Winifred Healthcare Limited

Winifred Dell Care Centre

Inspection report

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Date of inspection visit:
02 May 2016

Date of publication:
29 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 3 May 2016 and was unannounced.

Winifred Dell Care Centre provides accommodation and personal care for up to 76 older people who may also have dementia. Care is provided in four units over two floors. At the time of our visit there were 70 people living in the service. The service does not provide nursing care.

A registered manager was in post at the service. 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 a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not always minimise risk for people who were at risk of falls. Staff did not always analyse the reason why people fell or make necessary changes to the support being provided in order to keep people safe. You can see what action we told the registered person to take at the end of the full version of this report.

Whilst there was adequate staffing in some of the units, staffing on other units was insufficient to meet people's needs. In particular, where people with complex needs were visiting for a short term stay, staffing levels were not always increased as required.

The provider had systems in place to check the quality of the service, however these were not being used effectively to minimise risk and highlight areas of concern in the support people were receiving.

There was an open culture where people and staff felt able to express their views. Staff were enthusiastic about their work.

People were protected from the risk of abuse. There were appropriate arrangements in place for medication to be stored and administered safely.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. People were enabled to make their own decisions about the service they received. Staff followed processes in place to ensure decisions were made in people's best interest, involving family and outside professionals as appropriate.

People's nutritional needs were well met. Alternatives were offered where required, and drinks and snacks were available throughout the day. People's food and liquid intake was recorded and monitored.

People were supported to maintain good health and wellbeing and to access relevant health and social care professionals.

People were treated with kindness, dignity and respect by staff who knew them well. People knew who to complain to and the manager responded to people's concerns.

Care plans and risk assessments were person centred and provided guidance for staff about how best to work with people to meet their needs. Staff supported people to lead meaningful lives and to maintain links with the outside community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always look into why people were falling and put measures in place to minimise the risks to their safety.

Staff were recruited safely. However, there were not always enough staff to meet people's needs, in particular staffing was not always adjusted when people visited the service on short stays.

Staff knew what to do to protect people from abuse.

Is the service effective?

Good

The service was effective

Staff were supported to develop skills to meet people's needs.

People were enabled to make their own choices where they had capacity. Decisions made on people's behalf were done in their best interest.

People were supported to have a balanced diet and staff were skilled at minimising risk or malnutrition and dehydration.

Staff worked with other professionals to promote people's good health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff focussed on people as individuals and treated them with kindness and compassion.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Support was personalised around individual needs.

Staff were enthusiastic about enabling people to have meaningful lives both in the service and outside in the local community.

People knew who to speak to if they had any concerns and were assured of a personalised response from the manager of the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to check the quality of the service and obtain people's views however these did not always highlight areas of concern in the support people were receiving.

The registered manager and senior staff were visible and created an open culture where staff and people felt supported and listened to.

Winifred Dell Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 7 May 2016 and was unannounced.

The inspection team consisted of two inspectors 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.

Before the inspection 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 included in the PIR along with other information we held about the service. This included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. We met with the registered manager, deputy manager and the provider's head of care. We spoke with 11 members of care staff, 12 residents and four family members. We also spoke with two health and social care professional to find out their views on the service.

We reviewed a range of documents and records including the care records for people who used the service. We also looked at three staff files and documents relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service. A family member told us, "The family know [person] is in a safe place…it's so nice to know they are being looked after well." However, whilst many family members were positive about the service received, prior to our inspection we had feedback from some family members raising concerns about the safety of their relatives.

Staff did not always manage effectively the risks to people who had fallen a number of times. We saw in three people's care plans that where people had fallen, staff had not taken appropriate action to minimise the risk to this happening again. For example, one person had fallen six times in the last six months; however, there was no change to their care plan in response to the falls. There was no mobility risk assessment in place and they had not been referred to the falls clinic or to other professionals, such as physiotherapy or occupational therapy. Similarly, another person had fallen three times in the last six months and there was not a clear plan to assess whether any measures could help minimise risk of injury from falls.

There were systems in place to record in detail where people had fallen, however we did not feel the manager and staff analysed and addressed sufficiently why falls were happening. Whilst risks for some people were managed well, this was not consistent across the service and people could not be assured that their risks were being managed safely.

