Colleycare Limited

Willowthorpe Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Willowthorpe is registered to provide residential accommodation and personal care for up 56 older people some of whom are living with dementia. At the time of our inspection 55 people were living at Willowthorpe.

We last carried out an inspection of Willowthorpe on 30 September 2016. This was a focused inspection and looked at the effective and well led domain and was rated as good. This inspection took place on 16 August 2017 and was unannounced. At this inspection we found improvements were required in relation to deployment of staff, completion of care records and overall governance of the service.

Willowthorpe had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People told us they felt safe living at Willowthorpe. Staff were able to tell us how they kept people safe and how they positively managed risks to people's safety and well-being. There were not always sufficient numbers of staff deployed to support people; however the atmosphere in the home was calm and relaxed throughout our inspection. Staff were recruited following a robust recruitment process that ensured they were suitable to work with vulnerable adults. There were suitable arrangements for the safe management of people's medicines and people received their medicines as the prescriber intended.

Staff were supported to develop the required skills and knowledge to provide care effectively to people. Staff received regular support from management which helped them to feel supported and valued and they told us they felt able to seek assistance when they needed to. People's permission was sought before staff assisted them with care and where people lacked capacity to make certain decisions themselves, the registered manager had completed the required assessments. People received appropriate support and encouragement to eat and drink sufficient quantities independently however records relating to nutritional needs and weight were not updated consistently. People had access to a range of healthcare professionals who they were referred to quickly when their needs changed.

People's privacy and dignity was promoted and they told us they were treated with kindness and compassion by staff who listened to them. Staff spoken with knew people's individual needs and were able to describe how to provide care to people that matched their current needs.

People were supported to lead active lives and pursue activities that were important to them. People told us they felt confident to raise anything that concerned them with staff or management. People's relatives were able to visit freely at any time of day or night to maintain those relationships.

Peoples care records were not always regularly updated to provide a comprehensive account of their changing needs and care. However, all staff spoken with were aware about current care needs and how to

provide support to people. Governance systems did not consistently and robustly identify areas of improvement although arrangements were in place to obtain feedback from people who used the service, their relatives and staff members about the services provided.

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 safe.

Staff told us there were not enough staff available, although this did not mean the service was unsafe, we found deployment of staff was an area for improvement.

People told us they felt safe living at Willowthorpe.

Risks to people's health and well being were positively managed and appropriate equipment to mitigate those risks was in place.

People were supported by staff who had undergone a thorough recruitment and induction process.

People were supported to take their medicines as the prescriber had intended.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and development to provide safe and effective care to people.

People's consent was obtained prior to staff assisting them. Staff were aware of how to support people with making relevant decisions who may lack the capacity to decide for themselves.

People's nutritional needs were met and any risks relating to weight loss were quickly responded to.

People were supported by a range of health professionals as their needs changed.

Is the service caring?

Good

The service was caring.

People felt staff were caring and kind in their approach and that staff listened to their views.

People were supported appropriately by staff who ensured their privacy and dignity was maintained.

People were supported by staff who clearly knew them well.

People's confidential records were stored safely.

Is the service responsive?

Good

The service was responsive.

People and relatives told us they were regularly involved in developing and reviewing people's care.

People were supported to engage in a range of activities.

People were given the support they needed, when they needed it.

People's concerns were taken seriously.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Governance systems did not always address issues with the quality of care provided to people.

People's care records were not always reflective of their current needs.

People's views and opinions had been sought in relation to the quality of care they received.

Staff were able to express their views about the management of the home through regular staff meetings.

Notifications of incidents were submitted to CQC as required.

Willowthorpe Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 16 August 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also reviewed feedback sent to us by the local authority commissioning and safeguarding teams.

During the inspection we observed staff supporting people, spoke with four people who used the service, five members of staff, three people's relatives and the registered manager.

We also 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.

