

Four Seasons (Bamford) Limited

Keresley Wood Care Centre

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 22 March 2017. It was unannounced.

Keresley Wood Care Centre is a nursing home which provides nursing care to a maximum of 44 people. 19 people lived at the home on the day of our inspection. The home operates on two floors. The ground floor accommodation consists of a lounge, a dining room, a larger lounge/dining room and bedrooms. The first floor has bedrooms only.

At the time of our visit the home did not have a registered manager. The previous registered manager resigned in October 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager subsequently registered with the CQC in June 2017.

At our last inspection visit in May 2016 we found that the provider was not meeting the required standards. We identified two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not enough staff to meet people's needs and that care delivered was not person centred.

Following our last inspection we asked the provider to send us an action plan outlining the improvements they intended to make. At this inspection we found improvements had been made however one care plan did not reflect changes in a person's care needs. The manager addressed this during our inspection visit.

People who lived at Keresley Wood Care Centre and the staff who supported them, thought people who lived at the home were safe. There were systems and processes in place to protect people from the risk of harm.

We observed, and people told us, staff members were caring and however we received mixed opinions about if staff had enough time to spend with people that was not task focused.. People had access to call bells and these were responded to promptly by staff.

Staff received training the provider considered essential which provided them with the skills and knowledge to provide effective care to people. Staff understood how to support people who did not have capacity to make decisions for themselves and relatives were involved in this process.

People received a choice of food and drink which met their nutritional needs. We saw staff supported people to eat and drink and we saw people were offered drinks throughout the day. Records related to people's food and fluid intake were in place in order to ensure their health and well-being were being maintained.

People were supported to maintain good health. We saw some appropriate referrals were made to specialist healthcare professionals when people needed support, for example with eating and drinking and promoting good skin care.

Care plans and risk assessments contained information that supported staff to meet people's needs. People and their relatives were not consistently involved in reviewing the care that was provided.

Staff treated people with kindness and respected their dignity . Most people were happy about the activities available in the home however the manager acknowledged they could be better tailored to individual interests, especially for people who were cared for in bed. The manager was reviewing the activities offered by the home to improve this.

People and relatives were encouraged to share their views about the home and people were aware of how to make complaints. When a complaint was received the manager investigated it in line with the home's complaints procedure.

Staff felt supported by the manager and felt the provider had invested a lot of time into helping the home improve however this had been limited by a number of changes in managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People told us they felt safe but there were mixed views about if staffing was sufficient to meet people's needs. Medicines were administered and stored safely however we identified that pain levels were not monitored and this meant that we could not be assured that people received adequate pain relief. Staff were recruited safely. People received care and support at the times they needed it. Staff knew how to recognise signs of abuse and how to report it.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff had the knowledge and skills to support people. Staff were aware of their responsibilities regarding the Mental Capacity Act and Deprivation of Liberty safeguards. People received a choice of food and drink which met their nutritional requirements. People were supported to follow the faith of their choice.

Good ●

Is the service caring?

The service was caring.

Staff were kind and respectful when they interacted with people. Staff were encouraged to spend time with people that was not task focused, People's privacy and dignity was respected. Plans were in place to support people who received end of life care.

Good ●

Is the service responsive?

The service was responsive.

People received care that was responsive to their needs. People enjoyed activities in the home and the manager was reviewing the activities that were provided to ensure they were planned to meet peoples preferences. People were supported to maintain relationships with people who were important to them. People were aware how to make a complaint and these were responded to by the manager.

Good ●

Is the service well-led?

The service was not consistently well led.

Since our previous inspection there had been a number of changes in manager of the home which meant the management had been inconsistent. The manager had systems in place to monitor the quality and safety of care provided but these were not always effective. Staff felt supported by the new manager and the provider.

Requires Improvement 

Keresley Wood Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 22 March 2017 and was unannounced.

This inspection was undertaken by two inspectors, an expert by experience and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

Before the visit we looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners to find out their views of the service provided; they had identified areas of concerns and were monitoring the home .