We observed a third person being hoisted into a chair and felt the member of staff had failed to carry out this transfer safely or to provide the necessary reassurance to the person being hoisted. An early assessment carried out by staff stated the person could not weight bear. However, the standing hoist which we observed being used to support the person should only be used when a person can weight bear. The manager told us that the person could weight bear but the records had not been amended to show this and we felt the member of staff had not had the necessary information and skills in place to carry out a safe transfer. When we looked in this person's care plan we noted that they had fallen 13 times in the past year. There were no significant changes to the care plan or risk assessment in response to the falls, for example, there were no referrals to professionals. In addition, the chair the person was transferred into was very low and they could not get up from it. It was not clear why this chair was being used, rather than a raised chair which would be a less restrictive option. We fed back our concerns to the manager to enable them to ensure the member of staff had the necessary guidance and information to carry out a safe and less restrictive transfer.

People were not being protected consistently from the risk of falling. This was a breach of Regulation 12 (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that every resident in the home had a moving and handling risk assessment as well as a falls risk assessment, and that every fall in the home was referred to GP for necessary action. We were advised that the policies and systems in place were sufficiently detailed to support staff in completing actions. We felt however that whilst there were systems in place, these were not being consistently implemented.

Despite these concerns regarding the management of falls, we also observed good practice during out visit. For example we spoke to staff who had a good level of knowledge regarding minimising risk and a number of people had been referred to the falls clinic, for additional support in managing the risk of falls. Some people had equipment to help them keep safe, for example we noted that staff had placed a crash mat next to a person's bed, where they were at risk of falling out of bed. A member of staff was aware of how to support a person who was at risk of falls. They told us, "[Person] needs reminding to use the buzzer. They had a fall once trying to close the window. Now we make sure the window is closed after the cleaners have been so that [person] will have no reason to go and try to close them. We explain the risks to [person] and explain that if they get up too quickly they will get dizzy."

The manager showed us the system in place to assess and highlight risk levels across the service, for example, a person requiring night time care was rated as 'amber'. The manager told us this enabled them to deploy staff effectively throughout the service and manage risk more effectively. They explained staffing was decided based on people's needs and how much input was required from staffing.

On the day of our visit to the service we observed that there were enough staff to meet people's needs. For example, we observed that people's buzzers were responded to in a timely manner and where people had planned hospital visits the manager tried to provide a member of staff to accompany them, where appropriate. We also noted that the manager had arranged for additional resources to enable a group of residents to attend a tea dance outside of the service on the afternoon of our visit. We felt however that in some units, in particular where people were only staying at the service for a short time, staffing levels had not been adapted to recognise the additional pressures on staff time.

The manager told us that where units only had two members of staff on duty they made sure there was no one on that unit who required support from more than one member of staff, such as for hoisting. Staff confirmed that generally this was the case but that there were particular difficulties when people with more complex needs were on short-term visits to the service, and additional staffing was not planned in advance. Staff told us that assessments of need for people coming on short stays did not always take into account the needs of the whole unit, in particular the support they needed to provide to people who could get upset or agitated. Staff said there was not always a member of staff available to calm situations down and reassure people if a person was receiving assistance from the two members of staff on duty. We discussed this with a health professional who told us, "Some people just need a member of staff to sit with them for a bit. The service does not always flex up to the needs of the people." Managers and staff told us when staffing was short on one unit staff would call on another unit to assist.

Whilst the manager did not always assess and plan effectively for the staffing needs of people visiting the units, we noted an open culture in relation to staff highlighting issues with staffing. Staff felt able to express their concerns to the manager and we could see that the manager listened. For example, the manager had requested a re-assessment of a person's needs when a member of staff said they were struggling to cope with the staffing on duty. The manager also told us they worked closely to support staff on the unit by transferring people who required additional support to other units with more staff.

Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Where people were assessed as being vulnerable to abuse there was guidance in place and staff recorded any changes in behaviour or injuries so that these could be monitored over time. Staff explained how they might recognise possible abuse where people were not able to communicate verbally, for example through observing changes in mood. Staff said they felt confident raising concerns about a person's safety. We saw examples where staff had raised an issue with the manager when they felt a person was at risk from poor care. Our records showed that the manager was aware of their responsibilities with regards to keeping

people safe, and reported concerns appropriately to the relevant authorities.
Risks were managed well within the property and environment. There were evacuation procedures in place with plans for each person should they need to be supported to leave the building in an emergency. Adjustments had been made to the property in response to risk assessments, for example window restrictors had been fitted throughout the property.

