GCH (Willowmead) Limited

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

Summary of findings

Overall summary

The inspection took place on 13 December 2016 and was unannounced.

Willowmead provides care and accommodation to people who may need assistance with personal care and may have care needs associated with living with dementia. The service does not provide nursing care. The service is provided in two separate houses, called Wickham and Hatfield. The houses share communal gardens and other facilities. At the time of our visit there were 59 people living in the service.

A registered manager was in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last visited in 2015 we had concerns regarding the skills and attitude of some of the staff at the service. During this visit we found the manager had been pro-active about resolving the concerns and we saw improvements in the way staff supported and cared for people.

Whilst there were measures in place to support people to remain safe, we found that the risk of infection had not been minimised. This was because the accommodation people lived in had not been cleaned and maintained to an acceptable standard. Whilst there were significant plans in place to update the property in the near future, the manager had not ensured the current property met people's needs and kept them safe.

The manager was supportive and approachable. They had a positive working relationship with the deputy manager and they were both committed to improving the service. However, although numerous checks took place which looked at the quality of the care provided, these did not always pick up the concerns around infection control which we had found during our visit. Staff observations were also not used effectively to improve staff performance and attitudes.

People were protected from the risk of abuse. Staff supported people to take their medicines safely, as prescribed. There were sufficient staff to meet people's needs. Staff were well supported and were enabled to develop their skills in a variety of ways.

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

People had enough to eat and drink. People's food and liquid intake was recorded and monitored and any concerns addressed promptly. Staff worked well with health and social care professionals to support people

to maintain good health and wellbeing.

Staff treated people with kindness, dignity and respect. They took the time to get to know people and to reassure them when they were distressed. Care plans had been developed to support staff to provide personalised support. Staff motivated people to engage in a range of meaningful activities and pastimes. The importance of family relationships was valued and communication with families was excellent. People knew how to complain and received a personalised response to their concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The cleaning and maintenance of the service did not effectively minimise the risk of infection.

People were supported by sufficient, suitably recruited staff who knew how to keep people safe.

Is the service effective?

Good

The service was effective

Staff were supported to develop skills to meet people's needs. Additional training had been provided to help staff effectively support people with dementia.

People were enabled to make their own choices about the care they received. Decisions made on people's behalf were done in their best interest.

People were supported to maintain good nutrition and hydration.

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

Is the service caring?

Good

The service was caring.

Staff took the time to get to know people and treated them with kindness and compassion.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Support was personalised around individual needs and preferences.

People were supported to have meaningful lives and pastimes. Family relationships were valued and nurtured.

People knew who to speak to if they had any concerns. They were assured that any issues would be dealt with effectively.

Is the service well-led?

Requires Improvement 

The service was not always well- led.

There were systems in place to check the quality of care provided, however these did not always result in improvements.

The manager had focused on making improvements in the areas where we had raised concerns at our previous inspection.

People, families and staff were listened to and their feedback made a difference.

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.

The inspection took place on 13 December 2016 and was unannounced.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. This included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We met with the regional manager, the registered manager and the deputy manager. We spoke with 14 members of care and domestic staff, 10 people who used the service and five family members. We also spoke with two health and social care professional to find out their views on the service.

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

Requires Improvement

Is the service safe?

Our findings

Registered managers are required to ensure premises are kept clean and maintained in good physical repair and condition. Part of the service was provided in an older building which was a challenge to clean and maintain. There were detailed plans in place for refurbishing and rebuilding the existing properties. Whilst this was positive and would improve the quality of life for people in the future, we found a number of areas which were not being cleaned and maintained to an adequate standard. This posed a risk in relation to infection control.

We found a number of plastic aprons left on towel rails and around bedrooms. It wasn't always clear whether they were used or not. In one room we found a bowl of water under the sink with plastic gloves floating in it. Gloves and aprons should be worn as single-use items, and discarded after use. Unused protective equipment should be stored safely to avoid accumulating dust or germs.

A health professional told us hygiene and cleaning in the service was an issue, for example, toilets were often dirty. We found a large number of toilets and bathrooms which were not adequately clean and where the tops of taps were missing and plugs were broken. For example, in one bathroom we found hairs in a broken plughole and we saw a plastic bath chair was rough, which posed a risk of injury from a tear to the skin. The commodes in a number of people's rooms were uncovered and whilst they had been emptied, they had not received a deep clean. There was a smell of urine in some parts of the service.