Before the visit 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 were able to review the information in the PIR during our inspection. We found it accurately reflected the service.

We talked to three people who used the service and five relatives. We interviewed seven staff (this included nurses, care workers, domestics, and maintenance and kitchen staff). We observed the care provided to people and reviewed five people's care records.

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 also reviewed records to demonstrate the provider monitored the quality of care provided, medicine records, four staff recruitment records, and complaints, incident and accident records. We also spoke with the manager, the Residents' Experience Team Manager and the Senior Regional Manager who attended the inspection.

Is the service safe?

Our findings

At our last inspection of this home we identified that there were not enough staff to provide care and support to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider submitted an action plan detailing how they would improve this. We found improvements at this inspection and concluded the provider was no longer in breach of the above regulation.

At this inspection people and relatives had mixed views about staffing levels. One person told us "I feel there are enough staff, they do their best. It's no different at night." Another person told us they have a call bell in their room and staff respond quickly when they use it. One relative told us "Staffing seems okay." However other relatives told us, "No there isn't enough staff but I have never had concerns as a result of that." The relative went on to say "You can tell staff levels have improved." Another relative told us "I don't think there are enough staff, they always seem to be rushing around."

We spoke to members of staff who told us there were enough staff to keep people safe. One member of staff told us, "The last time you [CQC] were here things were hectic, there wasn't enough of us but now there are more staff it is fine." Another member of staff said they thought there was enough staff to keep people safe but went on to say that they would like to have more time to spend talking with people.

The manager explained the staffing levels at the time of our inspection was one nurse, four care workers, an activity co-ordinator and two regional support staff. The regional support staff worked with the care workers to check that good standards of care were being maintained and they also helped to update people's care records. The manager told us they had spent time to help staff become more efficient with their time. They gave an example that care workers would support someone with personal care but if they had forgotten to take something into the person's room they would have to walk back to a different area of the home. The manager went on to say care workers had been encouraged to take a trolley with them which contains all the items they needed and this helped care workers to be more organised.

At our previous inspection we had observed that there were not enough staff to help people out of bed or to provide personal care to people in a timely manner which resulted in people still waiting to be supported with personal care by mid-afternoon. At this inspection people and staff told us that they were supported to be washed in the morning and we saw that people who wanted to get out of bed were helped to do so.

People had access to call bells which meant they could call staff for support. We saw people who were cared for in bed had the call bells placed within easy reach and staff responded to them promptly.

We checked the administration of medicines at the home to see if they were managed safely and whether people received the medicines prescribed to them. People told us they received their medicines regularly and when they expected them. One person said "I have tablets three times a day. I have asked for pain relief, they are very good, they ask me how my pain is." We observed the nursing staff administer medicines to people. We saw the nurse took time to speak to each person before giving their medicines and completed

any checks needed before such as checking the person's heart rate before giving the person medicine which slows their heart rate. This was important because the medicine states it is not to be given if the person's pulse is less than 60 beats per minute.

Each person had a medicine administration record (MAR) which had a front sheet with a recent photograph of the person and allergy information. This helped staff to make sure medicines were given to the correct person how the person liked to be supported to take their medicines. When medicines weren't given the appropriate reason was recorded on the back of the MAR chart and the reason coded. Where PRN medication was administered the reason and effectiveness was recorded on the chart.

We looked at records for people who had a medicine patch applied to relieve their pain. These patches were a controlled drug and these medicines need to be carefully monitored and accounted for due to their strength. Controlled drugs are prescribed medicines which are controlled under the Misuse of Drugs legislation. A member of nursing staff explained that they checked each day that the patch remained in place and if it was comfortable for the person. They went on to explain that it was important to check where the previous patch had been placed so they could place the new one on a different area to help reduce irritation of the skin. The charts clearly showed the rotation of the patch on application and removal of the previous patch. The record also showed that there were daily checks of the site to confirm it remained in situ and there was no skin irritation.

