Bupa Care Homes (ANS) Limited

Collingwood Court Care Home

Inspection report

Nelsons Row
Clapham
London
SW4 7JR

Tel: 02076271400

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Collingwood Court Care Home provides accommodation and nursing care for up to 80 older people, some of whom had dementia. There were 56 people living in the service at the time of the inspection.

We last inspected the service on 29 February and 2 March 2016, where we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to medicine management, safeguarding people from abuse and unsafe treatment, dignity and respect, and good governance. The service was rated requires improvement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Collingwood Court Care Home' on our website at www.cqc.org.uk. The provider sent us an action plan on how they would make the required improvements.

We undertook an unannounced comprehensive inspection on 22 June 2017. At this inspection, we found the provider had made the required improvements from our previous inspection and met the legal requirements. We rated the service Good at this inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received their medicines in line with their prescription. Medicines were managed and stored securely to ensure they were safe. Controlled drugs received additional security audits to ensure they were not misused. Risk assessments identified issues that could pose risks to people's health and safety, and management plans were in place to promote people's health well-being.

People were safeguarded from the risk of abuse and improper treatment. Staff had received training on safeguarding and they were knowledgeable on the procedure to follow if they had any concerns. There were sufficient staff available to meet people's needs safely. Staff knew the procedure to follow to respond to emergency situations and events. Recruitment practices were safe. Applicants underwent checks before they were allowed to work at the service.

People consented to their care and support. People's relatives and, where needed, professionals were

involved in best interest decisions. The service complied with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in these areas and understood their responsibilities.

People's nutritional needs were met. People were supported to eat and drink as required. They were given choices of what to eat and drink and they had access to food and drinks throughout the day.

Staff were trained, knowledgeable and had sufficient experience to provide good quality care to people. They understood the needs of people and how to care for them. Staff received regular support and supervision to carry out their duties effectively. They liaised with various healthcare professionals to meet the needs of people. Healthcare professionals told us staff followed recommendations they gave.

People told us staff were kind and caring. We observed that staff treated people with respect and promoted their dignity. Staff communicated to people in the way they understood. They demonstrated an understanding of people's likes and dislikes and preferences. Staff also provided care to people in line with their preferences and choices. People at the final stages of their lives were supported in line with their wishes and were cared for in a dignified way.

People were kept occupied and encouraged to participate in activities. There were a variety of activities available at the service to occupy people. People were supported to maintain their religious and cultural beliefs.

People had their individual needs assessed and their care planned in a way that met their needs. They received care that met their individual needs and promoted their well-being. Staff held reviews with people and their relatives to ensure they support they received reflected their current needs and care plans.

People knew how to complain if they were unhappy with the service. The service followed their procedure to respond to complaints. People and their relatives had opportunities to share their views and give feedback about the service and these were acted upon. Regular audits and checks took place to assess and monitor the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were safeguarded from abuse because the provider had systems in place to ensure this. Staff were trained and understood the various forms of abuse that could occur and the signs to look for. They were aware of the provider's reporting procedures if they suspected abuse.

Risks were thoroughly assessed and management plans devised to reduce identified risks to people in order to keep them safe.

People received their medicines in line with their prescriptions. Medicines were managed safely including storage, recording and administration.

Staff deployed to work at the service underwent checks to ensure they were suitable for the roles they had applied for. There were sufficient numbers of suitably skilled staff to meet people's needs.

The environment was safe and well maintained. Health and safety checks took place.

Is the service effective?

Good

The service was effective. Staff were trained, supported and supervised to meet the needs of people.

People consented to their care, and where required, relatives and professionals were involved in the decisions. People had their care provided in line with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff and the manager understood their responsibilities under MCA and DoLS.

People were given food and drinks to meet their nutritional needs. People told us they enjoyed the food provided at the service.

People had access to a range of healthcare services to maintain their well-being and health.

Is the service caring?

Good

The service was caring. People told us staff were kind and friendly, and treated them with respect and dignity.

