Ranc Care Homes Limited

Brentwood 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 19 June 2018 and was unannounced.

Brentwood Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 112 people in one building, over three floors in four separate units including a nursing unit on the top floor. At the time of our inspection there were 74 people living at the service some of whom were living with dementia.

There was 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 2008 and associated Regulations about how the service is run.

At the last inspection the service was rated as requires improvement with a breach of Regulation 12; safe care and treatment as medicines were not always managed safely. Despite improvements in some areas which meant the service was no longer in breach of the regulations the rating remains requires improvement.

Improvements had been made to the safe management of medicines and staff supported people to take their medicines as prescribed. However, further improvements were required to ensure people received their covert medicines in accordance with prescriber's guidance. The provider had policies and procedures in place designed to protect people from abuse and staff had received training in how to safeguard people from the risk of abuse.

Risk assessments and management plans were in place to reduce risks to people's health and safety but care records had not always been updated to reflect the current risks to people. Appropriate recruitment procedures were in place and on the day of inspection people's needs were met by sufficient numbers of staff. However, mixed views were expressed by staff, people and professionals regarding staffing levels.

The environment was safely maintained and good infection control practices were adhered to. People reported satisfaction with the level of cleanliness and hygiene. Accidents and incidents were recorded and learned from with measures put in place to minimise the risk of re-occurrence.

Staff had received training and supervision to ensure their competence in their role, however annual appraisals of their practice had not been completed to support continuous learning and development.

Record keeping was not always robust, particularly on the nursing unit, which meant we could not be sure

people always received effective care and support to maintain their health and wellbeing. People were supported to access healthcare professionals but improvements were required to ensure timely referrals were consistently made. People were supported to have enough to eat and drink and were offered choices, however improvements in monitoring food and fluid intake were required.

People were supported to make their own decisions and choices. The environment was suitable to meet the needs of people living with dementia.

Staff developed caring relationships with people and supported them to express their views and be involved in making daily decisions about their care and support. Independence was promoted and people's privacy and dignity was respected.

People received personalised care that was responsive to their needs and enjoyed a range of activities, which were tailored to their interests and choices. People and their relatives had access to the complaints procedure. People were consulted about their end of life care choices and wishes.

Quality assurance mechanisms were in place to monitor and improve the safety and quality of the service. Staff felt supported by the management team and there was good morale and a strong sense of teamwork.

People, relatives and staff were included in the running of the service. Feedback was sought and points raised were acted upon to drive improvements. The registered manager worked in partnership with other agencies to ensure that the service continued to learn and improve.

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.

Improvements were required regarding sharing information on risks to people and how covert medicines were administered.

Staff were recruited safely however; mixed views were expressed by people and staff regarding the number of staff deployed.

Staff knew how to protect people from the risk of abuse and good infection control practices were adhered to.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction, training and supervision to support them in their role, however improvements were required to the appraisal process.

Gaps in recording practices meant that we could not be sure people had always received effective care and support.

People did not always receive timely referrals to health care professionals to maintain their health and wellbeing. Staff supported people to make their own choices and decisions.

The environment was 'dementia friendly' and met people's needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and knew people well.

People were involved in decisions about their care and support.

The service supported people to maintain important relationships.

Independence was promoted and staff treated people with

dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's needs were holistically assessed and their wishes and preferences recorded and upheld.

The service supported people to engage in activities of their choosing both within the service and in the local community.

There were systems in place to respond to complaints.

People's wishes for their end of life care had been recorded and the service worked in partnership with the local hospices to improve staff knowledge and practice.

Is the service well-led?

Good

The service was well led.

The systems and processes for monitoring quality and safety had improved.

The new registered manager was approachable and hands on and staff felt well supported.

People and staff were included in the running of the service and feedback was invited and acted upon to make improvements.

Brentwood 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 comprehensive inspection took place on 19 June 2018 which was unannounced. The inspection was completed by three inspectors, a specialist nurse advisor and two experts 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.

