Culpeper Care Limited

Willow Tree Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1and 3 February 2017. The visit was unannounced on 1 February 2017 and we informed the operations manager and home manager we would return on 3 February 2017.

Willow Tree Nursing Home provides accommodation, nursing and personal care and support for up to 47 older people. The home has two units. Cedar unit provides accommodation for older people living with complex health care conditions and physical frailty. Oak unit provides accommodation for older people living with dementia and / or physical frailty. At the time of our inspection visit 36 people lived at the home.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Following our last inspection in October 2016, the operations director informed us that the registered manager had agreed to a change in their role at the home and was to undertake the deputy manager role. A new manager had started working at the home during November 2016 and told us they intended to submit their application to become registered with us.

When we inspected the home in March 2016 we found the legal requirements and regulations associated with the Health and Social Care Act 2008 were not being met. Breaches of the regulations related to the safe care and treatment of people, gaining people's consent and the governance of the home. A requirement notice was served on the provider to tell us what action they would take to make improvements. At our last inspection in October 2016, we found improvements had not been made. We identified continued breaches of the regulations. A continued breach in the unsafe management of medicines and the governance of the home resulted in enforcement action being taken and we served warning notices on the provider and the registered manager. The home was placed in 'special measures.' The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Services in special measures are inspected again within six months following the publication of the inspection report.

At this inspection we looked to see if the provider had responded to make the required improvements in the standard of care to meet the regulations. We found that sufficient improvements had been made to remove the service from 'special measures.'

We checked to see if the requirements of the warning notices served had been met and found they had. Improvements had been made and further improvements were planned for.

Systems were in place to assess the quality of the service provided. Improvements had been made to numerous systems, such as the tools used to audit. However, some audits were not always effective and further improvements were required.

Feedback was sought from people and their relatives, improvements had been made in response to feedback received in the areas that mattered most to people. Staff felt supported by managers and that a positive culture was being nurtured and developed in the home. Staff felt they could approach the manager to raise concerns if needed.

Improvements had been made in the safe management of medicines. People had their prescribed medicines made available to them by trained staff. Further improvements were required in the guidance made available to staff about medicines with specific instructions such as eye drops and 'when required' medicines. Improvement was also required in records for people that received their medicines in a 'covert' way.

Risk assessments to minimise where people may be at risk of harm or injury and the required actions, had been taken. However, people's wound care records did not always contain the information needed for staff to prevent and manage the risks of skin damage.

People did not always feel agency care staff had the skills or knowledge necessary to provide safe or responsive care and support to them. The provider was actively seeking to fill staff vacancies and had a safe recruitment system in place.

People were supported by staff who were trained to know what abuse was and how to report any concerns.

People were supported to eat and drink and improvement had been made in the snacks offered to them between meals. Care records showed healthcare professionals were involved in people's care and treatment.

Nurses and care staff received training, and further training was planned for them to refresh and develop skills further and take on lead roles, such as 'dignity champions.'

Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people. The manager understood their responsibilities and acted in accordance with the MCA. The requirements of the Deprivation of Liberty Safeguards were followed.

People described regular staff as kind and compassionate and said they demonstrated a caring approach. Planned activities took place, which people told us they enjoyed.

People and their relatives knew how to make a complaint if needed. Complaints were investigated and action taken to resolve issues but some relatives felt improvements were still needed, for example in handling people's clothing.

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.

People had their prescribed medicines available to them and were supported to take these by trained staff. Guidance for staff about medicines to be taken 'when required' was not always accurate and information was not always available when medicines required more specific instructions.

Risks were assessed, and actions to minimise harm or injury were taken. People's care records did not always contain the information needed for staff to effectively manage risks of skin damage.

Staff were trained to know what abuse was and how to report any concerns. There were sufficient numbers of staff on shift. Staffing vacancies meant agency staff were used who did not always know people well and this impacted on permanent staff. The provider was taking action to recruit to fill vacancies and had a safe recruitment system in place.

Is the service effective?

Good

The service was effective.

Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people. The home manager understood their responsibilities and acted in accordance with the MCA. The requirements of the Deprivation of Liberty Safeguards were followed.

Staff were trained and further training was planned to refresh and update staff skills. People had choices about their food and drink and were supported to enjoy meals and snacks. Care records showed healthcare professionals involvement with people.

Is the service caring?

Good

The service was caring.

People were supported by kind and compassionate staff who

demonstrated a caring approach that was unrushed at the time support was being given to people. Staff promoted people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual care plans were not always person centred, however, they were in the process of being updated.

There were planned group activities for people to join in with and staff encouraged people to do things they liked to do.

