Bupa Care Homes (CFHCare) Limited

Netherton Green Residential and Nursing Home

Inspection report

Bowling Green Road
Netherton
Dudley
West Midlands
DY2 9LY

Tel: 01384410120

Date of inspection visit:
14 January 2016

Date of publication:
25 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection was unannounced and took place on 14 and 15 January 2016.

Netherton Green Residential and Nursing Home is registered to provide accommodation and support for 120 people. The home is a purpose built building and consists of four separate single storey buildings each accommodating up to 30 older people. The four units are called Saltwell, Darby House, Windmill House and Primrose. On Windmill House, nursing care was provided to people who lived with dementia and 28 people were in occupancy. Primrose provided care for people who lived with dementia and 29 people were in occupancy. On Darby House palliative nursing care was provided and 25 people were in occupancy. Saltwell provided intermediate/rehabilitation nursing care and 30 people were in occupancy. This is a step down support unit for people discharged from hospital who were not ready to return to their own homes.

At our last inspection of July 2014 the provider was not meeting two regulations that we assessed relating infection control standards and staffing levels within Primrose unit. Improvements were also required regarding the caring approach towards people and the level of interaction from staff with people who lived with dementia, on Primrose. Following our inspection the provider sent us an action plan which highlighted the action they would take to improve. Our inspection findings confirmed that improvements had been made. However we found other areas of practice that required improvement at this inspection.

There was a registered manager in post at the home. 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.

People were kept safe from harm or potential abuse by staff who had been trained and knew how to recognise and report concerns. Information about the risks to people's safety were communicated and equipment was in place to meet their needs safely.

There were enough staff across the different units but staff were not always effectively deployed to consistently meet people's needs.

People were cared for by staff who had been recruited safely and who had received induction and training. Additional training was needed and had been planned to ensure they met people's needs and kept them safe. Staff felt that they were well supported.

People's rights were met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). 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. Assessments of people's capacity and advanced decisions made by them were known.

Most people enjoyed the meals offered. Some people were not proactively given a choice because information about meals was not provided in a way they could understand. Some people did not receive the support they needed to eat and drink sufficient amounts.

People were complimentary about the staff and described them as kind and patient. However some people's support was not sufficiently personalised to meet their needs and preferences. People's dignity was at times compromised because staff did not always promote choice or anticipate the needs of people whose communication was limited.

People told us that they felt that activities at the service were limited. We saw the provider was taking action to improve this.

People were given information on how to make a complaint and systems were in place to manage complaints. People felt the home was well led. There was a new management structure in place. We saw quality assurance systems had improved and had picked up a number of shortfalls which the registered manager had plans to address. However we found additional areas that required improvement which demonstrate care practices and processes are not consistently embedded to ensure people receive person-centred, quality care.

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.

People were at risk of not having their medicines as prescribed because medicine records had not been accurately kept. Risks associated with people's medicines had not always been identified and there was a lack of supporting information to guide staff.

Staff were recruited safely and there were sufficient amounts of staff on duty although at times people were unsupervised.

Staff knew the actions they should take if they suspected someone was at risk of harm or abuse and risks to people's safety had been identified.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not actively supported to make choices about meals and did not always receive the support they needed to eat or drink sufficiently

Staff understood and worked within the principles of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005.

Not all of the staff had the knowledge and skills they needed to carry out their roles and responsibilities.

People were supported to maintain their health and well being by having access to healthcare professional support where required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was compromised because staff did not always promote choice or anticipate the needs of people whose communication was limited.

People and their relatives were supported to express their views about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were involved in planning their care but some people did not receive consistent, personalised care.

People felt activities were limited, the provider was taking action to improve opportunities..

People were given information on how to make a complaint and systems were in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems to assess the quality of the service had improved but the ethos of personalised care needed improvements.

People felt the home was well led. Staff felt supported by the management team and were confident that improvements had and were being made.

People's views were sought and acted on. Complaints and concerns were
properly investigated and addressed.

Netherton Green Residential and Nursing 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.

Our inspection was unannounced and took place on 14 and 15 January 2016. The inspection was carried out by four inspectors and a nurse specialist advisor. The specialist advisor provided specialist nursing advice and input into our inspection processes. Our inspection team also included a two experts 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. Our experts by experience had personal experience of supporting an elderly relative.

