GCH (South) Ltd

Willowmead Care Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Willowmead Care Home provides residential care for up to 60 people. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and we looked at both of these during this inspection. At the time of our inspection there were 47 people living in the service. The service was located in large grounds in a rural location.

This unannounced inspection took place on 15 and 18 January 2018.

The service did not have 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. We met the new manager during our visit and they told us were applying to become the registered manager of the service.

There had been a great deal of disruption at the service over the last year, with the departure of the registered manager and other key staff. The provider had not managed change well over this period. There had been a number of area managers responsible for the service over this time which resulted in an unsettled time for people, families and staff.

The provider had started to address the concerns and had increased investment in all areas of the service, including the fabric of the building and additional staffing. There was a new management team in place and increased support from the wider organisation to help drive the improvements. However, there had not been enough time for us to measure whether these changes were sustainable.

The provider had not ensured there were clear plans in place to manage risk to people's safety. Where staff knew people well, they provided them with safe support. However, lack of clear guidance to staff meant people could not be confident they would receive consistent support when they were at risk.

The provider had invested in improving the maintenance and cleanliness of the property, and had dealt robustly with concerns regarding infection control. Staff supported people to take their medicines safely. The provider and manager reviewed mistakes in the administration of medicine and used this information positively to make improvements.

Care plans were not always person-centred. People's support was not reviewed in a consistent manner. An additional member of staff had been recruited to improve the activities and stimulation provided to people at the service. There were more resources available to provide activities for people with dementia, however not all staff were offering these to people. The provider had implemented effective systems in place to investigate complaints, however they had not been well managed for a period in 2017. Care staff continued to communicate well with families.

Staff supported people when they were at risk of abuse and worked well with outside professionals to investigate concerns about people's safety. There were enough safely recruited staff to meet people's needs.

Staff were effective in meeting people's needs. The manager and provider had made changes to provide more support to staff and to improve the training on offer. We made recommendations about improving training for people with dementia.

Staff worked well with outside professionals to meet people's health care needs. People had enough to drink and eat in line with their preferences. Communication between the kitchen staff and the manager was improving. We made recommendations around increasing involvement and consultation with people when redecoration and improvements were planned to the property.

The manager met their responsibility under the Mental Capacity Act 2005 (MCA). Where people did not have capacity to make decisions, the manager consulted families and professionals to ensure decisions were made in the person's best interest.

Staff knew people well and treated them with kindness and affection. There were personalised systems in place to communicate with family members and involve them in the care of their relatives. Care plans included guidance on how people preferred to communicate. People were treated with respect and dignity.

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 consistently safe.

Staff did not have access to clear information to enable them to manage risk effectively.

There were enough safely recruited staff to meet people's needs.

Staff supported people with their medicines, as prescribed. The manager had made recent improvements to increase the skills of staff who administered medicines.

Is the service effective?

Good

The service was effective.

Staff had the skills required to meet people's needs.

People made choices about what they ate and drank. Staff worked well with outside professionals to meet people's health needs.

We recommended the provider involve people in decisions about redecorating and refurbishing the property.

The manager met their obligations under the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Staff knew people well and developed positive relationships with them.

There was guidance in place to support staff to communicate with people.

People were treated with dignity and their privacy respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider had not managed effectively the introduction and reviews of new care plans.

An additional activity coordinator had been recruited which had enhanced the quality of life for people at the service.

The provider had not ensured there was a clear system to manage complaints since our last inspection.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not managed change well, however they had increased investment in measures aimed at resolving the concerns at the service.

The manager and provider had not completed consistent audits and checks to monitor the quality of the care and accommodation.

A new manager and area manager were in post who were driving improvements and promoted a positive culture at the service.

Willowmead Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 15 and 18 January 2018.

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. At this inspection, the expert by experience had experience of caring for older people.