We reviewed care records relating to five people who used the service and other documents central to people's health and well-being. These included staff training records, twelve people's medication records in addition to their care records and various management documents and audits.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt there were sufficient staff deployed. However staff gave mixed views regarding staffing levels in the home. At the time of the inspection, based on the current assessed staffing levels the registered manager told us they had no permanent vacancies for care staff, although told us in their view people's dependency needs had increased. They told us they had not increased staffing levels in the home, but the management team supported in the mornings when needed. They told us they were actively recruiting for bank staff to provide cover when staff were on leave, and at the time of inspection were not authorising further leave due to pressures on the staff team.

On the day on inspection however we found that people suffered a delay when requesting staff assistance. Although this did not mean they received unsafe care, people did experience a delay. For example, two people were sat in the lounge without tea or a snack for over an hour. Staff did not check on them as they were busy elsewhere providing personal care. Once pointed out to the registered manager they served them tea and breakfast in the dining room, however these people became more agitated whilst waiting. We then saw once these people were sat in the dining room, a third person was also sat waiting for their breakfast. They were unobserved by staff in the assisted dining room, which was an area for people who required assistance with eating and monitoring. They had then managed to take another person's breakfast, which was not the correct consistency as assessed by the dietician. This placed them at an increased risk of harm through choking. Staff told us that they felt there were not enough staff consistently available. One staff member told us, "People's dependency levels are now much higher and we need more staff. For example, [Person] needs are so high that other quieter people are being left behind as the result. It is not fair on the other residents."

People told us they felt safe. One person said, "Absolutely safe here, there are always people around if I need help." A visitor told us, they felt that people were safe living at Willowthorpe. They told us, "We looked at other homes before choosing here but did so because it felt safe and homely."

Staff told us they had received training in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Staff were able to confidently describe how they would report any concerns both within the organisation and outside to the local authority safeguarding team. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike. This demonstrated to us that the provider had taken the necessary steps to help ensure that people were protected from abuse and avoidable harm.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for such areas as the use of wheelchairs, falls and mechanical hoists. These assessments were detailed and identified potential risks to people's safety and the controls in place to mitigate risk.

Staff were observed to assist people safely using appropriate moving and handling techniques. For example,

we observed two staff members using a mechanical hoist to assist a person to transfer from an armchair to a wheelchair. The staff members reassured and talked with the person all the way through the procedure.

People who had been assessed as requiring bedrails on their beds to prevent them falling had protective covers over the rails to reduce the risk of entrapment. We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition.

Where people had specific health needs we noted that care plans included clear instructions for staff to follow. For example, one person was at risk of anaphylactic shock and the care plan included clear instructions for staff to follow to accurately identify the symptoms of anaphylactic shock and to use the Epipen as needed.

People were supported by staff who had undergone robust pre-employment checks to ensure they were of sufficiently good character. Staff had provided appropriate references, a checkable work history and undergone a criminal records check. Once completed and verified, staff then undertook an extensive induction process which included face to face training, observation of their ability and regular review meetings. One staff member said, "The induction was brilliant, I worked through my book and found the face to face training helped me discuss and understand what was expected of me. I felt prepared to work once I had completed it and was confident about what I needed to do."

People had their medicines administered as the prescriber intended. We saw from people's medication administration records (MAR) that people had taken their medicine at the times prescribed. Where people were prescribed as required medicines, such as pain relief, we saw staff checked with people that they required this medicine and recorded accurately in the MAR that medicines had been administered. People who had allergies to certain medicines had this prominently recorded, and information was available to staff regarding side effects of medicines. People's medicines, particularly those used to manage mood or behaviour were regularly reviewed by the GP or other relevant health professional, which meant the service had a culture of offering care to people as opposed to a regime of managing behaviour with medicines.

There were suitable arrangements for the safe storage, management and disposal of medicines and people were supported to take their medicines by trained staff. We checked a random sample of boxed medicines and controlled medicines and found that stocks tallied with the records maintained.

The registered manager was able to evidence that regular meaningful fire drills were undertaken and fire marshal training was provided for the staff team. People had individual evacuation plans identifying what their needs were in relation to mobility and evacuation in the event of an emergency.

Good

Is the service effective?

Our findings

People and relatives told us they felt the staff were well trained and capable of providing effective care. One person said, "I think they are all exceptionally well trained." One person's relative told us, "The staff really seem to understand how to care for [Person] which suggests to me that they are well trained."