The provider had a safe system in place for the recruitment and selection of staff. Staff were recruited with the right skills and experience to work at the service. Staff told us that they had only started working at the service once all the relevant checks had been completed. We looked at recruitment files for three staff and saw that references and criminal records checks had been undertaken and the organisation's recruitment processes had been followed. On the day of our inspection we were told there were no agency care staff in place, which the manager explained enabled a more consistent level of care to be provided.

People received their medicines safely and as prescribed from appropriately trained staff. Staff told us they had only started administering medicines after receiving training, and they received annual medication competency checks from both the dispensing pharmacy and from their registered manager. The member of staff responsible for administering medicines wore a distinctive uniform to help prevent them being disturbed and therefore minimising the potential for errors.

Records of people's medicines were completed appropriately and we noted that they were accurate and legible. We saw that there was a protocol for medicines in place for each person, and these were tailored to their personal needs, for example where a person was going out for the day the member of staff had supported them to continue taking their medicines safely. When people had been prescribed medicines on an as required basis, for example for pain relief, there were protocols in place for staff to follow so that they understood when a person may require this medicine. Medication risk assessments reviewed monthly or sooner if something changed for people. We noted that where a person did not have capacity to take their medicines independently but would attempt to do so, there were the necessary measures in place to protect them.

Medicines were stored in a locked trolley and storage room and the member of staff was able to clearly explain the medication signing in and out procedure. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately.

Good

Is the service effective?

Our findings

Family members told us staff had the skills to support their relatives. A family member told us, "They look after [person] very well, and it's a very nice place."

Staff said they felt they were supported, for example a member of staff told us they had monthly supervision with a senior carer where they can talk through things. They explained that the same senior worked alongside care staff and carried out manual handling competency checks whilst working. We saw that the manager had ensured that observations took place to test people's competency. One member of staff told us they felt the supervision meetings were a bit of a "tick-box" exercise. However, we felt that throughout the day there were opportunities for informal supervision and sharing of information, support and guidance.

New staff received an induction before starting work. A member of staff told us that they had felt well prepared to provide support as they had had a three day induction, which included shadowing senior people. Staff told us they were supported to develop their skills through a mixture of practical and computer based training. They told us they preferred the practical training, for example manual handling training, one member of staff told us, "E learning is a bit of a cop-out." The organisation had a computerised system to track staff's training and support the manager in ensuring staff had the necessary skills to meet people's needs.

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).

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. Applications had been made to the appropriate professionals for assessment when people lacked capacity and needed constant supervision to keep them safe. Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance. They demonstrated an understanding of capacity and of giving people choice. We observed staff offering choice to the people at the service, for example about what to wear each day. In addition, we observed that staff sought peoples' consent before providing care. One member of staff told us, "I show [person] pictures, give choices, I put myself in their position. We always ask, we think about what is in a person's best interests and try to explain what is happening. If people don't want to consent to something we go away and come back later. We look at their mood."

Where decisions were made on people's behalf, staff had consulted with professionals and families to

ensure decisions were made in the person's best interest. There were forms in place for some people, which directed staff not to resuscitate them. We noted that where these involved people who did not have capacity to make this decision, the manager had ensured that the necessary capacity assessment and best interest decisions had been carried out by the relevant professionals.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We noted the manager had applied to the relevant authority for DoLS authorisation where people needed to be restricted from leaving the property independently for their safety.

We observed mealtimes and saw that the atmosphere in the dining room was calm and unhurried. People sat in friendship groups and there was laughter and chatting in the dining room. Staff were observant and helpful. They ate meals with people and chatted with them, informally encouraging them to eat and join in conversations. We observed that when a person said they had had enough to drink a member of staff encouraged them by saying, "Let's put a bit more in your cup as it will make you poorly if not."

When we arrived for our inspection we were told the permanent chef was no longer employed and the agency chef had not turned up. We felt the manager had coped very well with ensuring there was a choice of meals for everyone. We were told that recruitment was underway to appoint a new chef.