As part of the inspection, we reviewed a range of information about the service. This included a Provider Information Return (PIR). A PIR is a form completed by the registered manager to evidence how they are providing care and any improvements they plan to make. We also looked at 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 area manager, the new manager, the deputy manager, and twelve members of staff, including the chef and activity coordinator. We spoke with nine people who used the service and three visitors. We also spoke with three professionals about their views of the service.

We reviewed a range of documents and records including the care records for people who used the service. We also looked at a range of documents relating to the management of the service.

Since our last visit, there had been a change in the registration details for the service with the Care Quality Commission (CQC), which meant Willowmead Care Home was registered as a new service in 19 May 2017.

This new registration was due to a change in the legal entity of the provider. The registered manager transferred over and there was no tangible impact on the people at the service from this administrative change. Throughout the report, we have referred to our last visit to the service. This visit took place on13 December 2016, when the service was registered under the previous legal entity.

Requires Improvement

Is the service safe?

Our findings

The provider had addressed the concerns we had raised at our last visit regarding infection control, and the property was much cleaner and fresher. For example, staff had cleared bathroom cupboards and addressed unpleasant odours. In a survey carried out by the provider, 18 out 20 people said they were happy with the cleanliness of their rooms. A family member told us, "The cleanliness is wonderful."

The provider had notified us as required when there had been an outbreak of diarrhoea and vomiting. They had taken comprehensive measures to prevent the spread of infection in line with guidance from the relevant public health bodies, for example, additional hand gel was provided and a deep clean carried out. Staff had worked well with the GP to follow advice on how best to support affected people.

When we last visited the service, the provider showed us detailed plans for refurbishing and rebuilding the properties. We found at that inspection a number of areas were not adequately maintained. At this visit, we found there had been some improvements, and an intensive programme of maintenance was underway. The provider had prioritised tasks according to risk and there was a focus on areas such as fire safety and hygiene. For example, fire doors were being repaired and staff booked onto training on the use of fire evacuation chairs. We met the provider's maintenance officer during our visit, who assured us of the provider's commitment to completing all the outstanding tasks. However, due to the historical lack of ongoing investment in the properties, we continued to have some concerns whether the provider would sustain this level of investment over time.

People had individual risk assessments, for example, a person had a specific plan due to risk of dehydration. Care plans included personalised guidance to staff on how to support people to evacuate the building safely in the event of an emergency. However, the quality of care plans was inconsistent and did not always reflect the current risks to people. Staff had identified a person as having extreme confusion and the risk assessment in place did not adequately consider risk to their safety. Staff had not reviewed risk consistently, for example, a person had a risk assessment as they were at risk of falling. Staff had recorded the last review of this risk assessment in April 2017, yet other risk assessments in the care plan were reviewed monthly.

Another example highlighted the potential risk from inconsistent care planning. A person who was at risk of choking had been prescribed a thickener for their drinks on return from hospital. When we interviewed a member of care staff they were aware of this. At lunchtime, we observed another member of staff giving the person a drink which was not thickened. When questioned, the member of staff told us the person did not need the thickener. We observed the person coughing occasionally throughout lunch. When this happened, a member of staff offered them another drink without thickener, which may have increased the risk of choking. The person's care plan highlighted the inconsistency in the guidance given to staff. The eating and drinking care plan stated all drinks should be thickened. However, in a review staff carried out in the month before the inspection, staff had recorded, "Normal diet and eats and drinks well, no concerns," with no mention of the thickener.

We discussed our concerns with the manager and area manager. They had already planned a review of all

the care plans; however, in response to our concerns they immediately arranged a meeting with the GP to discuss the needs of all the people who were prescribed thickener in their drinks.

Despite this example, most of the staff we spoke with knew people well and demonstrated a good awareness of how to manage risk. For example, all the staff we spoke to were aware of a specific risk when supporting an individual, and what they needed to do to minimise the risk. We saw some examples where risk was managed well. One person's care plan stated they needed a reminder to walk with a stick and we observed them using their walking stick throughout the day. Staff considered how to keep the environment safe for people. For example, staff had identified where people had sensory needs, to ensure they had their glasses and hearing aids with them to help them move around the home safely. A health and social care professional told us there had been recent improvements in the safety of people who needed support to move and transfer.

