Care Quality Commission

Barchester Healthcare Homes Limited

Worplesdon View

Inspection report

Worplesdon Rd
Guildford
Surrey
GU3 3LQ

Tel: 01483238010

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17 November 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

The service was last inspected in June 2013. It was found to be compliant in all outcomes we looked at. This inspection took place on 16 and 17 November 2016 and was unannounced.

Worplesdon View provides 24-hour general nursing and residential care, which includes care for people who have a range of needs related to different types of dementia.

The service did not have a 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. The registered manager had left the home approximately three weeks prior to our inspection visit. The provider had arranged for a temporary manager to be in place, and at the time of our inspection they had been in place for approximately two weeks. The manager confirmed they intended to remain at the home, and would be submitting an application to become the registered manager in due course.

People were comfortable with the staff who supported them and relatives were confident people were safe living in the home. Staff received training in how to safeguard people from abuse and understood what action they should take in order to protect people from harm. Risks to people's safety were assessed and minimised to keep people safe.

People were supported with their medicines by staff who were trained and assessed as competent to give medicines safely. Medicines were given in a timely way and as prescribed, but guidelines in place for people prescribed 'as required' medicines were not always clear.

There were enough staff to meet people's needs. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff told us they were not able to work until these checks had been completed.

The provider ensured staff had information on the level of support people needed with decision-making so people were protected. Staff and the registered manager had a good understanding of the Mental Capacity Act, and the need to seek informed consent from people before delivering care and support. Where restrictions on people's liberty were in place, legal processes had been followed to ensure they were in people's 'best interests', and applications for legal authorisation had been sent to the relevant authorities.

Staff had basic training to help them keep people safe, but nursing staff and all staff supporting people living with dementia required more specialist training to be fully effective in meeting people's individual needs.

Staff were kind and caring, and treated people with dignity and respect. People were supported to make choices about their day to day lives.

People had access to health professionals when needed and we saw the care and support provided in the home was in line with what had been recommended.

Relatives told us they felt able to raise any concerns with the new manager, who was already making positive changes. They felt these would be listened to and responded to effectively and in a timely way. Staff told us the management team were approachable, but recent changes in management had proved unsettling. There were systems in place to monitor the quality of the support provided in the home. However, these systems were not always effective because they had not identified some of the issues we found during our inspection.

We had not always been notified as required about incidents and events in the home.

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's needs had been assessed and risks to their safety were identified. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. Medicines were administered safely and as prescribed, by staff who were competent to do so. Guidance for staff where people were prescribed 'as required' medicines was not always clear and needed to be reviewed. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People's rights were protected. Where people lacked the capacity to make all of their own decisions, the provider protected people's rights under the Mental Capacity Act (MCA) by assessing people's capacity and the support they needed with decision-making. Staff sought consent from people about how their needs should be met. People were supported by staff that were mostly competent and trained to meet their needs effectively. Nursing staff, and all staff supporting people living with dementia required more specialist training. This training was being planned by the new manager. People received timely support from health care professionals to assist them in maintaining their health.

Is the service caring?

Good

The service was caring.

People were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs. Staff showed respect for people's privacy and talked with them in ways they could understand.

Is the service responsive?

Good

The service was responsive.

Care planning and review was taking place and involved people and their relatives as appropriate. People were mostly supported in ways that were focussed on them and responded to their needs, though this was not always the case for people living with complex dementia. People had the opportunity to engage in activities which took note of their personal interests, likes or dislikes. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems designed to check the quality and safety of the service provided were not always effective, and had not identified some of the issues we uncovered during our inspection. We had not always been notified as required of incidents and events affecting people living in the home.
People felt able to approach the new manager and were listened to when they did. Staff felt supported in their roles, and there was a culture of free and open communication between staff and the new manager. The new manager had quickly identified areas for improvement and was working with staff to achieve this.

Care Quality Commission

Worplesdon View

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.

The inspection visit took place on 16 and 17 November 2016 and was unannounced. The visit was conducted by an inspector, a nurse specialist advisor, a dementia specialist advisor 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 care service.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked 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 as part of our evidence when conducting our inspection visit. We found it accurately reflected what we saw during our visit.

During our inspection visit, we spoke with eight people who lived in the home and five relatives. We also spoke with the new manager, the clinical lead, five members of nursing staff, two team leaders, the activities co-ordinator and six care staff.

