Barchester Healthcare Homes Limited

Wykeham House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection was carried out on 12 October 2017. Wykeham House is a purpose built care home providing nursing and residential care for up to 76 older people, some of whom are living with dementia. The service is separated into four units; two of the units are for people living with early to late dementia and the other two units are for people with greater nursing needs. At the time of our inspection there were 49 people were living at the service.

On this inspection we were following up on concerns that related to a lack of governance, a lack of supervision of staff, a lack of safe care and treatment, people not always being treated with dignity and respect, a lack of meaningful activities and that complaints were not always investigated. We found significant improvements in all of these areas.

Although there was no registered manager in post a new manager had started at the service and had submitted their applications. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 were appropriate plans in place to ensure that risks to people were managed. Staff understood what to do to minimise risks in relation to people. Emergency evacuation plans were in place and staff understood what to do if an emergency occurred at the service. Where people had accidents and incidents actions were taken to reduce this risk of them reoccurring.

People told us that they felt safe with staff. Staff had received training in safeguarding people from abuse and they had a good knowledge of what they needed to do if they suspected abuse. Staff at the service had robust recruitment undertaken before they started work.

Although people and staff told us at times there were not enough staff this did not impact on care. The Provider assured us that staff levels were going to be maintained to ensure that people's needs were met in a safe way. Other people and staff felt there were sufficient staff levels in other areas of the service and we confirmed this with our observations.

People understood the reason and purpose of the medicines they were given. The management of medicines was safe by staff who had the appropriate training.

People and relatives felt that staff were competent in their role. Staff received appropriate training and supervision and staff felt supported.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate assessments had been completed where

people's capacity was in doubt and applications to the Local Authority were submitted if people were being restricted in their best interest.

People enjoyed the meals at the service and said they had sufficient choices. People's health care needs were monitored included weight loss and any changes in their health. People had access to appropriate health care professionals where needed.

People and their relatives told us that staff were kind and caring and treated people in respectful and dignified way. This was confirmed through our observations. People had choices around their care and felt involved in their care planning. Relatives and friends were welcomed at the service to visit people. People and their relatives were given support when making decisions about their preferences for end of life care.

People had a range of activities that they could be involved in and trips out were arranged for people. People that were socially isolated in their rooms had one to one activities arranged for them.

Care plans were detailed and included specific guidance for staff to ensure that people's needs were met. Staff communicated changes to each other about any changes in people's care.

Complaints were investigated, recorded and responded to appropriately.

People and staff felt the management of the service had improved significantly. Staff said they felt more empowered and valued. We could see that they staff team worked well together and that staff enjoyed working there.

There were effective systems in place to assess the quality of care and to make improvements. This included audits, meetings and surveys where feedback was sought. Improvements were made as a result of this. The manager had informed the CQC of significant events including incidents and accidents and safeguarding notifications.

We could not improve the rating for well-led from inadequate to good because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Appropriate plans were in place to assess and manage risks to people. In an emergency staff understood what they needed to do.

People were protected against the risk of abuse and neglect. Staff understood they needed to do to protect people.

There were sufficient staff at the service to support people's needs.

Medicines were stored, administered and disposed of safely.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

Is the service effective?

Good

The service was effective.

People's care and support promoted their well-being in accordance with their needs.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their health.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was in line with appropriate guidelines.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service caring.

Staff treated people with compassion, kindness, dignity and respect. People who were at the end of their lives received appropriate care.

People's privacy were respected and promoted.

Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed when they entered the service and on a continuous basis. Information regarding people's treatment, care and support was reviewed regularly and shared with staff.

People had access to activities and people were protected from social isolation. There were a range of activities available within the service.

People were encouraged to voice their concerns or complaints. Complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was well led.

There were systems in place to regularly assess and monitor the quality of the service the service provided. The provider had met the breaches in regulation from the previous inspection.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

Staff were encouraged to contribute to the improvement of the service and staff felt valued.

The management and leadership of the service were described as good and very supportive.

Appropriate notifications were sent to the CQC.

We could not improve the rating for Well-led from 'inadequate' to 'good' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Wykeham 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.

On this inspection we were following up on concerns that related to the lack of governance, the lack of supervision of staff, the lack of safe care and treatment, that people were not always treated with dignity and respect, the lack of meaningful activities and that complaints were not always investigated. We found significant improvements in all of these areas.

This was an unannounced inspection which took place on 12 October 2017. The inspection team consisted of four inspectors (one of whom had a nursing background) and an expert by experience in care for older people (an expert by experience is a person who has personal experience of using or caring for someone who uses this type of service).