There were lists of maintenance jobs being carried out, and saw some updating had occurred, such as new flooring and a new lift. There were plans in place for daily and deep cleans. We were told of a number of cleaning audits which took place and saw records where cleaning had been checked.

We discussed these concerns with the manager of the service. Whilst we accepted many of the concerns would be resolved by the new and refurbished property which was planned, increased diligence was required whilst people were still living in the existing property to minimise the risk of infection. Whilst we had not received negative feedback from people and families, improvements in the physical environment would also offer a more pleasant quality of life.

People told us they felt safe at the service. They said, "I feel safe. They take you up to bed and you have got a buzzer and most times it is a matter of minutes before they come. The staff are faultless, very good" and "I feel safe, I know the staff would do something if I was in difficulties."

We observed there were enough staff to meet people's needs. People and staff confirmed our findings and told us staff attended to them promptly. One person told us, "They are very quick most times, nights are the same, weekends no different. I've never had to have a long wait." Staff said there were enough staff to keep people safe and the manager arranged for additional staff to come in, for example if someone was off sick.

Although there were enough staff numbers, we observed a few incidents where, staff did not work well together to meet people's needs. For example, we saw an incident where a person sitting in a lounge

became distressed and wanted the toilet. This incident was observed by a member of staff providing one to one support to an individual. This member of staff did not call out to their colleagues to assist the person. There was one other member of staff nearby but when they became aware what was happening they said they could not leave the room, as this would leave the other people unattended. We observed there were three members of staff from that unit at lunch during this incident. There was a delay of ten minutes to assist the person to the toilet, which could have been avoided through improved communication and planning. We discussed this with the manager who said staff did not usually have lunch together in this way, and from the feedback from people and families about staffing we were assured this was the case. The manager showed us different ways they were improving teamwork across the service, which included how 1:1 staff interacted with the rest of the staff team.

We looked at recruitment files for four staff to review the registered provider's procedure for recruiting staff. Robust recruitment procedures were followed to help check staff were fit to work at the service before they started their employment there. This included obtaining Disclosure and Barring Service (DBS) checks and seeking references. These processes helped to protect people from the risk of harm or abuse.

We observed people were comfortable when interacting with staff and approached them freely when requiring assistance or support. Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Staff said they felt confident raising concerns about a person's safety. Where people had been assessed as being vulnerable to abuse there was guidance in place for staff to follow. The manager had followed the correct procedures when a person was at risk of abuse. We noted they had actively investigated and dealt with a concern raised by a member of staff. When the manager described their daily routine it was clear they consciously checked whether staff were supporting people safely.

Despite the specific concerns we had around infection control, we found risk was generally well managed at the service. Staff knew the people well and were aware of risks and how to manage them. Accidents and incidents were logged and records included a drawn sketch of where incidents took place to help senior staff understand better what had happened.

Care plans provided staff with clear information to minimise risk. Each month when people's needs were reviewed staff considered whether there had been any changes in the risk levels. We saw on one person's plan that staff had realised they had become more frail and were now at risk of falling. They had looked at any changes they could make to help the person stay safe. For example, staff were required to check a person's footwear to ensure it was suitable and safe.

We saw staff carried out an assessment each time a fall took place, running through a checklist to ensure they were safe and whether further action was needed. For example, staff carried out observations and completed body charts to help them monitor any effects of the fall.

Staff were clear when supporting people to move, for example when using a hoist. Competency checks were carried out on staff skills when using equipment before they did any manual handling. Our observations confirmed staff had good skills in this area. For example, staff spoke with people before using equipment, talked to them throughout, giving clear instructions and reassurance. A member of staff told us, "[Person] needs a full hoist and there's always two of us when we move or reposition." We observed that when a person needed support from two staff to use a hoist, a member of staff ensured their colleague had arrived before carrying out the support, and explained to the person the reason for the wait.

Staff worked well with the district nurses to minimise the risk of pressure sores. We saw records confirming staff followed advice from the nurses and were turning people, where this was required.

People received their medicines safely and as prescribed from appropriately trained staff. Records of people's medicines were completed in line with the organisations' policy and we noted that these were accurate and legible. There was personalised guidance in place for each person for staff to follow when supporting them with their medicines. When people had been prescribed medicines on an as required basis, for example for pain relief, there were no protocols in place for staff to follow however the manager and deputy manager told us these were being developed currently. We observed a person being given PRN medication and saw the member of staff recording after they had administered the medicine.