We reviewed seven people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said, "Yes I certainly feel safe here! I can get around with my walker but I need to be careful. I had a fall recently and, when I fell, I pressed my pendant and they were there straight away and sorted me out. It didn't take long to get to me at all." People told us if there was anything they were worried about they would feel happy to talk to staff about it. One person said, "I do feel safe. If I had any concerns I'd have a word with one of the nurses if needed or I could go to management." We spent time observing the interactions between the people living in the home and the staff supporting them. We saw people were relaxed and comfortable around staff and responded positively when staff approached them. Relatives told us they thought people were safe and well cared for. One relative told us, "Yes yes yes, this place is safe, especially for my mum. The carers here are all very kind, extremely kind. I know that she's never left alone for hours on end, they do check quite frequently."

The provider protected people from the risk of harm and abuse. Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. Staff were able to give us examples of what might be cause for concern. One staff member said, "We look at whether people are eating, are they down, are there any bruises that can't be explained. Any changes in their general well-being." Staff knew when and how to report any concerns, and felt confident to do so. One staff member told us, "I would report any concerns to the nurse in charge straight away. There is a weekend on-call system too. The number is printed out and always available."

There were policies and procedures for staff to follow should they be concerned that abuse had happened. The registered manager had made safeguarding referrals to the Local Authority, and kept written records of safeguarding referrals made so they could keep track of them and identify the outcomes of any investigations.

The provider's recruitment process ensured risks to people's safety were minimised, and staff with the right skills, knowledge and values were brought in to work at the home. Staff told us they had to wait for checks and references to come through before they started working in the home. Records showed the registered manager obtained references from former employers and checked whether the Disclosure and Barring Service (DBS) had any information about potential new staff. The DBS is a national agency that keeps records of criminal convictions.

Risks relating to people's care needs had been identified and assessed according to their individual needs and abilities. Action plans were written with guidance for staff on how to manage those risks. For example, some people had assessments in place to protect them from the risk of developing sores on their skin. One record specified the person should be supported to turn whilst in bed to relieve pressure on their skin. Records showed they were supported to do so every two hours as directed. A wound to one person's skin had been appropriately documented and pictures showed that the wound had healed. Staff knew how to obtain advice about the management of sore areas of skin from the local tissue viability nurse should this be required.

We observed people in communal areas of the home. Where it had been identified people were at risk of falling, staff knew about the risks and were on hand to provide guidance and support. For example, one person who had been identified as being at risk attempted to get up from their chair on several occasions over lunch time. Staff talked calmly with the person and walked with them rather than trying to get them to sit straight back down. One member of staff walked with the person and returned to the lounge area shortly after. This kept the person safe without causing distress which could have escalated their anxieties.

Other risks, such as those linked to the premises, or activities that took place at the service, were assessed and actions agreed to minimise the risks. This helped to ensure people were safe in their environment.

Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. People had individual fire evacuation plans in place which gave staff guidance on how the person should be supported and kept safe in the event of a fire.

Some people told us they thought care staff were very busy and did not always have much time to spend with them and to chat. However, they said their needs were met and staff were able to respond when they needed them to. One person commented, "I do know that the staff here are worked off their feet. I've used the call bell and I think the longest I've ever had to wait was about 15 minutes. Normally it's a lot shorter than that. Sometimes it's immediate."

Some staff told us they thought there had not always been enough staff. For example, they explained there had been problems with staff not coming in as planned due to sickness. However, staff told us the new manager had begun to deal with this swiftly and effectively. During our inspection visits we observed people were attended to by staff when they needed support, over lunchtime for example. We also saw call bells were responded to within reasonable timescales. There were numerous occasions where staff were sitting, chatting and joking with people, though this was during quieter times of the day.

The provider used a 'dependency profiling' tool to establish how many staff needed to be on duty to provider care and support. This tool primarily measured physical dependency, and there was very little consideration given to the emotional and psychological needs of people, particularly those living with dementia. We spoke with the registered manager about the views some people and staff held that there were not always enough staff. They told us there were enough staff, but they were looking at how staff were deployed around the home and at how busier times could be better managed. They said they would review the dependency tool they used to take account of people's emotional and psychological needs. They explained they did not use agency staff, and that cover was found from the permanent staff group where this was needed. Staff confirmed this. One staff member commented, "We pull together, we support each other."

People told us they were supported to take their medicines when they needed them, and that nursing staff made sure they were involved in the process. One person said, "I can tell the medicine I am on and the time I receive them. When I ask to see the chart the nurse always explains things."