People were involved in planning their care and their views were taken into account.

People were supported to maintain relationships which mattered to them

The service provided care for people in the final stages of their life in line with their wishes.

Is the service responsive?

Good

The service was responsive. People received care and support which met their individual needs. People were able to follow their interests and participate in activities.

People knew how to complain if they were unhappy about the service and their complaints were responded to, in line with the provider's procedure. People were asked for their views and feedback about the service and these were used to improve the service provided.

Is the service well-led?

Requires Improvement

There was no registered manager. The service was run and managed by the regional support manager and area manager. Staff told us they had the leadership support they needed.

The service worked with other organisations to improve the service. There were a number of systems in place used to check and assess the quality of the service. Actions identified through quality assurance processes were implemented.

Collingwood Court Care Home

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 22 June 2017. The inspection team consisted of three inspectors, a specialist advisor and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse. The inspection team arrived onsite at 6am. This was because we wanted to see that people's choices were respected in terms of the time they woke up in the morning.

Before the inspection we reviewed the information we held about the service which included notifications of events and incidents at the service. We also studied the Provider Information Return (PIR) we received from the provider. The PIR is a form that requires providers to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During the inspection we spoke with seven people who used the service, five relatives, eight care workers, five registered nurses, two student nurses, one activities coordinator, the deputy manager, regional support manager and the area manager. We also spoke with two visiting medical practitioners.

We looked at 16 people's care records and medicines administration record (MAR) charts for the 56 people using the service at the time of our visit. We also reviewed six staff files including records of supervision and

recruitment. Additionally we checked other records relating to the management of the service including complaints, and documents relating to health and safety, and quality assurance systems.

After the inspection, we received feedback from two healthcare professionals involved in the care and treatment of people at the service, and the contracts monitoring officer from the commissioning authority.

Good

Our findings

At our last inspection of March 2016 we found that people were exposed to poor and unsafe practices in relation to how medicines were managed. We also found that the service had not followed their procedure to address allegations of abuse. They did always send us notifications as required and had not completed investigation in all cases.

At this inspection people and their relatives told us they felt safe. One person said, "Yes, I am well treated." Another person said, "…I do feel safe, I lock my room." We saw that the service had put measures in place to protect people from the risks of abuse and neglect. Staff understood the different types of abuse and the signs which might identify them. They were aware of how to report any concerns to their manager in line with the provider's safeguarding procedure. Staff felt confident that any concerns they raised would be taken seriously. One staff member said, "I know the various types of abuse. We have done a lot of training about it. I know how to report it to my manager. They [manager] will definitely do something. If they don't I won't keep quiet; I will call CQC." A nurse we spoke with told us, "Safeguarding is all of our business. I know the signs and I will surely report it and monitor that the resident is protected. The home manager takes it seriously too. I have a duty of care to contact social services if they [management] overlook my concern." The manager kept track of any safeguarding allegations raised and action subsequently taken. The records matched the notifications we received from the provider. These allegations were reported to the local authority safeguarding team, investigated and plans put in place to reduce reoccurrence.

People received their medicines safely in line with the prescriber's instructions. Medicines were administered by qualified nurses only. We observed a staff nurse administer medicines during our visit. They checked medicine administration records (MAR), prescriptions and labels on medicines blister packs to confirm relevant details such as each person's name, the name of medicine, dose and method of administration before they dispensed the medicines. They also informed and obtained consent from the person before giving them the medicines. We saw that MAR charts for the three week period prior to our visit were correctly and clearly completed. There protocols in place for staff to follow to administer 'as required' and covert medicines.

Controlled medicines (CDs) were kept in a separate locked cabinet. Staff understood and followed the guidance in place for the administration of CDs. Records showed they were regularly audited and accounted for. Staff were also clear on the actions they would take in the event of a medicines error. They told us they

would contact the person's GP for advice and if required call emergency service. They also stated they would complete an incident report and send a notification to CQC. Records showed staff undertook daily checks of MAR charts and medicines stocks. This enabled them to identify any errors promptly. We found records to accurately reflect current stock levels from the sample we reviewed.