People and their relatives knew how to make a complaint if needed. Some felt issues were dealt with and resolved, however others felt the management of some issues required improvement.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Improvements had been made following our previous inspection and further improvements were planned for.

Systems and processes were in place to monitor the quality of the service. The manager's daily 'walk-about' the home checks effectively identified issues that required action to improve. However, some audits were not always effective which meant that actions to improve were not always identified and / or implemented.

Staff felt supported by the manager and that an open communication culture was being developed.

Some paper-based records were not completed accurately by staff. Staff felt supported with the new electronic Person Centred Software (PCS) that they used to record daily care tasks.

Willow Tree 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.

The inspection took place on 1 and 3 February 2017. The inspection visit was unannounced on 1 February 2017 and we told the operations manager and home manager we would return on 3 February 2017. The inspection team consisted of two inspectors, a pharmacist inspector and an 'expert by experience' on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, two inspectors returned to continue and complete the inspection.

The provider had previously completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, a request for a new PIR was not made. Since our last inspection in October 2016, the operations director and operations manager had sent us updates about the improvements they had made to the service people received. During this inspection, we gave the operations manager and the home manager an opportunity to supply us with information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. The provider had informed us about incidents of poor care practices they had identified, by staff and the action they were taking.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent time with these people and observed the care and support they were given by staff in communal areas of the home. We observed nursing staff administering people's

medicines to them. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with nine people who lived at the home and nine relatives or friends, who told us about their experiences of using the service. We spoke with staff on duty including three nurses, five care staff, the cook, two housekeepers, the activities staff member, the deputy (clinical) manager, the deputy (non-clinical) manager, the home manager, the operations manager and operations director.

We reviewed a range of records; these included four care plans, eight electronic (PCS) care records, three wound care management plans and ten medicine administration records. We looked at quality assurance audits and the results of the provider's quality monitoring system to see what actions were taken from people's feedback.

Requires Improvement

Is the service safe?

Our findings

At our inspection in October 2016, we identified continued breaches in the regulations regarding the safe management of medicines and the safe care and treatment of people. The provider did not always protect people against potential risks or take action to mitigate such risks. We rated this domain 'inadequate.' We took enforcement action against the provider, serving them a warning notice regarding the management of medicines.

At this inspection, we checked whether the provider had implemented improvements to meet the requirements of the warning notice and whether improvements had been made in the safe care and treatment of people. We found sufficient improvements had been made to meet the requirements of the warning notice, however, some further improvements, in the safe management of medicines, were required.

Staff felt there were more effective processes in place to ensure the safe management of medicines in the home. A nurse told us, "There have been improvements in medicines administration. Since the new manager started there are proper audits and she watches everything."

Overall, improvements had been made in the supporting information available to nurses about people's medicines. This meant staff had the guidance they needed to safely give people their medicine in a consistent way as prescribed. People's medicine administration records (MARs) had photographs for personal identification and information about known allergies/medicine sensitivities available to nurses.

However, we found that medicine records did not always clearly tell staff how specific medicines should be given. For example, where people were prescribed eye drops, there was no record of which eye the drop should be administered in. We spoke with two members of staff about which eye they would administer an eye drop in for one person and each staff member told us a different eye. The staff told us that they know which eye to administer the drop in from memory or whichever eye looked "sore". This unsafe practice put people at unnecessary risk of having the medicine administered incorrectly and of any eye infection potentially spreading from one eye to the other. We discussed this with the operations manager and home manager and they told us action would be taken to ensure staff had the information they needed.

Some medicines prescribed to people had a short expiry date once opened, nurses had dated these to ensure they knew how long the medicine could safely be used for. Creams that had to be applied topically were recorded on a separate cream application body map chart that was kept in people's bedrooms with their creams. We looked at eight people's cream application charts and these showed care staff where the cream should be applied on the person's skin and how often. Charts had been signed when care staff had applied creams to people's skin and were in line with the prescribing instructions.

People that needed to take medicines 'when required' had protocols in place to give staff information to know when the medicine was to be given, but these were not always accurate. For example, some people were prescribed laxative medicine to take 'when required, but some protocols referred to a different laxative to the one they were prescribed. This meant people might not always be given their medicine consistently,

and at the times they needed them.

Some people were prescribed medicinal skin patches. Nurses kept a record of where the patches were being applied, on the person's body. However, these records were not clear and we found that skin patches were not being applied or removed in line with the manufacturer's guidance. This meant that people could potentially have unnecessary side effects. We discussed the recording tool being used with the operations manager and home manager and they agreed improvement was needed.

