Nethercrest Care Centre (Dudley) Limited

Nethercrest Residential Home

Inspection report

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Dudley
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 April 2018 and was unannounced. At our last inspection in October 2017, the following concerns were raised:

The provider had failed to ensure that staff had the qualifications, competence, skills and experience to keep people safe and ensure people were protected from harm. This resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. This resulted in a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to ensure that all people using the service have given consent before any care or treatment is provided. This resulted in a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to ensure people using the service were treated with dignity and respect at all times. This resulted in a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to ensure there were effective systems of governance, including assurance and auditing systems or process to assess, monitor and drive improvement of the quality of service provided. This resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to notify the Commission of authorisations with regard to DoLS, as is required by law. This resulted in a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 (Part4) Notifications.

Following the last inspection, we met with the provider to discuss our concerns and asked them to complete an action plan to show what actions they would take and by when, in order to improve the ratings of the key questions of Safe, Effective, Caring, Responsive and Well Led. We also imposed conditions on their registration which required them to provide us with information, on a monthly basis, outlining actions taken and improvements made. At this inspection, we found improvements were being made, but there still remained work to be done in a number of areas.

Nethercrest Residential Home 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.

At the time of the inspection there was a manager in post who had recently been recruited and was in the process of submitting an application to become registered manager. 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.

People felt safe and were supported by staff who were aware of the risks to them and how to manage those risks. Staff were aware of their responsibilities to raise any safeguarding concerns. A dependency tool was in place to ensure staffing levels were based on people's individual needs. Health and safety checks were in place to ensure equipment was safe to use. People received their medicines as prescribed but administration of medication was not consistently recorded. Accidents and incidents were reported, recorded and acted upon but information was not routinely analysed to ensure lessons were learnt.

Systems were in place to observe staff practice and training had been sought to ensure staff were provided with the skills to meet people's needs effectively. Where people were deprived of their liberty, the appropriate applications had been made, and staff routinely obtained people's consent prior to supporting them. Staff were not fully aware of who was being deprived of their liberty and further work was required regarding the recording of this information.

People's dietary needs and preferences were catered for and people were supported to make choices at mealtimes. Drinks were readily available to ensure people remained adequately hydrated throughout the day.

Staff were aware of people's particular healthcare needs and how to support them to maintain good health. People were supported to access a variety of healthcare services.

Improvements had been made to the environment and this had created a more homely atmosphere. There was a programme of works in place and this was ongoing. Where maintenance work was required, systems were in place to ensure this was completed in a timely manner.

People described staff as kind and caring and were treated with dignity and respect. Staff supported people to make choices regarding their daily living and where possible, encouraged people to retain some form of independence.

Care records continued to be reviewed in order to provide staff with more information and guidance to meet people's needs. Systems were being developed in order to involve people in the development of their care records. People were supported to take part in activities but there was recognition that this was an area for improvement and an action plan was in place to address this.

There was a complaints process in place and where complaints had been received, they had been responded to appropriately.

There was an improvement in the management oversight of the service. People were complimentary of the manager and the improvements that had taken place since the last inspection. Staff felt supported and listened to and were provided with the training and support to meet people's needs. Audits were in place to assess the quality of the service but there was a lack of analysis of information in some areas which would help drive improvement. People's opinion of the service was sought and action taken in response to concerns and suggestions made.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this

timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by sufficient numbers of staff who were aware of the risks to them and their responsibilities to raise any safeguarding concerns. People received their medication as prescribed. Accidents and incidents were reported and acted upon but not routinely analysed for any trends.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who felt supported and had received training to provide them with effective care. Staff routinely obtained people's consent prior to supporting them but not all staff were aware of who was being deprived of their liberty. People were supported to eat and drink and maintain good health.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and respectful. People's independence was promoted and encouraged by staff in accordance with people's individual abilities. Staff supported people to make day to day decisions about the care they received. People's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People received care and support that was individualised to their needs, because staff members knew people well, although there was still scope to continue improving how this was captured in people's individual care plans.

People knew how to raise concerns about the service they had received and were now more confident that these would be addressed appropriately.

There was no end of life care currently provided, although there were plans to ensure that if this was required for people currently living at the service the staff would have the knowledge, ability and support to provide this.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were a number of quality audits were in place to improve the service but not all highlighted the issues identified on inspection. People and staff were complimentary of the manager and the improvements that were taking place. Staff felt supported and listened to and efforts were made to engage with stakeholders to improve the quality of the service provided.