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion we did not ask the Provider to complete 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 did not ask them to send in a PIR as we were following up on concerns from the previous inspection. In addition we reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

During the visit we spoke with the manager (and other senior members of the management team) 12 people, five visitors, 11 members of staff and a health care professional. We looked at a sample of 13 care records of people who used the service, medicine administration records, training and supervision records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings, complaints records and audits of the service.

The last inspection was on 6 April 2017 where breaches of the regulations were identified.

Good

Is the service safe?

Our findings

We asked people whether they felt safe at the service. One person told us, "I feel safe. I don't even close my door at night. There is always someone around." Another person said, "They [staff] keep you safe. I know because I am quite capable and used to wander but there was always someone [staff] in tow. It is in their blood to care for you and keep you safe." A third told us, "The Carers are lovely people. They keep us safe."

On the previous inspections in April 2017 we had identified a breach of regulation that related to the safe care and treatment of people. Risks assessments were not always undertaken and people did not always have access to their call bells. We found on this inspection that this had improved and the breach had been met.

People told us that they felt staff understand the risks to their safety and was managed well. One person said, "I feel safe. You can't fall out of bed, It is against the wall and there is a rail as well. I used to fall out of bed when I was at home." Another told us, "They have fire alarms and we are told to stay in our rooms until someone comes. The door closes on its own and the ones in the corridors as well."

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. There were up to date and relevant risk assessments in place, particularly around contributing factors such as nutrition, skin integrity and mobility. For example, one person had developed a pressure sore whilst living at the service. Staff had referred the person to the Tissue Viability Nurse (TVN) for assessment and guidance. Staff followed advice and the treatment plan given by the TVN. There were body maps, photographs and skin integrity risk assessments in place so that staff could monitor the wound. Other risks assessed included falls and the use of bed rails. There were manual handling assessments and falls prevention strategies. We observed staff using hoists to move people which was done safely and effectively. There were bed rails risk assessments in place for those that required them. For those people that were unable to use call bells there were regular room checks in place to check on them. Others that were able to use them always had their calls bells by their side. One member of staff said, "I help to keep people safe because I make sure they have their call bells to hand."

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. One member of staff said, "If someone fell I would get help. I would call an ambulance if needed." When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. For example one person had fallen recently. Their medication was reviewed by the GP and reduced. Since then the person had not fallen. Another person fell from their bed and as a result their bed was lowered to reduce the risk of injury.

The premises were purpose built and as such did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP) in place for each person, which outlined how the person could be removed or kept safe in the event of an emergency, such as fire or flood. The level of difficulty and the number of staff required to do this had also been calculated. One member of staff said, "If the alarm goes off we stay where we are and reassure people. The

nurse will go and find out what is going on and tell us what we need to do." They showed me where the evacuation point was. They added they could evacuate, "Corridor by corridor." There was a service contingency plan in place in the event that the service needed to be evacuated.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One member of staff said, "I would report my concerns to the manager. We also have a designated number to call if we felt we couldn't speak to anyone. I don't have any concerns about abuse here." Another member of staff said, "We don't tolerate it [abuse]. We are like a family here." A third told us, "The signs of abuse are being withdrawn all of a sudden, being frightened when someone walks in the room, the person goes off their food, be anxious. I would report it to my line manager. If the line manager doesn't do anything I would whistle blow. We have a number to ring." All staff had received safeguarding training and staff were reminded of the safeguarding procedures during meetings with their managers.

People had raised with us that they felt there had been a recent reduction in staffing levels particularly in the afternoon. They did not feel however that this had impacted on the care that they received. Three members of staff also expressed their concern over the recent change in staffing numbers. One told us, "It's two staff today (on the unit). It was three but they cut it down, but I've told the nurse today that we need another staff." We raised this with the management team and they confirmed that there had some recent vacancies in the service from people leaving and they had made an initial decision to decrease the numbers of care staff. They told us that they understood now that was not sufficient and had assured us that the numbers of care staff would be put back to what it was. An additional member of staff was brought in to assist during the inspection.

During the inspection we found that people's care needs were met by staff and people were not left waiting for care. One person told us, "The Carers are always about and I can ring my bell if I need urgent attention." Other staff felt there were sufficient staff available on other units. One member of staff told us, "There are three staff. There are enough. Residents are looked after. It's enough for the number of residents. We always have a staff member in the lounge." Another told us, "Three carers and a nurse, that's enough." A third told us, "I don't see residents sat on their own. There are always staff milling about." A fourth said, One staff member said, "Yes, there are enough I think. Sometimes, someone will ring in sick but the managers try really hard to replace them, even if it's one in the morning when they ring in. We try to cover shifts with our own staff. It's a last resort if we use agency." We checked the rotas and found that the correct levels of staff were always on duty.