We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke with 33 people who lived at the home, 10 relatives, nine care staff, three nurses, three unit managers, the clinical lead, registered manager and area manager. We also spoke with two health care professionals and an advocate. We viewed care files for 14 people, medicine records for 18 people, recruitment records for six staff and staff training records. We looked at complaints systems, completed provider feedback forms, and the processes the provider had in place to monitor the quality of the service.

Some people were unable to verbally tell us their experiences of living at the home. We used the Short

Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. In addition we observed staff administering people's medicines, carrying out activities and supporting people during their lunchtime meal.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2014 we assessed that the regulation related to infection control was not being met because appropriate standards of cleanliness and hygiene were not maintained on Primrose. We also assessed that the regulation related to staffing was not met on Primrose Following our inspection the provider sent us an action plan which highlighted the action they would take to improve. We inspected infection control systems and staffing levels during this inspection and found that improvements had been made and the provider had met the regulations although some variance in cleanliness was evident.

On Primrose unit we noted that corridors and communal areas were tidy and clean and equipment was appropriately stored to reduce clutter around the unit. We saw there was a variety of new seating available including two-seater sofas, recliner chairs, and bean bags and that some people were relaxing in these. The décor was in need of refreshment as it was worn in places. One person told us, "It's clean and comfortable, no smells". We saw equipment such as hoists, zimmer frames, and wheelchairs were clean. We saw checks were in place to monitor hygiene standards although the impact of this was not always evident. In Darby unit there were tissues and bits of plastic and food on the floors in the corridors which remained there throughout our visit. We saw that there was a stack of 20 walking frames stored in the corner of the dining room. The nurse told us, "They are waiting to be collected by the community stores". We saw that the area surrounding the walking frames had a layer of dust. In the other units we saw that people had a clean and tidy environment to live in.

Since our last inspection the provider had increased staffing levels on Primrose unit.There had been a number of falls and the increased staffing levels were in response to the increase in people's care needs. On each of the units we found people who lived there had different experiences regarding staff availability. One person said, "I only have to look up and ask and someone will come to me". Another person told us, "They are always available to help". A relative told us, "There seems to be enough staff and they are very helpful to people". Our observations showed that staff were able to respond to people's needs but on occasion the main lounge areas were left unattended [Primrose] for five or six minutes.A staff member said, "We try to supervise people in the lounge areas, but it can be busy". A relative visiting Saltwells unit told us, "The only problem we have seen is that it sometimes takes a while to serve the meals up, there doesn't seem to be enough staff on and people are left waiting". We concluded that the delegation of staff could be clearer. A staff member from Saltwells unit told us, "There have been incidents of aggression and we could have done with more staff" The registered manager told us they were aware of these issues and had addressed them. "We have on-call arrangements to cover emergencies but staff had not utilised these at that time. We do not expect staff to work in difficult situations without support". A senior staff told us, "We can discuss all incidents such as staffing at our daily meetings so there shouldn't be a problem". The registered manager had an oversight of staffing levels and we saw they had reviewed these accordingly as emergencies occured or people's needs changed.

People we spoke with had no concerns about their medicines and said they had them regularly. A person told us, "The staff bring me my tablets I've never missed any". We checked the medicine procedures in each of the four units and found staff did not always manage medicines consistently and medicine records were

not always accurate. We observed that one person was left with their medicines without the nurse checking they had taken them. Our checks on people's medicines showed that balances did not always match the records. There were gaps in medicine records making it difficult to establish if people had their medicines. Handwritten medicine records were difficult to decipher as there was not enough room for staff to record amounts given and their signatures. Supporting information to guide staff was available in all but one instance. Body maps had been used to identify the site of medicine patch applications. There was no consistent count of balances for medicines prescribed as 'when required'. Processes were not followed to ensure medicines were within their expiry date. One person's medicines received into the home in September 2015 had no date of opening. We were not able to establish if this medicine had passed its three month shelf life and should have been discarded. The procedures for giving medicines, in line with the Mental Capacity Act 2005 were understood and followed.

Staff told us they had received training to administer people's medicines and competency assessments were carried out before they were allowed to administer any medicines. The discrepancies we found indicated that staff did not know how to maintain medicine records which could pose a risk to people getting their medicines as prescribed. The clinical lead told us that they were aware there were pockets of inconsistencies and were aiming to share better practice across the units and a full audit was planned to this effect.