Prior to this inspection we reviewed all the information we held about the service including notifications sent to us by the provider. Statutory notifications provide us with information about important events which the provider is required to send us by law.

During the inspection we spoke with 27 people who lived at the service, 6 visiting relatives and a health professional. Some people who used the service were living with dementia and were unable to tell us about their experience so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Throughout the day we also used informal observations to look at staff interactions with people and with each other. We spoke with the registered manager, the regional manager and operations director. We also spoke with 12 members of staff including care staff, nurses, activities and kitchen staff. We looked at 13 peoples care records, eight staff files and looked at information relating to the management of the service such as training records, supervision notes and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection the service was rated as requires improvement in safe with a breach of regulation 12; safe care and treatment as medicines were not safely managed. During this inspection we found that improvements had been made and the service was no longer in breach of the regulations. However, we still found there were areas requiring improvement so the rating remains the same.

Staff had been trained in how to protect people from the risk of abuse and demonstrated knowledge of the signs to look for and how to report any concerns. A staff member told us, "I would go straight to [named registered manager] or CQC." Staff were aware of the whistle-blowing policy which supports staff on how to report poor practice and told us they would feel confident to whistle-blow if necessary.

There were systems in place to ensure safeguarding concerns were investigated internally and reported to the relevant authorities. However, we found a recent example where the registered manager had not reported a safeguarding incident to the local authority after poor practice by agency staff nurses was discovered.

We discussed this issue with the registered manager who told us the risk had been mitigated as the agency staff had been dismissed. Nonetheless, good practice dictates that a safeguarding alert should be made and an investigation completed to assess whether other people had been affected. We were later advised that the safeguarding had now been raised.

People had risk assessments and associated management plans in place to provide guidance to staff on how to safely meet people's needs and manage risks. We saw that technology such as alarm sensors were used to monitor people's safety and prevent the risk of falls whilst respecting their freedom to move around. We did find that the information recorded in people's care records did not always contain the most up to date information on risks and in some cases lacked sufficient detail for staff on how to manage those risks. Nonetheless, in practice, we found that staff were aware of the risks to people and knew what to do to keep people safe. For example, one person's grab sheet which provided a summary of their care needs stated they were on a normal diet, but they actually required a soft diet to minimise the risk of choking. However, when we spoke to a member of care staff about the person's needs they told us, "[named person] is on a soft mashable diet." They went on to describe in detail how they supported the person to eat safely.

Whilst we found that staff knowledge reduced the risk of people coming to harm, there was the potential for risk, if new staff who were unfamiliar with people referred to outdated care records for guidance on how to safely meet people's needs.

We shared our concerns regarding the incidents of poor recording practices of risks we found with the registered manager. After our inspection we were provided with written confirmation that those people concerned had their care records reviewed to ensure they reflected their current needs and risks.

On the day of inspection, we observed there were sufficient staff deployed to safely meet people's needs.

Call bells were answered promptly and people were supervised by staff in communal areas. However, feedback from a health professional who visited the service reported that this was not always the case and people were sometimes left unsupervised in the lounge. We received mixed views from people and relatives regarding staffing levels. One relative told us "I always see staff around." Whereas another said, "They have a staffing problem here, staff come and go all the time, and that has a knock-on effect. I don't think they've got enough on duty for the number of very sick people up here." One person told us, "They don't always come very quickly when I call them; I'm told, 'You're not the only one who needs help'; I know that but that doesn't help me." Some staff also said there were not enough staff employed, particularly at night-time. One staff member told us, "Staffing is not that good; nights are pretty awful." However, they also added that this did not impact on people's care, stating, "Nothing is over looked but we work like trojans; we ensure that everyone has the care they need." Staff's hard work was praised by people and relatives. One visiting relative told us, "Staff work hard and sometimes it is hard to get through on the phone, especially at weekends, but when I visit there is usually two to three staff around. It would be good to have more as staff here work extremely hard."