The pro-active response by the new manager and the planned review of people's risk assessments demonstrated a commitment by the provider to fully address the concerns we found at the service. However, it was too soon for us to measure the impact on people's safety from these planned improvements.

On the day of our inspection one of the activity coordinators and a member of care staff were off sick. Despite this, our observations throughout the day found staff answered call bells promptly. We noted the deputy manager stepping in to support staff during busy periods. Staff told us there was enough staff to meet people's needs. People gave us mixed feedback, however, the majority of people told us there was enough staff on duty. One family member told us, ""It is well run, there are time when they are short staffed and staff are busy. It is not regular, just when there is sickness and holidays." People told us, "I definitely feel safe, there is always staff about, I don't use the buzzer I just call as I have my door open" and "Its first class care. Spot on, if I press my alarm they come quickly."

We found that staff were recruited safely. Checks on the recruitment files for three members of staff confirmed they had completed an application form, provided proof of identity and satisfactory references. The provider also completed a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

We observed staff administering medicines in both units. Staff only administered people's medicines when trained and assessed as competent. There were clear processes in place, which staff largely followed. However, we observed one member of staff hold tablets in their hand, without wearing gloves. We discussed this with the manager who showed us comprehensive checks where the staff member had dispensed medicines safely. Competency checks took place with the relevant staff every three months. The manager immediately addressed this concern with the member of staff to ensure it did not happen again.

Staff kept clear records of the medicines people received. There were processes in place for medicines which were only taken when needed, for example for pain relief and staff took time checking with each person, as appropriate, to check if they felt they needed to take these medicines.

Medicines were stored safely. Senior staff carried out checks and audits to ensure medicine was administered safely, and the correct number of medicines were in place. In the month prior to our visit, a person had not received their medication as required due to a delay in obtaining repeat prescriptions. The new manager had effectively addressed the concerns and improved the system for ordering medicines. The provider had arranged for a qualified nurse to carry out checks within the service, including looking at the

administration of medicines, which demonstrated a commitment to continuous improvement in this area. There had not been an impact on the person's health and the manager ensured lessons were learnt from this incident. A health professional told us they had no concerns regarding the administration of medicines.

Staff told us, and records confirmed they had received training in how to safeguard adults from abuse. Staff knew the signs to look for that might alert them that someone was being abused and they knew how to report concerns. A person told us they felt safe at the service. They told us, "It is secure, they keep the door shut and only open it when people are identified."

We looked at the response from staff when a person had been at risk due to a safeguarding concern. We found staff had taken immediate action to assess the risk and adapt the support to the person involved. They had also worked openly with safeguarding officers from the local authority. In addition, they had discussed their concerns openly with the family of the person. This incident had demonstrated a good understanding of the safeguarding process and of how to assess capacity when working with people with dementia.

Good

Is the service effective?

Our findings

A health and social care professional told us, "People receive good care but in difficult circumstances." A person said, "They know their stuff and despite the pressures they achieve what needs to be done." Whilst we had concerns regarding how the provider had ensured safe care planning and risk at the service, we found staff had the skills to meet people's needs. Despite all the recent upheaval, there was a core staff team who knew people and had an understanding of the support they required.

Staff received an induction when they joined the service. This included completing mandatory training and shadowing more experienced staff. One staff member told us, "I did 3 days shadowing and took two weeks to complete my training; every year we get refresher training." The manager sent us an action plan which outlined improvements in the induction training, in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers follow to provide them with the skills and knowledge they need to perform their role.

Some training was face to face, such as medicine training. The majority of training was paper based with staff working through a booklet. The new manager and area manager advised us they had started to review training for all staff and arranging refresher and improved training where there were gaps.