Staff told us that they received training to support them to be able to care for people safely. This included basic core training such as moving and handling and safeguarding as well as specific training modules such as dementia care. One staff member told us, "The training here, it is brilliant, second to none."

Staff confirmed they received frequent supervision and an annual appraisal with their line manager, and all the staff spoke with felt this was useful to enable them to review their development. One staff member said, "Supervisions are regular, we have a face to face chat and they [managers] watch me to see I am doing things properly, I find those discussions really helpful."

People told us that staff sought their consent prior to assisting them. One person said, "I have never been asked to do anything I don't want to, before anything happens the staff always ask." Our observations confirmed that staff explained what was happening and obtained people's consent before they provided day to day care and support. Staff spoken with were aware of how to support people with their decisions in relation to their care who may lack the capacity to decide for themselves.

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 had assessments in place in relation to their capacity to consent to care and treatment they received in the home. Where people were identified as lacking capacity decisions had been made in their best interest following a best interest process to keep them safe.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, we found that all people who were considered to require a DoLS had either had one authorised or were awaiting a decision from the local authority.

Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions or, where appropriate, their family members.

People told us that they enjoyed the food provided to them at Willowthorpe. One person told us, "The food is absolutely cracking, never ever have I had to complain. I think the chef is exceptional." A second person said, "We have a lot of choice of freshly cooked food that is not the frozen rubbish you get in some places. They even cook their own cakes and if I want they will cook me and my family our own private meal." People

were provided with a good choice of food and were free to choose where they wanted to eat their meals on a day to day basis. We noted that most people opted to eat in the communal dining rooms and some chose to eat in their rooms or in the communal lounge area. For those people who required a specialist diet due to allergies, intolerances or to follow advice from a dietician, this was provided. For example people who required a pureed or soft diet received this at lunch. The kitchen staff were made aware of people's dietary needs and foods were freshly cooked and supported a healthy lifestyle for people.

We observed the lunchtime meal served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent. We observed breakfast time on the unit accommodating people who lived with dementia. We noted that people had a choice of cornflakes, porridge or toast. We asked staff why people did not have a choice of cereals as they did in another unit in the home. One staff member responded that people who lived with dementia are overwhelmed by too many choices and therefore were offered restricted choices to make it easier for them.

At lunchtime people who lived with dementia were provided with choices of main meal by being shown both plated options so that they could make a meaningful selection based on the look and smell of the food.

However, we noted that breakfast was served between 09:30 and 10:00, lunch was served at approximately 1pm and that tea was served at approximately 5pm. Staff told us that tea and biscuits were taken around the home at approximately 8pm but that many people were already asleep by then. People therefore who were asleep at 8pm were likely to miss out on an evening snack from 5pm through till 9.30am. Although when discussed with the registered manager they told us that the kitchens were accessible throughout the night and that staff could prepare people snacks, this was dependent upon people asking. We saw that a resident forum meeting of 20 April 2017 stated, "My last meal was last night at 5:15 PM and my first meal this morning was at 10:15. This is unacceptable. Far too many hours without food." We discussed adding snacks to the drinks areas around the home, particularly for people living with dementia who may not sit for long periods to eat a meal, therefore enabling them to continue to snack.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people's needs.

People's day to day health needs were met in a timely way and appropriate referrals were made to health and social care specialists as needed. People's changing needs were regularly reviewed and we saw from records that visits to the home from district nurses, mental health nurses, dieticians, opticians and chiropodists for example were regular and reviews sought in response to a person's needs. For example a person had sustained recent falls that staff were unable to identify a specific cause for so had involved the person's GP to explore the possible causes promptly.

Good

Is the service caring?

Our findings

People and relatives told us they were happy with the care provided to them. One person said, "The staff are all very friendly, this whole place is caring and kind to us all." A regular visitor to the home told us, "I can't fault the place the care is first rate and the patience the staff show is amazing."

