once." Another member of staff said, "They [agency staff] don't really know the people as well, although we have the same ones coming in sometimes."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people and staff expressed concerns over the way that medicines were managed. One person said, "I have had my meds given to me as late as twelve at night, I rang my bell when it had gone nine to tell them I had not had my medication but no one came. I have also been given my meds in a little plastic cup and it had water or liquid in which made all my tablets soggy. I refused to take them and said I wanted new ones but they refused and made me take them." Two members of staff said, "[Medicines] are managed okay but then we have agency nurses in who don't know the rounds and don't know who is who. If there are errors it's because we've had to use staff who don't know the [people]." Another member of staff said, "It worries me that there are agency staff doing people's medicines and we're having to supervise them even though we're not trained ourselves."

The service carried out checks prior to using any staff from agencies to ensure that they had the correct training to administer medicines. The registered manager told us, "We've had to send agency staff home because we weren't confident in them. If I need to then I can do the medication rounds myself."

Following the inspection we were provided with an updated dependency tool which contained a more recent assessment of people's needs and the staffing levels that would be required as a result. The registered manager confirmed that she would be reviewing this following any new admission or when people's needs changed. We were told that an extra member of staff would be recruited to work across both floors, and that the deputy manager could be providing some direct care once they commenced their role.

There had been an increase in safeguarding referrals since November, and there had been a serious avoidable incident which had resulted in harm to a person. The local safeguarding team had shared concerns with us prior to the inspection regarding the significant rise in incidents, some of which were still under investigation at the time of our inspection. The registered manager described some of the ways in which she had tried to make improvements in response to these safeguarding concerns. For example we noted that it had been identified following an incident that increased levels of monitoring at night were required. We saw that the registered manager had carried out a night-time inspection shortly afterwards. Action plans had been created following each incident to account for the ways in which the risk of recurrence could be mitigated.

The staff we spoke with had received training to understanding safeguarding, and could describe the process they would follow if they had any concerns in relation to people's safety. They were able to describe ways in which they kept people using the service safe. One member of staff said, "People here are definitely safe, we always check their environment, check to see that the building is secure and make sure and follow their care plans."

Risk assessments had been completed which assessed the level of risk to people across different aspects of their care. For example we saw that assessments had been completed in areas such as tissue viability and

wound care, continence, falls and nutrition/hydration. Risk assessments were updated as people's needs changed, for example we saw that a change affecting somebody's mobility had been captured and assessed appropriately. For people who required support with moving and handling there were comprehensive risk assessments in place which detailed how they were to be supported to move. This included the type of equipment needed, the number of staff required and the instructions to follow to ensure that the person was moved safely.

Accidents and incidents were recorded in detail along with any remedial actions that needed to be taken in response to these and any accompanying investigation into the circumstances.

We observed the medicines round in the afternoon and noted that the correct hygiene procedures were being followed, and that staff were aware of the needs of each person. We looked through MAR (medicines administration record) charts for four people and found that these were completed correctly with no unexplained gaps. Medicines were stored safely in lockable trollies which were attached to the wall when not in use. The service kept stock records and audits of all medicines including controlled drugs. There was a robust process being followed to return excess medicines to the pharmacy as required, the staff were able to describe the steps they would take if a medicines error was made.

Each person had a personalised emergency evacuation plan in place which detailed the level of support that would need to be provided in case of emergency. There were robust contingency plans in place and there were regular fire, gas and electrical equipment checks carried out to ensure that the environment and appliances were safe for use. Regular health and safety checks were carried out across the environment to identify any issues relating to safety.

The service followed their recruitment policy to determine whether staff employed had the necessary skills and experience for their role. We looked at the staff files for four members of staff and found that each had verified employment references sought from previous employers. Each member of staff was asked to complete a health questionnaire and had completed a DBS (Disclosure and Barring Service) check. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

Requires Improvement

Is the service effective?

