St. Cloud Care Limited

Holmwood Care Centre

Inspection report

30 Chaddesley Road
Kidderminster
Worcestershire
DY10 3DJ

Tel: 01562824496
Website: www.stcloudcare.co.uk

Date of inspection visit:
19 October 2017
27 October 2017

Date of publication:
11 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 27 October 2017 and was unannounced.

The provider of Holmwood Care Centre is registered to provide accommodation for up to 60 people with personal and nursing care needs who may have physical disabilities or people with dementia. At the time of this inspection 55 people lived at the home.

There was a registered manager in post and they were present during our inspection. 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 quality monitoring checks the provider had in place did not consistently ensure staff followed safe and best practice in all areas. The management of people's identified risks and the equipment required did not consistently reflect people needs accurately. In addition, the management of people's creams were not consistently applied as prescribed to meet their individual needs.

We have made a recommendation about the management and administration of people's medicines and that mattresses are systematically monitored to ensure the correct settings are adhered to.

Furthermore some care records did not ensure clear guidelines were provided for staff to follow. This had the potential for important care instructions not being passed on to all staff and could impact on the care provided. The shortfalls in these areas had not been consistently identified in the provider's own quality checking arrangements. However, the registered manager ensured immediate actions were taken during the first day of our inspection and followed these through in an action plan they produced which they gave to us on the second day of our inspection.

We have made a recommendation about people's individual needs being consistently documented in care plans with the provider implementing improved methods to quality check care plans.

Staff did not always reflect there was a culture of reporting poor infection control practices which the registered manager saw and took action to remedy. There was also a culture of some of the staff team in consistently taking unplanned absences from work. This had already been identified by the registered manager as one of their biggest challenges since they had been in post but had not been fully resolved. However, the provider's procedures needed to be utilised so changes in staff culture were improved to benefit people who lived at the home.

People had various reasons for feeling safe while they lived at the home which included staff who had knowledge of their care needs and being available to support their requests. The differences in the staff

team's skills had been assessed alongside the numbers of staff required so people's care and safety was not compromised. The registered manager continually reviewed staffing arrangements to ensure they continued to meet people's individual needs and changes in these. This process assisted the registered manager to be flexible and there were proposed plans to increase staffing numbers at night.

People were complimentary about how staff who knew them well supported them with kindness and thoughtfulness. People were less enthusiastic about agency staff as they felt they were not as familiar with their particular needs. Where staff vacancies existed the registered manager showed they were taking action by methods of the on-going recruitment of staff to decrease the need for agency staff.

People were confident their care and health needs were effectively responded to and met by staff who had the knowledge to do this. Staff had been provided with the training and support they required to support people's specific needs. Staff also worked closely with healthcare professionals where required to meet people's needs. People enjoyed their meals and were able to choose what they wanted to eat although some people would welcome more choice which would be taken into account as the winter menu is produced.

People were supported to have maximum choice and control of their lives and staff assisted them in the least restrictive way possible; the provider's policies and systems supported this practice. Staff respected people's right to consent to and make their own decisions about their care and treatment. Where people did not have capacity to make their own decisions, systems were in place to support the ethos of people's decisions being made in their best interests.

People were confident staff practices were inclusive so people were supported to be involved in making their own choices in all areas of their daily life. Staff supported people to keep their dignity and encouraged people to remain as independent as possible with their privacy and confidentiality respected.

A programme of fun and interesting things to do supported people to choose what they wanted to participate in. People knew how to make a complaint if they wished to do so and their concerns were followed through so improvements could be made.

Further information is in the detailed findings below.

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.

Some people's care plans did not consistently identify all the potential risks to people and some equipment was not at the right setting to ensure people's safety was always maintained.

People's medicines were stored safely and available when needed. However, the management of medicine record keeping was inconsistent and did not always follow best practice.

Staff knew how to recognise signs of potential abuse and how to report any concerns.

Staff had time to meet people's care and support needs.

Is the service effective?

Good

The service was effective.