Nethercrest Residential 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 26 and 27 April 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We looked at our own systems to see if we had received any concerns about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We also spoke with representatives from the local authority prior to the inspection who commissioned services from the home. We considered all this information when planning our inspection of the home.

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.

We spoke with six people living at the home and three relatives. We spoke with the manager, two representatives from the management team, eight members of care staff, the cook, the maintenance man and a visiting healthcare professional.

We looked at eight care records, and six medication records. We also looked at records kept on accidents and incidents, safeguarding concerns, complaints as well as staff training records and audits completed to assess the quality of the service provided.

Good

Is the service safe?

Our findings

At the last inspection in October 2017, we rated the provider as 'inadequate' under the key question of 'Is the service safe?' This was because we identified there was a breach in regulation 18 as the provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. There was also a breach in regulations as the provider had failed to ensure that staff had the qualifications, competence, skills and experience to keep people safe. At this inspection we found there had been an improvement in staffing levels and the competency of staff and the provider was now meeting this regulation.

One person told us, "There are plenty of carers and they are all very nice and seem happy in their work. They do stop and chat but not very often. I do most things for myself but they are there if I need them". A relative said, "[Staffing] is better; there are less people with high end needs and staff are not pulled away". We saw there was a dependency tool in place to assist the manager in calculating the number of staff required to meet people's needs. One member of staff told us they thought there were enough staff to meet people's needs and were confident that as the number of people living at the home increased, so would staffing levels. We observed that people were responded to in a timely manner and staff were visibly present in communal areas. Staff told us, and we observed on staff handover sheets, that systems were in place to ensure staff were allocated to monitor the first floor to ensure people who preferred to stay in their room received regular checks. The manager told us, "All people have a dependency tool in their care plan and their needs are assessed. If they change we will look at the staffing levels".

We spoke with the manager about the provider's recruitment processes. There has been no new staff, with the exception of the manager, employed by the provider since our previous inspection in December 2017 as vacancies had been filled by staff previously recruited and transferred from another of their locations. The provider was ensuring staff were recruited safely at the time of the last inspection and our discussion with the manager evidenced that she was fully aware of the provider's recruitment processes. In addition she told us of the recruitment process the provider had followed when they were employed which reflected our findings from the previous inspection; namely that the providers staff recruitment practice ensured staffed were appropriately vetted prior to employment.

We observed people were supported by staff who were aware of the risks to them and had received the appropriate training to help them manage those risks. We found that people were being supported in line with their catheter care assessments. We spoke with a district nurse who visited the service. They told us, "I have no concerns, whenever I've visited they [staff] have been on the ball; they have called me out to look at catheters if they've had concerns. I'm confident they are responding to people's needs".

Information was displayed on a whiteboard in the staff office [out of general view] which provided staff with at-a-glance instructions for example, regarding the moving and handling for all people. We observed a number of transfers and saw that staff supported people safely in accordance with their risk assessment. Staff were able to explain which equipment they used for each person to assist with their transfers. However, for one individual, we noted what staff told us was different to what was recorded in the person's care

record. We also noted some inconsistencies in the information recorded in some people's risk assessments, for example, information relating to the reason for an alarm mat being in place and no risk assessment for a person who refused healthcare. We raised all these issues with the manager for them to clarify and ensure the correct information was recorded in people's care plans.

At the last inspection, concerns were raised as staff did not have the guidance and information to direct them when supporting people with behaviours that could be challenging. At this inspection, we saw that care records provided staff with the information and skills to support people with behaviours that may challenge. One member of staff told us, "If I approach [person] and their behaviour indicates they do not want for example, personal care, then I need to leave and go back shortly after and ask again. This usually will work as they forget the first time". They went on to describe a particular issue relating to one person and how they managed this situation, resulting in the person agreeing to get washed and dressed, enabling staff to change their bed linen at the same time.

People were supported by staff who were aware of how to respond to an emergency situation. One member of staff described how they responded to an emergency and told us; "I have put someone in the recovery position and I've done first aid".

We noted that checks were in place to ensure the safety of equipment, premises and communal areas. For example, regular checks of water temperatures, fire extinguishers and profile beds. All relevant safety certificates were in place aside from the lift servicing which we were told had been completed recently. The manager confirmed they would ensure a copy of the certificate was placed on file.

