Care Quality Commission

Methodist Homes

Torrwood Care Centre

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

Overall summary

This inspection took place on 16 and 17 June 2015 and was unannounced.

Torrwood Care Centre is owned by Methodist Homes and is registered to provide accommodation for persons who require general nursing or personal care. The home is organised into three units. Beech House and Copper Beech unit providing care for people living with dementia. Oak House provides care for people with nursing needs. At the time of our inspection there were 74 people living in the home.

There has been a registered manager in post since December 2014. 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.

Staff demonstrated a good understanding of the nature of abuse and their responsibility to report any concerns about possible abuse. However there was inconsistent understanding of how staff could contact outside agencies under the providers whistle blowing policy.

There had been improvement in the recruitment and retention of staff. This was confirmed by staff who told us there was more consistency and continuity of care

Summary of findings

because of improved staffing arrangements. We noted the staffing arrangements on Copper Beech unit did not meet people's needs. This meant potentially people's needs were not always being met in a safe and responsive manner.

Whilst there was generally good arrangements for the management and administering of medicines there was a failure to follow the service's policy about administering medicines covertly i.e. without the person's knowledge or agreement.

From our observation of staff we saw people being supported and responded to in a caring and respectful manner. One relative described the staff as "All very caring and friendly". However from our SOFI there were interactions which were neutral in that staff did not always fully engage with people. Whilst there were a majority of positive interaction there was a significant level of neutral and negative interaction.

There were inconsistencies when making decisions on behalf of people who lacked the capacity to make informed decisions. Whilst some decisions had been made following best practice, whereby relevant parties were involved in the decision making process, this had not always been the case for all the people at Torrwood.

Care plans did not always provide up to date or accurate information about people's care needs.

There was a quality assurance system in place which audited the care arrangements in the home. However they had failed to identify how some records were not accurate and did not have the necessary information for staff about people's care needs.

People told us they felt safe with staff who were "Friendly" and "Staff you can trust". Relatives were confident people were kept safe and told us how staff were able to provide safe care.

Risk assessment had been completed so staff had the necessary guidance to prevent risks to people's health and welfare. Some people could present behaviour which could challenge staff or people living in the home. There were care plans in place which identified actions staff should take in response to such behaviour. Staff had received specific training about how to respond to people's behaviour and how to help to reduce anxiety or distress associated with people who are living with dementia.

The appropriate action had been taken to protect people's rights in relation to placing restrictions on people's liberty through the use of legal powers. Staff had a good understanding of how to ensure people were enabled to make choices about their daily lives and routines.

Staff received formal one to one supervision and training so they had the necessary support and skills to meet people's care needs. The service had a significant number of volunteers who provided support to people assisting with meals and activities. Volunteers had received an induction and training as part of their role.

People and relatives told us there was a good choice of meals available. One person said "I really enjoy my food here. If there is something I don't like I can always get something else." There were arrangements to ensure people's nutritional needs were met. However this could possibly be improved for some people by looking at how meals were served taking into account people's dementia. Where concerns had been identified people were referred to the appropriate specialist or healthcare professional so they could receive the necessary support in meeting their care needs effectively.

People had access to a range of healthcare professionals such as physiotherapist, tissue viability nurse and chiropodists so their healthcare needs could be met.

People were not always able to verbally express their views or say what they wanted. Staff told us how had always tried to give people a choice verbally if possible. They noted how people responded and the behaviour they displayed. This enabled staff to recognise how people were feeling. Relatives were given the opportunity to inform staff about the particular care needs of their family member. They also attended care reviews to discuss if people's needs were being met or if the care provided needed to change.

Relatives told us how they felt staff had a good knowledge and understanding of the people they

Summary of findings

supported and cared for in the home. One relative told us how the use of medicines (to reduce anxiety) had dramatically reduced since their relative had moved to the home.

Care plans were informative in providing information about people's personal histories, interests and preferences. This helped to provide a range of activities which suited people's personal choices and interests.

Relatives were confident of voicing any concerns or making formal complaints. There was evidence that complaints had been dealt with in a positive way and improvements made where this was needed when complaints had been upheld.