Medicines were stored safely and securely. Where medicines needed to be refrigerated, records showed the temperature of the fridge was regularly checked and was within acceptable ranges. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely, and measures were taken to ensure they were properly recorded. Medicines were administered by nursing staff, who had their competency to do so assessed by the registered manager when they started. Thereafter, competence was checked on an annual basis, and records described how any identified issues during the checks had been dealt with. Staff who administered medicines had access to detailed and up to date guidance on the safe administration of medicines, along with the provider's policy and guidance.

Where people were prescribed specialist medicines, for example those with diabetes, these were managed effectively. Checks required, for example of people's blood sugar levels, to ensure medicines remained effective and appropriate for them, had taken place as people's individual guidelines required.

Where people took medicines on an 'as required' (PRN) basis, plans were in place for staff to follow so that safe dosages of medicines were not exceeded and people were not given medicines where they might not be needed. However, these were not always clear. For example, guidance for PRN pain relief did not specify what sort of pain they were for, or whether staff needed to carry out an assessment of someone's pain. For people with more than one pain relief, protocols did not specify in which order staff should try these pain medicines. Protocols for people who were prescribed medicines for anxiety on an as required basis were also not always detailed enough, and did not fully explore strategies staff should try before administering them. We discussed this with the manager, who told us they would be working with nursing staff to review PRN guidelines to ensure these issues were addressed.

Medicines were administered as prescribed. Medicine administration (MAR) were kept for each person who had prescribed medicines that staff supported them with, and these were fully completed and were accurate.

Good

Is the service effective?

Our findings

People told us staff were well trained and had the skills and knowledge to support them effectively. One person said, "Yes, I certainly do feel that they have the correct training and skills to look after me and the other residents." Relatives all felt staff were well trained. One relative commented, "They are certainly correctly trained I believe and they are very professional. They look after my mum quite well and they do exercise good judgement when dealing with [name]."

Staff told us they had an induction when they started working in the home. This included being assessed for the Care Certificate, and working alongside more experienced members of staff before attending to people on their own. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. The provider encouraged new staff to obtain further qualifications associated with their role. Staff were positive about their induction experience. One staff member said, "Yes, I like it here. I am happy. Staff are very helpful when you are new. If I don't know something, I've been asking them."

Most care staff told us they were well trained. They were mostly satisfied with the range of training available to them, although some were uncertain about how training would now be managed, as the provider had reorganised and training was due to be delivered differently and by different staff. We saw staff using what they had learnt to support people safely. For example, we observed staff helping people to transfer from one chair to another. They used a hoist where people had been assessed as needing this to support them. They did this safely and effectively, and were putting their training into practice.

The home supported a number of people living with dementia. Whilst we observed staff interacting with people in a kind, caring and respectful manner, daily records made by care staff for people living with dementia were mostly task orientated without reference to how the person's emotional and psychological need for meaningful activity, occupation and engagement had been met. Staff who supported people living with dementia expressed some concern that they dido not have sufficient knowledge and skills to support people with complex needs living with dementia, as they only received dementia awareness training.

Nursing staff were not always satisfied with the range of training that had been available to them. One nurse told us, "This is a lovely home, but we need training to inform safe and effective practice. It could be much better." Nursing staff assured us this had not impacted on the care people received. For example, they had identified they had received limited training on tissue viability. However, they told us they ensured they liaised with specialist tissue viability nurses locally where required, so people were properly supported. The manager had already identified nursing staff needed more targeted and comprehensive training, as they had spoken with nursing staff to seek their views on what could be done to improve the service. They were working to ensure nursing staff could maintain their skills and knowledge and maintain their professional registration. Nursing staff were confident their training needs were in hand and that things would improve. One told us, "[Manager] is good. They are interested in staff and have identified the problems. I think things will improve."

Staff had opportunities for formal supervision meetings, where they met with the manager or senior staff to talk about the needs of the people they supported and also their own development. The provider had a "Supervision" policy, which stated how often staff should have a supervision meeting and annual appraisal. The new manager told us one of things they were focussing on was ensuring all supervisions and appraisals were up to date as they had found they were not. Records showed progress was quickly being made on this, and the manager was working towards 100% of supervisions and appraisals being completed.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff asked for people's consent before supporting them. We observed how staff approached people and explained what they were about to do. There was clear communication, and people were asked their opinions about how they wanted to be supported. Staff understood their responsibilities under the Mental Capacity Act. One staff member said, "I really liked the mental capacity training. I know that if someone has capacity, their choices must be respected. If people don't have capacity we work in their best interests as we have a duty of care."