People received care and support that promoted their dignity. For example, people were supported to maintain their appearance as they chose, and when staff assisted people with personal care they did so behind closed doors. After lunch we observed one staff member see that a person was in discomfort, so they subtly approached them and spoke to them softly to see if they required assistance. When it was clear the person required support with their personal care, the staff member very discreetly took them to their room with no other person noticing. Staff spoken with told us that dignity and privacy was a key philosophy of the home and that they all promoted this. One staff member said, "We work as if these people are our own family and in some cases they have lived here that long they feel like my family anyway. That was the care we give is the same as what I would give to my own Mum, and the others are the same."

People and relatives told us they felt listened to and that their opinions mattered to the staff. Staff observed clearly had worked with people for a long time and had built up a clear rapport with them that enabled them to understand their choices and preferences. Staff spoken with were able to tell us about people's life history and interests, how they liked to spend their day and how they wanted to be cared for. One person confirmed this and said, "They know me, they know not to bother me with tea in the morning because I like to have an extra ten minutes in bed. They know how to help me and the limitations that I impose of their involvement. I have everything done my way, or it's the highway."

We noted that staff were generally courteous and kind towards people they supported, often sharing humour and jokes between each other in a respectful and dignified way. We saw instances where staff provided kind and thoughtful assistance for people. For example, a person became distressed because they didn't like the top they were wearing, a staff member re-assured them and gently supported them to return to their bedroom and change their clothes. When the person returned they were visibly more content and happier. Close relationships had been formed and we observed one night staff member talking sensitively to one person. The staff member told us that, "[Person] is lovely, they try to come home with me and the other day I had to try to get out without being seen otherwise it upsets them." When we spoke to the person they told us, "I love [staff member] they are very nice to me." This and other examples demonstrated that the staff approach was generally caring and person-centred and staff dealt with the things that mattered to people.

However, we observed one incident where a staff member spoke inappropriately and brusquely to a person. The person's care plan stated, "Staff need to be very patient with [person], they need to say things more than once and rephrase what they are saying before [person] understands. Staff to support and comfort [person] emotionally trying their best to understand and empathise." We shared this incident with the registered manager who took immediate action to investigate the concern and took appropriate action.

People's care records were stored in a lockable office in order to maintain the dignity and confidentiality of

people who used the service. We noted that the office was closed when staff were not using it.

Good

Is the service responsive?

Our findings

People and relatives told us they were regularly involved in developing and reviewing people's care. One person said, "I have my own carer who talks to me and writes up my care plan, but it is my decision what goes in it." One person's relative said, "I think the key worker scheme is brilliant as it gives us a link, not just for the big issues, but for the smaller things. They know for example that [Person] loves tennis and golf, so when it's on they watch and talk about the game, which is a small thing but to [Person] a very important thing."

Maintaining relationships with relatives and friends was an important part of the care provided at Willowthorpe. People were able to have their own phone lines installed so they could have private phone calls in the privacy of their room, and families or friends were able to visit at any time of day or night. We saw from the visitors signing in book that people had regularly visited late at night or early morning, and on the day of inspection one visitor was seen to take their relative early to an appointment. When relatives visited, there were a variety of private areas they could see people which enabled people to have social visits in privacy.

Records showed that people's relatives had been involved in developing people's care plans where appropriate. People's care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were invited to attend monthly review meetings and a relative told us that the staff were good at keeping them up to date with important events in people's lives.

People's care plans were sufficiently detailed to be able to guide staff to provide their individual care needs. For example one care plan we reviewed stated, "[Person] likes to have a shower every day and although they can wash their front they like staff to do it for them. [Person] likes to sit for a while under the hot water so quite often waits until after breakfast to have a shower." A second example noted, "[Person] sleeps in a divan bed with two pillows, a quilt and three blankets. [Person] does feel the cold and staff need to ensure their windows are kept shut unless [person] asks for them to be open." These examples showed that staff took people's individual preferences into account when managing their personal care needs.

Care plans for people who lived with dementia also contained guidance for the staff to follow when responding to people when they became anxious or upset. For example, one person frequently asked after their spouse and the care plan contained suggestions for staff in how to respond in a way that would reassure the person.

Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home. One person's relative said, "We had end of life discussions when [Person] first moved in, mostly around resuscitation which was difficult, but the staff were magic in how they supported us. We know the time is coming to develop a specific plan, and we know that we will get the full backing of [Registered manager] when we need to plan."