We discussed the negative feedback we had received regarding staffing numbers with the registered manager. They said that they believed improvements in staff's time management was required rather than an increase staff numbers and told us they planned to spend time working shifts across all the units to coach staff and support improvement. After the inspection the registered manager wrote to us to confirm they had worked various shifts across the service and found that the units were running well on the staff numbers allocated.

Safe recruitment processes were in place. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining an employment history and checking that the member of staff was not prohibited from working with people who required care and support.

At our previous inspection we found medicines were not always managed safely on all the units. At this inspection we found improvements had been made. Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. People's medicine support needs were recorded in their care records. Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. There was appropriate guidance for medication administered as required (PRN). The medication was kept and secured safely, and only appropriately trained staff had access to this. We observed the senior care staff member giving people their medicines and they did this by following a safe procedure. They checked they were giving the medicines to the right person. They also signed the medicine charts after they had given each person their medicines.

However, we did find that improvements were required in managing the administration of covert medicines. We looked at the records of two people who received their medicines covertly and found there was no clear guidance from either the GP or pharmacist relating to how the medicines should be covertly administered. Staff told us about a person who was receiving their medicines crushed on the advice of a medical professional but could not provide any evidence of this. In addition, there was no information on the person's MAR sheet from the pharmacist to say if crushing was appropriate for this medicine.

We spoke with the registered manager regarding covert medicines, they told us that a meeting was planned with the pharmacy and this issue would be addressed at that time .

When we arrived at the service first thing in the morning we noticed a strong odour of urine on two of the units. However, once cleaning staff arrived and started cleaning the odour was gone. People told us they were happy with the standards of cleanliness in the service. One person told us, "This place is spotlessly clean, it is a lovely building." A visiting relative said, "It never smells and is very clean, the rooms are cleaned daily."

We saw that staff used protective clothing when required and regularly washed their hands. There were supplies of liquid soap, paper hand towels, and hot water and protective gloves accessible throughout the building for staff use.

Systems were in place to record and monitor incidents and accidents including falls and these were analysed by the registered manager. This meant that when trends were identified action would be taken to prevent reoccurrence, for example, the provision of equipment, checks of the environment and referrals to relevant health professionals.

Lessons had been learned by the provider to improve safety. For example, there had been the realisation that the newly opened 'dementia village' where two units had been merged into one, was not having a positive impact on the people who used the service. The merged units had made the space too large and people living with dementia were put at increased risk of losing their way and becoming disoriented. In response, plans were being put in place to re-divide the space back into two smaller units.

There were arrangements in place to manage and maintain the premises and equipment safely. We saw that health and safety, maintenance and fire safety checks had been completed including checks of fire extinguishers, fire exits and smoke alarms. People had personal evacuation plans (PEEPs) in their care records which provided guidance to staff on the level of support people needed in the event of an emergency evacuation. However, in three care plans we observed there were no PEEPs in place.

We discussed our findings with the registered manager who confirmed in writing after the inspection that the missing PEEP's were now in place.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection rated the service as good in this domain. However, at this inspection we found areas requiring improvement and the rating has deteriorated to requires improvement.

Staff received an induction when they joined the service to help them understand their role and responsibilities and get to know people who used the service. Agency staff told us they were also inducted and felt supported to carry out their role. One agency staff member told us, "The senior takes you around and explains what's needed; we are shown the fire exits etcetera; I always work with member of staff not on my own. They [the service] are very supportive and I have not seen anything I'm worried about."

Staff were provided with training and supervision to ensure they had knowledge, skills and support to be competent in their work. The training provided to staff was tailored to meet the individual needs of people who used the service. A staff member told us, "We have on line training and face to face training and did the virtual dementia tour, it was very helpful."