We observed medications in the two different houses and saw staff were skilled at encouraging people to take their medicines. They offered people drinks, reassuring them and explaining what the medicines were for. Staff had received training before they supported people with their medicines. Where a medication mistake had occurred the deputy manager had met with the staff involved and observed their practice to ensure they learnt from their mistake. Where people had covert medication, for example where it was concealed in food, this was reviewed every six months and included the involvement of the GP and family, where appropriate.

Medicines were stored safely in a locked trolley and storage room. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately.

Good

Is the service effective?

Our findings

When we last visited the service we had concerns some staff were not adequately skilled to meet people's needs, especially where people had dementia. At this inspection we found the manager had worked hard to resolve our concerns. They had arranged for a 'dementia tour bus' to come to the service to provide training to staff. By bringing the bus to the service 40 staff were able to attend the training. Staff were very enthusiastic about the training. The manager told us it had prompted a good discussion, with positive outcomes, for example staff said they understood they needed to speak clearer to people. One member of staff told us, "I did the bus, I got a really good insight into how it feels to have dementia, I appreciate that there are things you can change, giving better explanations." Our observations were that improvements have been achieved in staff practice.

People told us staff had the skills to meet their needs. A relative told us, "Staff have the right balance and attitude, from what I have seen they have the right skills where [Person] is concerned" and "This is one of the best homes for care – the staff are exceptional."

All staff I spoke with said training was very good and they felt competent in their role. Training was a mixture of computer based learning and classroom sessions. The manager ensured all staff had received or were scheduled to go on mandatory training. There was additional training relevant to the people they supported, for example on diet and nutrition.

In addition, the manager and deputy manager carried out a wide number of observations to assure themselves of staff competence. We looked at around 15 observations and we noted these were universally positive. We discussed this with the manager, to highlight that whilst the observations were positive, opportunities for learning were being lost as they were not as sufficiently challenging.

All the staff we spoke to told us they felt well supported. New staff were enabled to develop their skills. We heard the deputy manager say to a new staff member, "If you have any questions or are not sure about anything, come and ask me, I don't care how many times you ask, just ask." Staff received regular supervision and appraisals. A member of staff told us, "Supervision is a chance to put our views across and we get the opportunity, the office door is always open." All staff also had an annual appraisal. This looked at their strengths, weaknesses, training needs and what they enjoyed about the jobs and set future goals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made to the appropriate professionals for assessment when people lacked capacity and needed constant supervision to keep them safe. The manager kept a log of the DOLs applications so they could track where assessments had been carried out and where they were still outstanding.

A senior member of staff told us they carried out MCA and DOLS assessments and was able to describe when these might be needed. We saw an assessment had been carried out when a person without capacity was being restricted by a lock on the front door or by a floor sensor mat which alerted staff when they got out of bed. We looked into another care plan and staff had appropriately supported a person who had capacity and had chosen to put bed rails in place, to minimise the risk of injury from falling out of bed.

Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance. They were able to explain how they helped people make decisions and the importance of gaining consent. For example, one member of staff said, "I always go through people's wardrobes to offer them choices." We observed this good practice throughout our visit. For instance, we saw staff gaining consent before giving personal care.

At our last inspection there was no chef in place. The manager had told us the location of the service meant it was difficult to recruit to this position. The current chef had been in post for three months and described how they planned the menus based on what people seemed to enjoy eating. There was an emphasis on 'homemade' cooking, with cakes and soup being made at the service most days. A relative told us, "It is home from home and the food is excellent."

Staff used a screening tool to assess whether people were at risk of malnutrition or dehydration. Where people were at risk of malnutrition they had a nutrition care plan in place, which included guidance on how often they needed to be weighed. There were varied arrangements for weighing people, depending on their level of risk. Arrangements to monitor fluid levels were also personalised, which insured people were not subjected to unnecessary monitoring. The chef prepared specialist food where required, such as soft or pureed diet or fortified food. Where necessary, people had specialist equipment such as plate guards.

People were offered choice the day before, but were told they could change their minds if they fancied something else. However, we observed that a mealtime's staff put plates automatically in front of people, which did not offer opportunity for them to easily change their minds. Whilst there were pictures up showing people what was for lunch, the pictures were not always used to offer choice to people when this was done the day before a meal. Staff were not therefore using all the tools available to help communicate with people and offer them choice. The manager responded positively to discussions with us and told us staff would now offer people a choice at mealtimes, where necessary showing people two plates to enable them to decide which meal they preferred.