A number of people were prescribed PRN (as required) pain relief but the records did not always evidence how their pain levels were formally being monitored or assessed. People with dementia who experience pain are not always able to express this and can be at risk of not receiving necessary pain relief. One person with a grade 3 pressure ulcer was prescribed a variable dose of paracetamol, their pain levels were not formally assessed. We brought this to the attention of the manager at the time of our last inspection and found that this remained the case at this inspection. A member of nursing staff told us that the person had been reviewed by their GP who had prescribed paracetamol for them. Pain levels were not being formally assessed and daily notes stated that the person "appeared comfortable." MAR charts showed that this person was regularly given paracetamol which indicated it was not being used "as required" but was being used as regular pain relief. We raised the issue to the new manager who arranged for a tissue viability nurse to visit the day following our inspection visit and who prescribed additional pain relief for the person. A tissue viability nurse is a nurse with specialist knowledge in wound care and promoting good skin integrity.

We found medicines had been stored safely and in line with legal requirements and there were good systems in place to manage and dispose of unwanted medicines.

We looked at what procedures were in place to ensure that risks related to people's care needs were identified and managed safely. We looked at the care records of five people and saw risk assessments provided information to staff about how to manage the risk. For example, one person was fed using a percutaneous endoscopic gastrostomy (PEG) tube. A PEG is used when a person is unable to eat or drink and nutrition is provided through a tube in their abdominal wall. The care plan provided details on how to care for the site of the PEG and details were provided about how staff were to administer meals through the PEG. Members of staff told us that they had time to read people's care plans so that they were aware of individual risks. We asked a member of nursing staff about how they cared for the PEG and the information they gave us corresponded with what was in the risk assessment.

The home had the equipment necessary to keep people safe. For example, people identified at risk of skin damage had pressure relieving cushions to sit on and alternating pressure mattresses to sleep on to reduce the risks. People who were at risk when moving had the appropriate equipment such as hoists and slings to

support them. Staff were knowledgeable about people and risks and how these were managed.

We spoke with staff about safeguarding procedures. Staff understood their responsibilities to report these incidents to the manager and the provider had a policy for informing staff of the correct procedures to follow. One member of staff told us "I would take any concerns to the Home Manager, I have no doubt that she would quickly take action, she's very hot on things like that." Staff were aware of the provider's whistleblowing policy and told us that they would feel confident in using it. Whistleblowing is when a person employed by an organisation speaks out about any wrong doing. We saw that details of how staff could contact external agencies to report concerns were on display in the manager's office.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The manager told us information was recorded onto a 'tablet computer' and that this could be done by any member of staff. The manager would then analyse the information and put action plans in place to make improvements, such as updating people's risk assessments or referring them to healthcare professionals for support. We saw evidence this was carried out.

The provider's recruitment process minimised risks to people's safety because checks were made to ensure staff who worked for the home were of a suitable character. Staff told us and records confirmed, Disclosure and Barring Service (DBS) checks and references were in place before they started work. The DBS helps employers make safe recruitment decisions by providing information about a person's criminal record and if they are barred from working with people who use services.

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. 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.

At our last inspection we found that although the provider had submitted applications to a supervisory body for DoLS, the information stated on the forms was not clear and did not state the restrictions in place. We also found capacity assessments to make decisions were not always reviewed when a person's capacity changed. In addition to this staff were not clear on their responsibilities under MCA and many had not received training about this. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. Following our last inspection the provider provided us with an action plan of how they would improve this. We found improvements at this inspection and as a result the provider is no longer in breach of the above regulation.

At this inspection we saw that capacity assessments had been reviewed and now included details of specific decisions a person could or could not make, for example if a person did not have capacity to manage their finances but did have capacity to make decisions about daily activities. If a person did not have capacity to make a decision we saw evidence that family members had been consulted to make decisions in the person's best interests. One relative told us that they had legal responsibility for their relatives care because their family member lacked capacity to make their own decisions. They went on to explain they regularly had discussions with staff about care decisions.