Our findings

We received mixed responses when we asked people about the quality of the food provided. One person said, "Food and drink is not brilliant, we should have more options." Another person said, "We get what's given and by the time it gets to this dining room it's nearly always cold. I could ask for something else but don't want to make a fuss." A third person said, "The food is mainly cold and the potato is lumpy, often the puddings are just cold ones like yogurts, mousses and ice cream." A relative said, "The food is atrocious and sometimes I must bring food in for [person] otherwise [they] would starve. Surely they must realise that with the amount of food they see on a regular basis left on people's plates."

One person expressed that while they had access to food and drinks, they weren't always offered much choice. They told us, "The food is adequate, not much choice. But I can't complain, they do their best considering. What I would say is that we are quite limited to tea and coffee, I would like to ask for one whenever I feel like one but to be fair they are short staffed so I go and get a glass of water whenever I want one." Another person said, "There's some choice for lunch but for dinner we just get whatever we're given." During our observations we noted that when tea was served at mid-morning, the staff member serving the tea told three people "that's all the biscuits I have, you can only have one each otherwise I will have to go back to the kitchen." During other times of day there were not always enough staff to consistently prompt people to eat and drink.

A member of staff said, "Breakfast and lunchtime is fine but the evening meal is a bit less inspiring, there's a lot of soup and I know you can't always have everything that everybody wants but I think there needs to be more thought put into what people like and what they would have eaten at home. It's not the cook's fault because [they] are working to a completely set menu."

We expressed people's concerns to the registered manager who showed us the menus used by the kitchen staff. Menus were operated on a four-weekly cycle and included a choice of vegetarian and meat options for lunch, followed by a more set menu for dinner. We saw that people's specific dietary requirements were taken into account, such as pureed diets or diabetes, and that adjustments were made accordingly. While this ensured that some of people's fundamental dietary needs were being met, the menus had not been formed with the individual preferences or choices of people using the service.

During our observations of mealtimes we noted that some people did not eat much food and that there was a significant amount of food disposed of at the end of lunchtime. People ate in different areas of the home including some who needed to eat in their rooms which meant that staff were stretched when attempting to meet everybody's needs at mealtime. Some food was served cold and some people were observed asleep with their heads down during lunchtime. Some meals were served when people did not have cutlery available to begin eating. The service completed their own dining experience audits which assessed the quality of the mealtime experience for people and the quality and quantity of food. Because the findings of these audits were largely positive, the registered manager expressed surprise at the findings of our inspection.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities Regulations).

People and relatives we spoke with felt that staff received the correct level of training to carry out their duties effectively. One person's relative said, "Yes I've been really happy with the staff, they're very skilled and the senior staff especially are very able. We have confidence that they're trained to a high level to meet people's needs." Another relative told us, "The staff are definitely very knowledgeable, there have been changes in staff but they seem to know what they're doing."

The staff we spoke with told us they received the correct training to be able to carry out their duties effectively. One member of staff said, "We do a lot of training, most of it is online but I'd say the quality is good. The end of life training we do has been invaluable when working with some people and understanding their needs towards the end." All staff completed training the provider considered essential as part of their induction, which included fire safety, food hygiene, moving and handling and infection control. There was also more specialised training available in areas such as person-centred care, dementia, understanding behaviours which challenge and skin integrity. Staff were able to access any of these training units at any time and encouraged to take responsibility for completing their own training when due for updates. We were shown a training matrix with demonstrated that the majority of the staff team had completed their training as required.

The staff we spoke with told us they received regular supervision and appraisal. One member of staff said, "I just had a supervision with [registered manager] and we have appraisals every year. I think we'll be having them every few weeks now or as we need them. I feel confident talking about things with [registered manager] and she does listen to our viewpoint." We saw a supervision matrix which showed that supervisions had been completed with all of the staff team recently, with more planned within the next few weeks.

Staff had received training and they understood the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS). 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some DoLS authorisations were in place while others had been applied for and were awaiting authorisation from the local authority. We saw that capacity assessments had been completed, best interest meetings held, and that the DoLS were appropriate for people's welfare and safety.