The atmosphere at meal times had improved since our last visit and we saw senior workers promoting good practice. Some staff were however still task based, for example, they focused on the process of assisting a person to eat and did not use the meal as an opportunity to interact with people. We saw however that the manager was consistently working on improving staff attitude and were assured they would continue to improve the dining room experience. Lunch time audits were regular and we observed the deputy manager promoting good practice and communication.

People were supported to maintain good health. On-going health needs were met and people were supported to access healthcare professionals and specialists according to their specific needs. We saw on a

person's records that staff had referred a person to the physiotherapist for support in increasing their independence. Another person was refusing to go to the dentist so staff were updating their care plan and there was an action plan in place to support their dental health. We spoke to a health professional who told us the staff worked well to put in place any guidance or actions which had been agreed on.

Good

Is the service caring?

Our findings

At our last inspection we found that whilst some staff were very caring, people were not consistently treated in a respectful way. At this visit we found received positive feedback from people and observed that staff attitudes had improved. We were particularly reassured by the measures the manager was taking to motivate staff in this area. For instance, the manager was working to positively motivate staff through a reward scheme where staff were rewarded if they went 'that extra mile' for people.

Prior to our inspection we had received one feedback that staff attitude was not positive. We saw during our visit however, the manager had been proactive in dealing with the specific concerns raised.

Feedback from people and families we met at the service was overwhelmingly positive. A person told us, "99% of the staff are good, there is always one you don't get on with but they are not unkind, I am never embarrassed, they are caring, I am always treated respectfully." One relative said, "It is fabulous, staff really care and nothing is too much trouble, they are really good with them and I have not come across one that I thought was not a good carer." Another family member told us, "[Person] has never had a bad word to say about them – staff are lovely and I come in on Sundays too and it is as good as any other day."

We observed a number of positive interactions and people looked comfortable speaking to staff. One person said, "Staff are fine, I have a laugh and joke with them." We saw another person told a member of staff that the watch they had bought out on a shopping trip had stopped working. The member of staff said, "The receipt runs out on the sixteenth, we can get you into my car with your walker and we will go and change it."

We saw that people were given a choice about their care. Staff had the skills and commitment to encourage people's involvement, if they were reluctant, whilst respecting their right to choose. We saw a member of staff inviting a person to a church lunch on the day of our visit. They told the person all their friends were coming.

When the person said they did not want to go the member of staff said, "Would you like some time to think about it, we don't leave until 11.30." Whilst the person was positively motivated they were given the right to make their decisions without any pressure.

Staff were kind when people were confused, treating with them with respect whilst also making sure they were safe. We observed a person put on their coat, and ask to go home. The member of staff said, "It's a bit foggy out there. I should hang on a bit, would you like another cup of tea?" By diverting the person, this situation was resolved without any distress.

Staff took time to reassure people. We heard a person calling out for help. A member of staff came over and chatted kindly, "Shall we raise up your chair and you can rest your legs on it. Is that better, do you want a cushion, a soft one for your head, here is a blanket." During this process the member of staff made sure the person agreed with what they had done then stayed with them until they were settled again. A family

member confirmed staff took time to speak to people. "[Person] has bloomed since coming here, the carers go beyond their duties and make time, they walk past and stop and talk and if the chair next to theirs is empty they sit and chat about [Person's] younger days."

Staff spoke of the importance of treating people kindly. One member of staff said, "Thank God we have some decent people, nothing is too much trouble – nobody says anything untoward." The deputy manager said they told staff, "Tender loving care is what we need to give." We spoke to a health professional who told us they visited regularly and found staff to be very caring, and more settled than they had been in the past.

Staff were able to communicate with people, taking the time which was needed. We spoke to a member of staff about how they communicated with a person living with dementia. They said, "[Person] uses their own signs to communicate, it's about getting on their wave length, explaining things in their terms, in ways they understand." Staff treated people respectfully, and were able to describe the importance of preserving people's privacy and dignity. A member of staff told us, "I always tell people what I will be doing, keep them covered when washing them, make sure they are comfortable and respect their choices."

We observed when a person was being hoisted their trousers came up above their knees; the member of staff noticed and pulled them down to maintain their dignity. A staff member said, "When the doctor comes, we always make sure they are seen in private, we shut the doors and close the blinds." Staff knocked on doors before entering people's rooms. A person told us, "I am always treated respectfully, they always knock and always called my name and tell me what they are going to do."