People understood the reason and purpose of the medicines they were given. One person told us, "They are very good with medication." One relative told us, "We know [their family member] refuses to take her anxiety pills at times but the nurse reassures her and persists." There were safe medicine administration systems in place and people received their medicines when required. Staff received regular medicine training updates and medicine administration competency checks were undertaken. Creams, dressings and lotions were labelled with the name of the person who used them, signed for on topical Medicine Administration Charts (MAR) charts when administered and safely stored. There were no gaps in the MAR records. Medicines requiring refrigeration were stored in lockable fridges which were not used for any other purpose. The temperature of the fridges was monitored regularly. Medicines given on an 'as needed' basis (PRN) were managed. PRN protocols were in place for all medicines taken this way; they outlined how, when and why they should be taken. We noted where a person could be given varying numbers of tablets, for example one or two painkillers, that this was clearly recorded on MARs. We also noted that 'time-critical' for example for people with Parkinson disease medicines were given at the appropriate time.

We noted the monitoring of certain medicines was undertaken to ensure concentrations of the drug in the

person were safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes or blood tests for those taking anticoagulants. Staff were knowledgeable about this and its management. Where people were in receipt of oxygen therapy this was managed safely in line with the provider's policy. There were a variety of daily and monthly procedures in place in all aspects of medicines management. The provider was also subject to a recent external audit by the dispensing pharmacist. This had identified a number of minor issues which the provider had since rectified.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Good

Is the service effective?

Our findings

On the previous inspections in April 2017 we had identified a breach of regulation. We identified a lack of clinical supervisions and gaps around the knowledge of new staff. On this inspection this had improved.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person said, "They [staff] are very well trained, new carers shadow senior carers and learn on the job."

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. When new staff joined the service they underwent a full induction that included mandatory training and shadowing staff on the shift. The deputy manager told us, "New staff are allocated a mentor. With their mentor the member of staff can decide how long they need to shadow which would usually be one week but can be extended if they need." We found that this was happening. One member of staff said, "I had training for two weeks, observations and then out on the floor." They said, "The training here is good and the refreshers. Every day you are learning more and the training makes you more confident."

Staff told us that the training had a positive impact on their work. One told us, "I did dementia training a year ago. I learnt about different types of dementia, what affects they have on people. Every person is different, how to support someone. It made coping easier. I could put the training into practice. I understood emotional outbursts and how to console people." We saw this in practice on the day. For example one person became agitated and we saw staff managed this person's anxiety in a calm and supporting way. Another member of staff told us, "It's [training] kept going even through everything. They are quite hot on training here." We viewed the records for staff which confirmed staff received training on a range of subjects including moving and handling, safeguarding, infection control, dementia, challenging behaviour and health and safety. We noted there was also training specifically for registered nurses that included, pressure ulcer management, end of life care, the management of diabetes, venepuncture (taking blood) and catheterisation. We also spoke with clinical staff about recent opportunities for training and development. One member of staff member said, "The training is good and very regular. We are expected to keep ourselves up to date".

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff said, "I receive supervision every three months. Normally with the nurse in charge. We talk about daily things for example giving personal hygiene, food and fluid charts. We talk about training." Another member of staff said, "[The nurse] has given us supervision. There's been a few. We had one a fortnight ago about doors not being locked. They did this person by person." Registered nurses also attended regular reflective practice meetings as part of their professional development. Clinical supervision was also undertaken regularly by the service clinical lead.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA). MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for

themselves. It applies to decisions such as medical treatment as well as day to day matters. People had received mental capacity assessments where this was appropriate and had sought the consent of people with capacity before acting. We noted this was done in the process of care planning. Where people did not possess mental capacity, we noted best interests decisions had been made about their care. Decisions made included the use of bed rails and the locked doors on some of the units. Staff had a good understanding of the principles of MCA. One told us, "It's about people making their own decisions and we should never assume they don't have capacity." Another told us, "I always ask them [people] first. I give them time to make their own decisions. Even though I know what they like, I still ask." People or their legal representatives confirmed that they were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Applications for DoLS authorisations had been made where restrictions were involved in people's care to keep them safe for example in relation to people going out without being supported by staff, bed rails and the locked units. One member of staff said, "I have had MCA and DoLs training. Number one, always assume have capacity to make decisions. If not we can look at the least restrictive option."

