

Amore Elderly Care (Wednesfield) Limited

Bentley Court 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?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This inspection was unannounced and took place on 09 and 10 October 2017; at the time of our inspection 71 people were living at the home. The provider is registered to accommodate and deliver nursing and personal care to up to 76 people. People who lived there may have needs associated with dementia, old age or a physical disability.

At our last comprehensive inspection in April 2017 we found the provider was in breach of Regulation 12 of the Health and Social Care Act in relation to medicines management. We also found that other areas required improvement including levels of staffing, the availability of personalised care and activities and the provider's governance arrangements. During this our most recent inspection we found that the necessary improvements had been made to medicines management to meet the breach of the regulations. However there were some areas that showed that the necessary improvements were not fully embedded.

There was no registered manager in post at the time of our inspection. The newly appointed manager had commenced in post two weeks prior to our visit and was being supported by the Operations Director. 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.

A sufficient level of improvement had been made to meet the regulations and satisfy the breach from our inspection in April 2017; however we found that there were some areas of medicines management that could be further improvement. Staff demonstrated a good awareness of their role and responsibilities regarding protecting people and were confident a member of the management team would deal with any concerns reported. People had risks relating to the care and treatment assessed and staff had guidance to refer to about how these should be managed. Sufficient staff were on duty to meet people's needs and forthcoming rotas had addressed and reduced the use of agency staff. Staff were employed through safe recruitment practices.

People were assisted to maintain healthy nutrition but choices about food on offer were not made readily available to support and involve people. Staff were well supported through supervision, the availability and variety of training and the quality of the induction provided to them. Systems in place ensured people were not deprived of their liberty unlawfully and people were appropriately supported to provide consent for the care they received. People were supported to access a range of healthcare services.

People were supported to be comfortable and at ease and their care was provided with dignity and respect. Further work was needed in relation to how people's sexuality was supported and explored as part of personalised care planning. People were supported by staff that were caring and respected their right to privacy. Staff treated people with dignity and respect. People and their representatives wherever possible were involved in making decisions about their care. Written information and contact numbers were not

available for people about how to access and receive support from an independent advocate, although staff knew how to direct people.

People were actively supported to take part in a range of activities; in addition the environment had been improved in order to stimulate people's interest. Staff demonstrated they were knowledgeable about people's individual needs and preferences. People's care records were written in a person-centred way and had been developed with the person or their relatives/representative. Complaints received by the provider were acknowledged, investigated and responded to complaints in line with their own policy.

The home had on-going governance issues and had failed to provide the necessary evidence over the three inspections we had undertaken since December 2015 that the service was well-led. Providers supporting systems such as the Quality Lead role were on the whole positive in identifying and acting on issues at the home, through on-going monitoring, audits and checks. The newly appointed manager had made a positive start in addressing some of the issues at the home, such as taking action to reduce the use of agency staff. Staff received a good level of supervision and were able to could seek informal support when needed. People were actively encouraged to provide their thoughts and opinions about 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?

Requires Improvement ●

The service was not consistently safe.

Areas of medicines management required further improvement in relation to their storage, the application of topical medicines and administration of medicines disguised in food.

People were protected from the risk of harm and staff understood their responsibility for safeguarding people.

There were enough staff to provide care and support to people when they needed it.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People were supported to maintain healthy nutrition; however the mealtime experience lacked support to enable people to make choices.

Staff received an appropriate induction, ongoing training and support.

Staff monitored and responded to people's health conditions.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who were kind and caring and respected their right to privacy.

People wherever possible were involved in planning and making decisions about their care.

Staff knew how to direct people to access and receive support from an independent advocate.

Is the service responsive?

Good ●

The service was responsive.

People's individual preferences, were reflected in the personalised care and support they received.

People were actively encouraged to take part in activities.

People and their relatives were confident that any concerns, complaints or issues they raised would be addressed.

Is the service well-led?

The service was not consistently well-led.

The provider had failed to assure us over the three inspections undertaken since December 2015 that the service was well-led.

Quality monitoring systems on the whole were effective and the appropriate action was taken when areas for improvement were identified.

The manager understood their responsibilities for reporting certain incidents and events to us and to other external agencies.

Staff were well supported and were encouraged to speak openly and honestly.

Requires Improvement 

Bentley Court Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 09 and 10 October 2017. The inspection was conducted by two inspectors, two pharmacy inspectors, a specialist advisor 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. The Expert by Experience involved in this inspection had experience of caring for an older relative who used regulated services including care homes with nursing. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected; they are deployed by the Care Quality Commission to support the inspection process. The Specialist Advisor involved in this inspection was a registered nurse with specialist knowledge and skills of nursing people with general and dementia care needs.