Medicines were stored securely and safely. These were locked in medicines trolleys which were kept in a locked room in each unit. Only staff responsible for medicines had access to the keys to these rooms. Medicines which required being stored in a temperature controlled environment were kept in a fridge and the temperature of the fridge monitored daily. We reviewed records of temperatures maintained and they were within the acceptable range for the safe storage of medicines.

People were protected against risks associated with their well-being, health and safety. Risk assessments were completed comprehensively and appropriately. These included manual handling, pressure sores, malnutrition, choking, falls and mobility. We saw action had been taken to manage risks safely. For example where risks to people's skin integrity had been identified, the service had involved the tissue viability nursing (TVN) team to help manage and reduce the risk of people developing pressure sores. We spoke with a TVN who visited the service on a regular basis and they told us they had trained staff in managing this area well, and were pleased with the way in which the service had worked to reduce the risk of people developing pressure sores. We saw that there were body maps documenting any wounds and these were well completed. We noted that people at risk had pressure relieving equipment in place to help reduce the risks of developing pressure sores. Where required, people were also supported to change positions in bed to reduce the risk of pressure sores developing. Charts showed staff followed the plan and assisted people to turn in bed. Staff knew the importance of managing incontinence issues and maintaining good hygiene by ensuring people were clean and skin well moisturised as part of managing risks of pressure sores.

People at risk of choking had management plans in place with the involvement of speech and language therapists (SALT). The plan included information about the types of food texture and fluid consistency that was safe for them. One person's had pureed diet and thickened fluids only in line with the recommendations of SALT. The person must also sit in an upright position when feeding. We tracked this person during mealtime and saw that staff complied with the instructions on the person's care plan. Moving and handling plans were also in place for people to ensure they were transferred safely from one place to another. We observed staff hoisting one person from an armchair in to a wheelchair. They followed safe transfer procedures. Staff told us they were up to date with their moving and handling training. We confirmed from care records and observations during the inspection that staff followed risk management plans in place and people were supported in a way that promoted their safety.

There were mixed views from people, relatives and staff as to whether staffing levels were adequate. One person said, "Yes, I think there are enough. They are visible." Another person told us, "No, there are not enough night and day." A relative said, "Yes mostly OK, very quiet here." Another relative said, "There are times at nights there are not enough staff, I have observed. If staff go off sick they are not always covered but take someone [staff] from another floor to cover." One member of staff told us, "We are fine now. The problem is when the unit is full if they [management] don't increase the number of staff it will be hard. Sometimes they do if we complain. Let's see what they [management] would do when that time comes." Another staff member said, "For now it is fine and manageable because the home is not full. When it is full capacity, sometimes they [management] don't always increase the number. We have complained in the past." Staff told us that the manager always made effort to cover absences but sometimes not successful if it was short notice. They told us they worked flexibly to accommodate instances like those and were encouraged to do extra shifts. Rotas showed each unit was led by a qualified nurse and supported by care staff. This matched what we saw for the night and day shifts when we visited.

We observed on the day that people's calls for help were answered promptly. We saw staff were able to support people in an unhurried manner. We discussed the concerns staff had raised about staffing levels with the regional and area managers who told us that staffing levels will be reviewed regularly using their staff determination tool. They explained that staffing levels were planned according to people's needs and occupancy. We saw the assessment conducted to determine the current staffing level and we were satisfied.

People were supported by staff who were recruited safely. Recruitment records showed at least two references and criminal record checks, identification and right to work in the UK were obtained for staff before they were allowed to start working at the service. We saw the registration status of qualified nurses had been checked with the Nursing and Midwifery Council to ensure they had not been disqualified from practice. Their experience, knowledge and qualifications were also checked as part of the recruitment process. This meant that only staff that were deemed suitable were allowed to support people.