Good

Is the service responsive?

Our findings

People told us the care they received met their individual needs. One person told us, "They wash and shave me, dress me, the shower is lovely and they wash my hair – the care is 100%." Another person told us staff supported them to have a daily routine which suited their preferences. They said. "By 6.30pm I am ready for sleep, it's my choice. In the morning, I have chosen the time I get up for breakfast. Later, I go and sit in the sitting room, read my daily paper, have lunch in the dining room, do a lot of puzzle books, word search books, magazines and I am knitting myself a jumper. I like to sit and do my thing."

Other people confirmed they were able to make choices to have their care provided flexibly. One person said, "I can have a lay in if I want." We had observed another person having a late breakfast, and staff told us, "[Person] does not like to get up until after half nine."

The manager or deputy manager usually carried out the pre-assessment of people's needs prior to admission, with more thorough assessments being carried out once they had moved in. This information was used to develop care plans which were very thorough and personalised.

Care plans included a "resident choice form" which had details such as the person's preference for rising and how many pillows they wanted in bed. There was information in the forms which enabled staff to discuss memories or people who were important in a person's life. For example, one person's form told staff that one of their regular visitors had been their bridesmaid 70 years ago.

We saw staff had read the plans and knew people well. They were able to talk about people's likes, dislikes and their life history. For example, a member of staff told us, "[Person] was a seamstress, they used to make their own clothes, we both used to live in London, we chat about that."

People's needs were reviewed regularly. There was a "resident of day scheme" during which a person's needs were reviewed. Every six months there was a more in-depth review where a person, their family and any outside professionals involved in their care were invited. A family member told us they found the reviews useful, "My sister gets a review every month on changes of medicines, weight, general wellbeing, eating." Staff used information gained at reviews to respond to changes in people's needs. After a review staff arranged for a person to see their GP as they were concerned they had fallen a few times.

Staff communicated in daily record books which detailed the support people received every day. There were also separate folders for turning charts and for monitoring any other specific issues. For example, staff recorded when they checked air mattresses which were in place to reduce risk of pressure ulcers. There was a bathing log which showed people had a shower or bath once a week. We asked one of the senior staff whether anyone had more frequent baths or showers and were told they could have but we found no records confirming this.

People were supported to engage in activities and pastimes of their choice. When we arrived at the service we noted that there was a nice atmosphere in the Wickham house. The music was on low and people were

doing word searches and puzzles, some with support from staff. The atmosphere was not as stimulating in the Hatfield house. Although we also saw some staff supporting people with their individual interests, we noted the atmosphere only really became animated when the activity coordinator entered a communal area.

We discussed this difference with the activity coordinator who told us, "At Wickham its very service user led, we do what people want. I know people, what they can do and are able to do, it's more challenging on Hatfield, they don't like group activities so I mostly do 1:1 with them." For example, she told us they would read the 'Daily Chat', a newspaper published specifically for care homes, with individual people. Care notes showed 1:1 time with the coordinator was used in a person centred way, for example, to take someone to the shops to buy a new pair of shoes.

We saw some people enjoyed the organised activities on offer. During our visit, the activity coordinator took five people to a church lunch and on their return it was clear the activity had been enjoyed. The coordinator told us, "It was amazing and they loved the lunch." Family had carried out a fundraising event which was put towards regular visits which took place from a theatre production company. The activity coordinator told us, "We involve the family, we always offer for them to come on outings with us or come and enjoy the entertainment that's put on."

Family relationships were supported at the service. A family member told us, "They have been very good at keeping me informed, they are friendly to us and we don't feel in the way, they offer tea straight away. I spoke to staff today and they filled me in and even when they are busy they have time for you." Family and friends were welcomed at the service and staff supported these relationships for example, by picking visiting relatives up from the train station. We noted that there were no separate meeting rooms or lounges for people to meet with families or other visitors. A senior member of staff told us, "Families can use my room, or they can go to loved ones rooms, there are two arm chairs in here, plus two fold up chairs and a coffee table – on the other house they can use the office there too." Plans for the new property included improved areas for private visits.

Every month families received a short personalised report, letting them know how their relative was and highlighting any particular issues. A relative told us how useful they found this, telling us, "I get a letter regularly fortnightly, and it lets me know the [Person's] weight, any medication changes, if they are joining in things, what they are doing in the day and there is a bit at the bottom for my comments," People's families were asked how frequently and in what circumstances they wished to be contacted by staff and this was clearly recorded.

