Larchwood Care Homes (North) Limited

Bryan Wood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 28 February 2017 and was unannounced. At the last inspection on 28 September 2015 we asked the provider to take action to make improvements in relation to people at risks of malnutrition, record keeping and compliance with the Mental Capacity Act (2005). At this inspection we checked improvements had made and sustained at Bryan Wood.

Bryan Wood is registered to provide accommodation and personal care for maximum of 45 people. There were 34 people living at the home on the day of our inspection. Accommodation is provided in an extension to the main Victorian house over two floors, with one floor designated for people living with dementia. There are also a small number of bedrooms in the Victorian part of the building accessed by a passenger lift.

There was no registered manager in place but the registered provider had appointed a new manager who was in the process of registering with the Care Quality Commission. 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. The registered provider had put in systems to support the new manager to develop into their role.

Since our last inspection there had been instability in the management at the home, as the previous registered manager had left the service and a new manager appointed but left after being in post for a short time. This meant that although significant improvements were found at this inspection, the home had not yet demonstrated improvements had been sustained. This included ensuring all staff received regular supervision and were trained to develop into their roles. This had been planned but had not yet been completed and there had been a gap where staff had not received supervision.

All the staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Standardised risk assessments had been undertaken for those people at risk of malnutrition and pressure sores. Other risk assessments such as choking risk assessments were in place and we observed practice which confirmed risks were reduced. There had been an improvement in moving and handling risk assessment and care planning since our last inspection and the number of falls at the home had significantly reduced over the past two months.

We found the necessary recruitment checks had been made to ensure staff suitability to work in the home and staff received an induction to ensure they developed into their role and were able to shadow shifts with more experienced staff to ensure they felt confident to take on the caring role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Food was freshly prepared and choice was offered at mealtimes. We observed staff supporting people with their meals and senior staff monitored people at risk of malnutrition to ensure they had adequate nutrition and hydration.

We found staff to be compassionate and caring when dealing with the people who lived at Bryan Wood. We observed staff protecting people's privacy and dignity and ensuring their needs in relation to equality and diversity were appropriately met.

People were provided with care which met their choices and preferences such as what time they got up, went to bed, what they ate and they were encouraged to share their views on how they wanted the service to be run. Staff we spoke with demonstrated they were aware of the needs of the people they were supporting and their individual personalities and preferences.

The activities coordinator engaged with people to ensure activities were meaningful to the people who lived there and there were plans in place to ensure activities were appropriate for people living with dementia.

We found an inconsistent standard and quality of recording but this had been recognised and care plans had been audited to give staff clear direction where improvements were required.

Staff spoke highly of the new manager who was being supported into the role by a peripatetic manager and a regional manager. The new manager was passionate about raising the profile of Bryan Wood to be a homely location where people would consider they were at home.

Both day to day and the quality improvement audits had improved since our last inspection and actions were completed where issues had been identified. The registered provider completed detailed audits of the home and identified actions to raise the quality of the service. They transferred these actions into a home improvement plan and outcomes were monitored by the regional manager. People were involved in developing the service and one person who used the service was actively involved in chairing the 'residents and relatives' meeting.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

All the staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risks were assessed and managed appropriately and we observed staff implementing risk reduction measures highlighted in care plans to ensure people were safe.

We found the necessary recruitment checks had been made to ensure staff suitability to work in the home.

Is the service effective?

Requires Improvement

The service was not always effective

Staff were receiving training to ensure they had the skills to perform in their roles, and the service was proactively seeking to supervise and appraise all staff. However, supervision and training was not all yet up to date at the time of the inspection and the service had not yet attained the registered provider's standard.

Food was freshly prepared and choice was offered at mealtimes. We observed staff supporting people with their meals and senior staff monitored people at risk of malnutrition to ensure they had adequate nutrition and hydration.

The service was meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion and ensured their cultural and diverse needs were met.

People's dignity and privacy was respected and staff were aware of the importance of involving people in the care they provided.

Staff supported people to remain as independent as possible during everyday tasks.

Is the service responsive?

Requires Improvement

The service was not always responsive

Staff were aware of the needs of the people they were supporting and their individual personalities and preferences.

The activities coordinator engaged with people to ensure activities were meaningful to the people who lived there.

Standards of recording were still inconsistent but had improved since the last inspection and the registered provider had undertaken a detailed audit with actions to improve these by a set date.