There was positive feedback from staff and relatives about the approach of the registered manager. People told us she was friendly and approachable. Staff said they felt they were well supported and their views were listened to with opportunities through staff meeting to voice their views. Staff said they had a good understanding of what the registered manager wanted to achieve in providing a quality service. The registered manager said they wanted to provide a dementia friendly and person centred service.

Relatives meetings had been held and relatives told us they were "Good" as it provided an opportunity to "Hear what was happening in the home." Questionnaires had been issued to people living in the home and they had a high rate satisfaction with the care provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

There were inconsistencies about the arrangements for staff to report concerns outside of the organisation under whistle blowing.

There were safe arrangements for the management and administering of medicines. However the system for administering medicines covertly was not robust to ensure people's health and welfare was protected.

Staffing arrangements did not always offer a safe and responsive service.

Staff demonstrated a good understanding of the nature of abuse and their responsibilities to report any concerns.

Risk assessments were in place to protect people's health and welfare and action had been taken to prevent risks to people's health and welfare.

Is the service effective?

Requires Improvement

The service was not always effective.

There were inconsistencies around the practice to ensure people rights were being upheld when making best interests decisions.

Staff received the necessary formal supervision and training to ensure they had the necessary skills and competence to meet the needs of people effectively.

People's health and nutritional needs were being met effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

There were occasions when staff interaction with people was not always positive and engaging.

There was inconsistent practice which ensured people were treated appropriately when providing support in having meals.

Where people were not always able to express their choices and feelings verbally staff had a good understanding of how people's behaviour could reflect how people felt.

Is the service responsive?

Good

The service was responsive.

The service provided a good person centred approach to the care they provided.

Summary of findings

People had the opportunity to undertake meaningful activities which suited their interests.

People felt confident about voicing their concerns and worries and if necessary make a formal complaint.

Is the service well-led?

The service was not consistently well led.

There was a failure to have an effective and robust quality monitoring system.

There were shortfalls in ensuring care planning and other records had been completed and records were robust.

There was an open environment and staff found the registered manager approachable and listened to their views.

Requires Improvement

Torrwood Care Centre

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 inspection took place on 16 and 17 June 2015 and was unannounced. It was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at information we held about the home. This included information regarding significant events that the home had informed us about.

During this inspection we spoke with ten people who lived at the home, 11 relatives and a healthcare professional. We also spoke with 12 members of staff and the registered manager. Throughout the day we observed care practices in communal areas and saw lunch being served in the dining room. We also observed staff interacting and supporting people using SOFI (short observational tool for inspections) This captured the experiences of people who may have cognitive or communication impairments and cannot give their opinion on the services they receive.

We looked at a number of records relating to individual care and the running of the home. These included nine care plans, risk assessments, quality assurance records and medicines records.

Is the service safe?

Our findings

We noted on Copper Beech unit there were two care staff on duty for 13 people. We were told by some care staff this meant staff were "Very stretched" and how when people were agitated or distressed staff were not able to be as responsive to people's needs. A relative told us "The home would benefit from more staff at busy times for example meal times. We observed when one member of staff went to administer medicines to people the remaining staff member had to tell people they "Would be back in a minute". This occurred on a number of occasions. Staff told us how volunteers sometimes supported people at breakfast but when this was not available a staff member told us "It was very busy and we are not always around when people need us". A number of people required two care staff to support them in providing personal care. This meant potentially people's needs were not being met in a safe and responsive manner.

The failure to ensure there was adequate staffing arrangements is a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Staff told us they would report to their line manager in the first instance if they thought someone was being abused or neglected. Staff said, "I would go to the nurse and hope she would go to her boss." Staff gave us examples of the kind of behaviours they would report; these included observing someone speaking harshly to another person. Staff said, "Safeguarding training is done on the computer, such as types of abuse" and "I'm not very good at reading but most of it is common sense." However, staff told us, "If nothing was done I would not know what to do" and "I know about whistle blowing because I've watched TV, but we've not had any training." and "There's a number we can phone but I do not know it." Other staff were aware of their responsibilities under whistle blowing. This meant there was inconsistent staff understanding of how to whistle blow to ensure people's health and welfare were protected.