People told us they felt safe. One person said, "I'm not worried about anything, I'm quite safe". A relative told us, "We know mum is safe here we have no issues". Another relative said, "I cannot fault things here we know [name of person] is safe". We found staff knew what constituted abuse and what to do if they suspected someone was being abused. One member of staff said, "We did suspect and report an incident and action was taken to make sure the person was safe". We saw procedures were in place for reporting accidents and daily management meetings enabled the registered manager to review incidents. Staff we spoke with confirmed they had received training in the safeguarding of people. The registered manager had reported any issues regarding safeguarding to us and the local authority safeguarding team as is required to protect people from harm.

A person living at the home told us, "I am bad on my legs but the staff help me". A relative told us, "I see the staff remind people to use their frames". We saw staff supported people to mobilise with stand aids and zimmer frames and used the correct techniques to support people. On-site physiotherapists supported people to mobilies safely. People who were prone to falls had sensor alarms in place to alert staff to their movements. Sensor mats and cushions were in use and staff we spoke with were aware of who was at risk of falling and what to do to keep people safe. One person's sensor mat was not placed correctly beside their bed whilst they were in the bed which could have resulted in the person attempting to stand without staff being alerted. The registered manager told us they would reinforce to all staff the importance of using equipment safely.

A staff member told us, "Before I started work I had to have a police check and provide references". There was documentary evidence that pre-employment checks were carried out. These included the obtaining of references and checks with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. Checks for nursing staff were undertaken with the Nursing and Midwifery Council (NMC), which confirmed that the nurses were eligible and safe to practice. This ensured people were not cared for by unsuitable staff.

Requires Improvement

Is the service effective?

Our findings

A number of people were complimentary about the meals. One person said, "Actually, it's not too bad. I have Weetabix, cup of tea, a banana and toast for breakfast every day". We saw menus were available in pictorial form on one unit [Saltwells] but this was not evident in other units where they were needed to remind people about choices. Meals were served from a list of choices decided by people the previous day. We saw staff did not ask people or remind them what was on offer when the meal was served to aid their understanding, particularly for people who had dementia. Although there was a choice of two cooked meals we saw on Primrose and Windmill units [both catering for people with dementia] that all the people had the same meal which would indicate choice was not actually promoted. A staff member told us, "We do ask the day before and if someone didn't want it we would get an alternative".

On Darby unit we saw gravy or sauce was added to each meal as was custard to puddings without consulting people. Condiments were not evident on tables to enable people to assist themselves. Some people struggled to cut up the meat; a person attempted to eat the whole piece from their fork but lost most of it to their lap. We saw another person attempt to cut up the meat with a spoon. No adapted cutlery or plate guards were in place to assist people and staff were unaware of some people who needed help. A staff member told us with reference to one particular person, "We have tried plate guards but [name of person] just removes them, they eventually eat". We found people were not sufficiently supported or encouraged to eat their meals.

People at risk of malnutrition had been identified and people at risk of weight loss and not eating enough had plans in place to support their eating. Weight loss was checked and monitoring tools were in place to ensure weight loss was picked up early for action. In all but one case people's weight was monitored consistently. We discussed one person's weight loss and out of date risk assessment with the unit manager who confirmed that the risk assessment for malnutrition had not been updated since November 2015. This meant the risk to the person had not been reduced or managed. Further concerns were evident on Darby unit where people did not receive support to drink. We saw instances where people's drinks were not touched and they had not been supported to drink them. Although staff told us and we saw that fluid monitoring charts were in place we saw that people were not actively encouraged to drink at regular intervals. The registered manager and clinical lead told us they recognised from their own observations and monitoring that the mealtime service needed improvement and they had developed an action plan to implement across the units. Mealtime experiences on the other units were more positive; people had the support and encouragement to eat their meals. Staff sat and engaged with people and prompted them and as a result one gentleman was offered a number of alternatives and ate a full meal. People's dietary needs were assessed and diabetic or soft meals were catered for.

People told us staff knew how to support them. One person said, "I have got better; I have more confidence to get up and walk". Another person said, "They are wonderful here, always help me and encourage me". A relative told us, "We are very happy with [name of person's] care, it is the best that it can possibly be, and we have no concerns at all". A visiting health professional shared that staff knew people's needs very well. A second visiting health professional told us, "They are all good here, always helpful, I've never had any

issues."