People were supported to have sufficient to eat, drink and maintain a balanced diet. One person told us, "The food is great. Breakfast can be whatever you like, full English and cereal, you can have it in your room if you like." We observed lunchtime in three different dining rooms. Staff were courteous and attentive, however we noted they did not use pictures when offering choice which would have assisted people with dementia to make a decision about what to eat. People told us they ordered meals the day before but often forgot what they had ordered. However, we saw that if they changed their mind they could have something different. Staff knew peoples preferences for example, where people did not like the choices on offer of fish or hotpot, staff knew to offer them an alternative, such as beans on toast or an omelette. A member of staff knew that a certain type of food exacerbated a person's health condition and ensured this was avoided. There was ample food on offer; we saw that where people cleared their plates, staff offered them 'seconds'. One person joked, "The food is good, but there's too much of it. I have a full English breakfast around 9.30, then they come with lunch at 1pm."

People's nutritional requirements were assessed and recorded to highlight risk of malnutrition and dehydration. We spoke with a member of staff who could describe exactly who had eaten what for breakfast and showed us how they recorded this information electronically so that people's intake could be monitored. We saw that where a person was at risk a dietician was involved, staff followed instructions and completed food charts, monitored weight and provided a fortified diet. We observed staff supporting a person who was at risk of malnutrition by encouraging them to eat by offering all their favourite food. They were eventually supported to accept their favourite cereal. We looked the care plan and saw staff had followed the guidance outlined. We felt this demonstrated a skilled approach to sensitively ensuring a person's wellbeing.

Where required, people had specialist equipment to help them eat. Staff were able to adapt flexibly to people's needs. We observed a member of staff swapping the spoon a person was using to support them to be able to feed themselves. Staff were aware of the risk of a person choking. A member of staff gave us an example, "We always give pureed food to [person], and give them time to swallow. [Person] needs to be sat upright".

There were plentiful and varied drinks available throughout the day. A member of staff knew the levels of

fluids they were supporting a person to drink to minimise the risk of them developing urinary tract infection.

People were supported to maintain good health. Where people had specific health needs there were details in their care plans on how best to support them. Ongoing health needs were met and people were supported to access healthcare professionals and specialists according to their specific needs. We spoke with a health professional who told us staff at the service were very open and responsive to advice. On occasion they felt there were some delays in raising concerns with relevant professionals, but we also saw good examples in peoples care plans showing where specialist help had been sought. For example, one person who had complex needs had input from a wide variety of professionals including an audiologist, chiropodist, GP and district nurse.

Staff also supported people with maintaining their good mental health. We saw an example where a distressed person had been referred to their GP and social worker to support staff to manage a complex situation and better meet their needs. This resulted in a review of the care plan by the social worker and a visit from the GP to review the medication the person was on.

Good

Is the service caring?

Our findings

People told us staff were caring, one person commented, "The carers are all lovely here – they're very nice to me," and another person said, "The carers are really all pleasant but I choose to be as independent as possible, and they know that and leave me alone – you see, I don't mix very well, so I like to be on my own." We observed that staff looked out for people. For example, a person was sitting in the lounge reading a book. A member of staff told us, "[Person] likes to sit and read with a cup of tea," and went off to get a cup of tea for them.

Staff knew people well and could tell us about their families, interests and personal histories. A member of staff described a person she supported with warmth and honesty, "[Person] has a dry personality, they can be changeable and outspoken. If they are upset they like a hug and a chat to cheer up." We felt that despite some pressures on staff numbers, staff prioritised spending time with people where possible. They told us "We like chatting with residents and getting to know them well" and "We have time to sit and chat with people and this is important especially when they don't have family."

Staff knew how to support people who were anxious or unhappy. We observed that when a person became distressed the member of staff knew what to say to re-assure them. Another staff member spoke about how they have learnt to recognise the triggers people with dementia might show to express their frustration and how to de-escalate situations. She said, "I've worked out the best thing to do is sit with [person], hold their hand, they get out of breath when they are upset, but this calms [person]."