We carried out this inspection because we had received concerns from a variety of external agencies including the local authority and the Clinical Commissioning Group (CCG). The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people. The concerns related to the number of safeguarding alerts being received from the provider, the high number of agency staff used at the home and serious concerns in relation to medicines management.

We looked at the information that we hold about the service prior to visiting the location. This included notifications from the provider about deaths, incidents and safeguarding alerts which they are required to send us by law. A Provider Information Return [PIR] request had not been sent to the provider prior to the inspection and therefore was not available to inform the inspection plans. A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make.

We spoke with seven people who lived at the home and seven relatives. We also spoke with eight members of care and nursing staff, two activities coordinators, the operations director, the quality lead, the head chef

and the manager. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. We used a tool called 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 reviewed the care records of five people and examined the medicine administration processes for 16 people and any associated records in detail. We looked eight staff files to review recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including accidents and incident records, complaints, the home improvement plan and quality monitoring reports.

Is the service safe?

Our findings

All the people we spoke with told us they felt safe. A person told us they trusted the members of staff that supported them and another person stated, "Yes its safe here".

At our last inspection in April 2017 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicines management as part of the safe care and treatment of people using the service. We found that people's medicines were not always available for them and that records could not always clearly evidence whether people had received their prescribed medicines and/or whether they had been administered in a safe manner. Following our last inspection the provider had sent us an action plan outlining how they would make the necessary improvements. On this our most recent inspection we found that a sufficient level of improvement had been made to meet the regulations and satisfy the breach. However we found that some areas of medicines management required further improvement.

We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 16 people, speaking to staff and observing how medicines were administered to people. We found the administration records for the oral medicines were good and were able to demonstrate that people were getting their medicines at the times they needed them. One person told us, "I can ask for pain relief when I need it and they [staff] bring it to me". We observed a member of the nursing staff supporting people to take their medicines. We saw it was done with care and followed safe administration procedures. We found the administration records for the topical medicines/treatments were not able to consistently demonstrate that they were being applied in accordance with the prescriber's instructions. For example, we found an analgesic gel had not been transferred on to a new MAR chart at the start of the new monthly medicines cycle.

We looked at how controlled drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found the Controlled Drugs were stored correctly and their administration was recorded accurately showing that these medicines were also being administered as prescribed. We found the analgesic skin patches were being changed after the prescribed time interval and were being rotated correctly around the body so that people did not experience unnecessary side effects. People who had been prescribed medicines on a when required basis had records that had sufficient information to inform the nursing staff of how and when to administer these medicines. We spoke with the nursing staff and found that they were knowledgeable about the people they were looking after and the appropriateness of when to administer the when required medicines.

We looked at the temperature monitoring of the refrigerators that were used to store medicines. We found the refrigerators were being monitored correctly. The temperature records on the ground floor showed that medicines were being stored at the correct temperature however the records on the first floor showed that the temperature had dropped below the minimum temperature two degree Celsius on three occasions. We found some temperature sensitive medicines called insulin that had been exposed to these low temperatures were still present in the refrigerator; therefore appropriate action had not been taken to ensure people would receive medicines that would effectively treat their condition. We also found three

topical medicines that required cold storage conditions were being stored in the medicine trolleys at room temperature. These storage conditions would have affected their efficacy to treat the conditions they had been prescribed for.

We found where people had to have their medicines administered by disguising them in either food or drink the provider had ensured this process was carried out with their best interests in mind. However we found that there was no written information to inform the nursing staff of how to carry out this process safely and consistently. We also found where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. Nursing staff administered medicines and records confirmed they had received appropriate training and understood how to administer these medicines. Regular audits and daily stock checks were completed on medicines by nursing staff and management and where shortfalls were identified actions were taken.

At our last inspection in April 2017 our observations and feedback received from people and their relatives was varied about whether staffing levels were sufficient. Our observations included people having to wait for staff to be available to support them and call bell not being answered in a timely way. At that time the interim manager told us they would be looking at staffing levels and the deployment of staff. During this our most recent inspection we found that improvements had been made in relation to the number of staff on duty with active plans in place to reduce the use of agency staff.