In the past 12 months 10 DoLS applications had been made. We saw the applications that had been made since our previous inspection contained information about what the restriction was, for example being cared for in a locked unit. The applications also provided information about why this decision had been made and who had been consulted in making the decision. Training records showed that the majority of staff had received training about MCA and DoLS and further training was scheduled. Staff's knowledge of MCA and DoLS had improved since our last inspection. One member of staff told us, "It's about giving someone choice and helping them make decisions or making a best interests decision for them. We would involve healthcare professionals and families in this."

People told us staff asked for their consent when supporting them. We observed staff sought consent when people required support. We heard staff ask "Can I help you with that." and, "Can I put your feet up." Staff waited for a response before completing the task.

We asked people if they thought the staff had the skills and knowledge to meet their needs. People and relatives thought that staff were well trained. One person said, "I have no complaints about staff" and a relative told us, "We have no issues about their [staff] capabilities."

Staff had been given training on induction when they first started working at the home to ensure they provided care safely and effectively. The training provided was in line with the Care Certificate. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people. Staff told us they had received training in areas the provider considered essential, which included moving and handling people, infection control and safeguarding people. Staff told us they found the training was useful to help them provide good quality care to people. We saw that the provider had arranged regular training for staff which included training specific to people's needs, for example training about dementia. A member of staff explained that the dementia training had helped them "understand some of the challenges people with dementia might have and how I can help them."

We observed staff moving and handling people and saw staff knew how to use equipment safely and understood how to reassure people when they were being moved. We saw that when a person had asked for help to move staff gave them clear instructions on what to do and waited for them before moving on to the next step. This included offering them reassurance and adjusting their clothing to ensure their dignity was protected.

Staff we spoke to told us they had regular meetings with their manager to discuss their performance and any concerns they may have. We saw a timetable which identified when staff were due to meet with the manager for their next supervision sessions and annual appraisals so that staff received regular support. The manager informed us they also completed meetings with staff which focussed on specific subjects, such as choking risk, safeguarding and skin integrity which was a chance to check staff knowledge. They used this as an opportunity to consider whether the staff member would benefit from additional training.

At our previous inspection we identified that drinks were not always available to people when they wanted them. At this inspection people and relatives told us that drinks were always available and we observed that people were offered drinks regularly. We asked people if they had enough to eat and drink and were told that people enjoyed the meals. One person told us, "The food is brilliant, you get two or three choices." Another person told us the meals were good and they enjoyed the cakes and biscuits available throughout the day.

We saw staff provided one to one support to people who needed assistance with eating. This was carried out at a pace which allowed the person to eat without feeling rushed and maintained their safety. A person told us that they could request help from staff if they needed it and a relative explained that staff had supported their family member with their meal.

People told us and records confirmed referrals had been made to health care professionals when necessary. One person told us, "The doctor comes to see me every couple of weeks to see how I am. Staff have taken me to the optician and the dentist." Staff told us they were able to make contact with relevant health professionals if they had concerns about a person. One member of staff explained one person had lost weight so they were referred to their GP and then to a dietician. The member of staff went on to explain that the advice received was then included in the person's care plan. Records showed the person was weighed regularly and the cook was aware of how to adjust the person's meals to prevent further weight loss. This approach was helping the person and we saw that they had not lost any additional weight since the support from the dietician.

Is the service caring?

Our findings

People and relatives told us that they thought staff were caring. One person told us, "They (staff) are caring, they sit and talk to me." One relative commented that since our last inspection staff had improved and were more caring. Another relative told us "They [staff] have a lovely attitude. It's like they treat her [person] like their own mother."

During our inspection visit we heard staff on duty communicated with the people effectively and kindly. Staff used different ways of enhancing communication for example, by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately. Whilst completing a SOFI we saw that this had a positive effect on people who smiled at the member of staff and reached to hold their hand. Staff were observed and heard to be discreet when people needed assistance. They reassured people and responded promptly, calmly and sensitively. One person became visibly more relaxed whilst the member of staff spoke to them and the member of staff stayed sat with them until they fell asleep. A member of staff explained that it was important to them to get to know each person and develop a relationship with them. They told us to develop relationships with people they asked lots of questions from them or their family. They went on to explain that when they were with people who were not able to communicate well, "I look for facial expressions and smiles and touch people on the arm to offer reassurance."