Some people living at the home had limited mental capacity and were unable to make decisions about their own care or treatment and had their medicine given to them in a covert way; hidden or crushed in their food or drink. We looked at five people's covert administration medicine records. Records showed that staff had followed the correct procedures in acting in a person's 'best interest.' However, of the five records looked at, three did not include all of the medicines that were being given covertly.

Some medicines needed cold storage and these were kept in a medicines fridge. Daily records showed staff monitored the temperature of the fridge. However, records showed that the fridge temperature was out of the recommended range and staff told us they had not reported it. Staff were unable to demonstrate how to take accurate temperature readings. We discussed this with the operations manager and home manager on the first day of our inspection and they told us immediate action would be taken. On the second day of our inspection, the home manager showed us a new thermometer had been put in place and one nurse showed us how they had taken the accurate temperature readings.

Nurses we spoke with told us they felt confident in administering medicines. One nurse told us, "The new manager seems to have up to date knowledge and I feel they would be supportive if I needed to check anything with them." Another nurse told us, "I feel I have the skills I need to give people their medicines, but I am always happy to update and refresh my knowledge."

On the first day of our inspection we saw that an emergency equipment trolley was not easily accessible because it was boxed in by six plastic crates of paper. The trolley was not clean and the planned fortnightly checks on the equipment, such as a suction machine, had not been completed since September 2016. We pointed this out to a member of staff and on the second day of our inspection, we saw immediate action had been taken to clean the trolley, make it fully accessible and a new check log was in place and had been completed.

Staff told us they knew what to do in the event of a fire, however, did not always know who was responsible for taking control. One staff member told us, "If there was a fire alarm, I would keep calm and follow the instructions and move people to a safe zone." Nurses told us they felt confident in dealing with first aid emergencies, such as a person having a fall. The home manager told us, "I will identify which staff member is the shift fire marshal and shift first aider on the rota from now on, so all staff are clear every shift of responsibilities."

We found some improvements had been made in the safe care and treatment of people. Some further improvements were still required, such as in the records kept about managing people's skin damage.

In October 2016, we identified risks to people's safety and welfare were not always identified, and action to minimise risks were not planned appropriately. At this inspection, we found improvement had been made. For example, actions to minimise the risks to people who smoked cigarettes and the risks of their smoking on others had been assessed. People who liked to go outside on their own to smoke, each had a fire retardant blanket and a pendant alarm, so they could proactively call for staff support, rather than wait for

staff to bring them back into the building. One person told us they had discussed the risk of being alone outside with flammable materials, and they were happy with the changes implemented to keep them safe. There was a newly designated area for smoking and a tall ashtray which the person could reach easily.

People's care plans included risk assessments and plans to minimise risks to their health and wellbeing. The care plans included the possible triggers that might cause a person to become agitated, the behaviour the person would display if they were agitated and the actions staff should take to support the person to regain their sense of wellbeing. Regular staff that supported people knew what these triggers were and how to reassure people to minimise their distress.

Staff demonstrated an understanding of providing pressure relief care for people who were unable to move independently. On Cedar unit, we observed staff safely use a hoist to reposition people in their armchairs. One care staff member explained to another that it was 'very important to reposition people who could not move themselves, so that they did not get sore skin'.

People had special mattresses on their bed to reduce the risks of skin damage. Staff had the information available to check what setting the air flow should be set at for each person based on their body weight. Care staff told us they would alert the nurse if they had any concerns about a person's skin and some care staff had completed skin care awareness training. One staff member told us, "We turn (reposition) people who are in bed during the day and the night staff have to do 'turns' every few hours, to reduce risks of people getting pressure sores. We record we've done it using the i-pod."

The home manager informed us that some people were being treated for sore and damaged skin. We looked at two people's wound management plans and found these were not sufficiently detailed. For example, photographs of people's sore skin were not consistently taken by nurses to assess progress and healing of skin wounds. We discussed this with the home manager who agreed that photographs had not always been taken, but would ensure these were done. The home manager showed us information they had received about (skin) tissue viability training by a specialist skin care professional. They told us they planned to book nurses onto the training to develop their knowledge in this area.

We received mixed feedback from people and relatives when we asked them if they felt there were enough staff on shift. Some people felt there were enough staff and that things had improved. One person told us, "I think things have got better here." However, others told us some staff had left and this meant a lot of agency staff were used.

One staff member told us, "The managers always try to get agency staff if we are short-staffed, but the agency staff don't always know how to do the basics so it takes time to explain things to them and it can be challenging supporting agency staff as well as supporting the people we are here for."