The health and safety of the environment was safely maintained. Risks had been assessed in relation to the management of infection, clinical waste, gas, electrical, and fire safety. Fire safety checks were carried out on a monthly basis. Staff told us, and training records confirmed that they had completed fire safety training. Portable appliances were tested to ensure they were safe for use. Equipment including firefighting and moving and handling tools were tested and serviced annually to ensure they were functioning properly and safe. Staff were aware of what to do in the event of a fire to keep people safe. We saw that fire doors were not wedged or obstructed to stop them from shutting automatically if alarms go off

Good

Our findings

At our last inspection of March 2016, we found the people were at risk of their liberty deprived as care records directing staff to use restraint were not written in line with the provider's policy and health and social care professionals had not been involved, consent or best interests had not been considered and staff had no training in remaining techniques. At this inspection we found that the service had complied with the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). We saw that service, in conjunction with relevant professionals, had assessed people's mental capacity in relation to specific decisions being made. Where appropriate people's records included details of mental capacity assessments having been conducted and best interests decisions made. These were clearly completed explaining the reasoning behind the decisions on capacity and covered everyday care, medication, and the use of restrictive equipment such as bed rails and wheelchair lap belts. Staff knew not to use force or use any form of restraint without being given the due authorisation and training to do so. There was no record, report or evidence to suggest that people had been restrained or deprived of their liberty unlawfully.

The 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. People were supported to consent to their care. Where people lacked the mental capacity to make specific decisions, records showed relatives or an appropriate representative such as an advocate had been involved in making the decision in their best interests. The manager and staff had good understanding of MCA and their responsibilities. DoLS applications were made to the relevant supervisory body where it was deemed necessary to maintain the person's safety. The service maintained record of DoLS endorsements and reviewed conditions attached to these regularly to ensure they cared for people with these in mind.

Staff received relevant training to enable them to care for people well. Staff told us, and training records confirmed that they received ongoing training. A member of staff said, "That's one good thing about Bupa; very good up to date training." Another staff member said, "We are always asked to do training. Sometimes

online, sometimes we go out. I think I have done all the training I need. We do refreshers too." Records showed that new staff completed an induction when they first started. The inductions covered learning about the organisation, policies and procedures and skills required to meet the needs of people. Training records confirmed that both care staff and nursing staff had completed training in moving and handling, safeguarding, health and safety, dementia care, dignity and privacy, and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We also saw that staff completed 'refresher' courses regularly to ensure their knowledge and skills were up-to-date. Staff also received training in specific areas such as diabetes and pressure sore management. These training areas provided them with the knowledge, skills and experience to care for people with specific conditions.

Staff told us they were supported and appropriately supervised in their roles. One staff member told us, "I get regular supervisions – every three months. They discuss your challenges, what you are good at and what you are not so good at, or things they need you to change." Another member of staff said, "I feel supported. If I have concerns or need to talk about something I can talk to any of the managers." Notes of supervision meetings confirmed supervision was held regularly. Issues discussed included the well-being of people using the service, team work, health and safety and training needs. Staff appraisals were also held annually and these were used to address performance issues and to analyse training needs to enable staff to improve their knowledge and skills, and develop in their careers.

People were appropriately supported to meet their nutritional and hydration needs. People told us they liked the food provided to them. One person said, "It is alright, I eat the food, I get a choice." Another person told us, "I get plenty to eat and drink." One relative said, "I think they are well fed, drinks are always available." Another relative commented, "They drink very often day or night, food anytime they can get it, very good food, and hot meals three times a day." People's care plans included information about the support people required to maintain a balanced diet, including any special dietary requirements. We saw staff supporting people in line with their care plans. We observed staff giving people choices of what to eat and drink. We saw that people who chose to eat in their rooms or were unable to leave their rooms also got the assistance they required during mealtimes. Staff offered snacks and drinks to people at regular intervals of the day. The day we visited was a hot day and we saw staff actively encouraging people to drink plenty of fluids. There were jugs of water available in people's rooms and in communal areas making it accessible to people.