People received care from staff who had the knowledge and skills required to meet people's individual needs and support their health.

People's abilities to make decisions were assessed when necessary and people were supported to make decisions about their care.

People had food and drink made available to them in sufficient quantity to meet their particular needs and preferences.

People were able to access healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff. Relatives were made to feel welcome and included as an important part of people's lives.

Everyone was positive about the care provided by staff. Staff knew people well and had good relationships with them which people valued.

People were included in their care and had their privacy, dignity and independence respected.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and people were confident staff provided care in their preferred way.

There were systems in place to ensure any changes in people's care needs were known by the staff caring for them.

People were happy with the opportunities to take part in things to do for fun and interest but for some people they would like more choices made available.

People had received information on how to make a complaint and their views were listened to with improvements made.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality checks did not always ensure safe and best practice was followed in all areas. This included consistently accurate and full record keeping.

Staff culture did not consistently show the reporting of poor infection control practices were shared with the registered manager.

The registered manager was supportive to staff and had a high profile in leading by example.

People were supported to share their views and felt involved in the running of their home.

Holmwood 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 which took place on 19 October 2017 by one inspector, one bank inspector 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 service and has knowledge about people living with dementia. One inspector returned to continue with the inspection on 27 October 2017.

We brought the inspection visit forward as we had received a numbers of concerns, particularly about how staffing arrangements did not effectively meet people's particular needs so people remained safe and well cared for. During the planning and conducting of this inspection we took into consideration the concerns we had received, together with the information we received from the provider and management team. This included events which we had been notified about, such as any serious injuries to people. We asked various organisations who funded and monitored the care people received, such as the local authority and clinical commissioning group. We also sought information from Healthwatch who are an independent consumer champion, which promotes the views and experiences of people who use health and social care.

We spoke with eleven people who lived at the home and five relatives to gain their views about what it was like to live at the home. During different parts of the two days we spent time with people and saw the support they were offered. We sampled seven people's care plans and daily records to see how their care was planned and delivered. In addition we saw parts of the morning medicine rounds to gain an insight into how people were supported with their medicines.

We spoke with four care staff, activities co-ordinator, chef and maintenance person about what it was like to work at the home. We talked with the registered manager and deputy manager about the management arrangements. In addition, we spoke with the providers head of compliance and the regional manager.

We saw records which showed how staff were recruited and trained to provide care and support appropriate

to each person's needs. We looked at how complaints, accidents and incidents were analysed and actions taken to reduce risks and drive through improvements. In addition, we saw the registered manager and provider's quality monitoring systems to see what steps had been taken and planned to improve the quality of the service.

Following this inspection the registered manager sent us documentation to reflect the action they had taken which included action plans, care plan checklist and quality checks.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found staffing arrangements for people who lived on the first floor of the home did not consistently support staff in meeting people's individual needs. For example, at mealtimes staff did not spend sufficient time people required to meet and respond to their particular needs. We rated the question of 'safe' as 'Requires Improvement'. At this inspection we found actions had been taken to make sure staffing arrangements were in line with maintaining people's needs in a safe way. However, further improvements were required to ensure identified risks to people's safety were consistently recorded.

Staff were able to tell us about risks to people and how they managed people's care safely. However, we found inconsistencies in the care planning process as some people's needs were not all recorded as assessed and reflected in the plans we saw or not fully completed. For example, one person did not have plans in place for falls and nutrition to guide staff when providing personalised care. Although these inconsistencies had not impacted on people's needs being met action was taken on the first day of our inspection by the deputy manager to help make sure people were not at risk from receiving care which safely met their needs.

In addition, we found for five people their air mattresses inflation pressures had been set incorrectly to match their individual weights and for one person their mattress had been set without knowing their weight. In addition we found there were some gaps in the written records completed by staff to reflect they had assisted people to change their positions on a regular basis. Although there was no evidence anyone had been harmed by these errors and procedural lapses, we discussed them with the management team. They acknowledged the inconsistencies we found and took immediate action to make sure all air mattress inflation pressures had been set correctly. The deputy manager also took action to ensure all gaps in care records were identified and corrected on the first day of our inspection.