We saw that not all agency staff understood how to support people, because they did not know them well enough. At lunchtime, the nurse in charge had to stop what they were doing to demonstrate to one agency staff how best to support a person to eat. We saw that an agency staff had miss-interpreted the guidance to monitor one person's whereabouts to keep them safe, and spent the afternoon walking a few steps behind the person as if they were on a one-to-one observation. We discussed the use of agency staff and the home manager told us, "We have been using four different agencies and we try to get the same staff back for consistency and less pressure on the existing team. Where issues have been identified about individual agency staff we have taken the appropriate action in reporting these to their agency manager and have not had these staff return to us."

Overall, staff felt there were enough staff to meet the needs of the people living in the home at the time of our inspection visit. One care staff member told us, "I think we have just enough staff on shift. We are working far better as a team now, and moving toward a person centred approach rather than shifts just being about tasks. But, this takes more staff to do things in this way because it is around the person. All the staff want to do this, but if we get more people, we'll need more staff."

People's care plans included an assessment of their needs and abilities with a 'dependency' score to support the home manager's calculation of how many staff were needed to support people safely. One person who was waiting in their room for staff's support told us, "The staff are good, but harassed. They come when I ring the bell, but they have too much to do." We saw a member of staff did arrive quite promptly and supported the person safely, but they did not have time to stop and make conversation with the person after delivering care and support.

Records showed that, on average, 450 hours per week of agency nurse and care hours had been used for the past three months. The home manager and operations manager informed us they had a nurse and up to five care staff vacancies and were actively working to recruit to these positions. The operations manager told us, "We have looked at our rates of pay and these will be increased from April 2017 and we hope to attract good staff so that we will be fully staffed to give people consistency. You have met our new nurse clinical lead who has started this week and, like the deputy manager, they will have supernumery hours each week to allow time for supporting staff and undertaking audits."

The operations director informed us the dependency assessment tool had recently been updated to determine staffing levels. Senior managers told us they felt once they had recruited to fill staff vacancies and the use of agency decreased, this would have a positive impact on all staff knowing people well. The operations director said that when people moved in to fill the empty beds, they and the operations and home manager would re-look at the staffing requirements for the home to ensure there were sufficient skilled staff on shift.

Recruitment processes were in place to protect people from the risks associated with the appointment of new staff. Since our last inspection, some new staff had started working at the home. One nurse told us, "The manager did a DBS check and checked my nurse registration." We looked at three staff files, references had been obtained as well as checks with the Disclosure and Barring Service (DBS) to ensure staff were of good character before they started working at the home. The Disclosure and Barring Service is a national agency that keeps records of criminal convictions.

People told us they felt safe living at the home and staff had been trained to protect people from the risks of abuse. One staff member told us, "I would certainly report any concern I had immediately to the new manager."

Good

Is the service effective?

Our findings

At our inspection in October 2016, we identified a continued breach in the regulation regarding the consent to care and treatment. We found the principles of the Mental Capacity Act (MCA) 2005 were not always followed. We rated this domain 'requires improvement' and served a requirement notice on the provider. The provider sent us an action plan telling us how improvements were to be made. On this inspection we checked to see if improvements had been made and found they had.

The Mental Capacity Act 2005 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.

There had been a change in management since our last inspection and the new home manager demonstrated their understanding of the MCA to us and we observed staff worked within the principles of the MCA. One staff member told us, "Sometimes, some people cannot make decisions. If [Person's name] doesn't want personal care, I try to keep talking with her to reassure her, or go back after a few minutes and try again. I might offer them a cup of tea. They might refuse care due to their dementia."

At our last inspection we found no evidence of how people living in the home had been consulted, by the provider, about the use of Closed Circuit Television (CCTV) within communal areas of the home. At this inspection the operations manager informed us that on reflection the CCTV was not required and had been turned off, with no future plans to use it.

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 are called the Deprivation of Liberty Safeguards (DoLS). The home manager and provider were acting in line with the requirements of the Act. The home manager informed us that 12 people were deprived of their liberty and had approved DoLs in place. Of these 12, three people's DoLS expiry date had passed, but records showed the home manager had applied to the supervisory body for a renewal. The home manager told us they had submitted DoLS applications for a further 13 people, because their care plans included restrictions to their liberty. For example, they could not go out independently, because they did not recognise risks to their safety outside of the home. People were supported by staff to access the garden if they wished to and the activities staff member gave us examples of when they had supported people on trips out.