People told us they felt safe when supported by care staff. One person said "Yes, I feel safe" and a relative commented "I feel [person] is safe and is treated with dignity and respect". Staff spoken with had a good understanding regarding safeguarding matters including the actions they should take and who they should report to if they had concerns. All staff told us they were confident that if they raised concerns they would be acted upon. We saw where safeguarding concerns had been raised they had been acted upon.

People told us they received their medication as prescribed by their doctor. One person told us, "I don't usually oversleep but I didn't wake until 9.30 am, the carers woke me as they had my pills and they were concerned about me I am glad they did". We looked at the medication administration records [MAR] for six people. We saw that on two occasions where medication errors had taken place they had quickly been identified by the daily audits that were in place. This meant that medication audit systems in place were effective in quickly identifying any issues of concern. However, we found that there were some inconsistencies when it came to recording the daily counts on MAR charts and the codes used to record if a person had refused their medication, making it difficult to audit and review MARs. For those people who were prescribed medications to be administered 'as required' protocols were in place to provide staff with the information required to make a decision as to whether or not to administer these particular medications. Staff spoken with were aware of in what circumstances to offer these medications and what they told us was reflected in people's care records. We saw for people who required pain relief in the form of patches, body maps were in place to identify where the last patch was placed and ensure staff followed appropriate guidance. However, we found for one person, who was to have their medication administered covertly, that they person routinely refused to eat some meals as they thought their medication was in the food. We raised this as a concern with the manager that this person's medication and their capacity to make their own decisions regarding taking it would need to be reviewed. The manager agreed to look into this immediately and we saw evidence of this.

One person told us, "The home is always clean, everyone works very hard". We saw that there were effective

infection control procedures in place. Staff we spoke with told us they were provided with enough PPE (Personal Protective Equipment) to help prevent the spread of infection. We observed staff use appropriate PPE when supporting people. We saw one person was at risk of infection, staff told us how they managed this risk and what they told us was reflected in the person's care plan. The home was clean and there was a team of staff available to ensure cleanliness was maintained.

We saw where accidents and incidents took place, they were recorded and some individual analysis took place to establish if any lessons needed to be learnt. However, evidence was not available to demonstrate that analysis of each individual event took place. For example, we saw that one person had fallen on three separate occasions over a period of three weeks. Each incident was recorded but the information was not collectively analysed for any patterns or trends which would inform staff on how to minimise the risk to the person in the future. Also, evidence was not available to demonstrate that relatives were routinely contacted following an accident as there was no record available to confirm this. We saw analysis of the number of falls had taken place, but again some of the recording was inconsistent which would not provide an accurate picture or inform the manager when identifying trends for example. We saw where other accidents or incidents had taken place, they had been recorded but the only analysis available was for January and we could not find evidence of this taking place in February or March. A representative from the management team who was responsible for this piece of work, told us it had been completed but they were unable to locate the information on the day of the inspection. We saw where accidents and incidents did take place, body maps were completed, medical help sought where appropriate, and people were placed on close observations for 72 hours.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in October 2017, we rated the provider as 'inadequate' under the key question of 'Is the service effective?' This was because we identified there was a breach in Regulation 11 as the provider had failed to ensure that staff worked in accordance with the principles of the Mental Capacity Act and evidence was not available to demonstrate that people's consent was routinely obtained prior to being supported. At this inspection we found that staff routinely sought people's consent prior to supporting them, but more work was required regarding the recording and sharing of information in respect of deprivation of liberty safeguards.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).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.

People told us, and we observed that staff routinely asked them for their consent prior to offering support. A member of staff told us, "You have to get people's consent and always give a choice".

We saw where people had DoLS authorisations in place, they had been applied for appropriately, but there was a lack of detail in records in relation to best interest decisions and who had been involved in these conversations. Further, staff spoken with were not fully aware of who had a DoLS authorisation in place. The whiteboard in the staff office, which held at-a-glance information for staff, did not hold information regarding who had a DoLS in place, despite there being a column for this to be noted. At member of staff told us, "I'm not sure who has DoLS in place", but they were able to explain why they thought a particular person would need to be deprived of their liberty. We saw people's care records now held information regarding their capacity to make specific decisions in their life, for example, what time they wanted to go to bed, taking their medication and support with personal care and staff spoken with were knowledgeable when it came to this information. One member of staff said, "Most people have the capacity to make their own decisions about what they want to eat or drink or if they want to go the toilet". We saw care records held a number of consent forms for people to sign and this had been identified and added as an action to the home improvement plan. We also saw that although decision specific information was held on file, it had not been incorporated with people's care plans. We discussed this with the manager who agreed to look into this. This meant that although we did not see any evidence to suggest that people were being unlawfully restricted, further work was required around the recording of decisions where people lacked capacity and staff's knowledge of who has a DoLS authorisation in place.