People and relatives told us that they had been involved in planning their care. We saw that when a person was not able to make a decision about their care family members had been consulted. The manager told us that no one in the home had an advocate however they had details of advocate services displayed and the manager stated they would contact the service if it was required. An advocate is someone who can speak on behalf of someone to make sure their views are upheld.

Although there were regular resident and relative meetings the manager explained that these were not well attended and that they would gain people's views about their care through one to one conversations which members of staff had with people each day.

Care plans were person centred and detailed information that supported people to maintain their individuality. For example, one care plan identified how it was important for one person to wear certain items of jewellery, we saw that this person was wearing their jewellery during our inspection visit. Care plans also recorded people's preferred names and we observed staff respected people's wishes and addressed them in the way they preferred.

People had detailed social history's that also recorded individual preferences, hobbies, likes and dislikes. Members of staff we spoke with had a good understanding of individual preferences and we heard staff speaking to people about their interests.

The home provided care to people when they were reaching the end of their lives and peoples preferences were recorded in their care plans. For example, access to a named priest, identification of a funeral director and who should be informed in the event of death in the home, such as family and friends. People requiring

end of life care were treated with dignity. People told us they were consulted about the service they received and we saw people's preferences were recorded.

People told us that staff respected their dignity. We observed staff knocked on doors and identified themselves before entering a person's room. A member of staff explained that when they provide personal care to a person they, "Make sure the person is comfortable with what I'm doing. I will cover any exposed areas to protect their dignity."

A member of staff told us that they support people to maintain their independence. The member of staff explained "I'll always help people to do things but I will encourage them to do things for themselves if they want to. If I'm helping someone with personal care I will offer them a flannel to clean their face with and not just do it for them."

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. Relatives we spoke with told us they were able to visit their family members when they wanted or where invited to by their relation .

Is the service responsive?

Our findings

At our last inspection of this home we identified that people did not always receive care and treatment that met their needs and preferences. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The provider had sent us an action plan outlining the improvements they intended to make and we found improvements had been made however there was areas where further improvement was required.

At our last inspection we found information was not always included in people's care records about how to meet individual needs. At this inspection we found that information recorded in people's care records had improved but we identified that recording of health related matters could be improved further. We saw that one person required their oxygen saturation levels monitoring following an admission to hospital. Staff were knowledgeable about how to support the person and when to make referrals to other health professionals but the oxygen saturation levels were not being monitored as advised by doctors. A health professional told us "The home is very good at making appropriate and timely referrals, the main issue is charts aren't always completed making assessments and reviews difficult." We raised this with the manager and they arranged for the care plan to be updated and a monitoring chart had been implemented before the end of the inspection visit.

In another person's care plan we read that they suffered from shortness of breath. We spoke to a member of staff who was knowledgeable about how they could reassure the person and what steps to take if they were short of breath. They told us, "I would encourage [Name] to sit in an upright chair and ask another member of staff to get [Name's] inhalers. I would stay with [Name] because it can be very worrying and sitting and talking can help to reassure them." The person's care records contained detailed instructions on how staff should support the person.

People were positive about the activities on offer in the home, one person told us, "I love sport on TV and reading the paper, they went on to explain they had enjoyed a recent visit to a pub. Another person told us, "I like darts, they have a board. Otherwise I like to read my book and newspaper. They [staff] take me out for a walk sometimes." The person also told us that they enjoyed trips to garden centres when the weather was warm.

However, relatives told us that activities for people cared for in bed were limited. One relative told us, "It's just reading and TV, they can't join in." Another relative told us "No, [Name] doesn't do anything... They seem to do less activities than they used to." However a third relative explained that their family member was unable to engage in many activities but that the activity co-ordinator attempts to encourage them with individual activities.