People felt that staff employed by the provider had the skills they needed to meet their needs and our observations of staff interactions with people supported this. One person told us, "[Staff's name] gave me a wash this morning, we had a good laugh and a chat. [Staff name] is good and knows what to do, I don't have to tell them. I prefer that." One relative told us, "We are delighted with our family member's care, previously they had not settled, but the staff have enabled them to improve so much, beyond our expectations."

Nurses and care staff told us they completed training in care skills. One staff member told us, "I started working here last year. I had an induction and then training. The face to face small group training is very good, better than the on-line sessions, as I find I can learn more and ask questions in the group training." Another staff member told us, "I had training in fire safety, infection prevention and control, moving and handling, continence care, health and safety, dementia awareness and food hygiene. I am now doing my level two diploma in health and social care." Another staff member said, "The deputy manager is my mentor and supervisor. I have regular opportunities to work with them, supporting people together. They are very helpful and supportive." A nurse told us, "We had a nurses' meeting and the manager shared feedback about their observations of our practice and gave us guidance."

The manager told us, "I have been working with staff, observing, supporting and guiding them. My experience as an agency nurse, before I started working here, really opened my eyes. I learnt a lot and developed some additional clinical skills" and "The expectation of nurses in care homes is very high. I have acquired more insight into the caring model through time-out of the manager role."

The cook and care staff supported people to choose what they wanted to each day. One person told us, "This week, the staff have started to give me the menu to look at. I'm in my bedroom each day, so I really appreciate that. Often I have the same thing each day because it is what I can manage to eat, but the staff always offer me something as a vegetarian option if I want it." The lunchtime menu was written on a chalkboard to remind staff of the options available to offer people. No-one who lived at the home looked at the board, but the choice of meal was offered verbally and visually by showing two plates with different options to each person in turn.

Some people were able to tell us they enjoyed the food and had enough to eat and drink. We saw other people, who were not able to verbally give us feedback, enjoy their meal and were relaxed with the care staff supporting them. On both Cedar and Oak units we saw people who needed encouragement or assistance to eat were supported by staff seated quietly beside them or standing at their level (due to special armchairs). No-one was rushed during mealtimes. If people did not eat their first choice of meal, staff offered them the alternative meal. People who ate well were offered second helpings.

Staff promoted people's independence and supported them to minimise risks. For example, tables were covered with cloths and there were jugs of drink on the table. We saw one nurse added thickener to one person's drink after the person poured themselves a drink. The nurse told us this was prescribed for the person because they were at risk of choking.

Some people were identified as being at risk of malnutrition and dehydration. Throughout both days of our inspection, we saw people had drinks made accessible to them and were supported with them and to enjoy a range of snacks, such as cream cakes or yogurts. Records showed staff monitored people who were at risk of poor nutrition. Staff recorded whether people ate well at each mealtime and what they ate in between meals. However, whilst the amount of drink a person had drunk was recorded, we saw people did not have a target amount of fluid to drink each day. We discussed this with the operations manager and home manager and on the second day of our inspection, we saw action had been taken to add this information to the i-pod staff used as a recording tool. This meant they could effectively monitor the amount people had and take action if this was below the desired target amount.

People's care plans included their medical history and monthly health checks to enable staff to recognise when people needed support from other health professionals. One nurse had managed to persuade one person who lived with dementia to have a health monitoring check, for the first time in several months.

Records showed staff made sure people were supported to maintain their health with regular visits from an optician and chiropodist for example. One person was supported by staff to attend a hospital appointment. The person told us they felt competent to attend their hospital appointments independently, but took comfort in staff's company and support.

One person told us, "I have had my medicines changed as I was in pain. "It would have been nice to discuss the changes with my GP." A nurse told us about significant changes that had been made to this person's pain relief medicine and that this had been through a telephone consultation. We saw some people with complex health conditions and who were very frail had not been seen in person by their GP for a long time. For example, the person who spoke with us had last been seen by their GP in October 2016. Another person had not been seen by their GP since June 2016, despite them having developed a skin rash in January 2017. We discussed this with nurses and they felt some GPs preferred to give advice over the telephone which the nurses followed.

The home manager told us that eight different GP practices were used by people living at the home and their experiences of these were varied. None of the GP practices offered a scheduled weekly visit to the home to review people. However, nurses told us some of the GPs visited when requested. We saw a GP had been asked to visit one person who had grazed their skin. A nurse told us what the GP had advised to treat the injury and showed us how they recorded the GP's advice, to make sure all staff knew how to treat the skin damage.

The operations manager and home manager had identified this was an area where improvement could be made. They informed us about their plans to hold discussions with people and their relatives about the GP services given to the home. The home manager told us they were keen to give people choice about their GP, but also wished to ensure they were provided with a good service and felt a weekly visit service would achieve this and be supportive to nursing and care staff.