We recommend that the provider seeks current advice and guidance to support staff in systematically monitoring and reviewing mattresses alongside peoples' individual needs to ensure the right settings are consistently adhered to.

We found medicine records were not consistently completed in line with good practice and national guidance and could increase the risk to people's safety. For example, on three occasions on one person's medicine record, the entries for the person's prescribed medicines had been handwritten by a staff member. In these cases it is good practice for two staff to sign the handwritten entry to show the medicine dosage and identity the details had been thoroughly checked. We found this had not happened and the person's medicine record entries had not been checked by a second staff member to ensure they were accurate. This practice had not impacted upon people receiving their prescribed medicines. However the management team would ensure staff followed good practices when managing people's medicines to ensure they are strong in supporting people's safety.

Additionally, two people were prescribed creams which staff applied. The records showed staff had applied one person's cream once or twice daily whereas the prescribing instructions were the cream was required to

be applied every 72 hours. There was no evidence people had been harmed by these discrepancies and the registered manager took immediate action to make sure staff were adhering to the prescriber's instructions.

We recommend that the provider implements actions to ensure staff receive support from a reputable source in how to improve their medicine administration practices taking into account good practice standards described in relevant national guidance, alongside strengthening the provider's own safety monitoring procedures.

People held positive views of how their medicine was available when they required this and how they were supported to take their medicines. One person told us they had received their, "Medication on time" and if they needed pain relief they received these. Another person said, "Trust nurse implicitly with medication."

We saw medicine rounds completed by various staff members including the registered manager and found people were provided with the time to take their medicines. Where people required different levels of support we saw staff had knowledge about each person's preferences and needs to do this in a safe way. We saw the registered manager checked the medicine records for each person before administering people's medicines, so the risks of people not receiving the right medicines at the prescribed times was reduced. Staff also worked with external healthcare professionals to make sure people had medicines available when they required these. For example we heard about the medicines which were in place for a person should they require these at the end of their life to ensure any pain they felt was eased so they were comfortable.

People we spoke with provided individual reasons for feeling safe. One person said, "I felt absolutely safe from the first day, I choose to sleep with my bedroom door open. Never heard a member of staff raise their voice." Another person told us, "So safe here as they [staff] always keep the front door locked, makes me feel secure which gives me comfort." A further person felt their personal valuable items were safe which was important to them. We heard similarly positive comments from relatives about the safety of their family members. One relative commented, "I feel mom is safe here." Another relative told us, "I know staff are on hand to help keep people here safe."

Staff had received training on the different types of abuse which people could be exposed to and were able to tell us how this may impact on people and how people may react to abuse. This allowed staff to be watchful for any signs which may indicate a person was at risk of being harmed whether emotionally, physically or financially. Staff were aware of how to raise concerns both within their own organisation and with external agencies such as, the local authority.

In addition, we found some risks to people had been identified and care was planned to reduce the risk of people experiencing harm. For example, people had equipment in place to reduce the risk of falls. We saw on different occasions how through staff actions people were supported to move safely around their home with some assistance and verbal prompts of reassurance from staff. When one person required reassurance due to feeling they were going to fall staff promptly provided this. The person showed through their facial expressions and body language their confidence and wellbeing improved as staff walked alongside them. Another person was receiving care to support the healing of their sore skin which had improved with the support provided.

The management and staff team worked together to ensure accidents and incidents were reported with systems in place where patterns and trends were analysed. We saw this approach assisted in the reduction of risks to people's safety and welfare. For example, a person had experienced an injury due to an increase in falls. Staff worked with the person's doctor to identify that a specific prescribed medicine resulted in side effects so the person's medicine was withdrawn and their falls reduced.

In addition, the registered manager showed they were knowledgeable and took a candid approach to sharing information about incidents and accidents. These were shared with people representatives, the local authority and the Care Quality Commission. For example, a person had experienced an injury which was reported and investigated by the management team who shared the outcomes and actions taken with the person's representatives and the local authority.