We asked a member of staff about what activities they do with people, they told us, "There is music and throwing the ball. I think we could do more to stimulate their [people's] minds." The chef told us that they worked with the activity co-ordinator to arrange events for people on "special days" such as making an Irish stew for St Patricks Day and they were planning a 'Cream tea' to celebrate Mothering Sunday. The activity

co-ordinator told us that they helped people write letters to pen pals, did taster sessions and played ball games such as skittles with people. They went on to say they have spent time improving group activities in the home. At our last inspection we found a lot of the activity co-ordinators time was spent supporting people with personal care. At this inspection we found that the activity co-ordinator continued to help with personal care in addition to their duties which was impacting on the activities available. We discussed this with the manager and representatives of the provider who planned to address this further.

On the day of our inspection visit a group of musicians were scheduled to visit the home. We saw people, relatives and staff joined in with the entertainments. People appeared to enjoy the music and sang along and played instruments that were provided. The manager told us that they were looking for ways to improve the activities available to people who lived in the home. The manager was eager for activities to reflect people's individual interests and for more one to one activities to occur, particularly for people who were cared for in bed. One way they had identified to do this was to start offering holistic therapies to people including massage and had secured funding to conduct a three month pilot.

Although people, or their relative, had been involved in planning their original care plan and had signed this they told us they had not been included in reviewing the plans. We asked people if they had been involved in reviewing their care plan and they told us "No, not really, it just happens." Another person told us "I would like them to [involve me] but they have never done that." The manager had identified this before our inspection and told us that they were writing to relatives to invite them to be involved in care plan reviews.

We saw that information was included in people's care plans how they preferred to communicate. We asked a member of staff how they communicate with a person who is unable to communicate verbally, they told us, "It is very important that we know how people communicate, it must be very frustrating if you can't get people to understand what you want. I always check how a person communicates and if I am unsure I will ask a member of staff who knows the person better to help me understand what they want." It was documented in one person's care record that they were not always able to understand verbal communication and that staff were to use visual prompts to make sure that the person understood what was being told. We saw that this was being done and was recorded in daily notes.

People told us that staff knew them well and were aware of their likes and dislikes. One person told us, "They know I like my sweets!" and, another person said staff understood how they prefer to spend their time. The person went on to explain they enjoy drinking whisky and lemonade in the evening and that staff always remember to bring them it.

People were supported to follow the faith of their choice. A member of staff told us that a priest regularly visited the home and that they supported people to attend their chosen place of worship. The cook was aware of dietary requirements for people who followed different faiths, they explained they were able to order Halal meat.

Staff told us there were staff handover meetings between each shift when they would be informed of any changes in people's health so they could respond appropriately. We observed a handover meeting between shifts and saw that information was shared about a person who had not drunk much and was to be encouraged to have more drinks during the rest of the day.

People and relatives were aware how they could raise a complaint. One person told us, "I'm comfortable enough to complain if I wanted. There's nothing to complain about." Another person said, "I would speak to my sister or a carer (care worker)." Relatives we spoke with told us, "There is a leaflet on display advising how to complain." And, "I would speak to a carer or the manager if I had a complaint." We saw there was information displayed about how people could raise complaints at the entrance of the home and a copy

was provided to all residents when they were admitted to the home. There was also an electronic feedback system where people could leave feedback.

The manager told us all complaints received were recorded so they were able to identify any emerging trends and take appropriate action. The manager told us they reviewed information entered onto an electronic feedback system regularly and addressed any issues raised according to the providers complaint procedure. They told us that information from complaints were discussed with staff in meetings so they could be used as a learning point to drive improvement . We saw that following a complaint that staff were not making accurate recordings of the care provided. Following this a staff meeting was held to discuss the importance of completing all records accurately and the manager increased the frequency that they checked room charts.

The manager kept a record of compliments received by people and relatives. We saw thank you cards displayed in the main foyer which thanked staff for care provided to people and for events that had been held to celebrate birthdays.

Is the service well-led?