We observed two members of staff assisting one person to stand. The person they were assisting was leaning back when they were raised to their feet. We asked if this was how they normally assisted this person. They said, "She's only just become this way, she's on a new drug and not been reassessed." Staff told us a member of staff was able to assess people's manual handling needs and also delivered manual handling training. Staff said, "We've not been told to do anything different, just help support her up" and "If she tries to stand on her own she'll fall." We observed staff using a stand aid to assist another person. Pillows were used to protect the person's legs and staff explained to the person throughout what they were doing. The sling used for the person was too big and rose up to the person's armpits while they were being lifted. We checked and found a variety of different sizes were available. However care plans did not provide details of sling size to be used for people who required the use of a hoist. We noted slings were not kept in people's rooms for their use only. We were told however a number of slings had been ordered so people would have a personal sling kept in their room.

People told us they felt safe in the home. One person said "The staff are so friendly and I trust them". Another said "The staff treat me well and I always feel they look after me and I am safe here." A relative said they felt their relative was "Definitely safe." and spoke of the security arrangements which kept their family member safe. They told us "I have not worried about them since they came to live here." Another relative said they had no hesitations in saying their relative was safe in the home. They spoke of how their relative's safety had improved since moving to the home as they had not experienced the frequency of falls.

There were detailed risk assessments in place as part of people's care plan arrangements. These included supporting people with skin integrity, nutritional assessments and the risk of dehydration. Risk assessments had been reviewed as part of care planning reviews and following any incidents. There were risk assessments related to people's behaviour which could challenge staff. Actions were identified which staff could undertake in response to agitated or distressing behaviour. Staff told us they had training about how to distract and respond to behaviour in order to make people safe from themselves and others. One staff member told how they spoke about specific topics such as interests or previous occupation when responding to one person who at times were distressed and agitated. For another person their care plan documented how speaking in calm and reassuring way helped in responding to this person's behaviour.

The registered manager told us there had been continuing improvement in the recruitment and retention of staff. At a

Is the service safe?

previous inspection this had been an area for improvement. Staff also told us staffing had improved. New arrangements had been put in place where care staff worked on specific floors of the home. Staff told us they preferred these arrangements. One told us "You get to know residents better and they get to know you. It's better for them."

Staff told us when they were recruited they had provided two references and the necessary checks had been undertaken. These had included criminal record check.

We looked at administration records and other records of medicines that required additional security and recording. These medicines were appropriately stored and additional records for these medicines and daily stock control was in place. We checked records against stocks held and found them to be correct. Administration records of other medicines were completed correctly and no gaps in recording.

Medication administration records showed that medicines received from the pharmacy were recorded when received administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

We looked at the arrangements for the administration of medicines covertly. This is where the medicines were mixed with food or drink, without the knowledge, of the person and was done in their best interest. The service had a covert administration of medication checklist. One person received medicines covertly. This had been agreed with their GP. However there was no completed checklist or documentation about a best interest's decision. The nurse confirmed there had been no consultation with the pharmacist. These both formed part of the provider's checklist arrangements. This had not been identified by the homes quality monitoring of care plans and medication arrangements. This meant the home's arrangements for the safe and effective administering of medicines covertly had not been followed.

One person managed and self-administered their medicines. There was a risk assessment in place and weekly monitoring of the administration records which included checks of medicine stock held by the person. This ensured the arrangements were appropriate and the person's was able to continue managing their medicines safely maintaining their independence.

Homely remedies such as pain relief were recorded when given and the nurse confirmed they were not administered for longer than 48 hours. At that time if the person still required such medicines a request for a GP visit was made so the person could be assessed to ensure medicines were being given safely and appropriately.

Requires Improvement

Is the service effective?

Our findings

There were inconsistencies around the practice of ensuring people rights were being upheld when making best interests decisions. For one person a capacity assessment and best interest process had been followed in making a decision about them receiving personal care and use of equipment which could be viewed as restraint. Other people had capacity assessments in place relating to specific decisions. However there were inconsistencies for example one person had a pressure mat to alert staff when the person got out of bed. Whilst this was an appropriate decision there was no evidence of best interest's decision process being followed. We have previously commented on a person who was administered medicines covertly with no best interests decision process followed. For another person there was a best interests decision plan about their receiving care however this had only been completed by a nurse with no involvement of others such as GP family or representative. This meant people's rights were not always being upheld.