Is the service well-led?

Requires Improvement

The service had not always been well-led

There had been instability in the management team since our last inspection. However there was a new manager in place who was being supported into the role by the registered provider. They were enthusiastic, passionate and dedicated to the service but it was too early to determine whether improvements would be embedded and sustained.

People and staff felt able to contribute to the development of the service and voice their opinion to the management team.

There had been a significant improvement in the monitoring of the quality of the service provided and plans were in place to continue to drive improvements.

Bryan Wood

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 8 and 28 February 2017 and was unannounced. The inspection team consisted of 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 we reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

The registered provider had been asked to complete a Provider Information Return (PIR). This 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. We used this information to help us plan this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with seven people using the service and two visiting relatives, the manager, the peripatetic manager, the regional manager, the deputy manager, the activities coordinator, the cook, the laundry assistant and two care staff.

We reviewed eight care records. We also reviewed the records related to the running of the service such as

maintenance records and the recent audits that had been completed relating to the quality of the service provided.

Good

Is the service safe?

Our findings

We asked people lived at Bryan Wood whether they felt safe. One person told us, "It is safe, it is clean, staff are very good, they come out during the night, they check on us". Another person said, "I feel safe, I am near my friends and my home, staying here is very pragmatic for me before my Alzheimer's get worse, I've got enough room and staff are very supportive, very engaging". One relative said, "The home is nice and clean, the doors are locked so staff know who to let in or out of the home plus residents have buzzers in case anyone falls".

The manager told us they had enough staff to meet the needs of the people who used the service. They used a dependency tool to determine staffing and although this showed they had too many staff, they advised the registered provider would not reduce staffing numbers. They told us they had two senior staff at each shift, and five care staff in the morning, four carers in the afternoon and the night shift consisted of one senior and three care staff. We verified this information on staffing levels by reviewing the previous three staffing rotas.

The registered provider had developed and trained their staff to safeguard adults from abuse. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with described the types of abuse they might find in a care home such as 'marks, bruising, change of behaviour, change of appetite, and reclusive behaviour'. They knew how to report abuse and if their concerns were not acted upon they told us they would take the matter to a higher authority. The manager told us there had been no recent safeguarding incidents at the home.

We found risk assessments in place in the care files of people who lived at Bryan Wood. These included standardised risk assessments such a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and a Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. The manager told us they completed risk assessments along with the deputy manager and the senior staff. They told us they completed risk assessments for any activity which may potentially cause harm such as people making themselves a hot drink in the kitchen, for those that want to shower themselves, falls, bed rails, moving and handling and malnutrition. We saw a choking risk assessment in place for one person and saw staff supported this person in line with the risk reduction measures in their care plan. We found the number of falls had significantly reduced over the last two months which the management team told us was due to proactive falls prevention measures. Accidents and incidents were recorded and analysed to ensure measures could be put in place to reduce further incidents. The service had a low number of fractures which demonstrated measures had been successful.

The regional manager told us two members of staff had recently attended the 'train the trainer' course for moving and handling to enable them to cascade learning and good practice at the home. They said one trainer had updated all the moving and handling care risk assessments and care plans. We spoke with this person during our inspection and they demonstrated to us their knowledge and passion for the safe

movement of people at the home.

Each person had a personal emergency evacuation plan (PEEP) in place to enable them to be safely supported in an emergency such as a fire. These included both vertical and horizontal evacuation requirements. Although detailed, further specific information such as which particular hoist, sling or wheelchair would be beneficial to ensure people are safely moved.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. For example, we saw evidence in each file that Disclosure and Barring Services (DBS) checks had been undertaken and two references received for each person. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We looked to see how the service was managing people's medicines. We found medicines were administered to people by trained care staff. The pharmacy providing the home with their monitored dosage system provided training for dispensing staff. Staff competencies to administer medicines were checked and the registered provider had a detailed competency tool in place, although their own audit had shown that not all staff had their competency checked three times in accordance with their own policy. We did not find body maps in place to support staff in determining where to administer topical creams and this was reported to the manager as an area for improvement.

Most medication was supplied in a monitored dosage system. We inspected medication storage and administration procedures in the home and found the storage cupboards were secure, clean and well organised. The treatment room was locked when not in use and there was a document for staff to sign when the key was handed over at each changeover of shift. Temperatures of the medicines fridge and the clinic room were checked daily to ensure medicines were stored at the correct temperature.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. The home had appropriate storage systems in place. We saw controlled drug records were accurately maintained and the giving of the medicine and the balance remaining was checked by two appropriately trained staff. We checked the register tallied with the amount of medication in storage.