We saw that some people, and their families had been involved in consenting to their care plan, but we

found the consent had in some instances been gained by relatives where they did not have the legal right to consent on behalf of the person. This was despite the provider having contacted the public guardian's office to confirm if relatives had lasting power of attorney (which gives the legal right to make decisions about their relative's health). We spoke with the manager regarding this. They were aware of the discrepancies and were working to put them right.

On the first day of inspection, we saw that a person had recently been admitted to the home. We found that this person's needs had been assessed prior to them moving into the home. We spoke with the person and their relative who told us they were happy with the arrangements in place. The person told us, "They [staff] are very kind, it's the best decision I've ever made". Staff spoken with had been made aware of the person's care needs and we observed staff introduce themselves to the person. Information had been gathered regarding the person's personal care needs, their medical history, dietary requirements, any cultural or religious needs and their personal preferences, including if they wished to be supported with their personal care by a male or female member of staff. We saw that information continued to be gathered and this was shared with the staff who supported the person. One member of staff said "When you shower [person's name] it has to be done in a very particular way and you just have to make sure they are safe. I have got used to people's routines and what order they like things done".

People were supported by staff who told us they felt well-trained. Staff who had been transferred from the provider's nursing home to the residential home when it closed, told us they had been provided with an induction that prepared them for their new role. Staff confirmed their training consisted of e-learning [completing a course independently on a computer] and some practical training in respect of manual handling. One member of staff said, "E-learning; you get used to it, but it's not like hands on". They told us they preferred the classroom environment as the conversation with others was useful. There was a training matrix in place to assist the manager to identify any shortfalls in training or when refresher training was required. Staff had received training in catheter care and practical moving and handling and systems were in place to ensure their competencies were assessed. We saw staff supervision had commenced providing staff with the opportunity to discuss their training or any concerns they may have. Staff told us if they had any concerns they could speak directly to the manager, without waiting for a formal supervision meeting. One member of staff talked of their initial concerns regarding the expectation on them to conduct supervision with other staff. They told us, "I was worried at first as I've known staff for years". They went on to tell us they had been supported by the manager and now felt more confident in the role and had received positive feedback from others.

One person told us, "The food is very nice, lovely in fact. We get two choices. Sometimes we have faggots which I don't like so the cook puts sausages on for me instead. You can have what you want for breakfast. I have a good relationship with the cook, she always knows what people like and dislike". Another person said, "I love my food, its nice food here and there is always enough to eat and drink throughout the day. It's all cooked very well, I can have what I want and I had an egg sandwich for my breakfast this morning".

We saw menus were on display letting people know the choices on offer at each mealtime. We noted that food was freshly prepared and for those people who required assistance in deciding what they would like to eat, each meal choice was presented to the person in the form of 'show plates' to assist them to choose. They were then provided with a freshly prepared meal of their choice. The cook was aware of people's preferences and dietary requirements and we observed her speak with people about mealtime choices and offer alternatives if they did not like what was on the menu. We discussed a new person who had been admitted to the home. The cook told us, "I introduced myself when they came in" and went on to detail the person's dietary requirements. Snacks and drinks were readily available throughout the day. For example,

we saw people offered a choice of milkshake, tea, coffee, squash and a selection of fruit. We saw that people were offered a variety of hot and cold drinks throughout the day and jugs of flavoured squash were readily available. People's dietary preferences were reviewed monthly to see if they had changed their mind regarding their preferences. For those people who were at risk of dehydration or weight loss, their food and fluid consumption was monitored and reviewed.

We saw systems were in place to ensure information was shared with staff across shifts and across other organisations. Staff were provided with a handover sheet at the start of each shift which provided them with basic details regarding people's care needs and the risks to them, for example, if someone was a risk of choking and required a thickener in their drinks.

People told us they felt well cared for by staff who knew their needs. We saw people were supported to maintain good health and have access to healthcare services. Where appropriate, food and fluid charts were completed in a timely manner. We saw that professional advice was sought in relation to changes in people's needs. A visiting healthcare professional told us, "I'm confident they [staff] are responding to people's needs. I have seen an improvement. They are spotting things and will raise them immediately". People were weighed regularly and if weight loss was noted, they were referred to the dietician and any advice was followed. We saw that one person had been taken ill during the inspection, and these concerns were responded to appropriately. Advice was sought and staff remained with the person and continued to monitor them and offer reassurance whilst they waited for the arrival of the ambulance.