We asked people whether they enjoyed the meals on offer at the service. One person said, "The Chef is very good." Another told us, "We have a lovely choice and someone comes in every morning to take your choice from the menu." A third told us, "You can have bacon and egg and sausage for breakfast if you want or any cereals." A fourth said, "If you dislike everything they will make you an omelette" and a fifth said, "At 5pm we have a lighter meal but also with soup and pudding."

We observed lunch being served in the dining rooms in each unit. Table linen was colour co-ordinated and tasteful. Tables were laid with cutlery, glasses and crockery. Various juices were served and people were offered an alcoholic beverage if they wanted. People sat together and chatted talking about their families and laughed together. Staff were attentive to people and offered support where needed. The food looked well-presented and appetising and people were enjoying it.

People's dietary needs and preferences were documented and known by the chef and staff. The service chef kept a record of people's needs, likes and dislikes. Nutritional assessments were carried out as part of the initial assessments when people moved into the service and ongoing. Every two weeks and sooner if needed a nurse updated the chef of people dietary needs that were recorded on a board in the kitchen. This included information regarding allergies, those that required soft or pureed meals and also people that required fortified meals. People regardless of the restrictions around meals that they had were offered two options. The chef encouraged people to feed back their thoughts on the food. We saw a comments book where all the comments were positive including, 'Lemon tart was excellent', 'Pork was succulent and very lovely', 'Roast turkey was beautiful and moist', 'Very nice. Delicious' and 'Lunch was very good.' In addition to the meals on offer people were able to request alternative meals which the chef catered for.

People's health care needs were monitored included weight loss and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One health care professional told us that staff were knowledgeable about the medical status of the people they were caring for. Staff referred to them appropriately and they managed people's care safely and effectively. Records showed involvement of community nurses, Tissue Viability Nurse, dietician, Speech And Language Therapist (SALT) and the local hospice. One person told us, "If you are ill they will send for the G.P who also comes every fortnight."

Another told us, "I have been to the dentist it is only next door and a Chiropodist comes in when needed."

Good

Is the service caring?

Our findings

On the previous inspections in April 2017 we had identified a breach in dignity and respect. People were not always treated in a way that was respectful to their needs. We found on this inspection that this had improved.

People shared with us that they felt staff at the service were kind and caring. Comments included, "The carers treat me very well and I know all their first names", "They [staff] are lovely people", "They [staff] are very good with personal care. We laugh and joke about. It is a very happy place"; "They [staff] know me well and ask if I am ok. It is my family. It is just like talking to my daughter" and "The carers are absolutely brilliant. They are so lovely and kind."

Relatives also shared this view. One told us, "They [staff] treat them [people] as if they are members of the family. With kindness and consideration." Another said, "They [staff] ensure she has her doll which she loves."

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. When people asked for drinks staff did this quickly and chatted with people asking them how they were. One member of staff said to a person, "Where would you like me to put your drink. Would you like to sit with your friend?" We saw several occasions where staff greeted people when walking past them. We heard one member of staff say, "Hello [person's name]. How are you? Are you alright?" On another occasion we heard a member of staff say to a person, "Are you alright [person's name]? Are you looking out for your husband? He will be here soon." You could see that this gave the person reassurance. One member of staff asked another person, "Would you like to have you hair done today?" The member of staff was gently rubbing their arm when asking. Staff asked people if they were cold and fetched them cardigans and blankets if they wanted. A member of staff noticed that one persons' tea had got cold and they got them a fresh cup.

Staff discussed people in an affectionate way and told us they enjoyed working at the service. One told us, "I love the home, the residents. People have so many stories to tell. You find out about their life stories." Another told us, "Some people don't have family. There are people that rely on us and we are here for them."

Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. One person's relative was unable to visit on the day of the inspection. Staff spoke to this person and offered for them to come and sit and chat with them which reassured the person. On another occasion we observed staff member kneeling down listening to a person who was upset. They gave each other a hug. The member of staff then asked if there was anything interesting in the newspaper the person was reading. A person was sat in the sun at the dining table and the light appeared to be bothering them. A member of staff asked them if they would like to move to the shade to be more comfortable. We heard a staff member saying to a person who was struggling to hold their drink, "Would you like me to put that on the table for you." Another person had to stay in their room for a period of time during the day due to their medical condition.

The hairdresser came to the person's room with a drying hood and put this on them room so that they did not miss out on having their hair done.