We saw 'as necessary' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. We reviewed records of medicines no longer required and found the procedures to be robust and well managed.

Concerns had been raised in the past in relation to infection control practices. The home had an action plan in place and they were actively improving areas of concern. We found an improvement to the cleanliness of the home following our last inspection, and liquid soap, paper towels and personal protective equipment was available in all areas inspected. The registered provider was in the process of further improvements to the kitchen area and other refurbishments were on-going in line with their refurbishment plan. The home had been closed in between inspections due to an outbreak of vomiting and diarrhoea, and had undergone a deep clean to ensure the virus was contained and people were appropriately isolated to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the meals. One person said, "We have a choice of breakfast. A cooked breakfast if you want with lots of choice and prunes. It's not Buckingham Palace but it's very good." We also received the following comments, "The food is better, it is now more or less what you would expect" and "I like food here, it reminds me of school dinners. Staff know that I got a big appetite" Another person said, "I am happy with the food now, good choices and it is more than adequate – we used to have squash, but now we have fresh juice as well. I was very impressed that as soon as the chef knew that I don't like the coffee they are serving, [name] went on to buy me a proper decaf coffee, which I like very much". Although one person said, "There is always two choices because I am fussy with food, some days I can't eat the food because it is not hot enough or not appetising".

We observed the lunchtime meals in both dining areas. Tables were laid out with table cloths, cutlery and condiments. Sauces were still in sachets, which people found difficult to open independently at our last inspection, and the manager told us these would be replaced with squeezy bottles. There was a menu which was rotated every four weeks, although this was not accurate to what was on offer on the day of inspection. People were served their meals one table at a time, the food presentation was good and people were observed to enjoy their meal which was unrushed. People were offered food in line with their cultural heritage and one person did not want what was on offer and was offered jerk chicken which they told us they had enjoyed. They said, "The staff give you everything you want, I enjoyed my steak." We observed another person who was displeased with their choice saying "I don't like this" and staff offered them a different choice, which they were happy to eat.

At our previous inspection we found issues with inaccurate recording and monitoring of people's food intake. We checked to see whether improvements had been made. The deputy manager who had recently taken up post was responsible for monitoring people's weight and had an overview of each person's dietary requirements and we saw people's intake was monitored and recorded. They had introduced snack boxes to encourage people to eat in between meals and we observed snacks and drinks were freely available for people to help themselves. The home had recently been supported by the dietician through the Clinical Commission Group to use the evidenced based Malnutrition Universal Screening Tool (MUST). It also includes management guidelines which can be used to develop a care plan. As a result of the work on people's nutritional and hydration needs, only two people were requiring a food diary and there was less dependency on nutritional supplements.

We looked at three staff files and found staff had completed a comprehensive induction although on our first day of inspection the manager told us they were not using the Care Certificate (the minimum standards that should be covered as part of induction training of new care workers). However, by the second day of inspection, all new staff had been placed on the Care Certificate which was in line with the registered provider's policy. The manager told us new staff shadowed experienced staff before being placed on the staffing rota which showed us new staff were supported to develop into their roles.

The manager told us staff had supervision every six weeks but more often if required. We found not all

supervisions were up to date as a result of the changes in management at the home but they were actively working on this including supervision of the night staff. The registered provider's policy stated this should happen at least five times a year and one appraisal and a review. Regular supervision of staff is essential to ensure that the people at the service are provided with the highest standard of care and this had not happened consistently at the home.

The registered provider offered training in the following areas; moving and handling, care planning, dementia awareness, dignity and respect, equality and diversity, fire safety, health and safety and infection control, safeguarding and nutritional awareness. Not all training was up to date but this had been given a high priority and was monitored through the home development plan and we saw staff attending training on both days of our inspection. This showed us the location was actively seeking to rectify this shortfall and had implemented a system to monitor the performance and development needs of staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our previous inspection we found the service had not complied with the Act and had not completed mental capacity assessments or considered whether people should have a DoLS in place to protect their human rights.
At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We noted five authorisations were in place. One person had conditions in place and we asked the manager and reviewed their care plan to evidence the home was meeting these conditions. We found one condition had already been met and the registered manager told us how they were meeting the second condition, although this had not been transferred into their care plan. Our review of their records and our discussions with the manager gave us confidence they were acting upon the conditions.