We noted following the last inspection, efforts had been made to improve the environment. There was appropriate signage on display which would assist people when navigating their way around the home. Each bedroom had the name and photo of the person who occupied it. For those who did not want this information on display, this was respected. We saw there was a programme of redecoration in place and initially vacant bedrooms were being refurbished. We spoke with the maintenance man who confirmed they had been provided with the monies to carry out the work that was required on the building. We noted the layout of the furniture in the communal areas had created a more homely environment and items of interest had been placed on walls and in lounges to catch people's interest. A relative told us, "They have done some work and the décor is beautiful, the signs, the door colours are a big improvement to the home" and another said, "They are trying to spruce the place up, loads better than a few months ago".

Good

Is the service caring?

Our findings

At the last inspection in October 2017, we rated the provider as 'inadequate' under the key question of 'Is the service caring?' This was because we identified there was a breach in Regulation 10 due to people not always been treated with dignity and respect. At this inspection we found there had been an improvement as to how people were treated.

One person told us, "I get on with all the carers, they are all very pleasant and helpful". We observed staff on numerous occasions provide care to people in a way that showed respect and consideration of their dignity and saw that staff responded to people in a friendly and polite way. When people spoke to staff we saw they listened to them and responded appropriately. On a number of occasions we saw staff speak to people living with dementia in a way that engaged with their reality and showed understanding of what the person was feeling. We saw staff routinely offered people choices, for example we saw staff member offer a person a choice of drinks and snacks, showing them the choices. There was also friendly and warm interaction as part of the discussion with use of touch that we saw was received well by a person who was smiling back at the staff member.

In contrast to what we saw at our last inspection in October 2017 people were seen to be well presented, fresh and dressed appropriately. We saw people's finger nails were clean and some people had their nails painted in colours they liked, this supporting their dignity. We also saw staff respected people's privacy for example by being discreet when discussing personal issues, and knocking doors before entry. A relative we spoke with told us of the staff, "They give [their relative] all, they all [staff] genuinely care for her". They also added that the consistency of care had improved and it was, "Just like home now. There was a lot of agency, not now its regular staff".

One person told us, "Sometimes I like to stay in my room, the carers don't ever make me come down to the lounge". We saw people were routinely offered choices by staff. For example when the morning drinks were taken around staff asked every person what drink and snack they wanted (out of numerous choices). We saw some people were undecided and staff took the time to show them all the options available and then allow them to decide in their own time. A visitor told us how their relative, "Communicates with expression and odd word" but the staff always asked and showed the person a choice even though they rarely verbally responded. They also told us their relative was, "Always smiling never upset". We spoke with staff about communication with people who had difficultly sharing their choices verbally and they told us they were conscious of the need to be aware of people's behaviour and what choices this was communicating. Two staff gave examples where they said if a person became anxious when asked if they wanted personal care they would withdraw and return shortly after to ask again when the person was calmer. Another staff member said people's consent to photographs (for records etc.) was always requested and there was one person who, "Won't let us take a photo, this is their choice".

We spoke with staff about their understanding of what made the service caring and they were able to relate positive examples of what was important so that people were treated with kindness, dignity and respect. One staff member said, "Talking to people like they are a person, knocking doors before go in, not sharing

private information". The last statement reflected some staff actions we saw where they spoke discreetly to people in communal areas where needed. Another member of staff told us how they liked to give people a lot of time and said, "Every day chat, talk about past, whether hair done , or outfit looks nice, or a person looked nice today, I said you look nice and his face lit up ". We saw this person was smartly dressed as we were told and relatives confirmed staff had made an effort with their presentation. We saw a number of people liked to walk with purpose and there were no occasions where they were restricted from doing what they wished. We saw staff when needed successfully redirected people through discussion and offering choices.

We saw people's independence was promoted in accordance with their individual capabilities. For example we saw staff may take people longer distances by wheelchair but would encourage them to stand and walk a short distance from wheelchair to armchair, this with appropriate encouragement. Staff we spoke with understood the importance of promoting people's independence. One staff member told us, "We try to get (people) to do as much as they can without help" and another member of staff said, "We prompt and encourage people to mobilise for example [person] is encouraged to walk from wheelchair to chair, needs encouragement".