Staff told us they would like more face-to-face training, especially in the area of dementia. Staff had received some training in dementia and in supporting people who displayed complex behaviours. We observed examples of good practice in this area, for example when a member of staff skilfully supported a person with dementia to have a drink, despite their reluctance. However, we had received feedback from a professional that staff had struggled when managing a person who was severely affected by dementia. Outside professionals had provided some guidance to staff when the previous manager had been in place and the current manager still needed to review how effective this had been.

We recommend the service seeks improved guidance on how to improve training to enable staff to support people with dementia, in line with current best practice.

Staff demonstrated they were able to meet people's physical health needs. They followed guidance provided by health professionals to support a person who was prescribed warfarin. One of the senior staff was the diabetes 'champion'. They were very knowledgeable about how to support people with diabetes and what signs to look for if someone was at risk. They said, "It's different from person to person, one person gets confused when their blood sugar is low and is slow to respond to us but another person doesn't show anything so we have to look at their skin pallor." A health professional told us they had advised staff caring for a person with diabetes and some staff had also been on a diabetes course to ensure they had the skills to meet the person's needs.

Prior to our inspection, we had received feedback from staff that they were not supported and there was a bullying culture at the service. This is discussed more fully in the Well-Led section of this report. Staff told us this had now improved and the manager and provider were providing better support. Staff received regular

supervision, which they told us they found helpful. One staff member told us, "I get supervision every three months, I can talk about issues one to one that I maybe wouldn't want to in a meeting."

During our inspection, staff called for an ambulance due to concerns regarding a person's health. A senior member of staff told us, "I called the GP out, but have called for an ambulance as I felt I had to act quickly rather than wait for the GP." We noted staff dealt with this situation calmly, working well with the paramedics when they arrived.

We found a number of other examples where staff had worked well with outside professionals. For example, staff referred a person to the continence advisory service, and they used this information to develop a detailed plan about their needs. A health professional told us the new manager and area manager were working well with outside professionals and had provided a "good, fresh outlook."

Due to the turnover of managers, there was a lack of systems in place to ensure this was done in a coordinated way. In the past, many of the referrals to professionals were channelled through the registered manager, using networks they had developed over many years. When the manager left, it highlighted a lack of formal systems. The new manager advised us they were working to address this.

The recording of health appointments was patchy, as was the review of people's needs, highlighted within the responsive section of this report. Staff supported people to receive health support; however, the recording was not up to date. Inconsistent recording meant it was difficult for senior staff to monitor the care people received. For example, one person's records showed their last chiropodist appointment was in May 2017, despite needing on-going treatment. The manager showed us the invoices for regular chiropody appointments and people confirmed the chiropodist visited regularly. One person said, "The doctor comes at periodic intervals. The optician, chiropodist and dentist have all come." When we returned on the second day of our inspection, staff had reviewed visits from the chiropodist and other health appointments. The manager told us their initial review indicated that all appointments were up to date but not recorded in line with the provider's policy.

Risks to people's nutritional health were assessed, recorded and monitored using best practice guidance so that they maintained a healthy lifestyle and wellbeing. People were weighed monthly and if a drop in weight was noted this was changed to weekly. People's preferences had been recorded. For example, one person's care plan stated; "Prefers porridge, hates tomatoes" and "Sometimes likes a beer."

People told us they liked the food on offer, and staff considered their preferences. One person said, "The food is very good. They come and tell you the two choices; portions are very good, definitely hot enough. They are always coming round with tea and coffee and know I am a coffee man."

Staff supported people to drink in line with their preferences, which helped minimise the risk of dehydration. People told us, "There are plenty of drinks and there is always a jug of cordial in the lounge" and "They have just taken my cup down. I get juice with lunch and can have juice any time. I used to have a jug but don't want one." We observed staff encouraging people who were reluctant to drink to have more fluids. A member of staff sat with a person and talked to them, while they prompted them to drink. This positive interaction focused on the person rather than the task.

We observed staff supported people to eat, where required. We observed a member of staff sitting at eye level engaging with a person and providing patient un-hurried support. When another person chose not to eat the main meal, staff made them some fresh toast. Some people ate in their rooms and we saw staff popped their head in and asked if they needed support. We received feedback from one relative that a

family member had not had their food cut up, despite needing this support. We discussed this with the senior on duty so they could resolve this immediately.