Staff were knowledgeable about people's preferred routines, likes and dislikes, backgrounds and personal circumstances and in many cases used this to good effect in providing people with personalised care and support that met their individual needs.

We saw that mostly staff responded to people's individual needs appropriately. For example we heard a person tell a staff member that they were cold. The staff member fetched the person a blanket and made them comfortable in a chair with the blanket around them. For a second person they became agitated and restless and staff were quick to distract them with an activity until they became reassured and calm. However, guidance was not consistently followed as on the morning of the inspection one person became very agitated and this started to affect the demeanour of other people in the vicinity. Staff told us that the person needed one to one support but they were not able to provide this because they needed to support other people to get up and prepared for the day.

People and relatives told us there were a range of group and individual activities arranged, and that people enjoyed the activities they did. One person said, "There is always something going on, something to keep my brain ticking over." A second person said, "They [staff] always try their best to find interesting things to do. The other day was a talk by a London taxi driver which was very good, and different." One person's relative told us the activity in the home had had a dramatic effect on their relative. They said, "It encourages [person] to socialise. When we first arrived, [person] stayed in their room, they were depressed and lonely. But now, she will sit and watch, she wouldn't choose to join in, but enjoys the social aspect of watching. That has been an amazing change."

A visitor told us that there was a range of activities available for people to engage with at the home. They told us, "People seem to be fairly occupied, they do craft sessions and music sessions." We saw photographs depicting people involved in activities, and we saw a programme of activities including people coming into the home from outside to play music and entertainment people. Day trips had been organised, and we saw that people were supported to follow their religious beliefs through services organised locally. Those people who were able to, were freely able to access the wider community visiting shops, local pubs and going for walks. However, we saw only minimal activity taking place throughout the home during the course of the inspection.

The unit for people living with dementia had been very well thought out and decorated and was adorned with numerous items for people to use for both reminiscence purposes and stimulation. For example, around the corridors were makeup and jewellery stands, cots and buggies, various dolls and items people could use to touch and wear. There were also numerous items that male people could explore such as old sporting items, news items, car manuals and male clothing items. None of these were simply for show, and we saw how staff supported people to use these items.

People and their relatives told us they felt comfortable raising any concerns or grumbles with staff and the management team and they felt these would be responded to. One person said, "[Registered manager] is very quick to put things right if we tell them."

There were regular meetings held for people who used the service and their relatives to share their opinions about the service and facilities provided at Willowthorpe. We saw that people were provided with feedback on actions taken as a result of issues raised in these meetings. For example, people had said that staff members were too noisy at night and sometimes tables were not laid properly with spoons and saucers often missing. The minutes from these meetings included actions taken to address concerns raised.

Requires Improvement

Is the service well-led?

Our findings

Staff told us that they frequently raised their concerns about the staffing levels at supervision with the line management but that this had little effect. We spoke with the registered manager about people's changing needs and the deployment of staff in the home. They told us that the staffing deployment had not kept in line with people changing needs. They told us that in the previous four months, people's needs had deteriorated meaning they required additional staff support. They told us that at the time of the inspection eight people required assistance from two staff with their personal care needs.

The registered manager completed a weekly staffing and assessment of people's needs however, when reviewing this assessment tool we found the needs of people remained similar to those in April 2017 and did not support their view people's needs had increased at the time of the inspection. One staff member said, "We need more staff to help when people have greater needs." Staff were clear that they did not allow the additional pressures to impact negatively on people's safe care. One staff member confirmed this by telling us, "[Person] this morning is very tired, [person] has Parkinson's so we need to be calm, this morning it was a fifteen minute job just to get [person] out of bed, then we had to shower and dress, but we will not rush whatever the staffing circumstances." The deployment and management of staff on the day of the inspection did not demonstrate that staffing levels were effectively monitored or managed. Although people's care needs were met with their personal care, other more subtle areas were not met in a timely manner. This is an area that requires improvement to ensure that the management team ensure sufficient numbers of staff are deployed on a day to day basis and as people's needs change.