The failure to ensure the requirements of the Mental Capacity Act 2005 (MCA) were being met is a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

We discussed with the registered manager their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). They told us they had made DoLs applications for the majority of people in the home. This reflected the nature of the service being one which supported people living with dementia. Because of their dementia people lacked the capacity to make certain decision, for example about where they lived and were restricted in their movements because of potential risks to their health and welfare. The applications had yet to be approved by the authorising body.

Staff demonstrated a good understanding of the MCA particularly about how it applied to people who had varying degrees of capacity. Staff told us they had undertaken MCA training. One staff member told us how everyone had some degree of capacity and the importance of making sure people are offered choices. Staff were able to tell us how they ensured people were offered choices about their routines such as clothes they wished to wear, asking to see their doctor and preferences. Other staff told us, "MCA (DoLS) covers aspects of people's liberty. We make sure people have a choice and they're not coerced; people feel safe."

Staff told us they received regular one to one supervision. They told us how training was provided and how they had completed a range of training including safeguarding, infection control and health and safety. There was a nominated dementia trainer based in the home. Staff had received extensive training about supporting people who had a diagnosed dementia. One staff member told us "The training was very good it helped me understand more about dementia."

The home was supported by a number of volunteers. We were told by the volunteer co-ordinator that all volunteers undertook specific training as part of their induction to the service. This included infection control and safeguarding.

People told us they enjoyed the meals and food available. We were told there was always a choice offered to people. A relative said the food was very good and how their family member's weight had improved. We observed the lunchtime and noted how people were told of the choices available. However people were not offered a visual choice in that this may help some people who are living with dementia make a more informed choice.

We noted how the layout of the dining area did not reflect the specific needs of some people who were living with dementia. There was no use of coloured plates, glasses or tablecloths which can support people distinguish food and highlight contrasts in food. This can help in improving the nutrition of some people who are living with dementia. We were told this had been suggested but the provider had

Is the service effective?

said they wanted consistency in all their homes in terms of cutlery etc. However this failed to reflect the specific and specialist nature of the service that of supporting people living with dementia.

We spoke with the chef who told us there was a seasonal three week menu which changed on a weekly basis. They told us there were "between food" available such as yogurts, pots of rice, fruit and cream. These were available at all times so people who needed supplements to their main meal or did not always eat their main meals were being catered for.

We asked staff how they knew about people's diets. Staff said, "I know my residents, it's on the chart" and "No-one has anything different unless we're told." No-one required food and fluid charts to be completed at the time of our visit.

There were nutritional assessments completed as part of people's care plan. There identified specific dietary needs as well as any potential risks. Where concerns had been identified about people's diet we noted referrals had been made to nutritionist or speech and language specialists. Additional care plans were then put in place when food supplements or other needs were identified. There was a weekly weight book and we saw where people had been referred to their doctor when a weight loss had been identified. One person's care plan identified how they needed support with their meals to ensure they ate adequately. We observed this person having the support of a care assistant at lunchtime.

People accessed health services such as GPs, chiropodists and opticians. Records showed people had seen health specialists such as dietician and speech and language therapist. Referrals had also been made to the tissue viability nurse to support staff in caring for people who were at risk of skin breakdown.

The registered manager told us they wanted to establish a dementia friendly service one which cared for staff as recruiting staff was their biggest challenge. They told us a focus was on providing person centred care. This was an area staff confirmed was important when looking at the quality of care provided in the home. The registered manager acknowledged there were areas particularly in relation to the environment which needed to be improved. The registered manager told had they had raised the environment with the provider and was being discussed as to how they could proceed with improvements. The registered manager was aware of where to research best practice in having a dementia friendly environment. They spoke of working in collaboration with other professions and were currently part of a project, through the local health commission group, to improve skin care and pressure wound care in care homes.

Requires Improvement

Is the service caring?

Our findings

We observed staff by using SOFI (short observational tool for inspections) This captured the experiences of people who may have cognitive or communication impairments and cannot give their opinion on the services they receive. When we analysed the data, we saw overall 59% of staff interactions were positive, 37% were neutral and 4% negative. Positive interactions were observed when staff encouraged and enabled people to do things for themselves and made sure people felt included. Neutral interactions were observed when staff spoke briefly with people but did not engage them in any way. The negative interaction we observed was a member of staff pushing someone into the dining room while they were still asleep; they were disorientated when they woke up.