The service was spacious and allowed people to spend time on their own if they wished. There were people sat in various parts of the service. Staff always ensured that they had a drink and snacks if they wanted. Each time staff walked past them they would ask if they needed anything and checked on their welfare. One person chose to sit in the reception area and staff included them in conversations and chatted to them.

Dignity and respect was shown towards people by staff. One person told us, "They [staff] treat me with dignity and respect. When I have my bed bath they cover the parts they are not washing." Another person said "They [staff] are very dignified when I shower and take my feelings into consideration. They think about the person within the skin." Staff knocked on people's bedroom doors before entering and ensured doors were closed when personal care was being provided. One member of staff said, "I will always call people by Mr and Mrs until they let me know what they want to be called."

People were encouraged to be independent and had choices around their care. One person told us, "I can do to bed and get up at the time I want to but I am quite independent." Another person said, "They [staff] let me choose what I am going to wear." We asked staff how they encouraged a maximum level of independence and choice. One told us "[The person) is encouraged to wash areas they can manage while we do the rest." Another told us, "I will encourage people to walk with their frames. It gives them exercise and assists with their independence which is important." We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans were reviewed regularly by staff. We also found evidence that people and their representatives had regular and formal involvement in ongoing care planning and risk assessment, in the form of care reviews. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. We looked at people's care plans in relation to end of life care. There was a clear understanding of what this meant to the person and to staff. The care plan was detailed and specific about the withdrawal of active treatment. We noted family members were involved in this process and had written to the manager expressing their agreement with the person's wishes. Although active treatment was no longer being pursued in one particular instance, we saw that efforts had been made to ensure the person maintained as good a state of health, day to day, as possible. For example, the person's care plan contained a nutritional assessment, which outlined the need for a high calorific intake. The rationale for this was to prevent skin integrity problems and to counter excessive weight loss, which was probable due to their condition. We noted the person was gaining weight.

People were able to personalise their room to make it feel more homely. You could see from the rooms what the person's interests were and what their previous professions were. Relatives and visitors were welcome into the service whenever they wanted. One person told us, "They [staff] are nice to my family when they come in for lunch." People also had access to services that related to the religious preferences.

Good

Is the service responsive?

Our findings

At our previous inspection in April 2017 we identified a breach of regulations in the way that people received their care and treatment. There were insufficient activities for people to participate in. On this inspection this had improved but there was recognition by the manager that work still needed to be done to sustain this.

People had a range of activities they could be involved in. Group activities people were able to maintain hobbies and interests, staff provided support as required. One person told us, "I like Bingo" and another told us, "I like musical entertainment." The activity coordinator told us that they working on improving activities within the service. They had already started on memories-quizzes and had recognised that people enjoyed art, cake decoration and baking. There were opportunities to go on outings. One person said, "I love going out to the garden centres." Recently there had been outings to Reigate Priory to feed the ducks and a garden centre where people chose plants. Outside entertainers were invited to the service including 'Hollywood Glamour' and singers. Knitting was a favourite occupation with some people and we saw them participating in this on the day of the inspection. The activity coordinator also visited individual rooms on a daily basis to chat or for hand massage and manicures. The Provider had actively recruited an additional activities coordinator who was due to start at the service.

People had their needs assessed before they moved to the service. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. People told us that they were involved in their care planning. One told us, "My family discuss everything with them [staff]." Care plans were legible, and person centred. People's choices and preferences were documented. We noted there were personal and social histories contained within them; it was possible to 'see the person' in care plans. Where it was recorded that people were independent we saw that this was the case. There was guidance for staff around people's mobility, continence care, sleeping, health care conditions and communication. For example, one person had diabetes and there was guidance for staff on the signs to look out for should the person become unwell. In one person's 'sleeping care plan' it stated what the person liked to wear and that they wanted their light off. It also stated that hourly checks needed to be done to check bed rails. We saw that this was done.

Registered nurses attended a daily 'Stand Up' meeting, convened by the manager and also attended by heads of departments. We noted day to day issues were discussed on these occasions, such as residents of the day, training, complaints, schedules, discharges and admissions in addition to department specific issues. Actions following these meetings were agreed and reviewed the following day. There was also a handover discussion when staff came on duty.

At our previous inspection we identified a breach in relation to complaints. This was because complaints were not always recorded with the actions taken documented. On this inspection this had improved and they had met the requirements of the regulation.