People we spoke with told us they felt staffing was adequate but were negative in relation to their experience of the abilities and effectiveness of agency staff. Their comments included, "They [management] use agency staff and they don't know the routine" and "Sometimes at night there are less on [staff], but during the day it isn't too bad. They use agency staff a lot at night". We reviewed the rotas and saw that the new manager had implemented changes to reduce the use of agency staff employed; this mainly consisted of using the existing staff on a bank basis to cover gaps in the rota. The manager had identified that agency staff had been putting themselves on the rota for future shifts before the hours were offered to employees; they shared with us how they had rectified this in the upcoming week's rotas. Staff spoken with were also aware of these changes. We saw that agency staff use would be significantly reduced as a result of the manager's changes. A staff member told us "They [management] are trying to slow down the use of agency staff" and another staff member said, "There is not always enough staff so they use a lot of agency". This meant that the provider was working hard to reduce the amount of agency staff and were aware of the concerns people and staff had about their use.

During our inspection we saw staff response times were timely in attending to people's needs. We looked at a sample of staff rota's which showed there were adequate levels of staff required to support people. The operations director told us a tool was used to assess people's dependency levels; we saw that this was revisited periodically or as required. We saw that the home held a 'ten at ten' meeting which included the heads of all departments where discussions about levels of staffing required were also reviewed. The manager confirmed that where agency staff were used they tried to secure the same staff each time for consistency; although they admitted this was not always achievable.

Staff had received safeguarding training and demonstrated a good awareness of their role and responsibilities regarding protecting people from harm. Those staff spoken with were knowledgeable about the potential types of abuse and harm people may be at risk of and were clear about the appropriate reporting procedures. We found that when incidents had occurred at the home, including medicine errors or omissions, learning had been taken from these events and they had been reported to the appropriate external agencies, including us at the Care Quality Commission. However we saw that the manager newly in

post had been tasked with completing more retrospective investigations into some medicines incidents as they had not been fully investigated at the time they occurred.

The provider further supported people to receive safe care through their recruitment and selection processes, by ensuring all the required checks were completed before new staff began work. This included checks on criminal records, references, employment history and proof of identity. We saw that the provider had implemented a new policy for staff to periodically complete a declaration relating to their criminal records check in April 2017; this process was to make sure, as far as possible, that established staff continue to be safe to work with people. However as the time of our inspection we found some delay had occurred in implementing the provider's new policy. The operations director assured us that this piece of work would be completed forthwith.

We saw that people had risks relating to their care and treatment assessed and records reviewed identified how these should be managed by staff. These included risks related to their mobility needs and the potential risk of falls and these had been regularly reviewed. For example, some people were at risk of choking and required additives to drinks to thicken them to minimise this risk. We saw when drinks and food were provided to people by staff they were aware of who was at risk of choking. Where people had been assessed as requiring equipment to keep them safe this was found to be in place and available. During our inspection we observed staff supported people to move safely, using the hoist when necessary. We saw two staff using the hoist and we heard them speak sensitively to the person they were supporting, as they explained what was going to happen and gently reassured them. This meant that staff were aware of the risks to people's health and their safety was well maintained by staff.

Is the service effective?

Our findings

People's comments about the quality and choice of food were varied. A person said, "The food? It's horrible, there is no choice for dinner and the mash is always lumpy". Another person said, "The food is decent". One person told us that the food in the home was 'good' and their relative who was with them agreed with this as they had occasionally eaten at the home. A relative said, "I stay for lunch a couple of times per week, the food is okay". We observed lunch being provided to people. We saw that food choices were not always given to people and no use of plated up food to show and to support people where possible to make a choice was used and no menus were available. No adapted cutlery or aids were in use to support people to maintain their independence. We saw one person having some difficulty getting their food onto a fork and so had to use their fingers when a plate guard would have remedied this. We spoke to the chef who confirmed that there was no involvement of people in planning menus but when meals were unpopular these options were removed and replaced. We spoke with the Quality Lead who advised us that as part of the homes improvement plan the meal time experienced had been improved; they were disappointed that the 'plate and show' and menus implemented had not been utilised.

Forms relating to people's preferences were filed away in the kitchen office but we were advised that all the staff knew them. Staff working in the kitchen had information about people's allergies and dietary needs. Staff supporting people told us they could access a variety of food to make additional snacks and sandwiches for people in between meals and if they were hungry during the night. We saw that people who needed assistance to eat, for example with cutting up their food, were supported in a timely manner. Staff demonstrated to us that they knew those people needing additional support and nutritionally at risk. Records we reviewed showed that people's weight was monitored and referrals to specialist dieticians were made when there had been concerns, such as in relation to weight loss and/or choking risks. People's needs in terms of nutrition and hydration were assessed and staff were seen catering for these identified risks, for example through the provision of a pureed diet due to an identified risk of choking. We observed that people were actively encouraged to drink and eat snacks and these were supplied frequently throughout the day.