People's needs in relation to diet, hydration and nutrition were assessed and reviewed as part of the care planning process. We saw that each person had a completed Waterlow assessments, had their weight monitored regularly and had a completed MUST (malnutrition universal assessment tool) assessment. People's dietary needs and preferences were detailed in their care plans. We saw that where people had lost a significant amount of weight, the appropriate referrals had been made to healthcare professionals. Fluid and food intake forms were then introduced as required to monitor the situation.

People we spoke with told us they were supported to attend regular healthcare appointments. One person said, "I would say that I'm supported by staff to go to my hospital appointments which is not very often, and

yes, we see a chiropodist we have just had our feet done." If people had any specific healthcare needs then these were listed in their care plans and we saw that these conditions were monitored if required and reviewed when people's needs changed.

Requires Improvement

Is the service caring?

Our findings

During our observations around the service we found that staff demonstrated a caring, compassionate and patient approach to people, but were under significant pressure to complete tasks. We found that there was a negative impact upon some elements of people's care as a result. For example while the home was generally tidy, we noted that many of the people using the service did not always have clean clothes on and that staff did not have time to focus on their presentation. We observed one person accessing the outside courtyard without supervision and picking up cigarette butts to smoke from the floor. During lunchtime we noted dirty tablecloths and unclean jugs and glasses. While staff were kind in their interactions, the pressure to complete tasks meant that the atmosphere in the home was flat and staff did not always have time to focus on people's presentation.

We received poor feedback concerning the use of agency staff at night. One person said, "Sometimes at night I get a migraine and I have asked night staff for some tablets but they just say go and lay down it will go off, I have complained but nothing is done about it." Another person said, "I rang my bell because I could not raise my head, and the night carer came after 20 minutes. I told [them] I couldn't raise my head and [they] looked and said 'I haven't got time' and [they] left my room without plugging my remote lead in." A member of staff said, "Some of the agency staff we have at night don't have a clue about our [people], I can see from the [notes] they have documented that some of them are probably fabricated because I know these residents inside out. Some of the things they have said don't ring true to me."

Some of the people we spoke with were positive about the quality of care they received and their relationship with the care staff, although they were aware of staffing pressures. One person said, "I think I have good care and I get on well with most of the staff." Another person told us, "The staff in the day are kind to me some of them know me and my likes and dislikes but not all they're very short staffed at times." A third person said, "Staff are skilled in my opinion but rushed off their feet, but still give us love and affection." A relative said, "The care that [person] gets is good and I'm pleased that they are here. I think they've adapted to [person]'s needs over the years."

Some of the staff we spoke with were positive about the quality of care they provided, while others expressed concerns. One member of staff said, "I think we offer really good care here, everybody tries hard and we do our best for people." Another member of staff told us, "I think the [other care staff] are amazing and they really do the best they can do." However another member of staff we spoke with said, "Something dreadful is going to happen here if things are not changed around." Another member of staff told us, "I am very fond of the people in here and it upsets me to see how things are being run."

People we spoke with told us they were treated with dignity and respect by the staff who worked during the day. One person said, "The carers in the day are good they do their best and communicate nicely with me, I like knitting and they have been very good in supplying the wool for me." Another person said, "I can't complain this [member of staff] knows me well and knows my likes and dislikes, [they] are very kind."

Staff were also able to describe the ways in which they treated people with dignity and respect. One

member of staff said, "We'll keep an eye on people's needs throughout the day so we can anticipate what they might need. We give them privacy when we're helping them out with personal care and we make sure they have space when they need it." Another member of staff said, "I treat people how I'd want to be treated. Good manners, respect and knowing when to take a break and ask for help."