We did see from minutes of a meeting chaired by the provider that a focus group had been held with a number of managers to discuss staffing and occupancy levels. Within this meeting, the provider commented that an additional four hour shift could be implemented in any home to accommodate those people with higher needs. However, there was a clear gap in the responsiveness of the staffing assessments and the time taken to increase staffing to ensure all people's needs were met. On the day of the inspection the registered manager met with a member of the digital marketing team to assist them with recruitment and develop a strategy. However, a staff survey carried out by the provider had identified that further bank staff were required, and that shifts had run short with a comment suggesting a floating support worker to assist when short. In the resident forum minutes we saw it had been raised that concerns were present in relation to staffing levels. In response to the concerns raised with the provider following the inspection, they immediately sought to review the staffing in Willowthorpe.

People's care records required improvement to ensure they were updated either when routinely reviewed or when people's needs changed. For example on one unit we found reviews of the care plan had not occurred for one person's risk of falls since March 2017, even though they were at risk of falls, and their nutritional assessment was not updated since May 2017, even though the persons weight had been recorded that demonstrated a loss of 900 grams from the previous month. We also found that health professional guidance for this person was not accurately recorded. In the care plan it noted a fork mashable diet, however the guidance on the wall in the staff office had been amended to a pureed diet. This person was seen with a bowl of cornflakes in the morning, and the registered manager agreed this was not appropriate.

Daily records were brief and provided very little detail of the care provided or how people had spent their day. A typical example of records relating to a whole day of a person's life, "[Person] assisted with all personal care, small meals taken, drank well today. Sat in lounge with others this pm." A staff member told us they were aware of the need for records to reflect what had happened in a person's life but said that they did not have the time to write in any detail. Where care plans had been completed, the language used did not always promote people's dignity. For example one record noted that, "without continuous support and assistance from staff, [Person] would be at risk of poor hygiene, sores developing and becoming smelly due to continence issues."

We spoke to the registered manager about the deployment of staff concerns and the need to ensure daily records of care were accurate as an area that requires improvement.

We looked at the providers audits of the service provided at Willowthorpe. This had been developed by the provider to align to the CQC key questions asked when inspecting a service that it is, safe, effective, caring, responsive and well led. We reviewed a copy of the current audit tool and found that key areas of each domain were not reviewed. For example, we found that staffing deployment was an issue in the home and noted examples where people needed to wait for support. The section of the audit that would assess staffing had looked specifically at medicines management but not the other key areas including staffing levels. On a subsequent visit a different senior manager looked at the same area but then reviewed cleanliness, infection control, health and safety and equipment. No other area of the SAFE domain had been reviewed, for example, recruitment, staffing or risk management. The overall monitoring of the service by the provider was not an effective system, and did not identify areas of concern found at this inspection. This is an area that requires improvement.

People and relatives told us they thought the registered manager was responsive, open and approachable. The registered manager demonstrated an in-depth knowledge of the staff they employed and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships. We saw them interact with people who used the service, relatives and staff in a positive, warm and professional manner. However, when we asked staff about their views of the management, no staff member gave us an opinion.

Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home. Staff were able to provide examples of where they had made suggestions in meetings that had been responded to. For example, one staff member told us how they had approached the registered manager to purchase more crockery. They had carried this out and the staff member told us having a surplus had made their mornings easier setting out the dining rooms.

There were a range of checks undertaken by the registered manager routinely to help ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails, inspection of the call bell system, and fire checks. We noted that where issues had been identified through this system of audits they were passed on to the relevant person to address. For example, a person's sensor mat had failed, this was reported to the maintenance person and addressed.

Care plan audits were regularly undertaken and the registered manager told us ten percent were sampled monthly. These audits where they did identify gaps were robust in identifying areas for improvement. For example, where a person's medicines may need to be reviewed or where plans around managing a specific risk may need to be more personalised.

We reviewed a variety of certificates that evidenced regular inspections of areas such as fire extinguisher

checks, lift checks, boiler inspection, air conditioning checks, portable appliance testing and deep clean of premises. This showed us that the registered manager and provider were committed to providing a safe service.