We observed lunch in the dining room of the Oaks. A member of staff put some music on and asked who would like a drink, without speaking directly to anyone in particular. Staff wore plastic aprons and cutlery was put in front of people when they sat down. Some people had clothes protectors put on them without being asked. This meant people were not given the choice or involved in the decision about wearing clothes protectors.

In Copper Beech we observed how people were supported to have their meal in a sensitive and caring manner with the member of staff talking with the person checking they were ok with what they were doing when assisting them. However we noted on Cooper Beech medicines were administered during the mealtime and this was a distraction for people when having their meal. This meant there was only one member of staff to help with the meal and be available to all the people having their meal. People did not get the response needed because lack of staff availability and meals were served over a longer period.

People told us they found staff friendly and kind. One person told us "They treat me as I would want to be treated you cannot fault them". Another person said "All the staff are lovely they respect me and I respect them." A relative told us "My relative has always been treated kindly and with respect." Another relative said "Staff are very kind and caring, lovely home and lovely staff."

All staff we spoke with told us they would ensure doors and curtains were closed when providing personal care to ensure people's privacy and dignity was respected. Staff said, "We talk to people all the time when giving personal care, we were taught that in dementia training" and "We keep doors closed, ask their permission, help them, keep them covered, talk to them all the time and get them to do what they can."

Staff told us, "We do what we can for people." While chatting with a member of staff, one person joined us. They told the member of staff "You're good to me" and they were obviously very fond of them. We observed the chat between them and it was clear the member of staff knew the person very well. The person derived great pleasure from being with the member of staff. Staff told us, "You wouldn't be doing your job if you didn't get attached to people" and "Staff are like family." Other comments included, "We love the fact that we're a family. The bond between staff makes it better."

One relative said the staff were very kind in caring and will always listen to what you're saying and "I have never heard anyone speak harshly or unkindly to residents in the time I been here."

Relatives told us they could visit at any time and how they were always made to feel welcome. One relative told us "I feel staff keep me informed about everything and whenever I visit they let me know how my relative is and any concerns."

People were not always able to express their view about the care they received. However we observed care staff giving people choices where they wanted to be and checking they were happy with what was happening. Staff told us they noted how people behaved and this was a way of making sure people were settled and not distressed. One staff member told us "I always try to ask people what they want to do, to wear and involve them in getting up for example. Some can tell me others I know by their reaction how they are feeling about something." Another staff member told us how they tried to involve relatives in the care and ask them about care needs of people. This was confirmed by a relative who told us they had been involved in a care review and was always asked about the care being provided to their relative "Whether it is what they need". Another relative told us "We were asked alot about what my relative wanted in the way of care and we went to meeting about whether the care was working well or not."

Good

Is the service responsive?

Our findings

A relative told us staff "Have a good understanding and know my relative". They told us how staff had learnt to respond to their relative in a positive and personal way and knew how to react to their behaviour. The use of medicine had reduced dramatically from when they had lived in another care home. Since living at Torrwood it was used "At most every three weeks maybe." Another relative told us how the home had involved sensory loss specialist to help in communicating and supporting their relative.

Staff told us they felt they knew people and had a good understanding of people's care needs. We observed friendly and warm interaction between people and care staff. People appeared relaxed and staff were clearly knowledgeable about people. On occasions we saw staff asked specific questions of people which reflected their understanding and knowledge of the person. Care plans provided information about people's life history, interests and daily routines.

People told us they were able to join in activities if they wished. One person told us "I like doing some of the things they provide, I especially like the music." Another person said "There is something to do here." One visitor told us their relative preferred to stay in their room because they didn't like noise or singing and this was their choice. Staff told us, "There's no time for activities in the morning, but we get time in the afternoons to have a cup of tea and a chat with people."

A relative said there were regular activities with lots of volunteers and how they were able take their relative out. Another relative said how there "Always seems to be something going on." However they said there was limited opportunity for people to go out with staff. "I can't always get here to take my relative out it would be nice if there was more opportunity for people to go out." This was confirmed by staff who said they were not able to go out with people as much as they would like.