Some people were positive about the way in which the service allowed them to have their views heard and to develop their independence. One person said, "I can do most things for myself and they do promote me to do so. They do listen to me, for example I asked if I could have a key to my locker that is in my room because I am not happy to leave it open people wander in and out and they had no problem in giving me a key which made me happy." Another person said, "My preferences are to have my door closed at night and my curtains open. The senior carer who is on in the day has made that clear to the night staff now after one incident, but that was dealt with straight away. Just recently I have been thinking of becoming a Roman Catholic and one of the [staff] is Irish, [they] told me [they] will bring me a rosary bead and get it blessed that's very kind of [them]."

However others we spoke to did not feel that their choices and dignity was being promoted. One person said, "I was in my room and I like my curtains open at night. My TV was on and a night carer came in and switched my TV off, closed my curtains and told me to go to sleep. My room is my home and it's my choice when to go to sleep." One relative said, "I came here one day to find [person] upset; they said a male carer had washed [them] that morning without asking [their] permission. I asked staff why this had happened and they just said sorry, they were short staffed."

Requires Improvement

Is the service responsive?

Our findings

We received mixed responses when we asked if people had access to activities and were engaged and stimulated throughout the day. One person said, "There's usually something going on although I don't take part." Another person told us, "No, I am never asked what my preferences are. The activity co-ordinator said [they] might bring someone in to do exercises with me but I'm still waiting." A third person said, "I just walk around in circles most of the day. I have never been asked if I would like things done any differently; staff don't have time to talk." A relative said, "They could probably do with more things going on in there; [person] does [their] own thing."

There was an activity planner displayed on the wall on the first floor of the home, however this did not appear to correspond to the activities which were taking place each day and could have proved misleading to people. One member of staff said, "Some people do just seem to get left in bed all day. You see people just slumped in their chairs because there aren't enough staff." A visiting professional said, "It's disappointing to see people just sitting around dozing because there's nothing really going on."

During our inspection there was no structured activity taking place and people had little to stimulate them. There was an activities co-ordinator in post who usually worked Monday to Friday but was absent on the day of our inspection. One person we spoke with was particularly positive about the activity co-ordinator and said, "Since the new activity lady started she has really brought me out of my shell." However little consideration had been given to how to engage people in their absence, and there was little activities provision at weekends. The registered manager acknowledged this and told us she would consider how they could meet this need going forward.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence through people's care plans that they did enjoy a variety of activities including games, colouring, a range of therapies and visits from entertainers and musicians. People were given access to dementia-specific activities and some people regularly visited a local 'singing café'. Because of the higher needs of some people using the service it could be difficult to find appropriate means to keep them engaged, and we saw that this was reflected in their care plans. Things people enjoyed and hobbies which were meaningful to them had been assessed.

People had care plans which were detailed, person-centred and created with the involvement of people and their relatives. Prior to admission to the service a needs assessment was completed which was then used to create a more comprehensive care plan. Each person had a profile in place which included information like "what people like and admire about me" and "important things in my life". There were detailed backgrounds and social histories in place for people which included information about their family life, work history, places they had lived and what was important to them. This helped staff to develop a deeper understanding of the person and where they had come from.

Some people and relatives told us they were involved in care planning while others were not aware they had a care plan in place and did not feel involved. One person said, "They go through it with me every so often." A relative said, "We get phone calls every three months to ask if we're happy." Another relative we spoke with had a meeting planned to review their family member's care plan and had been asked to contribute views and ideas. Each person's care plan included a 'record of involvement' which detailed the contact made with people and relatives to inform them of changes and ask for their input.

The service carried out an analysis of all falls within the home to identify trends or patterns of concern in relation to particular people. This helped to recognise any changes in mobility or mental health and enabled the service to be responsive to people's changing needs over time. We also noted that falls awareness meetings were held every three months to remind staff of the importance of taking appropriate action in response to falls within the home.