People and their relatives told us they felt staff had the right skills to be able to support them. One person told us, "They [staff] do anything you ask they are really good", and another person said, "I am looked after well enough". The provider had identified some staff training deficits and need for updates and we saw that in recent weeks a number of updates and additional training sessions had been provided. At our last inspection in April 2017 staff told us they thought they would benefit from training in how to support people with challenging behaviour and this training need had now been met for most staff. Staff spoken with were happy with the support they received in relation to their training needs. A staff member said, "If we ask and it's relevant they [management] will provide specific training, I have just completed first aid and training about compression bandaging".

Alongside training provided staff were also supported with regular supervision and a structured induction. The induction provided to new staff included a range of mandatory training and familiarising themselves with people's needs by shadowing established staff on shift before working more independently. No observed practices or competency checks were currently being undertaken by the provider, we raised this

issue and they agreed this needed to be considered further. Our observations in relation to staff practices were that they were skilled. For example staff we observed supporting people who were anxious or as they used moving and handling equipment, displayed a good level of skill and proficiency. Throughout our inspections we observed that the shifts were well organised and staff appeared to be clear about their duties and responsibilities.

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).

People and their relatives told us and we observed that people were not unlawfully restricted and that their consent was actively sought by staff before assisting or supporting them. The manager and staff had an understanding of the MCA and DoLS and applications had been completed appropriately for people under the Deprivation of Liberty Safeguards; 20 authorisations were in place at the time of our inspection.

Staff had attended training and demonstrated an understanding of the people subject to authorisations and their role and responsibilities in relation to MCA and DoLS. A staff member demonstrated their understanding of the need to seek consent, telling us, "If a person refuses something you can leave and come back, or ask someone else to try including asking family members, if this becomes a regular occurrence and the person is refusing something that could be of detriment, we would have a meeting and discuss what's in the persons best interests". Staff told us how they included people as fully as possible in decisions and how they gained consent from people before providing care. We observed staff speaking at peoples pace and as clearly as possible to ensure the person's understanding.

Documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were well completed; they were signed by a doctor and wherever possible had the person's and/or a representatives knowledge, participation and agreement. A staff member we spoke with told us that there was a handover at the start of each shift which included discussing people's resuscitation status. We saw that the resuscitation had been considered in line best practice guidance.

All of the people we spoke with told us they had their health care needs met and saw external professionals such as chiropody and GP's. We saw staff worked effectively with external healthcare professionals and adhered to any management plans they provided. Staff told us effective systems were in place, such as communication books and handovers where information about any changes in people's condition were provided to alert them and keep them updated. Records we reviewed evidenced that the home was responsive to fluctuations in people's health needs and healthcare professional referrals were sought in a timely manner as required.

Is the service caring?

Our findings

People and their relatives spoke positively about the staff whom they described as, 'kind' and 'friendly'. One person told us, "They [staff] do anything you ask, they even do shopping for me they just say 'do me a list'". Another person said, "They [staff] are lovely and ever so caring". A third told us, "All the staff are decent kind people". Relatives all spoke very positively about the kindness and caring attitude of the staff. A relative said the staff were 'brilliant and they really care you can tell by their attitude'. Another relative told us, "The staff are very caring".

During the inspection days we observed many examples of kind, considerate and respectful care towards people living at the home. Staff demonstrated empathy and compassion as they attended to people and ensured they were appropriately covered and their clothing readjusted when being moved by use of hoist equipment, to help protect their dignity. We also saw that people who had some difficulty initiating standing and moving were appropriately supported and encouraged by staff with patience. Staff were observed and heard when doors were closed to knock on the door and identifying themselves on entering the room; doors were kept closed when personal care was being given.

Everyone spoke highly of staff and said that they were very caring and respectful. We saw staff on duty communicated with the people effectively and used a variety of ways to enhance communication. For example by touch and gestures, ensuring they were at eye level with those people who were seated, allowing the person to set the pace of the conversation and altering the tone and volume of their voice appropriately. All the interactions we observed were warm and compassionate between staff and people.

Staff were discreet when people needed assistance. For example staff were heard and observed seeking consent to interventions and offering to support people with their personal care needs, asking 'can I help you with that?' and/or 'are you comfortable?' Staff provided reassurance to people who were anxious and distressed by responding promptly, calmly and sensitively to them. We saw people were relaxed with staff and responded positively to them, at times enjoying friendly and good natured banter. This meant people were supported to be comfortable and at ease and their care was provided with dignity and respect.