The manager and clinical lead understood the legislation in relation to the Deprivation of Liberty safeguards (DoLS). Where restrictions on people's liberty had been identified, the manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation.

Risks to people's nutrition and hydration were mostly minimised. People with specific needs and risks in relation to their diet had a nutritional assessment and care plans were in place detailing actions required. Records showed weight loss was identified quickly and close monitoring through weekly weights was instigated. People were referred to a dietician and supplements were observed to be prescribed and administered. Where required, people had usually been referred for a speech and language therapist (SALT) assessment to help guide staff on food and fluid consistency to reduce risks to people. However, records showed one person had required emergency support because they choked when drinking. The GP had been informed, but the person was not referred to the local SALT as on a previous recent incident of a similar nature with another person, the SALT had said they have insufficient staff to manage the referral and to ask the GP to prescribe thickened fluids. Records showed staff had contacted the GP who had prescribed thickened fluids. We raised this with the new manager, who agreed a referral to SALT should still have been made. They assured us they would action this immediately.

We spoke with the chef about how meus were planned. They told us menus were determined based on what seemed to "go down well" in the past. There was a monthly food forum which also helped kitchen staff to put together the menu. The chef said they had started to name meals after particular people who had suggested or asked for a specific dish, so people knew they were listened to and "felt special." There was a chart on display in the kitchen which showed kitchen staff where people had specific dietary requirements and what these were. The chef told us they had received training on how to meet specific dietary requirements, for example needing food to be puréed. They had also received training on how to 'fortify' foods where people were at risk of weight loss. They explained they used creams, butter and other foods

with a high fat content, which they added to food to help with this.

Over lunch time, we saw people were assisted to eat at a comfortable pace, with staff communicating with people throughout. When people who required support had received that support, staff sat and ate with people. There was a happy, convivial atmosphere. People were offered a verbal choice of what they wanted to eat but did not always appear to understand the options available to them. Where this was the case, particularly in the part of the home where people living with dementia were supported, people were supported by staff using a picture menu for discussion followed by showing and describing tester plates to help people make their choices.

We observed staff encouraged people to eat and drink independently. For example, one staff member said to a person, "Why don't I bring you a gravy jug and you can pour it yourself and decide how much you want?" People had a choice of drinks with their meal, and were encouraged by staff to drink while they were eating.

Within the part of the home where people living with dementia were supported, great attention had been paid to designing an environment which supported people with dementia. There were destination points at the ends of corridors for people to sit quietly or to potter. Signage was appropriate and sensitive to people's needs. People's rooms had memory boxes to help people to find their rooms.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and treated them with respect. One person told us, "I absolutely love them [staff] all. They all do their best for me and the other residents; actually it's a very loving place indeed! If I want something and ring my bell they respond quickly. When they're with me, they do take time out if they've got it to chat. It makes nice company." Another person commented, "They deserve their crown when they get to heaven!"

Relatives felt there was a caring, family-type atmosphere in the home which helped people to feel cared for and valued. One relative told us, "The quality of care is absolutely excellent. It's bordering on the brilliant. The carers are very friendly, very kind, and very, very professional."

We observed the interactions between people and staff over the two days of our inspections site visits. These were all positive, and staff spoke to people kindly, patiently and treated people with respect. People were observed to be comfortable around staff, and had a good rapport with them. They were happy to laugh and chat with staff, and staff made time for this to happen. Staff spoke with us about what being caring meant for them. One commented, "It is about sitting with people and treating them like I would treat my own parents." Another staff member said, "You need to know about care and you've got to like people and your job. We have that here."

People told us staff always ensured they supported them in ways that maintained their privacy and dignity. One person said, "The carers here are very good indeed! They do what they can for me, they've never, ever been rude and they always are respectful and respect my privacy and dignity." Another person told us, "I have to say, they do knock before they come in and then they will enter. They have always shown me the greatest of respect and they do respect my privacy and look after my dignity." Relatives agreed. One told us, "They're certainly respectful to mum and they would ask me to leave to retain her dignity if they needed to undress her. They've done it so I know that that would happen." Staff understood the importance of this. One staff member told us, "We make sure the door is closed and we knock on people's doors. We always reassure people about what we are going to do."

Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. We heard and observed staff seeking people's consent where people required support with personal care. Staff were also observed and heard to knock on bedroom doors and identified themselves on entering the room.
Staff encouraged people to be as independent as possible, supporting people in ways that made it possible for them to do things for themselves. One staff member told us, "If I know people can wash themselves for example, I encourage them to do it. Some people need to be encouraged rather than assisted."

People were supported to maintain relationships with family and friends. Relatives told us there were no restrictions on when they could visit or how long they could stay for. One relative commented, "I always feel welcomed here." On the day of our inspection visit, a number of relatives were visiting people, and we saw they were comfortable with staff and were made to feel welcome.

Where people were being supported with end of life care, this was done sensitively and in partnership with medical professionals. One person's progress was being closely monitored by their GP. The person had 'anticipatory' drugs prescribed should their condition deteriorate and they needed strong pain relief. Staff were in constant communication with the person's relative. The staff team had decided not to involve the palliative care nurse at this point, but knew how to access them should this be required.

Care plans for people being supported with end of life care were not always as detailed as they should have been. For example, they did not contain information relating to end of life wishes or advance care planning, and there was no evidence of preferred place of care having been discussed. We raised this with the manager who assured us this would be addressed.

We saw people's personal details and records were held securely at the home. Records were filed in locked cabinets and locked storage facilities, so only authorised staff were able to access personal and sensitive information.

Good

Is the service responsive?

Our findings

People told us they, or a relative where the person wanted this, had been involved in putting together their care plans. One person commented, "My daughter-in-law was the one who set up the care plan with the home, and I do know the records are updated on a regular basis. I'm apparently due a review shortly in any case." Records showed care plans had been reviewed, and evidenced involvement from people or their relatives where appropriate. One relative commented, "Every six months or so we all have a look at [name's] care plan." Staff confirmed people's care plans were changed as their needs changed. One staff member said, "If a care plan needs changing we tell the nurse and they will sort it."
People's care plans were well written, detailed and clear. They included information on people's likes, dislikes and preferences, and some also included information on people's life history. However, the manager had already identified care plans were not always as personalised as they needed to be, and neither were they always reflective of people's needs. The manager showed us an action plan they had developed, to review all care plans with support from nursing staff and the home's clinical lead. Staff spoke with us about people's needs and knew people well. They spoke knowledgably about what support people needed and were familiar with what had been agreed for their care and support.

People told us their support was adjusted as their needs changed. For example, we were told about one person who had been supported to eat via a tube which went directly into their stomach, but who had been reassessed as it was now felt they could eat solid foods. Records confirmed this, and the person told us, "At one point I was tube fed but I am now able to eat on my own, I like food."
Some care plans did not provide staff with the information they needed to respond to and meet people's needs. For example, care for one person whose care plan we reviewed in detail, was not always responsive to their needs. Staff had sought expert advice and guidance from a local specialist team, who had been fully and actively involved in trying to support the care team to manage the person's resistance to personal care. However, there was nothing documented about ways to use the person's life journey and experiences to build trusting relationships. The care team on the "dementia specialist" Memory Lane community, described their training as basic dementia awareness, and whilst their communication skills were generally good and their approach kind and caring, they needed further development to actively support people with complex needs.

People told us they were supported to meet their religious and cultural needs. A local Anglican vicar visited the home on a monthly basis, as did a Catholic priest. The activities co-ordinator told us if people followed other faiths, they would bring people in from the local community who could help people met their religious and spiritual needs.

People told us they were supported to maintain hobbies and interests that were important to them, and that they had the opportunity to be involved with activities provided in the home. One person commented, "Yes, I do have plenty to do during the day. I have my own interests, listening to music, reading etc, but I also go to the activities when they appeal. I can potter around the gardens too as they have raised flower beds for us to use and tend and we are encouraged to do so." The activities co-coordinator spoke with us about their plans for enhancing the activities offered to people. They explained they wanted to take a different

approach, and were in the process of working with people, their families, and staff who knew them well, to establish what people were able to be involved with and what they enjoyed. They explained they were looking to offer activities to smaller groups based on ability and interests, rather than offering standard and repeated large group activities that people accessed only if they wanted to. Records showed how this was being done, particularly with people living with dementia.

Where important decisions needed to be made regarding care to be given at the end of a person's life, we saw that people were consulted and their decisions recorded. Where people lacked capacity to do this we were able to see how decisions had been made in the person's 'best interests' and in conjunction with others, for example family members.