People gave us different responses about how their safety was maintained by staffing arrangements. One person told us, "Company rule that buzzer must always be in reach, staff respond to buzzer as soon as possible, may check and then come back." Another person said, "Press buzzer and they come, girls work hard." A further person told us, "Definitely not enough staff available on this floor (top) should be three and only one or two, staff do the best they can, don't know how they do it."

Relatives also gave us their differing views about staffing arrangements. One relative told us, "If mom uses buzzer respond in a reasonable time." Another relative commented, "Care okay, seems less staff about than when she [family member] came in January especially at weekends, in the lounge yesterday afternoon and didn't see any staff."

Staff we spoke with told us they believed there were sufficient numbers of staff to meet people's needs and the registered manager always ensured shifts were covered. For example, agency staff were supplied to cover shortfalls if permanent staff were unable to do this at times of unplanned staff absences.

During discussions with the registered manager we established staffing levels were based on assessing people's individual needs to make sure these were safely met. This included continually reviewing staffing arrangements so there were sufficient numbers of staff deployed to cover days and nights. For example, the registered manager had reviewed staffing numbers alongside people's needs at night and had plans to increase these.

We saw staff supported people so their safety was not compromised. For example, when people required staff to assist them this was provided so risks were reduced to their welfare. In addition, staff did not rush people when providing care and support which suggested the staffing arrangements had a positive impact on people's safety and welfare.

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

Good

Is the service effective?

Our findings

At our previous inspection we found people were provided with care and support which met their health and wellbeing needs and we rated the effectiveness of the care provided as 'Good.' At this inspection we found the rating continues to be 'Good.'

People told us they had confidence in the staff in meeting their needs. One person said, "Staff trained to hoist me." Another person told us, "Staff are trained to help me move." Relatives were equally positive about how staff's knowledge in meeting their family member's needs. One relative said, "They [staff] certainly know what they are doing as it shows in the care they [staff] give."

Staff told us when they had started work at the home they received an induction which helped people who lived at the home to become familiar with them. Shadowing experienced staff was also part of the induction training along with the completion of the care certificate. The care certificate is a set of standards that health and social care workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. One staff member said their induction alongside the training they received assisted them to learn about their roles and responsibilities.

Staff received training that was specific to the needs of the people they supported. They told us their training helped them to understand and support people in meeting their particular needs. Staff felt supported in their roles and told us they had opportunities to discuss their practice which helped them to improve the quality of care they gave to people. One staff member talked about how training in equipment used to support people with their physical needs had benefitted their understanding of the different ways equipment could be used to meet people's individual needs effectively. They also told us how staff had received training from other health professionals to meet people's specific needs. Another staff member talked about how the national vocational at level 3 had helped to expand their knowledge in how the brain works which links into understanding dementia so they are more effective in supporting people's needs.

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS)

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 looked at how the provider had ensured people's freedom was not restricted. We found applications had been made to the local authority to ensure any restriction was lawful.

.

People's records confirmed decision specific capacity assessments had been completed and best interests

had been made where people did not have capacity. For example, where a person required medicine to meet their health needs a specific decision was made for this to be administered covertly [disguised in food].

Staff practices showed they understood the principles of the MCA when supporting people to make choices and decisions. For example, staff asked a person before they moved their chair to let another person pass with their walking aid. Another person was asked if they would like to go and join people for lunch. In addition, we saw staff used various ways of assisting people to express their wishes. One example was how staff considered a person's facial expressions and body language to determine the support they required to feel more reassured.

People shared their different views of the meals offered at the home. One person said the, "Food is Delicious. Three different chefs since I've been here, first was Italian and the best, current one nervous but doing well." Person went on to say there were, "Usually two or three choices" and you, "Choose the day before but can still change your mind if you wish or [staff] will do something else. Staff help people who need it and specialist equipment if needed." Another person told us, "I have large handled cutlery to help, don't want a plate guard yet, some people use them, I choose to use a beaker in a morning when having breakfast." Another person said, "Meals very nice, plenty, not a lot of choice." A further person told us it would, "Be better if we knew what meal we were going to get, sometimes it's cold." In addition we heard from relatives about meals provided at the home. One relative commented there was a, "Choice of meals" while another relative said if they visited at lunch time they saw staff assisting people with their meals.