Staff demonstrated they were knowledgeable about people's individual needs and preferences. People had a range of diverse needs and staff showed a good understanding of what these were and what was important to people. This included supporting people appropriately with their cultural, religious and language needs. For example, a number of people were supported with their dietary needs in line with their culture and preferences.

People also had a sexuality care plan, which outlined people's preferences around clothing, gender of staff preferred to support them and relationships that were important to them. However we found that some staffs interpretation of sexuality and how it should be explored were not always presented appropriately. We shared our findings with management and they agreed the care plan was wrongly worded. They assured us that further work in relation to how sexuality should be explored as part of personalised care planning would be revisited.

No information was available, such as leaflets or posters that promoted access or information about how people could access and receive support from an independent advocate. Advocacy services act to speak up on behalf of a person, who may need support to make their views and wishes known. Staff spoken with said they would contact the local authority for details of available advocacy services; the manager told us they would ensure some information was made available.

Staff told us there were no restrictions about people receiving visitors and relatives confirmed they could visit their family member at any time. We found people's personal information was respected as it was managed and stored securely and appropriately.

Is the service responsive?

Our findings

At our last comprehensive inspections in December 2015 and April 2017 we found that people did not have access to a range of meaningful activities and the support needed to be involved in those on offer. At this inspection we found the required improvements had been made and on the whole people were more actively supported to take part in a range of activities; in addition the environment had been improved in order to stimulate people's interest.

We saw that the home had dedicated activities workers, one on each floor who supported people to take part in a variety of activities such as crafts, music and singing that took place. We saw that they supported people both in groups and made time to do individualised activities, such as reading or looking at books to support reminiscing with people about their lives. On the lower floor a board displayed a weekly activity board with pictorial information about what was happening each day for people to refer to; however this had not been populated on the upper floor. We saw that a number of improvements had been made to areas around the home where people with dementia were supported. These included a bus stop and bench, art work on the corridor walls rather than the previously blank white walls, a sensory area and a Victorian sweet shop which opened for people to use with staff support. An activities coordinator told us, "We have had 'creative minds' training and also now all the company's activity coordinators meet up, about every quarter to share ideas and good practice. We also have a dementia coach who works for the homes now; they have been in to support us. We have worked really hard to improve activities and the environment for people".

We saw evidence of the improvements made to the home and how staff worked hard to engage people in activities. For people who were nursed in their rooms staff told us they 'read books, played games or looked at pictures the person is interested in'. We saw that most people had their rooms personalised with items that depicted their past and present lives, however not all of people rooms had their names on their door. We raised this as a risk based on the homes current use of agency staff, as not all people at the home would be able to confirm their identity owing to cognitive impairment or speech and language difficulties. The manager said they would address and rectify this as soon as possible.

We observed people participating in a group arts and crafts activity with people being supported individually to create their craft object. People were also enjoying music being played and having a discussion about it. We also saw other people enjoying music and using musical instruments to join in with the rhythm and others were whistling and humming, demonstrating they were stimulated and enjoying the activity. Since coming into post the manager had identified a lack of activities available at the weekend and so had met with the activities coordinators to ensure a seven day service was provided.

People's care records and newly created 'grab sheets' [one page summary of needs] were written in a person-centred way and had been developed with the person or their relatives/representative. The quality lead told us, "We involved care staff who know people well in completing the one page summary". Information was recorded that included people's likes, personal preferences and information about their history to enable staff to support people in the way they preferred. We did find one person's grab sheet

information that was clearly in need of update and discussed with the quality lead the need for the summaries to be routinely included in any internal auditing of care records to ensure their on-going accuracy.

People using the service and their relatives confirmed to us that they were involved in the assessment of their needs and planning of care and support. We observed that people's care was delivered according to their individual needs and wishes and in line with their care plans. An assessment was undertaken prior to people moving in to the home to ensure that their needs could be met effectively by the service. Staff told us they were kept up to date about people's current health and well-being. For example, a meeting took place between each shift change during which staff shared information about people's changing needs. This helped to ensure people's needs were consistently met and staff could be aware of and/or respond appropriately to any changes in people's condition.