People had access to healthcare services when they needed them. One person said, "I do see them especially the doctor often. I have seen the optician recently." From records we reviewed there was significant evidence that people received input from a number of other healthcare professionals when required. These included tissue viability nurses (TVN), a palliative care team, podiatrist, GPs, dentist, optician, and dietitian and community psychiatric nurses. Professionals we contacted told us that the service liaised with them and followed any instructions they provided to meet people's healthcare needs.

Good

Our findings

At our last inspection of March 2016 we saw staff did not always respect people's privacy and dignity. At this inspection we noted that people's privacy and dignity was respected. We observed that staff knocked on doors to people's rooms and waited for a response before entering. On different occasions we saw different staff members assist people with their toileting needs. They informed the people what tasks they were going to undertake and checked with the people if they agreed. The staff spoke to the people in a dignified manner and ensured they were as discreet as possible. They closed the doors while they assisted the person in the toilet. On other occasions, the staff waited outside the toilet after making sure the person was comfortable and safe. The staff member explained that the person would call for their help when they finished. The staff members added that it was inappropriate to stay in the toilet with a person when they do not need this level of support as it would make the person uncomfortable. Staff we spoke with understood what it meant to promote people's dignity and privacy. They were confident in giving us examples of how they promoted this in their day to day work.

People and their relatives told us staff were kind and caring. One person told us, "All staff polite and kind." Another person said, "They staff do not swear at us." A relative told us, "Oh! Yes, [people are] very much treated with dignity. They [staff] are very hands on; I could not say a bad word against them."

We observed caring interactions between staff and people. Staff knew people well and were friendly towards them. They addressed people with their preferred names and knew how to engage with people and cheer them up if needed. For example, we saw one staff member encourage a person who was restless and becoming agitated to settle and relax. The staff member started singing a song the person liked and the person joined in. This enabled the staff member to escort them to the lounge and settle them. Staff showed empathy and understanding in the way they approached and cared for people. We observed gentle touches being used to reassure and comfort people. On one occasion, a person requested a hug and the staff did not walk away but stopped and held the person's hands.

Staff understood people's needs and preferences, and cared for people accordingly. Clear information was provided on records about people's choices around their care and routines. People and their relatives, where possible were involved in their care planning. We saw staff complied with people's choices and daily routines. When we arrived onsite for our inspection, the people awake early that morning confirmed it was their choice. We saw that people were assisted in and out of bed as they wished. Staff communicated with people in a way they understood. One staff member bent down to a person's level and maintained eye contact with them while speaking to them. In another example we observed a staff member speaking to a

person who they realised could not hear them, so they adjusted the person's hearing aid to enable them to understand what they were saying.

People's relatives could visit the home as they wished. We saw relatives and friends visit during our inspection. They told us they were always welcomed. Some relatives spent time with people in the communal areas and some visited people in their bedrooms. Staff gave them the space they needed.

People received the end of life care they wished. There were Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documents in place. Most were appropriately completed with information and in consultation with people and their relatives and GP. The reason for the decision was also stated. In one case the discussion with the person stated that they wanted full active treatment but not CPR. We saw that specialist nurses such as end of life nurses and GPs were involved in the care of people at this stage of their lives so that they were kept comfortable and pain free as much as possible. The nurses we spoke with demonstrated they understood people's DNACPR status. They also showed they knew people's end of life plan, how to manage the people's pain and who to first contact if the person was near to death or had just passed. A staff nurse gave an example in relation to a person who had clear religious requirements for them to follow. The nurse demonstrated they understood the person's plan well and felt confident they would fulfil it accordingly.

Good

Our findings

People's individual needs were met by the service. People and their relatives told us that they received the care they needed. One person said, "I get treated as an individual." A relative told us, "I believe [relative] gets what they need day to day." Care records showed initial assessments took place before people were admitted to the service. The deputy manager explained that the assessment process gave them the opportunity to know the person, understand their needs and establish if the service could meet their needs. It also gave the person a chance to decide if they wished to move into the service.