Nursing staff were supported through clinical supervision and provided with relevant clinical training such as end of life care, syringe driver and medication management. The nursing staff told us they were subject to competency assessments to ensure their practice was in line with the training received. We reviewed the training matrix and this confirmed that the nursing staff were up-to-date with their training or where it hadn't occurred the relevant training was scheduled. All of the nurses we spoke with told us they felt supported by management with respect to their professional development. One nurse told us, "If there is a course that I need to go on for my revalidation, I'll just speak to [named registered manager].

Whilst we found that all staff had received regular supervision, they had not received an annual appraisal of their practice. Annual appraisals provide a means of supporting staff development and identifying learning needs and goals for the coming year.

We discussed the lack of staff appraisals with the new registered manager. They advised us that appraisals had lapsed under the previous management but they were in the process of booking them in. After the inspection we were provided with evidence that this process had begun.

Care staff recorded the daily care they provided. However, we did note some gaps in record keeping, for example, when people required repositioning. There was no evidence that senior members of staff had explored the gaps to investigate why. Similarly, on the nursing unit, monthly evaluations of care plans and progress notes kept by nursing staff were not always regularly updated. Therefore, we could not be sure that people were receiving the necessary monitoring and oversight required to ensure their continued health and wellbeing. The inspection team included a specialist advisor (a qualified nurse) who observed a consistent pattern with regard to record keeping on the nursing unit. Whilst the appropriate risk assessments and care plans had been completed, for the majority (4 out of the 5) of care records reviewed, there was some element of the record that was not up-to-date or completed. This was primarily the evaluation and progress notes which provide a record of the nursing care given, any changes and whether what is being delivered is

effective. These omissions did not represent good record keeping practice for clinical staff.

The service used the Malnutrition Universal Screening Tool (MUST) to monitor risks around nutrition. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. People who had been assessed as 'at risk' received additional nutrition as needed either using supplements or fortified foods with added butter, cream or syrups. However, the food and fluid charts which were used to monitor people's intake were not always filled in or monitored by senior staff to check that people had received enough to eat and drink to maintain their health.

We shared our concerns around poor recording and monitoring practices with the registered manager. They advised us that they currently completed random checks to monitor people's food and fluid. However, plans were in place to introduce a new handover sheet which would provide a more consistent method of monitoring peoples food and fluid intake. This form was later provided to us however as it was not yet imbedded in practice we were unable to comment on its effectiveness.

People had access to a range of health professionals to support their on-going health needs. Records showed that people had been visited by GP's, mental health specialists, opticians, dieticians and district nurses. A visiting health professional told us that historically there had been issues on one of the units where staff had not followed their guidance to support a person's health needs, however they added that this had recently improved. Staff we spoke with appeared knowledgeable about people's health needs. One staff member told us about a person who had diabetes. They said, "If ever [named person] is pale, not eating or seems unwell, we check their blood sugars and let the GP know straight away." A visiting relative told us, "They are quick to get the GP if they need to and they let me know and keep me up to date." Another said, "Last week [named family member] had high blood sugars, they contacted the GP and called us straight away." Most people we spoke with felt that staff would be quick to notice any change in their physical, mental or emotional health, and would be helpful to them in any such eventuality. One person told us, "I'm sure they would realise if I wasn't well, and they'd call a doctor or nurse in to see me. They know me well enough to recognise the signs." On the day of inspection, we did find two examples, where it had been identified that people would benefit from a referral to speech and language therapy but this had not been actioned. We brought this to the attention of senior staff and the referrals were then made.

People were supported at mealtimes to have access to food that met their needs and preferences. Specialist diets were catered for, meals were pureed when required and alternative foods offered both at meal times and in between times. We observed lunch being served on one unit. Throughout lunch staff engaged with people sitting at the tables, often laughing and joking together. A choice of drinks was available to people whilst they waited for their meals, and their glasses were refilled where this was required. Tables were laid attractively with condiments and sauces available. Staff often showed people the two meals on offer plated up, so that they could make a more informed decision. Most people ate quite independently, and told us that they enjoyed their meal. One man had a member of staff who sat alongside him, and supported him in eating in a kind, and friendly way. Where people had finished their meals, they were offered seconds. People told us they enjoyed the food. Comments included; 'I quite enjoy the food here, I've got no complaints about it.' And, 'If I don't like what's on offer, they're happy to offer me an alternative, I don't go hungry.' People repeatedly told us, and we observed, that people were always provided with plenty of hot and cold drinks. One person told us, "I've always got plenty of drinks, and they remind me that it's important to keep drinking."