Good

Is the service caring?

Our findings

At our last inspection in October 2016, we found planned improvements following our inspection in March 2016, had not been made and the domain of 'caring' continued to require improvement. This was because staff did not take a consistent caring approach toward people. On this inspection we checked to see if improvements had been made and found they had.

One person told us, "The staff that work here all the while are caring toward me, they are so kind and always check I am alright." One relative said, "My family member is well looked after." Another relative told us, "The regular staff are excellent, they always give me feedback." However, this relative had concerns about the high use of agency staff who they felt did not always show a caring approach to people. They had shared their concerns with the home manager. The home manager informed us that issues identified with some agency care workers were being addressed by them.

We saw staff supported one person to feel comfortable by re-arranging their clothes and putting a blanket over their knees, when they appeared to be sleepy in the afternoon. They fetched cushions for another person, to help them stay upright in their chair when they appeared sleepy and started leaning over the side of their chair.

Whilst people were supported to enjoy afternoon snacks and drinks, we saw positive interactions between them and the staff. People appeared relaxed and were smiling with staff. Staff spoke with people whilst giving support and were not focused purely on the task, which showed a caring approach.

One staff member told us, "Since your (CQC) last inspection here, things have improved. The permanent staff are more of a team now and work well together. It will be better when we are fully staffed with our own staff, but I think we are caring. We take our time now and don't rush people, we try to put them at the centre of what we are doing, rather than just doing the job." Another staff member said, "I like this job. You never know how the day will be. I like working with people and learning about them." A further staff member told us, "People are all individuals. I say to them, please tell me how you like things to be done. I want to get it right (for them). I am a keyworker for three people. I speak with their family and deliver personal care and check their rooms are okay."

People's bedrooms were personalised which helped them feel as if it was their home. One person had a large electronic organ and their 'My Life' document recorded that they used to play the organ and sing in a choir. The activities staff member told us they were in the process of ensuring everyone had a 'My Life' document. They told us this information would help staff know about people, and value them as individuals and develop a person centred caring approach.

Throughout the two days of our inspection visit, we saw staff treat people with dignity and respect and promoted their privacy. For example, one person pulled off their blanket from their legs in the communal lounge and staff gently replaced this to cover them. People's clothing was clean and people cared for in bed had clean bed linen and told us they felt comfortable.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in October 2016, we rated this domain as 'requires improvement' as further improvements were still required in delivering personalised care and meeting people's support needs. On this inspection we checked to see if improvements had been made and found, overall, they had. The operations manager and home manager also told us about further planned improvements, these included the updating of people's care plans and delivering personalised care to people.

People felt that during the daytime shift, most of the time staff responded to them when needed. One person told us, "If I press my bell now, they will come. I'll show you." This person pressed their bell and within two minutes a staff member arrived at their bedroom. However, this person told us, this was not the case at night time, they said, "Staff might tell me to wait, or they don't have time." Another person said, "The staff are good, they always come during the day and if I have to wait a bit, they tell me but come back. But, at night it's different." Some relatives told us they felt more staff were needed at night because their family member had given them examples of support needs not always being met in a timely way.

We observed people's needs were responded to in a timely way during our inspection visit. However, some relatives felt improvement was needed in staff responding to people's needs. One relative told us, "My family member is often wearing dirty clothes when I visit and when they asked staff to support them to the toilet, they were told 'you'll have to wait.' The time they had to wait was about an hour."

Initial assessments were completed with people and their relatives before they moved into the home. These assessments then fed into the development of a care plan. However, care plans were not always personalised and did not always show people and their relative's involvement once they had been living at the home for some time. The home manager explained to us that updating people's care plans was 'work in progress' and they had scheduled review meeting dates and wherever possible wished to include people and their relatives in these. Some relatives told us they had recently received letters inviting them to attend care plan reviews. One relative told us, "I've just had a letter today regarding a one to one meeting about my family member's care plan."

The deputy manager told us, "We are in the process of re-writing everyone's care plan as part of the reviewing process. We want them to be more person centred. The team have started to work in this way, but the paper based care plans are still being worked on." The home manager told us their target date for the completion of updating people's care plans was the end of March 2017.

The activities staff member had begun a programme of getting to know people through one-to-one conversations, and documenting what was important to the person. They shared their new knowledge with staff verbally and in a 'Life history' record. The life history included the person's family tree, childhood, teenage and working life, hobbies, pastimes, interests, dislikes, partner, 'things that worry me' 'things I like and how I like to spend my time. Staff told us that people's individual stories 'moved' them and they had a better understanding of the person's motivations and behaviours and how best to support them once they had this information.