Staff told us they received an induction before they started work which included training and shadowing other staff members. One staff member said, "In my week's induction I learned so much about people's needs". Staff files held documentary evidence that induction processes were in place. The registered manager had implemented the Care Certificate. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people's care. All of the staff we spoke with told us that they felt supported in their role. One staff said, "Such positive changes; home manager is very supportive, he really listens and the clinical lead is fantastic, very supportive of the staff and the residents". Staff told us that they had regular supervisions and an annual appraisal to reflect on their care role and performance. Staff had received a range of training but did not always demonstrate that they had the knowledge and skills they needed to carry out their caring role. The registered manager had planned further training to include dementia awareness so that staff could support people on the different units.

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 interest 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.

We saw staff sought people's consent and accepted when people declined support. One person told us, "They always ask me if I want to do something". Another person told us, "Well they do ask first because sometimes I don't want to do something". We saw that people made their own decisions about where they sat, what time they got up or went to bed.

Staff we spoke with understood they could not restrict people's liberty. Records that we looked at confirmed that some people needed restrictions to keep them safe. We saw applications had been made to the local authority and these had been approved. Staff could describe the restrictions in place for individual people and had received training in MCA and DoLs. We saw they practiced effectively to ensure that people's human and legal rights were respected. Where people lacked capacity regarding aspects of their care, decisions had been made on their behalf and in their best interest. These decisions had been recorded to guide staff. A nurse told us, "Where people are unable to make decisions we have to consider their best interests and involve other people such as their family, GP or social services". Some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) instruction in place. Staff understood this process so that people's decisions about DNACPR ensured the person's wishes were known.

People told us that they saw the doctor when they needed to. One person said, "The doctor comes every day". A relative told us, "I have no concerns about their health; they see the doctor and the nurse". Referrals were made to health professionals such as the dietician and speech and language therapist for advice where people had difficulty in swallowing. We saw that recommendations made were available in people's care plans. Some people had on site physiotherapy and told us that this was an important part of their rehabilitation. One person told us, "I have improved so much here, they have been very good and I am looking forwards to going home". Staff we spoke with were aware of people's health care needs. However the lack of support to people with meals and drinks could lead to health issues.

Requires Improvement

Is the service caring?

Our findings

Staff were generally responsive to requests from people who were able to communicate with them. However, at times there was limited anticipation of people's needs; particularly where people could not always communicate their needs. For example our observations over mealtimes showed people did not always get the caring response they needed; people were left unsupported to try and eat their meal, food dropped into their clothing, and limited choices about the meal they were provided with.

We found that there was a lack of consistency across the units to ensure that people's likes and dislikes were acted upon. On Primrose two people told us that their needs were not responded to. Both people independently of each other told us they had not had a bath or shower 'for weeks'. One person said, "Since I've been here, I've had one shower and one bath", the other person told us, "I feel as if I need a shower but I can't seem to get one. It's been three weeks I'd like a bit of attention". We checked the care records for each person for the preceding month and confirmed that one person had a bath once that month the other person had no record of a bath. We found that the provider has improvements to make so that care is organised in a way that ensures the dignity and respect. The registered manager told us they had invested in training and would be monitoring the impact of increased training on each unit.

People living on other units were complimentary about the staff. One person told us, "Most of the carers do care, some are very kind". Another person told us, "They are excellent; [pointing to a staff member] she's my keyworker. She bought me about three bracelets". People told us they were happy and that staff knew what care they needed. Relatives and friends said that people were well cared for. Their comments included, "No-one in the family has got any qualms. We didn't want [name of person] to come into a home, but we're so happy". Another relative told us, "She's looked after, staff take care of her".

On Windmill unit we observed a number of caring interactions between staff and people. One person expressed some confusion and was comforted by staff and offered biscuits which she enjoyed. We saw a person was taken ill and staff responded with compassion; reassured them, assisted them to change their clothes and brought them tissues. We saw people had been assisted with their appearance; care had been taken to co-ordinate colours and outfits. People confirmed that they were supported with their personal care and had access to baths and showers regularly. A person said, "I have a shower every two days". We observed that people looked well presented. A relative told us, "[Name of person] always looks clean and smart and smelt nice the other day when we came in". The staff took pride in their roles to support people in this area. We saw that staff regularly checked on people in their bedrooms and spent time talking with them.

On Saltwells unit the interactions between staff and people were kind and compassionate. People told us, "It's nice – everything you want you get. They're angels". Another person said, "It's a weight off my shoulders to be here". Staff acknowledged people by name and took interest in what they were saying. One person told us, "They [staff] are excellent; she's a lovely girl [referring to the unit manager], she's a brick".