We were told by the activity co-ordinator of the range of activities: music therapy, name that tune, quizzes and yoga. There were also one to one activities such as reading or "Just having a chat." The activities co-ordinator told us they were completing people's life histories which included hobbies and interests "So we can offer activities people want or are used to doing." They told us they tried to offer "personalised pastimes" such as one person liked to help in the dining room laying tables.

The service had a non-denominational chaplain who provided spiritual and pastoral support to people.

A relative said they could chat with the manager and the staff when they needed to and they would happily raise a concern or make a complaint should that be necessary. They said the staff were very good at dealing with difficult situations. Another relative said they were happy to make the manager aware of any concern.

Everyone we spoke with said they had no complaints about the service. Staff told us, "If someone complained to me I would straightaway explain it is my job to take it further, and I would take it to the nurse" and "I would say something." Another member of staff said, "I would discuss any issues with relatives and involve the nurse in charge."

There had been a number of complaints made and we looked at these and any actions taken as a result of the complaint. We saw complainants had received a written response which included being told of actions taken to address their complaint. One relative had raised concerns about the care arrangements for their family member. This had been discussed and new care arrangements to meet their needs had been put in place. Another related to staffing concerns and again this had been discussed with the specific staff concerned and the matters raised addressed with them in terms of care practice.

Requires Improvement

Is the service well-led?

Our findings

There were quality monitoring system in place which audited care plans, medication arrangements and infection control. These identified where improvements were required such as more detailed care plans and improved information about people's life histories. However they had failed to identify the care planning shortfalls to ensure records were accurate and reflected people's care needs. The provider's quality monitoring arrangements had not identified failings in the use of covert medicines or best interest decisions for DoLs.

The failure to have an effective and robust quality monitoring system is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Robust records were not in place for some people. For example, we saw one person had a grade two pressure ulcer which required treatment. There was no completed body map or a support plan for this person's treatment. We saw another person with a wound noted in their care plan, however there was conflicting information as to where the wound was located. The nurse told us a wound assessment had been completed and treatment applied to the wound but there was no record or treatment plan in the person's file. The nurse told us, "When any wounds are noted the care assistants will body map this and report to the nurse. They will then write a support plan and work out the dressing regime."

Support plans also gave conflicting advice for staff regarding whether one person should be hoisted or to use a stand aid. One person's care plan recorded the use of a cream for a rash; when we asked the nurse about this she said, "The cream is not being put on now, the care plan needs updating." This meant potentially people's care needs were not being met because of the lack of robust, accurate and completed records and care support plans.

Accidents and incidents had been recorded and analysed to establish any specific areas for improvement. We noted action had been taken for some individuals such as referrals to the falls clinic, changes in their environment and improved interaction from staff to support people when moving around the home.

One person told us "I like the one in charge she comes and has a chat." Another person said "The manager is good she comes and speaks with us I tell her what I think." A relative said that there was good management and the registered manager was regularly seen on the floor. Staff told us they found the registered manager approachable and "Someone we can speak to". One staff member told us "They {the registered manager} are very friendly, approachable and listening." Another staff member said "It is a very open culture."

The registered manager told us there were regular staff meeting and this was confirmed by staff we spoke with. Staff told us they found the meeting supportive and helpful. One told us "They are an opportunity to keep us in touch with what is happening and things we need to improve on. We get an idea what the manager wants which at least lets us know we are on the right track." Another told us "It is a chance for us to find out how we are all doing and the manager has told us what she wants to see in the home which is good. We have had a lot of manager changes in the home." There were heads of department meetings. We were told care staff were not represented at these meetings however the registered manager said they would look to change this and include care staff representation.

A relative told us they had attended relatives meetings. They said these were a good opportunity to make suggestions and comment on the quality of care being provided. They were able "To hear what is going on in the home." Minutes showed a range of topics being discussed including staff changes, recruitment of staff, meal time experience and menu ideas.

There had been questionnaires sent to people using the service and relatives. Results showed 97% satisfaction with the care provided at Torrwood. It was noted there had been an increased satisfaction rate in all areas: staff and care, choice and having a say and quality of life from the previous questionnaire results.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's legal rights were not consistently being upheld because the requirements of the Mental Capacity Act 2005 specifically in relation to making best interests decisions were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The quality monitoring system was not robust and effective in identifying shortfalls in the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The staffing arrangements did not always ensure people's care needs were being met in a safe and responsive manner.