The home offered various planned group activities and posters reminded people of the dates of visits by the 'music man', monthly church services and Holy Communion and seasonal events, such as, 'My funny Valentine'. One person told us, "There is always something going on. I prefer the sing-alongs." During the afternoon in Oak, people were encouraged to join in group activities and staff read magazine articles to people on a one to one basis whilst sitting together with them. In Cedar unit, afternoon activities included nail care for ladies and other people enjoyed listening to music.

Staff told us activities usually took place in the afternoons when there was more time to spend with people. We observed this on both days of our inspection. For example, during the morning time we saw people in Cedar unit communal lounge had the television on but no one was watching it. One staff member said, "I need more time just to spend time with people, talking and listening with them, there is just not enough time to do that." Other staff echoed this, with one staff member explaining, "Things have improved a lot here, and we are making every effort to be person centred as far as we can, such as when we help people have their morning drink, we try to have a brief chat with them." We observed staff did this and where time permitted they made every effort to personalise the care given to people.

Information was available about how to make a complaint. We received mixed feedback from people and their relatives when we asked them if they had any concerns or complaints about the service they received. One relative told us, "I'll sing praises about staff forever, I'm happy with things." Another relative said, "If I had any concerns, I'd raise them straightaway with the manager." A further relative told us, "Things have improved here since October (2016), when you did your last inspection. When I sent a recent letter of complaint about my family member's bedroom and clothes. It was dealt with immediately. I am satisfied." However, some relatives felt there were issues that still needed to improve. Comments to us included, 'laundry does not get returned,' 'missing slippers that have been lost' and 'cleanliness in bedroom could improve.'

Requires Improvement

Is the service well-led?

Our findings

At our inspection in October 2016, we identified a continued breach in the regulation regarding the governance of the service. Systems and processes, such as audits, to monitor the quality of the service to ensure, people's health and wellbeing needs were safely met, were not effective. The provider did not always protect people against potential risks or take action to mitigate such risks. We rated this domain 'inadequate.' We took enforcement action against the provider, serving them a warning notice regarding the governance of the service.

At this inspection, we checked whether the provider had implemented improvements to meet the requirements of the warning notice and whether improvements had been made in the governance of the service. We found sufficient improvements had been made to meet the requirements of the warning notice.

A new home manager had started working at the home during November 2016 and told us they were in the process of submitting their application to become registered with us. The home manager told us about improvements that had been made and those that were 'work in progress,' such as personalising people's care plans and staff taking on lead roles. The operations manager said, "There were a lot of improvements to make, following the last inspection, and we have all been working hard to achieve these. Many have been implemented, though there are some areas we are still working on."

Improvements had been made in the open communication between managers and staff. One staff member told us, "When the new manager started, we all had a big staff meeting. The management told us about the last inspection and that things really needed to improve, that we all needed to work together as a team to make it better for people living here." Another staff member said, "We got given a copy of the inspection summary and managers told us it was serious, but they did not blame us. They said we needed a positive change. I think things have improved. The new manager is always about checking things and the other manager (operations manager) has been here nearly every day." Staff felt supported by the home manager and comments to us included, "So far, so good. It is early days, I hope the improvements continue," and, "I hope they (the home manager) continue to get the support they need once this inspection has been done." Other staff told us they felt everyone was 'pulling together' after 'agreeing what needed to be done' to achieve the identified improvements.

The home manager and operations manager told us they had also sent a copy of the October 2016 inspection summary to people's relatives. Most relatives spoken with recalled receiving this. One relative told us, "I saw a notice on the home's front door about the 'special measures' and looked at the full report on your CQC website. I was invited to a meeting at the home about it. Things have improved since October, I have a positive impression now of more attention being given to my family member and their care, things are better managed."

The home manager told us they had spent time talking with staff and how the service was delivered and how communal rooms were used and had made suggestions to improve people's experience. For example, by putting music on instead of the television at lunch time. The home manager told us staff felt empowered

by their discussions. For example, when a relative had asked to have the television on while they were visiting, staff felt confident to decline, because music is more conducive to a good lunchtime experience, particularly for people who live with dementia.

The home manager had plans to change how people used the lounge and lounge-diner in Oak unit, to make better use of the space and continue to enable people to spend time alone, with others and in small group activities. The home manager planned to offer one person a ground floor bedroom, so they could more easily access a quiet space of their own and to recreate the small communal lounge. The activities staff member had suggested using the small lounge as a 'bar' to encourage the men to meet and play cards and dominoes, which was being given consideration.