People were supported to have enough to eat and drink and maintain a healthy diet. Information on people's dietary requirements were known to staff and they knew the risks associated with each person at the home. We saw people's weights were monitored alongside the amounts of food they ate. For one person it was unclear from reading their records whether they had been referred to the doctor to assess their nutritional needs but we were assured by the deputy manager they had. The person was also recommended to be supported to maintain their nutritional needs by offering choices, such as finger foods and puddings. Staff assured us the person was offered these choices but they had not always been recorded in a consistent way which staff were reminded to do. The chef was able to tell us how they catered for people's individual nutritional needs and how everybody had the same opportunities to enjoy varying food options. For example, people with diabetes had options of desserts which were made to meet their health needs so they were not disadvantaged. We saw people eating meals which they had chosen. Staff provided the support people needed and sat with them and chatted whilst they ate their meals.

We consistently heard from people who lived at the home and relatives how staff supported people with their healthcare needs. One person told us, "You will get a doctor if you need them and staff will go with you to appointments." The person went on to confirm an optician, dentist and chiropodist regularly visited. Another person said, "If any problems they [staff] get the doctor." One relative commented their family member has their, "Own doctor and practice nurse visits every week" and another relative said their family member, "Sees doctor when needed." Staff showed a detailed knowledge of the health and emotional needs of people who lived at the home and ensured any issues were followed up promptly. This was supported by one person who said they had seen the doctor who had prescribed medicine to meet their current health needs.

In addition, we saw staff practices were responsive to people's individual healthcare needs so these were effectively met people's diverse needs. For example, one person who required insulin injections to manage their diabetes had their blood sugar levels taken before their insulin was administered. Another person who had swallowing difficulties required their drinks to be thickened. Staff we spoke with had knowledge about the correct consistency and the amount of thickener required which provided a personalised approach to

responding to the person's particular needs.

Good

Is the service caring?

Our findings

At our previous inspection we found people had formed friendships with staff whose practices reflected they cared about people who lived at the home and was rated as 'Good.' At this inspection the rating continues to be 'Good.'

People we spoke with made positive comments about the care provided at the home and the kindness of staff. One person told us, "Staff very caring, always got time to listen to you." Another person said, "Care very good, staff very caring, have a laugh and joke which is nice." Relatives we spoke with were reassured by the caring conversations they saw between their family members and staff. One relative told us, "I think [the] care is fine, they make [family member] smile, it's pretty good." Another relative said, "Staff love mom, very nice and kind."

We saw people were treated with respect and in a caring way. Staff were friendly, patient and discreet when providing support to people. Staff spoke with people as they supported them. We saw positive communications and saw these supported people's wellbeing. For example, a staff member spent time reassuring someone who was feeling a little unsettled. Through the staff member's conversation with the person we saw they smiled in recognition of the kindness shown.

People told us how staff gave them as much choice and control over their lives. One person told us, "If you want anything they will do it. Staff say it's up to you it's your home." Another person said, "Staff stand back from wardrobe with door open for me to choose my clothes. Staff ask if things you want and nothing changes without it being discussed." We saw various methods were used to support people's involvement in their care. For example, there was a wishing well which assisted people in making their aspirations known about different aspects of their life at the home. This included one person wanting to go swimming again and while another person wanted chickens. People felt involved in their care and when we asked two people about their care plans they were aware of these but did not have a particular wish to see these. One person commented, "I know they [staff] involve me in everything so why do I need to look at records to tell me this. I am quite happy and they [staff] know what I like."