Our findings

At the time of our visit the provider did not have a registered manager in post. Since our previous inspection there had been two new managers and an Interim Support Manager. The current manager of the home was employed in January 2017. The provider had also employed a new Deputy Manager. People, relatives and staff spoke positively about the new manager and felt that they were making improvements within the home however they acknowledged that there had been inconsistency in the management of the home due to the number of changes. In June 2017, the manager was registered with the CQC.

The manager completed audits on a weekly and monthly basis which included checks on medicines, accidents and incidents and falls analysis. The manager told us that if any improvements were identified these were discussed with staff and a time frame for the changes to be completed was agreed. The provider told us they also completed regular audits of the checks made by the manager and identified if any actions had not been completed. We found that these audits were not consistently effective because care plan audits had not identified that care plans were not always up to date with details of people's health needs. A medication audit had not identified that a person was not receiving appropriate pain management.

We saw that another person had been admitted to hospital on two occasions in the seven weeks prior to our inspection but their care records did not reflect this. Hospital discharge records stated that staff were required to monitor the person's oxygen saturation levels and to seek medical advice if they fell below a certain level. This information had been communicated with staff when the person returned to the home however the oxygen saturation levels were not being monitored or recorded. We spoke to a member of nursing staff who explained that they regularly checked the persons oxygen saturation levels they did not record this anywhere. This meant that staff or medical professionals would be unable to identify any trends or changes in the person's levels. We raised these issues with the manager who took immediate action to correct them .

We spoke with the manager on the day of our inspection visit to discuss what improvements they had made since starting the role. They told us, "The stability and dedication of our staff is much better. We have more understanding of people and relatives needs and I want to see more person centred care being given." They went on to explain "I have told staff to stop looking at watches to complete tasks and to focus on person centred care."

The manager acknowledged that the home, "Is not yet where we need it to be" but went on to say that they were progressing well. The manager stated that their priority was to sustain the improvements that had been made and they completed regular audits to identify where further improvements needed to be made.

Staff told us that since our previous inspection the provider had put a lot of support into the home including the resident experience team and that this had helped to make the improvements. Staff told us that they felt supported by the manager. One member of staff told us, "[Manager] makes me smile and makes me feel comfortable to approach her." Another member of staff told us, "I would like [manager] to stay. She listens to me."

We asked people if they felt the service was well led, they told us, "I didn't know the old manager, it's much better now." Another told us, "I know the manager, it changed recently, they keep me informed about things." Relatives were positive about the new manager, one relative said, "It's the best it's ever been, there is a lot going on in the lounge and in individual rooms. Before, the manager didn't know what was going on [Manager] takes time to talk to everyone and they know what's happening. It has been a huge improvement."

We received mixed responses from people when we asked whether communication was good and if they felt informed and involved in the running of the home. One person told us, "We have a meeting once a month at 6pm on a Wednesday. They are quite useful." Whereas another person told us, "There are no meetings as far as I know." We saw minutes from the last residents' and relatives' meeting which was held in January 2017. People and relatives raised their concerns about the lack of consistent management and expressed fears for the future of the home. The manager reassured people and relatives they [provider and management] were dedicated to improving the care provided in the home and that they welcomed any additional feedback in between meetings.

The manager sent regular quality assurance questionnaire to people who lived in the home, relatives and healthcare professionals. In the most recent questionnaire the majority of the feedback was positive and where improvements were suggested we saw what actions the manager had taken. People had previously expressed dissatisfaction about the number of agency staff which were used in the home. The manager and provider had recruited new staff through additional recruitment and the number of agency staff used had been decreased.

The manager and provider told us of their plans to further build on the improvements made in the home. These included a new holistic therapy project which would include massage and sensory therapies. The aim of this new project was improve people's physical and mental wellbeing. The home was also in the process of being redecorated, communal areas and a number of bedrooms had already been refurbished and whilst we were at the home we saw new chairs being delivered. A relative told us, "The atmosphere is much better." and a member of staff commented on the environmental changes. They said "It was quite depressing before but now the home has a much brighter and homely feel to it."