People's concerns and complaints were encouraged, investigated and responded to in good time. We asked people if they knew how to make a complaint. One person told us, "I would tell the nurse. Chain of

command." Another told us, "I would tell the manager. It would not be a problem."
The staff members we spoke with were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. One staff member said, "I would always try to resolve a matter myself before it became a formal complaint. I would let the manager know too." Another said, "We need to be open. I would share the persons concerns with the appropriate person. I will listen to people. It's really important to listen."

We noted the complaints procedures was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. All of the complaints had been investigated with actions taken to make improvements. For example, one relative made a complaint about their frequency that their family member received personal care. Staff support with personal care was increased for this person and their relative was happy with response.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we had identified several breaches that had been continuous from inspections before. Prior to this inspection we had identified systematic failures to identify and put right the shortcomings at the service. Robust action has now been taken by the Provider to ensure that improvements are made and sustained. Since the last inspection the Provider has been sending in regular actions plan to confirm the improvements being made. On this inspection we were able to corroborate these improvements.

We could not improve the rating for well-led from 'inadequate' to 'good' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

People and staff had confidence the manager would listen to their concerns and would be received openly and dealt with appropriately. After the last inspection an interim manager from another of the provider's services was brought in to the service to assist with the improvements. They have now handed over to a new manager who is applying to the CQC to be registered. People and relatives told us that they had seen improvements in the management of the service. One relative said of the interim manager, "They brought [the interim manager] in to sort things out he is amazing. He understands everything." One person said of the new manager they were, "Going to be a great success." Another person said, "She [the manager] is very approachable and wants to get to know everyone." A relative said, "We have met the new manager she will be very good and the staff seem happier now."

Staff also fed back about the new management team and how they felt this had improved. One told us, "The last 18 months have been awful here, but [the interim manager] was approachable and [the new manager] seems really nice." They said they had seen improvements in the culture within the staff team. They said, "I really enjoy working here." Another member of staff said, "Management has improved. We always had support but it's improved. The new manager hasn't been here long but so far she's good. I have met her a few times." A third told us, "[The interim manager] made people feel calm. The leadership skills are so different."

The managers had developed the staff team to display appropriate values and behaviours towards people. Staff at the service told us that they enjoyed working there and looked forward to coming to work. One told us about why they enjoyed their work, "It's because people can do what they want here and that's so good for them." Another said, "We work much better as a team and we all want what's right for people. It's a much happier home."

Staff felt valued and listened to which had a positive impact on the care they provided. One member of staff told us, "[The manager] is in constant contact with me. She has confidence in me. Its helps me feel valued. We sort things out." The member of staff told us that they had asked the manager to review the telephone systems at the service which meant that staff around the service were easier to get hold of when calls came in. We saw that this had been arranged. Each morning the head of each department met with the manager to discuss people's needs. We observed one of these meetings taking place. The interim manager told staff,

"Let's have a good day. Let's make it a really good day for people." Staff told us that they appreciated this positivity. One told us, "[The interim manager] makes us feel at ease with themselves." Regular staff meetings also took place where staff were reminded of policies within the service, training and any other areas that staff wanted to discuss. One member of staff told us, "They are useful for staff to bat ideas around." Another member of staff said, "It's a great way of us communicating with all of the staff."

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. There were regular resident and relatives meetings where people were asked for their views on the service. One person said, "They have regular residents and relatives meetings. I always attend. We talk about menus, activities and outings." We saw from the minutes that these areas were discussed. Another person said, "At meetings you can ask questions of the chef, the maintenance man and the activity carer. It is getting off the ground and everything is getting better." As a result of feedback received from people changes had been made to the menu and additional activities had been organised. Relatives had asked if night checks were going to be undertaken by management and this was arranged. Surveys were each year and any actions needed would be addressed. Thank you cards from people and relatives had also been shared with staff and included, 'Thank you for all the kindness and care', 'You are all professional and kind', 'Thank you for all the care you gave' and 'Wonderful care has been given.'

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the service. The deputy manager, who was also the services clinical lead, convened monthly clinical governance meetings. These were attended by registered nurses and were used to review the clinical management of people in areas such as tissue viability and the management of illnesses. Internal and external audits were completed with actions plans with time scales on how any areas could be improved. Audits were undertaken that covered health and safety, care plans, training, medication, staffing levels, meals and environmental issues. The manager had an ongoing where areas that had been identified were constantly reviewed. This included the maintenance around the service, care plans, recruitment, meal experience for people and staff training and induction. We saw that additional training had been provided to staff as a result of audits and improvements were made around the quality of the care plans.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager had informed the CQC of significant events including incidents and accidents and safeguarding notifications.