Staff assumed people had the ability to make their own decisions about their daily lives and gave people choices in a way they could understand. They also gave people the time to express their wishes and respected the decisions they made. Some people lived with dementia, had reduced comprehension skills and needed some support to communicate their feelings. For example, we noted how staff had learnt to understand what could make a person feel anxious and were able to use techniques to communicate as a way of reassuring people, such as providing hugs for people who liked these. One person liked to spend time in one of the offices sitting and chatting to staff. The person also liked staff to refer to them in a particular way and staff were seen to do this so the person's choices were upheld.

The management team reflected a caring ethos in how they wanted to improve people's sense of wellbeing and daily lives. For example, a programme of on-going work to the home environment was identified to bring about improvements for people so they had a pleasant place to live. Another example was how the

registered manager had taken action to open a locked door on the middle floor of the home as they had recognised this was not required and was of no benefit to people who lived on this floor. During our inspection we saw the registered manager spoke with people in a caring way and instructed staff when they needed to so people's needs were met. These examples showed the registered manager was a positive role model for her staff team which was appreciated by people who lived at the home and staff alike.

People we spoke with were positive about how staff supported them in ways which took account of their individual needs and helped maintained their privacy, dignity and independence. One person told us, they were, "Encouraged to do what I can for myself" and another person said they tried, to do what they could for themselves and, "Be as independent as possible and staff allow this." We saw people's levels of independence were supported, such as where people required aids to support them to explore their surroundings these were provided." Staff knocked on people's doors before they entered rooms and were discreet when supporting people with their personal care needs. One person told us staff, "Knock my door and if using hoist or commode they [staff] shut the door." Another person said, "If doing any personal care they [staff] shut the door."

Staff told us and we saw when people invited us into their personal rooms they had photographs of family and/or older photographs of themselves at a younger age. This gave staff a point of reference for conversation and gave people a sense of identity. We heard staff spoke with a person who lived at the home about an important person in their life which showed staff valued people's own beliefs and identity. Regular services were held in the home to help people to maintain their diverse religious and spiritual needs. One person told us, "I'm a very religious person" and told us they were supported to attend religious services.

People who lived at the home and relatives were positive about how staff always welcomed them. One person told us, "Visitors are welcome and offered a drink." Another person said, "Relatives really made welcome and can have a drink if they want one." One person's relative said there had never been any restriction on visiting. They gave us an example, "I can turn up at the home at any time and staff welcome me." Another relative said, "Relatives are really made welcome and can have a drink if they want one."

Staff had access to local advocacy services and would use this to support people if they required independent assistance to express their wishes. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

At our previous inspection we found there were arrangements in place to support staff in providing care which centred on people's particular needs and was rated as 'Good.' At this inspection the rating continues to be 'Good.'

People who lived at the home and their representatives told us they were involved in deciding how their care was provided. We heard consistent comments from everyone of how people's individual needs were discussed with staff on a regular basis with staff acting on any changes to people's needs. One person told us, "They (staff) always help me in the mornings with my hair and know exactly how I like it to be done. This is important to me." Another person said, "They help me with buttons which I find awkward to do on my own, which is of great help to me."

Relatives told us about how their family members had their individual needs assessed prior to coming to live at the home. Relatives commented on how the assessment included their family member's history and we consistently heard how this process had been helpful in staff getting to know people. One relative commented, "Staff know mom." Another relative told us, "They certainly know [family members] likes and dislikes and respond to these."

We saw staff included relatives in their family members care where appropriate. For example, one person was supported to have their medicines and there was friendly banter between the person, their relative and the staff member supporting them to take their medicines. This approach was responsive to the person's needs and supported the person in taking their medicines in their own particular way which was comforting for them.

We saw people's needs were responded to by staff who had grown to know each person's individual ways over the years. For example, one staff member told us how people were supported to remain living at the home and did not have to move when their health deteriorated which meant people continued to receive care from staff who knew them well. One staff member said they knew a person enjoyed a particular food and when they became unable to always communicate this, staff continued to ensure the person had the food they liked.