The registered provider has trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. We found capacity assessment in the care files we reviewed which evidenced people were assessed in line with the legislative requirements. We found consent had been sought for those people who were able to consent to their care and treatment.

The home was split into three separate areas, the older building providing accommodation for people with a physical disability, whilst the ground floor of the newer part of the building was designed to be 'dementia friendly.' The peripatetic manager supporting the home told us they were planning to change the layout so the entire home was accessible to people with no division separating the units, with people free to access all areas. The lounge in the dementia friendly unit benefited from patio doors which gave access to an enclosed outdoor space with raised flower beds. The unit supporting people with dementia had been designed with contrasting colours and equipment to assist people with orientation. Toilet and bathrooms doors used pictures and words of a size easily recognised and one person using the service pointed this out to us and told us this had been useful to them. They also showed us their photograph on their bedroom door telling us, "That's me. That's my room." One member of staff we spoke with told us, "Table cloths are changed at every meal. White for breakfast, red at lunchtime and peach at tea time. Otherwise it might seem like every meal is breakfast." This showed us the staff at the home were thinking about how to support people living

with a cognitive impairment to orientate themselves during the day.

People told us they were supported to access health professionals when required. One person said, "They called the GP for me and I think I was seen to by a chiropodist last Thursday" Another person said, "When I am not well, I tell staff, they know what they are supposed to do". We confirmed people using the service had access to other health care professionals for example, GPs, district nurses, chiropody, dentist and optician from a review of their care records.

Good

Is the service caring?

Our findings

People and their relatives told us staff were respectful, caring and kind and that they listened. One person said, "Staff are very approachable, they do give you a lot of feedback". Another said, "There is no point saying anything else, staff are very nice, they are well trained" and another said, "Staff are very good, laughing and joking, making the place just right". A further person told us, "Staff are alright". One person described care to us saying, "There is lots of unannounced kindness, when staff suddenly offer you a cuppa, that's an atmosphere I would like to be in when I get worse".

Throughout our inspection we saw people were treated with respect and in a kind way. We saw staff spoke with people patiently and respectfully and used touch appropriately when speaking with people who were not always able to verbalise their feelings. The staff were friendly, patient and discreet when providing support to people. We saw staff took time to speak with people as they supported them.

People's privacy and dignity was maintained. Staff told us they did this by ensuring care was undertaken in private and by knocking before entering a person's room. Documentation was kept in locked rooms and staff told us they ensured this was not left out for people to access to ensure information was kept confidential. We observed staff encouraged people to do as much as they could for themselves. For example, at breakfast time staff encouraged one person to hold their own tea cup to promote their independence. The registered provider was in the process of updating the kitchen area on the dementia friendly unit. The regional manager told us they would be installing a 'one cup' hot water dispenser to improve the safety of those people who wanted to make their own hot drinks. They told us, "We've got to move away from typical residential care and focus on promoting independence." People living at the home had been involved in choosing the colour scheme for the carpets and walls on the unit. In addition, one person at the home told us they chaired the residents/relative meeting and said, "It has given me a sense of purpose, doing something for others"

We asked about equality and diversity and how people were supported in relation to their religious and cultural needs. One person told us they attended church and were able to socialise with their friends. The manager told us local church groups were involved with the home and we observed people with a West Indian heritage were offered an alternative menu on both days of our inspection. This showed us the registered manager was considering the cultural and religious needs of the people who lived at Bryan Wood.

.We discussed advocacy with the manager who told us they would involve a Independent Mental Capacity Advocate to support people who lacked capacity to make decisions, if they had no family involved.

Our review of care plans evidenced there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. This included an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. In addition the Clinical Commissioning Groups (CCG) Care Home Support team had assessed each person and there was an emergency care plan in place which referenced people's wishes at this time. There was no one at the home

requiring end of life care but we could see discussions were taking place in relation to people's wishes at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

We asked people at the home whether they had been involved in writing their care plan. One person said, "I recently sat with [manager] and went through lots of care plans". One of the relatives we spoke with said, "I have been quite impressed with staff supporting my [relative], they have gone through with me lots of paper work, lots of assessments". Another relative told us, "Somebody comes and sits with us and ask us about how we feel regarding the care [relative] receives". Most people we spoke with did not know they had a keyworker or who that person was. One person said, "Staff talk to you about all that, but I don't know about keyworker".