We met with the chef who had been at the service for seven weeks. They had worked as a care staff previously and understood the importance of nutrition in maintaining people's health and wellbeing. However, the management team had not communicated well with them about their responsibilities. There had been inadequate communication with the chef to ensure the appropriate checks and audits were carried out in the kitchen. Systems were not in place to ensure people were involved in developing menus. The chef told us they had inherited the menu and were tweaking it, as they got to know people's preferences. The chef demonstrated a good commitment to carrying out checks and involving people, however we found this process lacked oversight by the manager.

When we returned to the service for the second day of our inspection, the manager had already addressed our concerns and clarified the responsibility for the checks on quality and safety. They had also set up a catering feedback book and improved communication about dietary requirements.

We discussed with the manager and area manager how they planned to involve people in the decisions about redecorating and improvements at the property as we had concerns the provider had not appropriately consulted people in the past. They assured us this was central to their planning of future improvements. The provider had not historically demonstrated they had considered best practice when considering changes to the property, for example to consider how to use the design and decoration of the property to support people with dementia.

We recommended the provider seek further guidance regarding best practice around adapting and designing premises and physical environment to meet peoples' needs and help promote their independence.

We checked whether people were being supported effectively in line with the Mental Capacity Act (MCA). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. Senior staff had involved other parties, such as social workers when assessments and decisions had to be made in a person's best interest.

People's capacity was considered in their care plans that included the help people required to make decisions and guidance to staff. For example, one person's care plan stated, "Has dementia, can be confused but is able to make simple decisions independently." Consideration to people's capacity was interwoven throughout their care plans. For example, a person's summary of their care needs stated they were able to choose what they wanted to eat. Our observation of staff found they supported people appropriately in relation to their capacity.

Where people's freedom was restricted, senior staff had requested DoLS, as required and these were up to date. There were effective trackers in people's care records to ensure staff were aware of any restrictions and where Best Interest Decisions had taken place. When staff reflected on what was in the person's best interests, care plans prompted them to consider other options which might be less restrictive.

Some people had sensor mats in their rooms, so that staff could monitor their safety from a distance. Staff

told us this was less restrictive then erecting locks or barriers. We also discussed with the manager whether they had considered other more discrete options, in line with best practice, such as motion sensor lighting. The manager agreed to look into these options.

Good

Is the service caring?

Our findings

We found staff had remained committed to the care of the people at the service throughout the recent unsettled period. The provider had recognised the importance of improving staff morale and had recruited a new area manager and manager who promoted a positive and caring culture.

Feedback from people was overwhelmingly positive about how caring staff were. People told us, "I love it here, it's is a nice place to be, staff are all very helpful" and "I am better off being looked after here, they are cheery people." There was a pleasant atmosphere in the communal areas. We observed staff spontaneously dancing and singing with people when a favourite song came on.

While parts of the care plans were not sufficiently person centred they did provide some information to help staff get to know people and form positive relationships. Plans outlined people's likes, dislikes, hobbies and what was important to them. There was also guidance on how best to support people's happiness. For example, one person's care plan stated they liked musicals and brass bands.

Staff told us they got to know people by reading their care plans, talking to them and their relatives. Staff were able to demonstrate they knew people well and supported them in a person centred way. For example, we observed a member of staff move a bag somewhere safe for a person, but they did this kindly and gave them a hug first. We observed another member of staff reduce the lighting for a short period in one corner of the lounge where a couple of people were sleeping in armchairs.

We observed staff interacting positively with people who were in their rooms. They focused on the person and not the tasks being carried out. A member of staff offered one person a cup of tea and when they asked for 22 sugars the staff member said, "Sorry only got 21 sugars today." There was laughter on both sides and the contact was fun and unhurried. Another person told us, "Staff are very kind, they help me get up, and go to bed, use the commode, cut up my meals and if they have time they chat. They might stay 5 to 10 minutes."