Another example was how staff responded to a person's unique physical abilities and communication. We saw staff's approaches when supporting the person assisted them in feeling reassured. We saw through the person's facial expressions and body language their anxieties were lessened. We saw the aids the person needed were detailed in their care records and were with them as they walked together with staff support to ensure their needs were fully responded to.

However, we found inconsistencies in the care planning process as some people's needs were not all recorded as assessed and reflected in the plans we saw or not fully completed. For example, one person did not have plans in place for falls and nutrition to guide staff when providing personalised care. Although these inconsistencies had not impacted on people's needs being met action was taken on the first day of

our inspection by the deputy manager. This was to ensure people had all their needs written into care plans to help make sure people were not at risk from receiving care which was not responsive to their needs.

We recommend that the provider seeks advice and guidance from a reputable source to support staff in improving their knowledge and practices around the importance of writing people's individual needs into care plans to show how these should be met, together with the provider implementing more reliable methods whereby people's care plans are regularly quality checked.

Staff we spoke with told us they learnt about people's changes in needs through staff meetings held daily between shifts to handover information about people's needs. The provider also had a system which staff could access which gave them details about any changes in people's needs. One staff member told us they found this useful as recently when they had been away from work the system confirmed to them a person was in hospital. Relatives we spoke with were appreciative of how staff made sure they were informed of any changes to their family member's needs in line with the person's consent. One relative commented, "Every time I walk in they [staff] update me and telephone when [family member] poorly." Another relative said they were, "Informed of any changes."

The provider employed three activities coordinators who worked alongside the staff team to deliver a varied programme of fun and interesting things for people to choose to participate in. An activities coordinator talked about, "Enriching people's lives" and their passion in supporting people to try new experiences. People we spoke with told us how they appreciated the support they received to be able to enjoy recreational activities and some people would welcome more things to do. One person told us they, "Go down for lunch, after lunch [there is] bingo, exercises, cards, crafts [and] board games. The person went on to say there were, "No trips out and I would like that. They do some planting out; we had a singer the other day. Nothing goes on, on Sunday." Another person said they have, "A chat before lunch and stay downstairs until about 3, school children come in and sing at Christmas which I like. The person went on to say they missed their. "Garden more than anything, they do have raised tables, for planting. They are hoping to do more trips which I would like but it's down to staffing levels." A further person told us, "I like to be in my room; if I want to I can join in as they [staff] always tell me what's going on and ask me."

Relatives we spoke with were positive about the recreational activities provided at the home. One relative told us the, "Activities [are] very good, [staff] work really hard to get them [people who lived at the home] to join in." Another relative said, "There always seems to be things going on, they try really hard to bring in lots of different things to do." During the inspection we saw people were supported to remember and share different things in their lives. For example, people had fun in sharing their answers to questions posed and people also had the opportunity of participating in meditation and flower arranging. Additionally we saw the activities coordinator supporting people on a more one to one basis which included chatting to people in their rooms.

The provider used different ways of gaining the views of people who lived at the home, relatives and staff. For example, they held meetings, had a suggestion box, sent questionnaires and a regular newsletter was produced for people, their relatives and friends. People who lived at the home and relatives were aware of the meetings held. One person told us, "We have had residents meetings and families come, think they take notice of what is said." A relative said, "When residents meeting notice on the door" and another relative commented, "Receive emails inviting us to residents meetings." We heard an example of how people's views were listened to. One relative told us they had raised some issues about their family member's room and this was listened to with action taken so improvements were made.

People who lived at the home and relatives we spoke with told us they felt comfortable raising concerns if

they were unhappy about any aspect of their care. One person told us if they had a, "Complaint or worry, the manager would come up and deal with it." Another person said if they had, "Any concerns" they, "Could speak to any of them [staff]" but had never needed to make a complaint. One relative commented, "If serious complaint would go straight to manager" as they were, "Very approachable." Another relative told us they had, "Never made a formal complaint but the manager is very approachable." There was a complaints procedure available to people who lived at the home and their relatives. The registered manager and staff told us they would use complaints as a learning opportunity and to, 'Put things right for people.' We found an example of where this had happened. Some concerns had been raised about the cleanliness of a person's room and these were listened to with action taken so improvements were made. This included learning from the concerns to remind staff about their care practices and areas where improvements were required.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the provider had effective systems in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. However, at this inspection improvements were required as while the provider had quality monitoring systems in place, these were not always effective in identifying potential shortfalls to enable staff to improve their practice. We found shortfalls in the management of people's prescribed creams, inconsistencies in managing risk and completing care records to accurately reflect people's assessed needs.