We saw there was information on display in the home in respect of advocacy services. We spoke with the manager who told us no one currently had an advocate at present. They had identified two people who may benefit from advocacy and had made referrals to Dudley Advocacy for support. At the time of our inspection we were told them were awaiting a response to the referrals.

A relative we spoke with confirmed there was no restriction on visiting and the staff accommodate the family even when there was quite a few of them.

Good

Is the service responsive?

Our findings

At the last inspection in October 2017, we rated the provider as 'inadequate' under the key question of 'Is the service responsive?' This was because people were not involved in the development of their care plan or reviews of their care. People's care needs had not been reassessed and their care records did not hold the most up to date information regarding their needs. Care records did not sufficiently guide staff on people's current care, treatment and support needs placing people at risk of inappropriate care. We found there had been improvement as to how responsive the service was at this inspection.

From our observations we saw examples of staff responding to people efficiently in a way that reflected their individual needs. One person told us, "Yes, I am happy, I love it here. It couldn't be any better than it is now. The carers are very good, very kind and helpful and they really know what they are doing". We saw that staff overall took time to communicate with people with the use of touch, visual cues (showing them items to choose from) and observing body language if people were unable to communicate verbally. An example of this was where we heard a person ask a member of staff for a specific book. The staff member was seen to take the time to check which book, then retrieve the book and show it to them to make sure they had the right one. There was also some discussion about the book and time spent to ensure they could open and read it (as it was quite large). We saw the staff member was facing the person when speaking with them and seemed to be maintaining eye contact to assist with communication.

We looked at a number of people's care files and in the main, that these were reviewed monthly although in some instances we found information was difficult to find. There was evidence that the staff were updating the care plans although this was clearly still 'work in progress' as identified on the provider's action plan. We did see that in some files there were 'snapshot' care plans that helped capture people's most important needs and preferences and were easier to access. We did discuss use of more accessible formats for care plans with the management so these could be developed for people living with dementia who may have difficulty understanding the current written formats. We also saw that the provider had identified the need to better record people's diverse needs and was taking action to rectify this matter, initially by ensuring the pre-assessment process included obtaining this information.

We spoke with staff about how they used care plans to help them understand people's needs and preferences. A senior staff member told us that the work in maintaining care plans was now delegated to them, and they showed a good understanding of the needs of the people we discussed with them. Other staff said they had only seen a limited number of care plans, but were able to tell us how important information about people's needs was communicated to them through a daily handover sheet. We saw a copy of one and this included information about people the staff member could refer to that included how they were supported to move, what diet they were on, risks to their health such as falls and whether they had a DNAR [Do Not attempt Resuscitation] in place. We were told these were given to staff at the handover (at the start of their shift) and were updated in line with people's changing needs. Staff told us this system worked well and helped them retain critical information about individuals.

We asked people how they occupied their day. One person told us, "The church come in every fourth Sunday

of the month, sing hymns and read from the bible and someone plays the organ too" [and we observed this]. Another person said, "They used to have a lot of activities to break the monotony, I enjoyed 'play your cards right' and bingo and sometimes there are quizzes. There are a lot of activities for the ladies, hairdressing, baking, pampering. Not my kind of thing. I like my sport and old western films". From our conversations with the manager, we noted that she had identified this as an issue and was keen to offer more activities to meet people's personal interests. One relative we spoke with said their relative was involved in activities dependent on their interests and safety. They told us staff knew what activities were safe for the person to take part in. We saw that the provider had consulted people and relatives through meetings on a number of issues including their opportunities for daily occupation. People's views were incorporated in the provider's action plan and from discussion with people/relatives and observation we could see that there had been improvement in this area since the last inspection. For example, when we spoke with the activities co-ordinator they show us how they were developing an activities programme to reflect what people wanted. This included skittles and bingo which had been two requested pastimes. They told us the aim was, "To keep residents happy and occupied" at a level that was consistent with the person's individual preference and wishes. We saw that there was awareness amongst the staff team about focusing on person centred stimulation for people. We saw one member of staff come in with numerous free newspapers and offered one to anyone who had an interest. We saw one person living with dementia, which at times would be seen to be anxious, took the newspaper and was reading it for an extended period, with the expressions on their face showing interest and happiness.