People had a communication profile that provided guidance to staff on how best to communicate with people. These recorded how people indicated yes and no and expressed pain. People's sensory needs had been identified and staff told us how they communicated with people living with dementia who experienced sensory loss. One staff member told us, "We don't just put tea in front of people but we need to tell them what it is, prompt and give the information."

There were good systems in place for communicating and involving families in people's care as appropriate. Monthly feedback forms sent out which recorded any changes and a space for relatives to respond, add their comments and sign agreement. The form talked about activities the person enjoyed and any changes to their care and support. A family member told us, "I get a sheet once a month, telling me how [person] is progressing but if they are ill I get a phone call,"

Where appropriate, staff had asked families how much communication they wanted which ensured contact

was personalised, depending on the circumstances. Some families asked for regular contact and updates and other families only to be contacted if their relative became ill. Families told us they felt welcome to visit the home. There was some dissatisfaction with the high turnover of managers, and communication during this period but families told us this was now improving.

Staff supported people to increase their independence. One staff member said, "[Person] likes to wash themselves so I just hold the flannel." People were encouraged to continue carrying out personal care tasks independently, where possible. A person told us, "I get up and wash and shave around 5am. It's my choice."

People told us staff treated them with respect and our observations confirmed this. A person told us, "They knock on the door briefly and open the door; my privacy is not intruded, I am quite happy to see them in my room and we chat a bit, my privacy is respected." We saw that senior staff promoted the need for dignity. A person was on the toilet receiving personal care from staff and we saw a senior member of staff walk across and say, "just closing the door for privacy."

We noticed when there was an emergency and paramedics were called out to a person who was not well, staff respected the dignity of the person and placed a screen around them whilst they received treatment. Since our last visit, the provider had purchased new lockable units which staff could place in the lounge to increase the confidentiality of people's personal records.

Requires Improvement

Is the service responsive?

Our findings

At out last visit to the service we found the care plans to be easy to navigate and person centred. When we returned we found there were new care plans and information was harder to find and less personalised than previously. For example, one person's care plan stated their dietary requirements were 'normal' and did not highlight any likes or dislikes. We found this information elsewhere in the care plan under a section called "My life so far." This made it more difficult for staff, especially new or agency staff to find information about a person's needs.

Guidance in the new plans was more task based, listing what staff needed to do and not always describing people's needs in a holistic way. The new area manager had recognised this was an issue prior to our inspection and had started to address this. They showed us a new set of guidance for staff around writing care plans. This had the potential to be an excellent tool to enable care to be planned in a more personalised way. For example, whilst current care plans stated if a person liked to have a wash, the new guidance required staff to asked people if they preferred to use a flannel, sponge or their own hands. As these improvements were not yet in place, we could not measure how effective they were.

The changes in management and care planning had resulted in an inconsistent review of people's care. For example, a personal profile provided "At a glance" information about people's key needs. Staff had reviewed the profiles monthly between June and September 2017, but not since then. They had updated other parts of the care plans more regularly, for example in response to risk. We were concerned information was not kept up-to-date, especially as there had been a high turnover in staff and managers. New staff did not know people as well as the more established care staff and required plans to contain clear information about people's needs.

Due to a lack of oversight, the manager could not demonstrate people received consistent care across the service. For instance, care plans stated whether people liked a bath or a shower and how often. Bathing records on Wickham unit showed people regularly received support with a bath, shower or bed bath. On the Hatfield unit, a member of staff told us, "Everyone gets a shower here; they don't get a bath, it doesn't get used, never used since I've been here."

Feedback from people was largely positive in relation to the care they received. One person told us, "I shower once a week, it's very nice and I don't mind if it is a male or female carer, we have a nice chat." They described care that was flexible around their preferences. People told us, "I am happy here and looked after. I have my meals in my room, its less hassle and my choice. But I do go into the lounge occasionally to keep in touch" and "No one bothers me about going to bed or getting up, I do as I please." At lunchtime we spoke to three people who ate in armchairs rather than at the dining room table and they all told us it was their choice. One person said, "My hips have gone so I would rather be here in the chair."