The registered manager showed a responsive and reflective management style. She was quick to acknowledge the improvements required to medicines management and care records and had put action plans in place to drive these through. These actions included conveying to staff the aspects of their responsibilities which needed to be improved on. In addition the regional manager told us the providers quality checking systems would be focused on to assist in maintaining their effectiveness.

In addition, the registered manager told us one of their biggest on-going challenges since they had been in post had been to change the culture of some the staff team. This had not been fully successful as we heard similar themes from the management and staff how the unplanned absences of some staff could impact upon people who lived at the home and staff. Comments from staff included, "Staff constantly off sick, puts pressure on other staff," "Always have the right amount of staff but some go off sick which does not help" and "Challenges are staff sickness but we know [Registered manager] tried really hard with this at turning it round." The registered manager and regional manager provided assurances other methods would be focused upon including using the provider's disciplinary procedures where required. This was to assist in improving the culture of some of the staff team to reduce the consistency of unplanned absences.

We saw some medicine pots had been left to dry on a radiator within a communal bathroom area. The registered manager was quick to respond to remedy this and knew it was not in line with the provider's infection prevention and control procedures. The registered manager and regional manager confirmed they would be contacting the agency who had provided the staff member to inform them about the practices which did not assist in reducing the risks of cross infections. However, staff went into this bathroom and had not identified this was practice could increase the risks of cross infections and report this poor practice to the registered manager. This did not reflect there was a culture of staff consistently taking action to help drive through improvements.

We found other quality checks and staff practices which had been more effective and supported people in living at a home where the registered manager alongside staff had made significant improvements. For example, new furniture and carpets had been purchased. On the first day of our inspection new chairs were delivered. We heard positive comments from people who lived at the home, relatives and staff about how the chairs were bright and comfy whilst supporting people's posture when sitting in them. Another example was one room had been redesigned into a tea room and personalised items added for people's enjoyment. One person said, "The room is bright and so colourful with little bits and pieces." Items included decorated cups and saucers sitting on a dresser and decorated blinds.

People were positive about the management and felt the home had a welcoming atmosphere. One person told us, "I know the manager very well their approachable, the atmosphere is very friendly." Another person said, "Haven't regretted coming here, touch wood." Relatives also held positive views with one relative commenting, "Already booked my room, staff raise money to buy gifts to make it more like home." Another relative said, "My sister wrote a very positive letter to head office."

The registered manager was supported by a deputy manager and together they had an overview of the clinical care people received. In addition the provider's senior managers, such as the provider's head of compliance and regional manager visited the home to offer their assistance and support to the management team. There were on-call arrangements to ensure staff were able to contact a member of management for advice and guidance if required. One staff member commented that any of the staff were able to contact the registered manager and deputy manager at any time of night. Staff also knew about the provider's whistle blowing procedure. They said they would not hesitate to use it if they had concerns about aspects of people's quality of care, which could not be addressed internally.

There was a clear management structure in place which staff understood. The registered manager was instrumental in working with staff to ensure a stable team so the use of agency staff could be reduced. We saw the registered manager led by example which reflected a supportive approach to their staff team. For example, on the first day of our inspection the registered manager administered some people's medicines due to an unplanned absence by a nurse. We noted the registered manager knew about important points of detail such as which members of staff were on duty and which tasks they were going to complete. The registered manager was also able to tell us the reasons for some people remaining in their rooms and how they supported their staff team with the ethos of gently encouraging people to take part in social events and/or spend time in the lounges. This showed the registered manager made consideration to staff effectively supporting people who lived at the home in the best possible way.