We saw the provider had a complaints procedure, and a copy was on display in the reception area of the home. This would have benefitted from being in an easy read format so people could access important details; for example telephone numbers of who to complain to. We were told that complaints procedures were available in each person's room as well. We spoke with a relative who told us if any concerns they, "Will raise with staff or manager" and things would be resolved. They were aware of the formal complaints procedure as well. We looked at the provider's complaints recorded and saw that any concerns received were recorded and it was possible to track responses and outcomes. We saw all but one complaint had been responded to in the timescales set by the provider. This one complaint was a more complex issue though and there was a record of discussion with the complainant and actions that were in part reliant on the involvement of external professionals. The extension of the complaint timescales was therefore outside of the manager's/provider's control on this occasion.

We saw that informal comments from survey, residents and relatives meetings where there was a suggestion for improvement or concern, whilst not captured as an informal complaint, were clearly recorded in the provider's improvement plan with actions needed identified. An example of this is where it was raised in a meeting that there was a need more appropriate activities for people with limited eyesight. The improvement plan had recorded that the manager was looking for resources from a specialist resource as well as staff training. The manager expanded on her plans for following this suggestion for improvement up in discussion with us.

At the time of inspection no one was living at the home, who was in need of end of life care. The manager told us that they did not accept people who had a terminal illness as she felt this was currently outside of the scope of the service they provided. We heard confirmation of this when a senior took a phone call from a commissioner about a placement for a person with a terminal illness, and they explained that they were not able to offer a place for a person with this need. The manager did say that they would consider providing end of life care to people who lived at the home if this considered in their best interests and was currently looking at sourcing additional training for staff in this area. We saw people and/or relatives were approached in respect of the wishes regarding end of life care but records showed some did not wish to discuss.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in October 2017, we rated the provider as 'inadequate' under the key question of 'Is the service well-led?' This was because we found significant shortfalls in the provider's systems to monitor and improve the quality of the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that some improvements had been made

At our inspection in October 2017, the manager at that time had been in post two days. Since then, they had left and a new manager had been appointed. The new manager was appointed in March 2018 and at the time of the inspection, had been in post approximately six weeks. They told us it was their intention to become registered manager of the service and they had already submitted their application for this.

Following the last inspection, the provider had created a home improvement plan in response to the concerns raised. This plan was forwarded to the Commission on a monthly basis, identifying areas for improvement and actions taken. During the inspection we saw evidence of the actions taken. However, there remained areas for action and improvement and not all audits in place identified areas for improvement that came to light during the inspection. For example, we noted where incidents or accidents took place, they were recorded and acted on appropriately. However, they were not consistently analysed to identify any patterns or trends which would help identify lessons to be learnt in order to reduce risks. We saw some analysis of falls but this was inconsistent and there was nothing in place for the analysis of other accidents or incidents or safeguarding concerns. We saw applications had been made to deprive people of their liberty, but audits had failed to identify that staff continued to lack knowledge about people who had a DoLS (Deprivation of Liberty Safeguards) authorisation and ensure the principles of the Mental Capacity Act 2005 (MCA) were being followed.

We found a variety of audits had been created in order to assess the quality and safety of the service, for example, medication audits, pressure care and infection control. Care records had been re-written and staff spoke positively about the new format and the information they contained. The manager told us they could see potential for improvement in this area, but did not want to change things immediately as staff were still getting used to the new format. We saw that staff were now completing care records in a timely manner. Systems were in place to assess staff competency levels and staff told us they felt supported in their role. Staffing levels were now based on people's dependency levels. Staff allocation systems were in place to ensure staff were proactive in their approach and able to meet the needs of the people living in the home. At our last inspection we found systems were not in place to ensure maintenance work requested was completed in a timely manner. At this inspection we found that areas for improvement were highlighted and acted on.

The manager also told us about how they were now monitoring staff responses to call bells. Each member of staff were allocated a day where they would randomly set off a call bell and check to see how long staff took to respond. This was logged in an audit form which the manager reviewed. The manager said the target was five seconds. While not always meeting this target we did see from out observations on the day, and from this record that staff were responsive to the call system.

One person told us, "I don't think there is anything I would change about the home, I like it as it is" and a relative said, "I've met the new manager, she introduced herself, I was very pleased".
Staff spoke positively about the improvements that had taken place since the last inspection and the changes the new manager had introduced. A member of staff told us, "[Manager's name] seems to know what she is on about and what is needed for the home, I have confidence in her" and another said, "I think [manager's name] is trying [to improve things]. We had an open day yesterday and she has introduced carer of the month. I see her on the floor more; she is visible and asks if things are ok and if there's anything she can do". We observed the manager had a good knowledge of people living at the home, although she told us, "I know a snapshot about people but not enough as I would like".