We asked the manager whether all people who were admitted to the home were assessed to ensure they could meet their needs. They told us this was the case and in an emergency situation, a senior carer would assess the person. We reviewed the preadmission assessment for one person and could see this was a detailed assessment which would have enabled care staff to support this person.

As part of our inspection process we reviewed eight care and support plans. We found the standards of recording to be very mixed but there had been an overall improvement since our last inspection. The new care plans which had recently been completed were of a high quality, detailing person centred information. This included a record of what the person could do for themselves and identified areas where the person required support. These files contained an audit by the regional manager advising staff what further information was required to complete the care plans to a high standard and we saw this had been done to those audited prior to our first day of inspection. Some care plans contained people's life histories which informed staff of the history of the people who lived there. We observed good correlation between what the care plan required and the care given and this was consistently recorded.

Other care plans did not have all the up to date current information, such as one care file of a person on a fortified diet which had not been added to their care plan even though the care plan had been evaluated. Some daily monitoring sheets did not contain the exact amount people had eaten. For example, 'chicken, veg, mash and cake and custard' was recorded rather than how much of each had been eaten. By the second day of inspection all care plans had been thoroughly audited; each had a plan in place where further improvements were required and the deputy manager told us these would be completed by the end of March 2017.

Information in the completed care plans was person centred and detailed people's preferred ways of support, such as "It is very important to me that my hair is dyed and styled. I do not like my hair to be grey." Care plans referenced what time people wanted to go to bed and what time they liked to get up. Where people had specialist needs requiring additional care plans, we found these had been completed, such as a care plan around a person's visual impairment.

Relatives told us they were fully informed about their relations' care needs. One person said, "The staff communicate with me at least once a day about my [relative]" and another said "The care home allowed us to get a telephone for [relative] in their bedroom, that way we can keep contact anytime"

People we spoke with told us they had been offered choice in how their day was planned. One person said "You can go to bed at any time, it is your choice." Other people told us they had a choice to have a shower or a bath or a wash.

At this inspection we checked to see whether people had meaningful occupation throughout the day to enhance their mental wellbeing. There was an activities coordinator during the week and they coordinated planned activities. We were told staff undertook activities at the weekend, and families often visited at the weekend. Before lunch on the first day of inspection there was a pianist paying tunes such as 'Daisy, Daisy', 'I did it my way' and 'God save the Queen' which got some people dancing and singing along. On the second day of inspection a pianist and singer attended the home and encouraged people to sing along and pancakes were offered as it was pancake day. We could see people were enjoying this planned entertainment. We also observed five people painting spring flowers with classical music playing in the background which created a really pleasant atmosphere for the people partaking in this activity.

We asked people how they were supported with activities and hobbies. One person said, "I do my crosswords, read or watch telly, I don't go out, and I wish there were more trips outside the care home" Another person said, "I like the fact that everyone receives an activity planner for the week to keep in their bedroom, so they can decide if they want to take part of not". One relative told us, "Even though my [relative] has been here not for long, I observed that there is always a lot going on which is not only relevant to [relatives] age group, but there is a lot more for them to join in". A further person told us, ", I like painting, music and watching TV. [Activities coordinator] will take us out for trips, I like it when we visit Castle Hill, the TV tower, which is one of the Yorkshire landmarks".

Staff we spoke with demonstrated they were aware of the needs of the people they were supporting and their individual personalities and preferences. They told us, and we saw how they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care.

We asked people if they were confident to speak up if they had any complaints or concerns about the service. People said, "I am confident that I can speak to staff about any concerns I may have" Another person said "I always speak to [manager's name] They are lovely. Other comments included "I am happy here, don't have a reason to complain" and "Don't usually have complaints, but I am confident that I can find someone to tell".

The manager told us the service had a complaints procedure, which was available to people and their relatives. They said anyone with a complaint could take it up with a senior member of staff. They acknowledged informal concerns were not recorded to enable the service to evaluate the quality of the service provided but stated, "We are starting now" and recounted an issue with the drainage system as an example of how such as concern was dealt with.

Requires Improvement

Is the service well-led?