People we spoke with told us they would be confident making a complaint if necessary. One person said, "I've never complained but I would speak to [registered manager] if necessary." Another person said, "I would go to [senior carer] with any complaints." The registered manager was able to show us the system for handling complaints and how she would manage them in future in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who had commenced their role two months prior to our inspection and was still developing into their role. The people and relatives we spoke with knew who the manager was and were complimentary about her. We found that the registered manager was knowledgeable and caring but would have benefitted from further input from the provider during her induction period. Because she had inherited the service at a time where a number of incidents had taken place, this had compromised the time she had available to acclimatise to her role. The registered manager said she was happy to ask for guidance. When she was asked if she'd received adequate support through her induction she said, "I could have had more [help]. But when they're here [visiting the home] they're really supportive and I can call if I need anything."

We saw that while some complaints had been received by the service, it was not always clear how these were being resolved. The previous manager who had received these complaints had since left and we were unable to see evidence of how each complaint had been managed or resolved.

The quality monitoring systems in place had not been effective in managing people's safety by ensuring the provision of enough staff. The care plans were person centred but the care provided and the hobbies and activities that were on offer to people did not always meet people's assessed needs; and this resulted in them spending time alone in their room or sleeping in the armchairs in the lounge. People were not always able to exercise choice for example in the meals they wished to eat or in the choices of when they chose to rise or go to bed. Our observations on the day and speaking with people and staff enabled us to evidence that the management systems in place were either ineffective in identifying these issues or were being ineffectively implemented.

The failure to identify some of the shortfalls in the service and identify improvements that needed to be made was a breach of Regulation 17 of the Health and Social Care Act 2008.

The registered manager completed a 'daily walk around' to audit different elements of the service including infection control, observations of practice and feedback from people. This enabled her to quickly identify any pressing areas for improvement and take prompt action to resolve them. In addition to these daily audits the provider also completed a two-monthly home visit to audit the whole service, including staffing, safeguarding and the environment. We noted that this was then used to create an action plan with remedial actions and timescales, and that these were being resolved promptly. For example we saw that each of the maintenance queries that had been raised within the audits had since been completed.

Most of the staff we spoke with were positive about the support provided by the registered manager, although we received mixed feedback from others. One member of staff said, "I think things are better since [registered manager] came in, although it's always going to be difficult getting everyone on board." Another member of staff said, "The new manager is doing a wonderful job, she's backing the staff and helping us out as much as she can, doing what she can to support us all. There's been so many things happen recently but she's been out on the floor and her door is always open." A third member of staff said, "I think now we've got

a new manager the leadership is stronger. She's a breath of fresh air and she knows her stuff. She does take time out to talk to residents and staff even though she's busy."

However other staff remained unsure as to the aptitude of the registered manager. One member of staff said, "I think we needed somebody with more experience. I think if she gets enough help and support then she'll be fine; she is knowledgeable and caring but sometimes forgetful because she's taken so much on at once." Another member of staff said, "I worry that she's more concerned with her registration than the residents and there's a lack of experience there."

The registered manager said, "I want to help the staff to develop as much as possible, and I want us to feel like a team and like people can come to me with anything." The manager had started to hold a 'manager's surgery' each Friday morning where staff had the opportunity to share their views and contribute to the service. She had identified the areas which were in need of further improvement. She said, "I know some of the documentation needs to improve and the quality of notes. I'm trying to spend as much time with the staff as possible to give them guidance."

Staff were able to contribute to the development of the service through team meetings, which provided them with an opportunity to share views and provide feedback. We saw that team minutes were taking place every two months and items discussed included training, key worker roles and care planning for people. In addition to these the manager held a daily 'flash' meeting which provided staff with the opportunity to share issues on a daily basis with the registered manager.

We saw that satisfaction questionnaires were sent to people and their relatives but that a formal survey had not been carried out since March 2014. A staff survey had been completed in June 2015 and staff were asked to answer questions such as "residents are encouraged to contribute to the running of the home" and "I am proud to work at the home." A report had then been published to collate the responses and identify areas for improvement. We raised with the registered manager that no surveys had been completed since these dates and she told us this had been raised with the provider, who were responsible for generating the surveys and collecting the results. Following the inspection we were informed that fresh surveys would be taking place immediately.