We observed positive and compassionate interactions. For example, we saw that when a person didn't hear their name being called out the member of staff went across to them and touched them gently on the arm to get their attention. We observed a member of staff encouraging a person to walk to the dining room by using positive language and saw they had a laugh together as they walked along, chatting all the way. When we passed a room we could hear a member of staff inside talking in a very friendly and warm manner to a person about their family who had been to visit them. When we looked inside we saw the member of staff was supporting the person with eating and drinking. We felt this was a very positive interaction and demonstrated a focus on the individual being supported rather than the task being carried out. When we spoke with the member of staff, they were warm and affectionate about the person, "[Person] likes company and loves to chat. We speak about their family and I reassure them that they are coming to visit."

People's privacy and dignity was maintained. A member of staff was able to describe how they maintained people's dignity when supporting them with personal care, for example making sure doors were closed and towels used to protect people's modesty. We observed a member of staff returning washed clothes to people's rooms and saw that they knocked and called out to let people know they were coming in. Confidentiality was maintained, for example people's records were kept in a locked room.

Good

Is the service responsive?

Our findings

People were positive about living at the service and about the support provided by the staff. One person told us, "Sometimes I sit outside in the gardens which I like doing." We observed staff made an effort to create a stimulating and enjoyable environment, which people were free to take part in. A person told us, "I'm very content here – I prefer my own company really, and I won't join in the singing, it's not for me. The staff are nice, and treat me very well, although I don't need much help."

People's care needs had been fully assessed before moving into the service. The care plans we reviewed outlined each person's needs and were individually personalised. For example one person's records said, "[Person] would like their door opened at night, with the light left on." Another person's plan said that if they became distressed, for example when being offered personal care, then staff should leave them for a short period of time before returning to offer the support again.

Care records were computerised, which staff told us worked well. When monitoring and recording people's wellbeing, such as their daily fluid and dietary intake, staff inputting on the computer could select from a number of options, for example, "[Person] ate well and was cheerful." Whilst initially this seemed quite impersonal, it meant each person's care plan contained the required level of detail and it was straightforward to monitor changes over time. People's care plans reflected what we saw happening in practice. Care plans had up to date risk assessments and detailed information about people's health and social care needs. We noted that people were included in planning their care. Regular reviews took place and where appropriate people's family were invited.

We were told that one person was chosen as 'resident of the day' on each unit. During our visit we saw it used as an opportunity to offer people a meal of their choice, to make sure their records were up to date and their rooms had a deep clean. We felt this was a positive approach, and when asked, all care and domestic staff knew who the resident of the day was. The member of domestic staff we spoke to was able to describe what the person's needs were, for example, how they managed the deep clean with a person who did not want to leave their room.

We felt there was a focus on ensuring positive and appealing activities were on offer. One member of staff told us, "We do see people with dementia more engaged with the group activities - the more capable residents tend to be more reserved." We felt that there had been an effort to create opportunities for people who did not like to join in group activities, and staff told us that when staffing levels allowed it, they spent 1:1 time with people, developing their personal interests. We were told by managers that volunteers also visited the service to spend time with people, for example to help people who wanted to do some gardening.

Winidell Choir, the home choir, met every Tuesday morning and we were able to observe around 20 people attend the activity, supported by a number of staff and volunteers. We saw singing, clapping, instrument playing and laughter. The staff estimated that around over half of the residents attending had dementia and we felt this was a very positive experience for all involved. We were told the choir had their first concert last summer involving friends, families, local press and neighbours. In addition to the choir, other activities were

arranged throughout the week, for example, 13 residents went out on the afternoon of our inspection to a tea dance which offered the opportunity to forge links with the local community. The variety of activities on offer did mean most people found something to get involved in. One person said, "I get invited to all the activities but I like to keep myself to myself really, but I am going out to the tea dance this afternoon."

A staff member told us they had made an aviary in the garden which people enjoyed, and one person said, "I do enjoy going down to see the little birds – they have lovely colours – I go down very often". There was a pleasant garden which we saw in use. A shed had been turned into "The Great Escape" and was decorated with old tools and newspapers, door knockers, fishing rods, a radio, gardening books and a dart board. During the inspection we didn't see anybody use it, despite the mild weather and felt that with the available staffing on duty, it could only be used with ease by more able people and people with families and friends who could take them there. However, we felt this was a pleasant place to relax and well designed for people with dementia or those who may have had a similar shed in the past.