People told us that staff were polite and respectful and spoke to them in an appropriate manner. One person said, "They are respectful and try to assist me, I don't get fobbed off". Staff told us they tried to get to know people and their histories so that they could engage with them in conversations. We saw that staff tried to spend time with people enjoying a conversation although this was less evident on Primrose and Darby House.

We saw on all of the units that staff protected people's dignity and privacy whilst personal care was being provided. Staff ensured that doors and curtains were shut and we saw they assisted people to adjust their clothing or their position if their dignity was being compromised.

Staff told us that they would ask people what they would prefer to be called. People told us that staff knew their preferred name and used this. There was information about people's choices and routines and most people told us these were respected. On most units we saw staff offering people choices about where they wanted to sit, what they wanted to eat or activities they wanted to do. Several people chose to eat in their bedrooms and were happy with this. We saw people had personalised their rooms and had been encouraged to bring in possessions to make them feel comfortable. Family and friends told us that they were made welcome. One relative said, "I visit every day, always welcomed and staff will chat to me and update me, I think the staff are very kind".

Information was available for independent advocacy services. The registered manager confirmed that advocates had been used where people needed support to make decisions. We spoke with a visiting advocate who told us they were supporting a person with regard to their care.

Requires Improvement

Is the service responsive?

Our findings

On Darby unit we found that support was largely task based and care was not sufficiently personalised to meet people's individual needs and preferences. We observed staff were busy and did not always interact with people. We spoke with a visiting advocate who told us there had been historic issues of a lack of person centred care. On Primrose we saw people did not always receive personalised care.

A person from Darby said, "I don't go into the lounge because you cannot talk to anyone – it does get so lonely in here. There are no activities – I would be really fed up if it wasn't for the TV". The unit manager told us that they were working on opportunities and a weekly tea dance had been organised at the local pub which was displayed on the activities board. We saw a gardening activity take place with some people enjoying planting spring bulbs in pots.

People on other units told us that there were things to do and enjoy. One person said, "They've just started a little church service every Tuesday & I do look forward to it". Other people told us: "Sometimes we have a karaoke", and, "We went on a trip to Weston Super Mare. It was lovely". Another person said, "We have a regular singer – he's good. We have games, bingo, karaoke and a church service every now and then". We saw over the two days that varied activities took place on different units. One person on Saltwells unit told us, "There is a person who comes and spends time with me for a chat sometimes". Another person told us, "I spend most of my time in my room but I do go and join in the music activities. They have singers visit sometimes and we can join in and sing along that's really good". On Primrose unit we observed people enjoying a pampering session. There were examples of people's work on the wall and we noticed a supply of games, books and crafts.

There were two activities co-ordinators who worked across the units who told us they were trying to increase the range of activities on offer for people. Some people had been taken out for lunch on a monthly basis and a bowling trip was being arranged. Both activities workers acknowledged the range and frequency of leisure opportunities could be improved. Whilst there was a variety of activity provided we found that people's preferred leisure pastimes although detailed in their care files, were not offered consistently. One person took part in seven activities over a three month period, another person took part in eleven.The activity records did not indicate regular activities were taking place.

We saw that before people were admitted to the home a full assessment of their needs was undertaken. This detailed all the person's personal and health care needs and how these should be met. Most people told us that they felt staff supported their needs. One person told us, "I discussed my needs at the assessment and staff do follow my plan". People told us they generally had the care and support they needed and that staff knew their needs and routines. Staff spoken with were aware of people's needs and were able to tell us what they liked, how they wanted to be cared for and what they were able to do for themselves.

We saw that care plans captured people's needs and personal routines and had been reviewed with them on a regular basis. One person had required one to one care at a specified time of day. This had been reviewed and was no longer necessary and the care plan had been updated. We saw that the cultural needs

of a person had been considered in relation to hair and skin care and this had been detailed in their care plan and followed by staff. Care files showed that where people were not able to contribute to their care plans their families/representatives had been consulted. On Saltwells and Windmill units our observations showed that staff responded to people's needs. The staff showed an interest in people and care tasks were carried out with a smile and kind word. Visiting relatives were full of praise for the staff and complimentary about how staff responded to their needs.

People told us they attended meetings to discuss things they would like to do and any improvements they would like to see in the home. One person told us, "We do have meetings; I have never raised anything though because I am really happy with everything." People said that they had been asked for their views via surveys. The registered manager told us they used feedback as a means of making improvements. They also conducted their own quality checks and had identified where improvements were needed for example the meal time service and provision of activity co-coordinators.