We discussed with the manager the challenges she faced when she came into post. She told us, "There was a lot of negativity at first, there have been a number of managers here". She went on to tell us she had made it a priority to introduce herself to all staff, people living at the service and their relatives. This included spending a week coming in early to ensure she met with all night staff. A member of night staff told us, "[Manager's name] is good, she is approachable". The manager had arrived at the home but found there was no current administrative support in place. The manager had been provided with some support from a regional manager, and other support was available over the phone from head office, but the lack of administrative support had presented its own problems as the manager was not familiar with the business side of the service. Other staff commented on this and told us they were concerned that the manager was not provided with the support she needed. The manager told us "I'm very much hands on; I need to find a balance between the business side of the job and the care side. I am very passionate about care". She told us her priority was making sure the environment was right for people and making the positive changes required to improve the service. We observed the manager had a visible presence in the home and staff commented positively about this. One member of staff said, "[Manager's name] is approachable, really nice, can go to her with stuff. She is settling in". We observed the manager actively seeking relatives out and spending time with them to listen to their concerns and support them. We observed a relative tell the manager, "Thank you very much, [for their support]; it's a relief [person] is here".

We saw the manager was mindful of ensuring both she and her staff were prepared to take new service users and ensure systems were in place to meet people's needs safely and effectively. We saw that the manager was aware of her responsibilities regarding this and had refused to admit a person until the appropriate support and staffing was in place.

All staff spoken with described the manager as 'approachable'. One member of staff told us, "She is the most approachable manager we've ever had" and another said, "She actually came into the kitchen to introduce herself; I've never had that before, I was impressed". Staff told us they felt listened to and when they raised concerns with the manager, they had listened and acted appropriately. We saw the manager was keen to support and empower staff in their role. She told us, "You have a senior on shift for a reason, I have spoken to seniors and given them permission to deal with issues there and then, but they also have my number to contact me if they need to".

We saw arrangements were in place to involve people in the development of the service. Meetings had taken place with people living at the service and their relatives and action plans were in place in order to respond to the issues raised. For example, one person had raised they would like more activities, particularly quizzes and this had been reflected in the action plan and passed onto a member of staff to act on. The meetings recorded that people had noted improvements in the service and positive comments were received. We saw that updates on progress since the last CQC inspection had been provided to relatives and they too had suggested people would benefit from more activities. The manager had also recognised this and had also highlighted that more activities needed that were of interest to the men living at the home. She told us this

was something she was also keen to improve on.

The manager showed us the comments they received from a relative's survey carried out in January 2018. These could be completed anonymously if wished. We saw all the 10 completed forms that were returned and these were in conclusion very positive about the service people received with all saying the home overall was good or excellent. We saw that some comments were made about possible improvements and we did see some of these were actioned by the provider; for example providing the staff with name badges.

We saw the manager was keen to develop her learning and work with other agencies to improve the service delivery. They told us of developmental work that was in progress to ensure they were able to meet the needs of people who were currently living at the home, if they became terminally ill. This included engagement with end of life /palliative care specialists from Mary Stevens Hospice, who we saw, from emails, had already visited to speak with the manager. The manager was looking to source training for staff in palliative care and this was planned for June 2018. They told us they wanted people and their families to be confident people's needs could be met. They also told us end of life care plans would be implemented, and she would look at involving external professionals in any such planning. We also noted a number of examples where the manager had sourced additional assistance in order to meet people's care needs. For example, she told us, "There was a dip with [person's condition] and the mental health nurse is now working with me". A healthcare professional told us, "[Manager's name] is lovely; she knows what's what and [senior care staffs name] is really good too". A representative from the local authority reported, "I was really impressed with developments when I visited. The home has a completely different feel to it and there was clear progress being made towards meeting the action plan and I left feeling really positive".

At our last inspection, we found that notifications for five people had not been submitted to the Commission, as is required by the law. At this inspection, we found that notifications were being submitted.

We saw that the provider had the ratings for the home from our last inspection in October 2017 on clear display in the home's reception area and on their website. We also saw from meetings with relatives, staff and from the comments made in residents survey forms that the outcomes from our previous inspection had been shared and discussed in some detail. One relative told us they had read the latest CQC report. This showed the provider has been open and honest about the concerns we raised in our October inspection.