People had a personal profile of themselves included in their care file. The profile gave summary of their physical health, mental health, personal care and social needs. Information about their backgrounds, likes and dislikes, interests, hobbies, preferences and routines were also included.

Care plans were devised based on identified needs and how these needs would be met. The information provided on the care plans we reviewed were detailed and provided staff with the necessary guidance they needed to support people appropriately. Staff told us, and our observations and reviews of daily logs confirmed, they understood people's care plans and complied with them. For example, one person with a mental health condition and cognitive impairment care plan which stated how staff were to support them to manage their behaviour and confusion. Relevant professionals such as the local mental health team and a psychologist were involved in the person's care and provided support to ensure their needs were met. The person's care plan stated that staff should provide emotional support in the form of listening and reassurance as a way of supporting them with their behaviour. It also emphasised the need to involve the person in activities and one-to-one discussions. We saw staff support this person in accordance with their care plan. Another person's care plan detailed how staff were to support them manage and improve their nutritional intake as they were underweight. Staff had involved a dietitian and monitored the person's weight weekly. They followed a special meal plan which included build up foods and drinks with the right level of nutrients and calories. Staff also kept record of the person's food and fluid intake to ensure this was monitored. Records showed that the person's weight had gradually increased. A nurse we spoke with told us they would continue with the plan until the person's weight reached the recommended level.

People with diabetes, heart conditions, and other physical, mental and/or personal care needs also had care plans on how their individual needs and conditions should be met. However, we noted that information on one care plan was not sufficient enough, although when we spoke to the nurses and staff on duty they understood these needs and were clear how they supported the person in question and ensured their needs were met. For example, one care plan noted the person had haemodialysis. There was no

information in a care plan indicating a fluid restriction or special dietary needs. The nurse could tell us about this and understood the reasons and importance but it was not documented. They took immediate action and included this information in the care plan and also put up a notice for staff on the fluid restriction so that all staff would be aware of the restriction and the importance of documenting it. Staff told us changes in care plans were communicated through handover meetings and in people's daily care notes.

We recommend the provider reviews care planning and recording within the service to ensure all people's needs are appropriately documented.

People's cultural and religious needs and requirements were met. One person's food was prepared in a specific was to meet their religious requirements. The catering staff were aware of this. Another person only had female care staff attend to their personal care needs as requested in line with their personal and religious requirements. Local religious ministers visited to conduct services and people were supported to attend if they wished.

People had a range of planned activities that they participated in to keep them engaged. The service had an activities coordinator who was in charge of planning activities. We observed the activities coordinator deliver a session of activities. They encouraged and engaged people well and ensured they received the support they needed to participate to their level. There were a lot of jokes and laughter indicating people enjoyed the session. The activity plan included both individual and group activities and indoors and outdoors. Special themed events such as Valentine's Day, St Patrick's Day, and black history month were also celebrated. People told us of a recent music performance that took place. They shared how much they loved it. People who preferred not to or were unable to join in group activities due to their circumstances received one-to-one activity time with the activities coordinator. These people were engaged with activities such as reading a book of their choice, singing, massage and beauty therapy like pedicure and manicure. We saw posters of various events that took place and it reflected a diverse range. This showed people had time to socialise and relax as they pleased.

The service sought feedback from people and their relatives and welcomed their contribution and suggestions on how they wanted their service delivered. Regular meetings were held with people and their relatives. Minutes of most recent meeting we reviewed showed updates were provided from previous meetings and relatives were involved in planning the service. For example, they contributed to the planning of the menu and activities offered to people.

People and their relatives told us they knew how to make a complaint. The service had a complaint procedure which set out what to expect if a person expressed their unhappiness and how to escalate their concerns if their concerns remained unresolved. Complaints records showed that the service had followed their procedure when complaints had been received. For example we saw complaints received were acknowledged, investigated within the specified timeframe and a written response had been provided to the complainant.