People's need and choices were assessed prior to moving in to the service in accordance with best practice guidelines. This helped ensure people's needs and expectations could be met by the service. People were asked how they would like their care to be provided. This information was the basis for their care plan which

was created during the first few days of them living at the service.

Technology was used to support the effective delivery of care and support and promote independence. Alert mats were used to alert staff when people were moving around, if they had been assessed as being at risk of falling. This meant staff could provide support in a timely manner.

Relatives spoke positively about the effectiveness of care staff. One relative told us, "They are very good with dementia here, they know how to care for people, I have learnt so much from the staff here, my [family member] likes to stay in bed until quite late otherwise they are not happy and all the staff know this and let them lie in; staff are never cross and know how to cope with each individual."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the service was working in accordance with MCA legislation. There were mental capacity assessments held on people's care files which demonstrated that the best interest process was followed to ensure the service worked in the least restrictive way. We also saw that appropriate authorisations for DoLS had been submitted. The registered manager kept a DoLS tracker which helped them to monitor applications. This ensured that people's rights and freedom was upheld.

Staff told us they received training in the MCA and understood the importance of gaining consent. We saw that staff supporting people to make decisions and choose what they wanted to do. A staff member told us, "We always ask people, give options and show them; if they can't decide it's about knowing them; we look at their past history and preferences to guide us." We saw that the registered manager reinforced staff learning around the MCA during staff meetings.

The environment was suitable for people's physical needs. There were hand rails in corridors, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was signage which would assist people living with dementia to better orientate around the environment. In Windsor (the dementia unit) there was different brightly coloured areas in the corridor that included reminiscence themes such as music and fashion from the 60's and 70's and another area with musicals. Each area had seating for people so they could sit and enjoy the different areas.

Good

Is the service caring?

Our findings

At our previous inspection we found staff to be kind and caring and the service was rated good. At this inspection we found the same and the rating remains good.

We observed staff to be caring in their support of people. For example, we observed a person had fallen asleep in the chair, a staff member fetched a pillow and gently placed it under the persons head. Staff were seen to speak kindly and courteously to people when offering or giving support, or when serving food and drinks. People told us they felt well cared for by staff. One person said, "I get changed every day despite being in bed; they keep me clean, and comfortable for which I'm very grateful.' She added, "If I spill anything on my sheets, they'll immediately change it for me without a moan."

Relationships were positive between those who lived and worked at the service. We saw and overheard lots of positive interactions between people and staff throughout the day. Staff took time to speak to people, asking how they were. We also noted that other ancillary staff such as the domestic staff taking time to talk with people. A relative told us, "I love it here, the care and attention is always there; staff have time for us including the cleaning ladies."

Staff understood the importance of ensuring people were supported to maintain relationships with those who mattered most to them. People's relatives and friends were made to feel welcome when they visited the service. Staff offered visitors refreshments as well as privacy if they chose. One relative told us, "Relatives come in and have lunch, it is a good care home." Another said, "I'm very grateful that they let me come in at any time, and don't ever make me feel like I'm being a nuisance to them."

Staff respected people's privacy and dignity. We observed that staff knocked on people's bedroom doors and waited to be invited in before entering. Independence was supported and encouraged. A person told us, "I live almost completely independently here, though of course they're here if I need them." She added, "If I was unwell, or I wanted some extra help they'd step up and do whatever I needed."