The home manager told us they were in the process of re-introducing 'keyworker' roles to staff. They explained the purpose of these was for an identified staff member to be a named link person for each person living at the home. One staff member told us, "The manager has said that this is not about who we support on shift, but we check the person has everything they need. For example, if they run out of toiletries we can let their relatives know or the manager. We also can build a positive relationship with the person and their family."

The operations manager and home manager also told us about plans for lead roles for staff members. The home manager said, "We are in the process of discussing these with staff. Rather than just allocating roles, it is about finding a staff member's area of interest. Lead roles will be for nurses and care staff and will include end of life support and care planning, infection prevention and control, tissue (skin) viability and care and dementia care. There will be dignity in care 'champions,' we have given staff information about this and this will be implemented before the end of February 2017." The home manager said they were sourcing further training for staff to refresh knowledge or develop further skills they needed to fulfil lead roles.

Overall, improvements had been made to the systems and processes to monitor the quality of the services provided. Some further improvements were made in response to our feedback during our inspection visit, such as to the tool used during the home manager's daily walkabout. The improved recording tool shown to us on the second day of our inspection meant the tool was effective in recording what had been checked and what actions, if needed, had been taken.

A survey had been sent to people's relatives during December 2016, giving them the opportunity to feedback on the quality of the service. Results had been analysed and actions had been taken or were planned for. For example, one action was for people that stayed in their bedrooms to be given a menu and one person told us this had commenced during the week of our inspection visit. This meant that the provider was seeking and acting on people's feedback to improve the quality of the service.

We looked at two medicine audits that had been completed by an external health professional from the Clinical Commissioning Group. These audits gave the provider clear outcomes and actions. However, the one medicine audit that had been completed by staff at the home did not have clear actions to implement about the shortfalls in medicines management identified by the audit.

The December 2016 audit to monitor people's weights recorded the actual weights for people that month, but there was no analysis to determine whether there had been an increase or decrease in weight. The lack of information on the audit meant the home manager could not have oversight of whether appropriate actions, such as fortifying food or referring to a dietician, had been taken and were effective. We discussed the audit with the home manager and they agreed that the audit tool needed revising so that it was more effective.

The January 2017 monthly wound audit recorded that wounds were 'improving' for the four people identified as having skin damage. The audit also recorded a check had been made on each person's wound management plans. However, the audit did not identify the issues we found. For example, the challenges of determining the progress of people's skin damage and whether there was improvement or deterioration when photographs were not always taken at each dressing change. We discussed the audit with the home manager and operations manager and they agreed improvement was needed to the audit tool itself and further refresher training was planned for staff on skin care and wound management.

Accidents and incidents were recorded and analysis completed. However, further improvements were needed in record keeping by staff about accidents. For example, in one person's care plan, records of incidents and body maps which recorded the site of any injuries, were filed in three different places, and some body maps were incomplete or wrongly completed. Although the file included time and dated photographs, it was difficult to identify whether incidents had recently increased or decreased and whether they were due to changes in the person's care, support and treatment. Such improvements would mean accurate information informed the overall analysis of accidents and incidents.

The provider had recently implemented a system of 'person centred software' (PCS) electronic recording. One staff member told us, "It's like an i-pod, so that's what we call it. Nurses have a larger i-pad version. We are getting used to them and we all have our own log in details." The home manager told us, "We have shown relatives what we are doing with most of our records (changing to electronic daily entries) and put out flyers and had a meeting. We have identified a member of staff who is really comfortable recording electronically, using voice activation, and who is training and encouraging other staff."

Nurses and care staff used the PCS to record daily care tasks, such as how people were and the care, support and treatment given. Staff told us they felt supported by managers and one another in using the PCS. We looked at eight people's PCS records of daily care and saw some gaps in the electronic records. It was unclear whether this meant staff had not delivered some planned interventions, such as supporting people to reposition, as planned, or whether some staff were not confident in using the PCS recording system.

We discussed this with the home manager and operations manager who told us staff were becoming more confident in using the PCS, but were aware of a few 'errors' such as staff having pressed the incorrect icon that had then recorded something not relevant to the person. The home manager explained a 'red flag' appeared if a task had been missed and this alerted care staff to either undertake the task if it had not been done or to update the PCS if they had forgotten to do this. One nurse told us, "I periodically monitor my i-pad during the shift, this shows me what has been done and anything that has not been done." The home manager and operations manager confirmed that nurses were responsible for the monitoring of the electronic records to ensure people received the care and support according to their care plans and that risks to people's health and wellbeing were identified and appropriate actions taken.