The monthly reports proved an excellent method of gaining relatives views. Positive communication with families and people meant there were few formal complaints as concerns were dealt with at an initial stage. Where complaints were received these were logged, investigated and people received a positive response. We looked at a complaint regarding staff attitude and saw that it had been thoroughly investigated. The manager had communicated well with the member of staff and managed the concern in a positive way. A family member told us they felt able to speak about concerns. "I have no complaints but would report to whoever was on duty that day, if I did."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the provider and registered manager already had plans in place to deal with many of the concerns we had found, for example around inconsistent staff attitudes. At this inspection we found the manager had introduced effective measures, such as the "star of the month" scheme and the investment in good quality dementia training. New care plans were being introduced gradually which provided more person centred information and ensured information was available to staff 'at a glance'. The visibility and commitment of the manager and deputy manager was most effective in driving improvements at the service. For example, they made a number of unannounced checks at night time, when they looked to see what staff were doing and that people were safe.

However the observations of staff practice which were carried out by senior staff were not being used effectively to drive improvements. There was a large number of observations, yet they rarely highlighted where staff could improve their practice. Whilst the manager had worked to address the issues around poor attitudes highlighted in our last inspection, they had not used the regular checks to support this improvement. As a result, the observations were not proving an effective use of management and staff time and could not be used to monitor change over time.

There was a well-structured programme for checking the quality of the service people received. For example, there was a daily walk around, weekly audits, a monthly health and safety audit and six monthly compliance visits by the provider. Whilst the checks were extensive they were not always effective. For example, we saw that the daily walk rounds were usually signed off without actions being required. This meant that there were oversights, for example in the deep clean of commodes, where staff were not always clear about who was responsible for certain tasks.
We noted that action was often taken when risks or concerns were found but it was clear the fabric of the building was proving an on-going challenge in terms of upkeep. The provider and manager were working on plans for refurbishment and rebuilding of the properties, which would offer an improved experience for the people living at the service. The focus on the new plans meant attention had slipped from the challenges of ensuring the existing property provided a pleasant and safe physical environment for those people still living there.

The manager acknowledged they needed to ensure they kept on top of the maintenance and cleaning of the old building. After our visit, the manager contacted us with an action plan to implement an improved cleaning regime. This included better guidance about which staff were responsible for which tasks and improving the "deep clean" timetable for each bedroom.
Feedback from people and families was positive, in particular about the personal support they received from staff and management. A person told us, "The staff are faultless." Relatives said, "The atmosphere feels good and I come unannounced, it is as relaxed at it can be" and "The manager is great and always got time for me, the deputy is lovely, fantastic and the care could not be better."

There were examples where the manager had taken action in response to feedback from people. For example, people and their families said they liked the same staff to be based in the two houses as this

provided consistency. The manager had created a more settled staff team in each house, although was able to describe the importance of ensuring there was a consistent skill mix across the houses.

The manager was very visible and told us they frequently arrived before 6am to ensure they were involved in the handover between night and day staff. This visibility was appreciated by the people we spoke to. One of them told us, "The head one is very nice and is usually here at breakfast time and in the morning." The manager and deputy manager worked positively together and their skills and style of management complemented each other well.

Staff told us they were well supported. A member of staff told us, "This home has its challenges but I am fully supported." They said they had regular staff meetings and felt confident to speak up and could make suggestions which would be actioned. A member of staff told us they had suggested using different coloured plates to support people with visual impairment and this had been done. There were also meetings held daily between the heads of each department, which helped with communication across the service.

Surveys were carried out with people, relatives and staff. Resident and relatives meeting were held every six months and there were good discussions, such as in the area of activities. We were told by the member of staff organising the meeting, "The last one was a good meeting, we spoke about having lighter meals at lunch time and the entertainment. They talked about what they would like to do – it was a very positive meeting and everyone was listened to and had a chance to put their pennies worth in."

The manager listened to what people raised, for instance when they had received a recent donation of money this had been put towards activities, partly in response to feedback received. An action plan was developed after each meeting, which was displayed on the noticeboard. There was evidence that what people said made a difference. For example, some people had asked to go and watch a football match which had been organised. A person had asked for a vicar to visit and there were now visits from the local vicar who came to carry out a service and meet with people.

The manager worked well with other agencies. For example, they had invited staff from the local authority to visit them to understand the impact of the rural location. They had looked outside of the service when accessing dementia training to ensure staff received up-to-date information and guidance.