People told us they had not had cause to complain, but knew how to do so and felt confident about how they would be responded to. One person said, "I've never had cause to complain hopefully never will, having said that I would know what to do should the occasion ever arise. I'd go straight to management and I'm sure they would sort it." Staff knew how to support people to make a complaint. One staff member told us, "I would listen to what people are saying and reassure them. I would tell the nurse in charge who would go and talk to the person about it."
The provider's complaints policy was accessible to people which informed them how to make a complaint and how to pursue it if they were not satisfied with their response. Records showed that complaints received within the last 12 months had been resolved to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People were positive about the new manager, but were aware there had been several changes in management and said they thought this had been disruptive for the service. One person said, "I believe the new manager is called [name]. The changes haven't really upset us but there is uncertainty to a certain extent. I think staff probably suffer more than we do. I have to say I feel the home is certainly very well managed. I can't comment on whether the staff are being led in the right direction but, if we don't have too many complaints they are I suppose." Relatives were also unsettled by the changes, though they too were positive about the new manager. One relative commented, "It's certainly unsettling to the staff, these changes. Hopefully, it will settle down and everyone will settle down with it. The staff need a base and some continuity and they haven't got it at the moment."

All the people and relatives we spoke with told us that, in spite of the changes and the uncertainty, the home was well run and the quality of care was good. One relative explained, "The activities are good, the food is good, the staff are friendly. There's nothing major wrong with this place and yes, we would recommend it without hesitation."

Staff were positive about the manager and felt they were already making positive changes. They told us there had been a lack of support prior to this, which had led to instability and low staff morale. One staff member told us, "Everything we need we get from the manager and team leaders. We are always supported. We just need to be stable now." Another staff member commented, "Morale has been low because of a lack of support and lack of motivation. We are being thanked for our work more now. That is why appraisals and supervisions are so important. They are happening now." They added, "This is a lovely home. It has the potential to be the best. I think [new manager] will do a great job."

The new manager had been at the home for approximately two weeks when we visited. In that time, they had been speaking with people, staff and relatives about the service, and had already begun to make changes. They showed us plans they were developing to address issues they had identified. For example, they had established staffing levels had been an issue because staff absences had not been well managed. This was now in hand, and staff themselves told us they felt this was being dealt with which was making a positive difference. We observed two meetings, one focussed on clinical governance with the clinical lead and nursing staff in attendance. The
manager had an inclusive, listening approach, which helped people feel able to express their views. They provided good direction and leadership, taking decisive action and asking people for ideas and encouraging them to come forwards to help the service move on. For example, staff were encouraged to use their skills and knowledge to help staff become more effective and take on 'champion' roles in relation to end of life care for example.

The new manager had also given the wider staff team opportunities to share their views at staff meetings. Records showed staff had the opportunity to discuss the developing needs of people living in the home and share any concerns they might have. Staff told us they were listened to and that made them more likely to

share their views. They told us issues were discussed, actions were agreed and progress on actions was fed back by the manager.

The provider had systems in place to gather the views of people, relatives and others with a view to learning more about the service they provided and how it could be improved. People and their relatives confirmed they had completed questionnaires asking for their views on the service, and records showed responses had been mapped to the key questions asked by CQC when we inspect services, with a corresponding action plan.

The provider had systems to monitor the quality and safety of the service with a view to improving it. There was evidence that these were routinely carried out and the results used to inform an action plan. However, actions identified had not always been completed. For example, an audit completed in early 2016 had highlighted the need for staff working directly with people living with dementia to have more specialist training to help them meet people's needs. However, this had not happened, and we found during this inspection that staff still felt this was an issue and staff were not always able to fully meet people's needs as a result. Medicines had also been audited regularly, but these audits had not identified deficiencies in the guidance in place for people prescribed 'as required' medicines that we uncovered during our inspection site visit.

The new manager understood their legal responsibility for submitting statutory notifications to us, and was able to explain how and when they needed to notify us. This included incidents that affected the service or people who used the service. However, we found we had not always been notified as required. For example, we saw records of two safeguarding alerts that had been raised with the local authority earlier in the year. Whilst it was clear these had been dealt with properly and people had been kept safe, we had not been notified as necessary. Another person had been assessed by the local authority, and authorisation had been agreed to deprive the person on their liberty under DoLS. Again, we had not been notified of this as required. We raised these with the new manager who confirmed we should have been notified of these, and committed to doing so now that they were managing the home.