People and their relatives, where appropriate, were included and consulted in decisions about their care and support. For example, we spoke with a relative who was in the process of moving their [family members] room to incorporate the changes the service had planned on the floor. The relative told us they had been consulted and involved in these changes. They said, "We did not really want to move at first but we can understand what they are trying to do in splitting this floor; we were showed alternative rooms and consulted."

The service had introduced a new daily initiative called 'Together for 10.' This required everyone who worked at the service (including management and directors) to stop what they were doing and spend 10 minutes engaging with people. This supported staff to get to know people and form positive relationships. People and relatives told us that staff knew them well and provided care and support the way they wanted. One relative told us, "They really know my [family members] ways, what they like, and their behaviours, they really know them well."

We looked at how the service recognised equality and diversity and protected people's human rights. Care records captured key information about people including any personal and religious beliefs. We saw that people who used the service could request a preference of gender of care worker and this was respected to help people feel comfortable and at ease with receiving care and support. People's spiritual needs were supported as the service organised church services to run each month, one by a Baptist church, and the other by the local Anglican church.

Good

Is the service responsive?

Our findings

At our previous inspection we found the service was responsive to people's needs. At this inspection we found this was still the case and the rating remains good.

People's assessed needs had been integrated into care plans which guided staff on how to meet those needs. People's preferences had been documented and staff were knowledgeable about the care people required and how they liked to be supported. Staff understood the importance of providing person-centred care which means care tailored to each individual's needs and wishes. A staff member told us, "It's about knowing everyone is different, for example, [named person] doesn't like to be touched or loud noises so we describe what we are doing and keep things quiet and on a one to one basis."

A team of activities staff were employed to support people to engage in activities of their choosing. Activities were organised both in and out of the home, in groups and on a one to one basis for people who were unable to leave their rooms. One person told us, "They once brought a pony into my room to visit me, what a treat, and what a surprise. I loved seeing him, he was so well behaved."

The service promoted links with the community with trips out and through the use of the local hospital radio station. People were invited to make requests and these were then played on the radio. People could listen to their songs being played which supported their social inclusion.

In the far end of the 'dementia village' there were lots of dementia friendly items to engage people's interest such as a 'tovertafel table' (An interactive games table, designed to stimulate both physical and cognitive activity). There were also sensory items for people to pick up, touch and feel. However, the service was in the process of reorganising this floor back into two separate units and so this equipment was not readily available for everyone. Nonetheless staff did tell us that people were supported to use this area regularly. This was confirmed by a relative who told us, "Activities have increased with interesting tools such as the interactive table which we have used. I have definitely noticed a change."

Systems and processes were in place to respond to complaints. A log was kept of formal complaints and these were recorded and investigated. We saw the registered manager was pro-active in trying to resolve complaints by having an open-door policy and offering to meet with people face to face to address their concerns. People expressed mixed feedback about how complaints were managed. One person told us that they had complained about issues in the past, and said that, "Whilst the manager will listen, action and change are not always seen as a result." The registered manager told us that dealing with complaints was one of the challenges of the service. Lessons had been learned and to improve people's satisfaction levels they had introduced a 'Niggles' book which was used to record and address people's concerns in a timelier fashion as they arose. The book was updated as progress was made dealing with each issue. This meant that if the registered manager was absent, other members of the management team could refer to the book to keep people updated as to what had been done to resolve their concerns. The new system had resulted in less formal complaints being made.

The service had formed links with the local hospices to support staff with providing end of life care when required. The hospices provided training for staff and were also involved in providing advice and guidance to people's family members. We saw that where appropriate Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were held in people's care records which were completed in consultation with people or their families. If people expressed particular preferences for their end of life care, this was documented so that the service could support people in the way they wanted. The registered manager told us there were plans to work with the local clinical commissioning group for support with improving end of life care planning.

Good

Is the service well-led?

Our findings

At our previous inspection we found the service was not consistently well led as medication audits had not been effective at picking up on the mistakes we found. This resulted in a breach of the regulation 12; safe care and treatment and the service was rated requires improvement in well led. At this inspection we found improvements had been made and the rating has therefore improved to good.