Requires Improvement

Our findings

At our last inspection of March 2016, we found that conflicts within the staff team had not been effectively managed. A healthcare professional and several staff used the term, 'a culture of bullying' when describing the relationship between care staff and nursing staff. Several staff made references to nurses being intimidated and ignored by care staff. There was also concern expressed by people, their relatives and staff about the instability of managers.

At this inspection, professionals spoke well of the staff team and their willingness to bring about positive change. They told us staff provided 'quality care' to people and implemented any actions they recommended. Staff told us they felt supported and had the leadership they needed from the deputy manager, regional support manager and area manager. The deputy manager told us, "We have recruited a new manager who is due to start shortly. I do feel supported by the regional support manager who is here Monday to Friday. I can call on her at any time." One member of staff told us, "The management are very good. The home is really improved and very much better. The management do try. They are supportive and I can speak to them whenever I want to. I feel free to talk about anything and that's good. Generally it is good here." Another staff member said, "The manager [deputy manager] is hands on. When they are on shift they make an impact and makes things go well… They approachable and listens and comes back with a solution." Another staff member commented, "When there's no manager, the regional support manager and area manager will support. The area manager is supportive and I can call her at any time."

However, staff continued to feel insecure due to the high turnover of registered managers they had experienced in recent times. One staff member said, "I hope [deputy manager] will stay. We are getting used to her and she supports us." Another said, "The registered manager changes all the time. I just focus on looking after the service users." There was currently no registered manager in post. The last registered manager left the service a few months ago. The day to day management of the service was provided by the deputy manager and regional support manager. The regional manager and a registered manager from another service also gave ad-hoc support to see that the service was running well. We raised the issue of a stable management with the area manager and they explained the challenges they had encountered with recruiting managers. They told us they had now tried a different approach and had recruited a manager who was undergoing their recruitment checks and due to start soon. They were hopeful the new manager would be effective and stay. We will continue to monitor this.

The management team held regular meetings with staff to involve, and consult them in the running of the service. The meetings were also used to provide feedback, updates and to share experiences. Notes from these meetings showed discussions about staff roles and responsibilities in delivering good care to people and ensuring the service ran well. The management structure and reporting line were clarified with staff so they knew who is responsible at each level and who to go to for decisions at the first instance. The area manager explained that ensuring staff understood the management structures and reporting lines had improved trust and accountability in the team. We saw care staff consult with their unit leaders on any issues that arose during our inspection and followed the directions they were given.

The service had introduced schemes to empower and improve staff motivation. They had introduced rewards programmes such as monthly employee awards where staff were given recognition for their hard work and commitment. Staff nominated colleagues for this using agreed criteria and told us they felt positive about this programme.

We reviewed the log of accidents and incidents and saw that the service had notified CQC of incidents categorised as reportable in line with the requirements of their CQC registration. These were reported in a timely manner.

The service conducted a survey in April 2017 to gather feedback from people and their relatives. The survey indicated that people felt safe and that their individuality was respected. We saw the provider had put an action plan in place to address areas that required improvement based on people's feedback such as the refurbishment of the building which had been completed when we visited.

The service had a number of systems to assess and monitor the quality of the service. These were conducted by unit leaders, the manager and area manager and included audits of care delivery such as falls management, pressure sores, infection control, medicines management, and health and safety. The area manager also conducted a bi-annual quality review and we saw actions from the most recent audit had been completed. For example, the review had identified that daily fire systems checks were not consistently happening and that portable appliance testing (PAT) was overdue. Immediate action had been taken to rectify these issues.

The service worked in collaboration with the local authority to improve the service. The feedback from the local authority monitoring team was positive. They commented on the consistent progress the service had made to improve the quality of care provided to people. They stated "Our current perception of Collingwood Court is that it has a capable staff team providing good quality care to those who live there. We believe residents at the home are now consistently receiving personalised care/support and are treated with dignity and respect."