The deputy manager showed us a copy of "The Daily Sparkle" which the service bought in for people to read. This was a reminiscence newspaper designed to promote stimulation and reading material to people in care homes, with articles such as "The way we were." We were told us it was also intended for use by staff to promote conversation with the people they cared for. We saw the 'Daily Sparkle' in resident's rooms and in the lounge. The activities coordinator told us, "We hand it out to the more capable residents and we read it out in the lounge for residents."

We felt the reception to the home was welcoming, with sofas and photos and information on display showing what was going on. Visitors were made welcome and the general décor of the service was airy and there was a large seaside mural and other ornaments which provided stimulation and opportunities for reminiscence.

The provider had a policy in place for responding to concerns and complaints. People and their families told us that they felt comfortable raising concerns and giving feedback. People had access to the complaints policy, for example it was displayed in the reception and on the wall of in the lift. Complaints were rated to ensure that the complainant received a proportionate response, for example some families would prefer a verbal answer if they raised a minor concern, whilst other families would expect a written letter if the concerns raised were more serious. Managers also logged where a complaint had resulted in a safeguarding investigation to ensure the correct procedure had been followed. We saw from the log of complaints that this proportionate approach had been applied to the complaints received.

Requires Improvement

Is the service well-led?

Our findings

Throughout the inspection, staff were welcoming and open in coming up and talking with us. We had positive feedback regarding the manager and deputy manager of the service, for example one member of staff told us, "This is a lovely place to work. The management are very supportive and approachable." Despite this positive feedback, our findings highlighted that the systems in place to check the quality of the service had failed to pick up some of the concerns we had found. Incidents, such as falls, were reported on and dealt with immediately, however systems aimed at minimising risk further were not always effective.

The provider had a number of regular audits which were wide ranging and were carried out by the registered manager and by the provider. A weekly care audit was carried out to determine levels of risk and need within the service, such as nutrition, hydration, safeguarding, infections, and falls. The manager attended a monthly meeting with their director where they reported on issues relating to the quality of care and finances of the service. For example, this included whether any people had pressure ulcers or whether they were losing weight, and how this was being dealt with.

We felt that whilst the manager reported incidents and concerns to the provider there was scope to improve the collection and analysis of information gathered during the quality checks. For example, the checks carried out by the manager and provider had not picked up the gaps in support for some of the people who had fallen a number of times. Care plans outlining the support people received were audited regularly, yet recent audits had assessed that care plans met the required standard. The checks had not highlighted the people who had not had the necessary referrals or where plans and advice to staff had not been updated following falls. Likewise, we looked at the records for checking staff competence and found the forms were not completed in any depth and this process was not being used effectively to highlight gaps in skills. This meant it was difficult for the manager to analyse gaps in knowledge and skills across the service and to drive improvements over time.

Despite this, the manager demonstrated they were committed to resolving issues of poor practice. On two occasions staff members were investigated when the manager had received feedback about the quality of the support they were providing, for example where a member of staff had not provided the appropriate care to someone with a specific condition. We saw the manager had been thorough about investigating the concerns and had dealt appropriately with the member of staff.

The manager promoted an open culture in the service. They ensured staff communicated well with each other and the management team. There were daily meetings between the manager or their deputy and the head of each unit. The manager reported to the provider's head office after these meetings. On the day before our inspection they had discussed a number of medication errors which had occurred. The member of staff involved had received immediate supervision to discuss the concerns and arrangements had been made for them to receive additional training. We felt that this was pro-active response which was aimed at resolving issues of concern swiftly and effectively. There were opportunities to handover information throughout the day, which ensured staff knew what people's care needs were. This promoted a consistency in the support people were receiving. A staff member told us, "I do like working here. There's a staff meeting

everyday where we can bring things up. I do feel supported by the manager, they get things done."

In our discussions with the manager we felt they were committed to their role and took pride in their service. They told us that they had been distressed when the kitchens had failed a Food Hygiene inspection earlier in the year and we saw they dealt swiftly with the issues raised. This was recognised in the follow-up inspection, when the report stated the concerns had been resolved and there had been, "A fantastic response noted to review food safety management and associated systems."

The manager encouraged an open culture where people and their families were supported to speak out about their concerns. The manager held meetings with residents and their relatives and we saw from the records that these were open and informative. For example, subjects discussed ranged from a relative reminding staff about their family member's food preferences to an explanation from the manager about staffing changes.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not being protected consistently from the risk of falling.