Since our last inspection a new activity coordinator had been appointed, so there was now one for each unit. We found activities was an area which had improved. Staff spoke with pride about various activities on offer. A member of staff told us, "The activity coordinator has got one person knitting squares and another

doing a shawl." One of the people told us, "I am knitting the edging for a shawl I have made."

The activity coordinator was knowledgeable and enthusiastic about their role. They told us they had replaced children's puzzles with dementia-friendly puzzles and jigsaw puzzles in line with the interests of the people at the service, such as flowers and trains. They discussed recent activities and told us, "Residents planted sunflower seeds in cups and later we shall plant them outside, we do a weather board and I ask the residents to look out of the window and tell me the weather." They had also arranged their timetable to include time with people who remained in their rooms. They told us, "I do 1-1's and go to rooms. One person likes cooking so I took the bowl and the eggs and they mixed the eggs, I then went to the next person and they put the flour in and mixed it. I have got giant playing and foam cards and I get them to tell me what is on them before we play."

The activity coordinator showed us a selection of resources in the activity cupboard to provide stimulation to people with dementia, such as tactile objects. On the day of our inspection one activity coordinator was off which left one coordinator organising all the formal activities. We did not see other care staff offer people the dementia resources, in line with their needs.

The provider had not ensured complaints were managed in a consistent manner. When we asked the manager to show us a log of complaints they showed us a new system that demonstrated senior staff had dealt with and investigated complaints openly and thoroughly since November 2017. They had taken action which made a difference to people's quality of care. For example, a person had increased access to activities and the manager gave staff improved guidance on communication with families.

Although the new systems meant people could be confident they would now receive an improved response to their complaints, the provider had failed to demonstrate they had fully investigated and responded to complaints received prior to November 2017. Although the provider had started to address a number of concerns in a pro-active way, we were not assured concerns had been dealt with and lessons learnt from all the complaints received since our last inspection.

At the time of our inspection there were no one receiving end of life care at the service. People had advanced care plans which outlined their preferences for end of life care and funeral arrangements. Staff recorded if the person had Power of Attorney. There were clear records where people had chosen not to be consulted. Where appropriate, staff had discussed with families about these plans.

The manager told us of improvements they had made to their end of life processes following a specific incident. They described a situation where a person had been well cared for, but the incident had highlighted the processes in place around ordering medicines were not effective. The manager demonstrated they had learnt from this experience and had openly discussed this with the staff team to ensure improvements in the future.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection, there had been a number of highly disruptive changes to the management team. The longstanding manager of the service had left, as had the administrator and some care staff. The deputy manager had also left temporarily, though they had now returned. There had been a number of new area managers, who had implemented various changes and initiatives. The provider had not always managed the transition between managers and area managers in a positive way, which contributed to the unsettled climate and lack of continuity.

A month prior to our inspection, the provider had recruited a new manager who was applying to become the registered manager. There was also a new area manager covering the service. Initial signs indicated these were positive appointments and the two managers were working well together. However, there had not been enough time for the new management team to settle in and for us to measure if the improvements they had implemented were sustainable.

When we spoke to the area manager and manager, they outlined the plans to resolve the concerns discussed throughout our inspection. The manager told us they had voluntarily limited new referrals to enable them to concentrate on urgent tasks. They demonstrated a good awareness of managing risk, for example, they prioritised people with the most complex needs when addressing the concerns around the new care plans. Maintenance staff were working through a risk based action plan to ensure the most important jobs were tackled first.

Staff told us morale had improved since the recruitment of the new manager and area manager. One staff member said, "I feel positive, just waiting to see the impact of the changes, new decoration will be coming and that will be nice." Communication with staff was improving but the new structure of meetings was still being introduced. The manager told us there had been a meeting called "10 at 10" which was a brief meeting with all the senior staff but these had tailed off.