Our findings

We asked people living at the home whether they thought the service was well-led. People spoke highly of the new manager who they described as approachable and fair and we received the following comments, "Since [name] was a manager, there has been lots of improvement in the care home such as new carpet and other renovation. I have also seen a massive improvement in staff training, food and snacks.The home is run better" and "The manager knows most residents and [they are] good with staff, since [they were] a manager we see staff constantly going training." Relatives told us the atmosphere in the home was positive. One relative told us, "I am just happy that this is a perfect location to visit and I am very happy at the way things are".

There was no registered manager at the time of the inspection. The registered provider had appointed a manager who was in the process of registering with the Care Quality Commission. We noted posters on the wall with a photograph and introduction to the new manager with the following message, 'Please feel free to approach if you have any queries'. The new manager was supported daily at the time of inspection by the registered provider's peripatetic manager to develop the manager into their role. The regional manager was also supporting the service between two and three times a week. The registered provider had recently appointed a new deputy manager and we were told they planned to recruit a second deputy to ensure there was manager presence at the home seven days a week.

The peripatetic manager told us there had been a culture of segregation at the home between the different units, but the intention was for all people to have free access around the home's communal areas so for example, people living with dementia would not be segregated but the home would be updated to ensure all areas were safe for people no matter what their dependency.

They told us the atmosphere at the home had changed and staff had told them they felt more supported and valued and they said, "Valued staff means delivering the quality of service we want." Staff affirmed this and told us the atmosphere had improved and they were happy with the current management arrangements. The manager shared their vision for the service with us. They said, "I want to empower the staff. I want to try and bring out what we see in them." They recounted how they had supported one member of staff to take on additional role following encouragement and building their confidence in their own abilities.

They peripatetic manager told us they received compliments from professionals and GPs and the number of falls had reduced demonstrating they were referring to the right professionals and they were looking at managing risk appropriately.

The manager told us they undertook a daily walk around at the service as part of their monitoring arrangements. We asked how effective this was in identifying areas to improve where actions were required. They told us as part of their walk around the day before they had observed a shower chair had not been cleaned. They had spoken with the person responsible for the team and reinforced the need for this person to effectively manage their team to ensure this did not reoccur.

We reviewed the minutes of the latest staff meeting held on 13 January 2017. These showed discussions were held around team working, culture of the home, training and staff sickness. Other topics such as safeguarding, maintenance, care records, medication, meal times, infection control and communication were also discussed. Staff were also asked to think whether they would be happy for a member of their family to live at the home. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service and the service was meeting this requirement.

The home held residents' and family meetings every two months and we saw the schedule for the future meetings displayed near the entrance. We were shown the minutes of the latest meeting which had taken place on 18 January 2017. These showed a two way discussion where people were not afraid to discuss where they thought improvements could be made. However, the minutes did not show who was responsible for any actions, or a review of the minutes of the previous meeting which would have demonstrated actions had been completed between meetings. The registered provider had sought feedback from people using the service, visitors and staff during May 2016 by means of a questionnaire. We were shown the results of these surveys which showed 14 people using the service, four visitors and nine staff had responded. One person at the home also told us, "I had a survey asking different questions about facilities and it has been great lately".This meant there was evidence that feedback was being monitored and analysed to identify areas where the service needed to improve and to acknowledge what they were doing well.

We reviewed audits which had been carried out at the home. These included the following audits; mattress, skin tear, bed rails, medication, weight loss and a pillow audit which demonstrated the home was monitoring these aspects of service delivery to drive improvements.

We reviewed a detailed audit conducted by the registered provider's compliance officer which had been undertaken in January 2017. This highlighted areas of good practice but also where the home needed to improve. The areas for improvement were transferred into a home improvement plan and we could see the actions that had arisen from this, some of which had been completed and some which were ongoing. The auditing systems had improved significantly from our previous inspection and were more robust to ensure any areas identified for improvement had been actioned.

The home had not notified Care Quality Commission about all the approved Deprivation of Liberty Safeguard authorisations due to the management changes, but they had already got this in hand by the time of our inspection and had determined which ones had not been done by liaising with the local authority and the Care Quality Commission. The notifications had all been done by the second day of inspection.

We inspected records of lift, hoist and sling servicing and testing which recorded all maintenance checks had taken place. We also reviewed audits which confirmed electrical hard wiring and gas services had recently taken place and all portable electrical equipment testing was up to date. The registered provider had a health and safety book to record all weekly and monthly checks to ensure all health and safety requirement as the home had been met.