People were not always sure of how to raise a complaint but confirmed they had been provided with information. One person said,, "I was given a book but I'm not sure what to do with it". Other people told us they had no complaints and were happy with the service. We saw from records that three complaints had been made regarding standards of care. Each had been investigated and some escalated for further enquiries. We saw that letters had been sent out to the person and their family with an outcome and an apology. We saw that action had been taken to improve practice following complaints so that learning from complaints was implemented.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2014 we assessed the provider's quality monitoring systems had failed to ensure that shortfalls relating to infection control standards and staffing levels had been addressed. At this inspection we found that the provider had made improvements to the cleanliness and checks on the environment. We saw that infection control audits were carried out and walk around checks to view the standards on each unit were in place. We saw this was not fully effective as there was evidence in Darby unit of waste and dust.

We saw the provider had taken action to increase the staffing levels on Primrose unit in response to the higher dependency needs of people. There had been a number of falls and the increased staffing levels were in response to the increase in risks in people's care needs. Whilst we found there were sufficient staff we saw they were not always visible and therefore clearer delegation of staff was identified. The registered manager told us they were visiting units to monitor staff presence and performance.

People and their relatives were complimentary about how the home was managed. A person said, "I think it is quite good; they try". A relative said, "I've always had good responses from managers when I had queries".

The provider had notified us of accidents and incidents as they are required under their statutory obligations. Staff had information about whistle blowing and told us they would have no concerns about reporting poor practice of colleagues.

Since our last inspection there had been changes to the management structure. A new registered manager and clinical lead person were in post. Staff told us they had noticed a lot of improvements in the home since the changes; particularly communication. We saw the clinical lead had introduced monitoring tools to use on eachThis was a large home with four different units meaning the registered manager was reliant on good communication from the unit managers and staff to ensure the home was well led. One member of staff told us, "We now have a clinical lead. She will come and talk to us about how to improve the care we provide to people." Another member of staff told us, "We are all striving to give the best care possible. This is shared amongst all of us and we are well supported by managers to improve the service." Each of the unit managers were complimentary about the senior managers. They told us they would have no problems approaching them with ideas or for support.

We saw that daily meetings were held with each unit manager and heads of department to discuss any issues or concerns and to identify and respond to any risks to people's welfare. The unit managers told us that they found the meetings useful and supportive. We saw that some risks had not been identified in care records and therefore record keeping is an area for improvement. Staff were particularly complimentary about the new clinical lead. One unit manager said, "She has been absolutely brilliant; she talks to us, advises us and checks we are following up on issues". The clinical lead was able to show us a number of audits and tools to monitor aspects of the service. We saw that a falls analysis tool was used and that action had been taken to update people's risk assessments and source appropriate equipment. We saw staff used

a 10 point audit tool to check medicine records but we found this did not identify the shortfalls we found. Mealtimes had been audited and shortfalls identified. The clinical lead was implementing an action plan in each unit to share good practice from other units to rectify shortfalls in these areas.

The management team had worked on the tools and platforms needed to obtain an oversight of the standards within the home. The registered manager told us, "We have worked very hard to improve and we are continuing with our efforts". Further training was planned to support staff with the skills necessary to drive good practice. We saw that further development of the staff team was needed on some units to ensure all staff displayed the right values towards people. For example ensuring that staff understand how to protect people's dignity and provide a caring, person-centred approach.

A regional manager, quality manager and Admiral nurse [a nurse who works and supports people living with dementia] visited the home to complete audits and review specific areas of practice. We saw this included people's care plans, risk analysis, management of pressure sores, falls and accidents. Training and staffing levels and other aspects of the home were also reviewed. Where shortfalls were identified measures were put in place to address them. For example checks on quality had resulted in an improvement plan for mealtime experiences. The registered manager was aware of the shortfalls and was trying to address these; dementia training for staff had been identified. There had been some changes to the unit managers and we saw that their needs were being considered to ensure they had the training and support to manage their unit. Where there had been a lack of effective audits since our last inspection progress had been made.

The findings showed that the provider had processes in place to work towards improvement and development. They had taken reasonable steps to identify the shortfalls in their own service provision. They recognised what needs to change so that care practices are consistently embedded to ensure people receive person-centred, quality care.