There had been a high turnover of registered managers at the service. People and relatives told us that they thought the service had suffered due to the various changes of managers over the years, explaining that this had affected both people using the services and the staff. However, feedback we received during this inspection indicated that things were improving. A staff member told us, "There have been loads of management changes; they are going on the right route but it is going to take time." A visiting relative said, 'Despite having made a complaint recently, I can see that there is a lot of good here, and I believe the manager wants to improve things even more; I am satisfied with the vast majority of what goes on here."

Since our previous inspection there was a new registered manager in post. They told us that despite not having a deputy manager when they joined they felt well supported by the provider and received ongoing support from their regional manager. We were advised that a new deputy manager had recently been recruited. There was also a clinical lead employed to oversee the nursing unit. Together they made up the management team and were responsible for the day to day running of the service. We found that staff, management and the provider were all clear about their roles and responsibilities.

The new registered manager was well thought of by staff. One member of staff told us "The manager is lovely really, really nice; if I had a concern about anything I can speak to her and she deals with stuff straight away; she is professional but friendly at the same time." Another staff member said, "Named manager] is a very good manager indeed; she interacts with relatives and helps with care as well. [Named deputy] has joined now and she also interacts and takes part; they both help if you are short staffed; the little things help a lot."

Staff told us that morale was good at the service and there was a strong sense of teamwork. A staff member said, "Staff are good; we work well as a team and all help each other." Staff told us that since the new manager joined there had been a reduction in agency staff usage which meant the service had improved as the regular staff had a better understanding of the service and the people who used it.

Regular resident's meetings were organised so that people were included in the running of the service. We saw that where people had raised concerns, an action plan was developed and the issues were promptly dealt with. This was confirmed by a staff member who told us, "Management are very concerned about people's happiness and deal with issues immediately. [Named registered manager] has an open-door policy, and will drop everything; we all drop everything for the wellbeing of the residents and the families."

To support openness and transparency the service displayed information publicly using a 'You said, we did' display board to demonstrate that the service listened to people and actioned their concerns. For example,

we saw the board advertised that where relatives had complained it was difficult to get through to units after 5pm and at weekends, the service had responded by purchasing portable phones for staff to carry. On the day of inspection, we observed a staff member carrying a phone which they used to support a person to receive a phone call from their relative.

Staff meetings were also organised to include staff in the service and support their learning and development. Meetings were also used to learn from mistakes so that the quality and safety of the service improved. A staff member told us about a past incident where a staff member had not shared information about a person who had become unwell. They told us, "We had a meeting and learned from it; to think about what needed to be done to ensure that it didn't happen again."

There were systems and processes in place to monitor the quality and safety of the service such as health and safety, infection control, medication and care plan audits. We saw that the checks in place had been effective at picking up on issues that required improvement. The service had an improvement plan in place which had identified many of the issues that we found during our inspection, for example, poor recording of food and fluid, consent forms not always being signed and care plans not always being reviewed monthly. We saw that the registered manager had taken action to address the failings. For example, in place of the current method of randomly checking people's food and fluid charts, a new handover sheet was being developed to provide more consistent monitoring of people's food and fluid intake.

The registered manager told us they completed a daily walkaround of the service each morning. The walkaround was used to monitor aspects such as incidents of infection, and pressure ulcers, GP referrals and accidents and incidents. The manager also took the opportunity to talk to people who used the service to monitor their satisfaction levels. At the weekends when the registered manager was not working at the service, a weekend handover sheet was in place which recorded those aspects usually covered during the daily walkaround. This information was later reviewed by the manager to ensure they had consistent oversight of the service.

We found that the service was pro-active in developing partnership working with external agencies for the benefit of people who used the service. For example, forging links with the Alzheimer's Society and Age UK to arrange coffee mornings and guest speakers to provide advice and guidance to people and relatives.