People and their relatives told us they knew how to make a complaint and felt they would be listened to and acted upon. A relative told us they had raised concerns about their family members care and that they now had regular meetings every month to discuss how things were going they said things 'are improving'. Information about the provider's policy and procedure for raising a concern or complaint, which included information as to how any complaints made would be handled was available in the home. We reviewed the complaints received by the provider and found they acknowledged, investigated and responded to complaints in line with their own policy. We also saw that when complaints had been upheld, learning had been implemented and in resulting meetings and letters with/sent to people and their relatives the provider had apologised. Staff spoken with were clear about how they should direct and/or support people to make a complaint.

Is the service well-led?

Our findings

At our last comprehensive inspections in December 2015 and April 2017 we rated the provider as requires improvement in the key question of 'well-led'. The reasons for this included the quality assurance systems in place failing to identify when improvements were needed to be made. Some issues identified by us during this our most recent inspection showed that leadership and oversight of the home was less than robust; for example issues with medicines management, gaps in environmental checks and incidents not fully investigated. This is the third comprehensive inspection of the service that we have undertaken since December 2015 that has been rated as requires improvement overall. While we can see that the systems in place were improving but there were still some areas for further development. This demonstrated that the home had on-going governance issues and had failed to provide the necessary evidence that the service is well-led.

We found that regular checks and audits to monitor the safety and effectiveness of the service were undertaken both by staff, the manager in post and the Quality Lead. On the whole the effectiveness of the audits was evident, but we found that environmental checks had failed to pick up our findings in terms of the poor condition of one bedroom; whilst we saw action to replace furnishing and floor coverings had commenced. Records we reviewed confirmed learning and/or changes to practice following incidents were cascaded to staff in a timely manner and reporting of incidents of serious injury to external bodies were appropriately actioned. We saw that the new manager had been tasked with investigating several safeguarding issues that preceded them taking up post.

The Quality Lead visited the home regularly and undertook additional monitoring checks. We were able to see that the input from the providers supporting systems such as the Quality Lead, were positive in identifying and acting on issues at the home, through the audits they undertook when they visited. However we noted in their recent absence some slippage was seen in terms of sustaining necessary changes made or checks and audits implemented taking place.

There was no registered manager in place. At the time of our inspection the manager of the home had been in place for two weeks, however they had not yet registered with us at the Care Quality Commission [CQC] but they had plans to do so. From our findings and speaking with staff and the manager it was clear the new manager had made significant strides in a very short time to make improvements and demonstrated that they were a positive appointment. Feedback received from the local authority prior to our inspection who had met with the new manager, further supported our finding that they also provided them with a clear idea of the issues that needed to be addressed and discussed their plans in relation to these. The new manager understood their responsibilities for reporting certain incidents and events to us and to other external agencies that had occurred at the home or affected people who used the service. The new manager showed a keenness to promote an environment where staff can speak openly and honestly. Staff told us they felt well supported to perform in their role and had been spoken to by the new manager about her plans for the home.

People overall were not completely sure who the manager was stating, "I don't know who the manager is,

she is a temporary one I think" and "Apparently we have a new boss I haven't seen her yet". A relative said, "I am not sure who is in charge, it changes"; however people did express to us they felt the service was well managed. We saw that the new manager was initially not taking on all aspects of their role and was being supported by the Operations Director. The Operations Director told us this was so that the new manager could get a good account of the home, any issues and familiarise themselves with staff and introduce herself to people and gain a clear understanding of their needs in the first instance.

Staff spoken with confirmed they had met with the manager and they had discussed with them her approach and any changes and improvements they were planning. A staff member said, "[Managers name] has met with me and told me her plans". Another staff member said, "[Managers name] has made it clear when she spoke with me what she wants, I am hopeful about some of the changes she has planned. I do feel things have improved here and I feel valued". We saw that staff received a good level of supervision and they told us they could seek informal support when needed. Initiatives and improvements seen since our last inspection for recognising and valuing staff were positive. For example, redecorating and furnishing the staff break room and introducing a 'staff member of the month' scheme which sought to identify exceptional staff and value their contribution. From our observations and staff feedback we were able to confirm the effectiveness of the provider's on-going support provided to staff in their role. Staff spoken with were aware of the providers whistle blowing policy and how to access this. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

People were actively encouraged to provide their thoughts and opinions about the service. People and their relatives told us although they had seen meetings advertised they had chosen not to attend them. Some relatives told us they attended regular reviews of their family members care and others said they had been sent letters and invites but had chosen not to attend. This meant that the provider was keen to actively involve people to express their views about the service provided.

The provider had displayed the rating that was given to them by the Care Quality Commission as is required by law.