Staff felt supported by the new manager. Astaff member told us, "The manager said to me you can call me at 4 am it doesn't matter the time; this is what I like about them", "I like working here, the changes have been difficult, but the new manager is very nice" and "The new manager is a bit more approachable and wants to improve things. Staff are less stressed now and happier with the new manager."

At our last inspection, we found formal daily checks took place to monitor the quality of the service. At this visit, we found the checks had been completed inconsistently due to the changes in management in 2017. We reviewed the quality of the checks which had been carried out and noted they varied in quality, depending on who had completed them. In addition, new managers had not always carried out actions identified by previous managers. The new manager and area manager were gradually addressing this.

When used correctly, the previous checks provided an effective tool. For example, the previous registered manager had picked up in their daily checks when the kitchen drawers needed cleaning or when staff delayed in responding to a call bell. They used the audits to speak with two members of staff and two

people every day to find out their views on the service. This had been an excellent example of involvement from people and staff which was no longer taking place under the current management. The area manager told us they were reviewing all checks to make sure these were robust, personalised and made good use of senior staff time.

The manager told us about a number of other checks, for example the maintenance audit. These included infection control checks, which helped address some of the concerns we had raised at the last inspection. There was more structured involvement from representatives from the wider organisation so there was better support for the manager in their role. The provider had not implemented many of these changes, such as the required upgrade of the property, in a timely manner after the end of our last visit. However, we were assured by the actions they were now taking to drive improvements at the service.

The new area manager had arranged for a qualified nurse, who was the manager of a neighbouring service, to carry out an audit at Willowmead Care Home. This was a good use of the provider's resources and promoted the sharing of good practice across the local area. The provider and manager were using the outcome of the checks to inform the action plan and improve the service. For example, it had helped advise the manager on the gaps in staff skills so additional training could be arranged.

There was a period between our inspections when we had received concerns regarding provider's management of the service. A significant number of staff had notified us about an increase in bullying. By the time of our inspection, the concerns had been addressed. Staff told us they no longer felt bullied; however, we were concerned the provider had not recognised the issues and responded sooner to minimise the disruption to the service. For example, during this period, staff had been required to re-write care plans using paperwork that was not part of the provider's usual process. The provider's representative had halted a number of positive practices by the previous manager, such as the daily checks. The new measures had reduced the focus on the people at the service and reflected a less inclusive culture and approach.

We discussed our concerns with the area manager who told us the provider was implementing a new system to improve the oversight of the service. For example, the manager and provider would be able to track the supervision sessions with staff, and monitor any gaps. The provider had also created a new quality team to support the manager with the improvements at the service and monitor the care being provided.

There were other signs the concerns about the culture were being addressed. Recent team meetings have involved honest and open discussions with staff. A representative from the provider's human resources department visited the service and spent time talking to staff and making recommendations for improvements at the service.

Historically there had been excellent communication with families, and some of these practices still continued, such as the monthly contact with families, as appropriate. People had completed a satisfaction survey since our last visit and some of the answers reflected the number of changes in the service. For example, nearly half of the people who completed the survey said they did not know who to complain to and did not feel consulted and involved in decisions. The survey showed people continued to be satisfied with the level of care and support provided. For example, 19 out of 20 people said they received the support they needed with their personal care.

The focus on managing risk meant best practice was not implemented consistently across the service. For example, we found staff had received training to provide personalised support for a person with diabetes but other areas had not had this level of input. We also noted the service had not used all the opportunities available to build up links with other organisations. The registered manager responded pro-actively to our

discussions and immediately contacted PROSPER, an initiative run by the local authority to improve the quality of support provided in care services.

The manager and area manager were working well with outside authorities to respond to concerns raised. We received feedback from professionals that the new team were committed, one health and social care professional said, "The atmosphere in the home felt better and the staff appeared and also said they were a lot happier. A lot still needs to be done but I do feel positive that they are addressing issues and reviewing their action plan on a weekly basis."