

Four Seasons (Bamford) Limited

Keresley Wood Care Centre

Inspection report

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Date of inspection visit:
06 March 2018

Date of publication:
20 April 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 6 March 2018 and was unannounced.

Keresley Wood Care Centre is a 'care home' with nursing. 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. The home provides nursing care to a maximum of 44 people. Sixteen 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 and dining room, and bedrooms. The first floor has bedrooms only.

The home had 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 worked for the service for four months at the time of our inspection visit.

We last inspected the home on 22 March 2017. The home was rated as 'requires improvement'. Since our inspection in March 2017, the home had been through another period of instability. The manager and deputy manager present at our last inspection left the service, as did a high number of staff. This meant the improvements made at our last inspection were not sustained, and there was a further dip in the quality of care people experienced. The provider worked with the commissioners of the service and with the CQC in providing information about how they were managing and improving the situation.

A new registered manager and deputy manager were now in post. We received positive comments about their management style, and saw stability was returning to the home, with relatives becoming more confident they would address any concerns raised; and staff feeling more supported.

Whilst there had been a high level of staff vacancies since our last inspection, and therefore a high level of agency staff usage; at the time of our visit this was significantly decreasing, and the home was beginning to enter a more stable period. There were sufficient staff on duty to meet people's needs.

There had been concerns since our last visit that risks to some people's health and well-being had not been managed well. The new management team had worked hard to improve risk assessments and to monitor and act on identified risks.

New and existing staff had received training to support their roles and responsibilities. Newly recruited mental health nurses were in the process of receiving training to improve their responsiveness with general nursing needs.

People had access to other healthcare professionals when required. Medicines were managed safely and people received their medicines when they should.

The clinical support provided to people had improved, but the home was less responsive in providing social and emotional support to people. Activities were provided but these did not seem to reflect people's interest or hobbies.

The registered manager was open to listening to concerns or complaints about the service and responded to individual complaints in accordance with the provider's policy and procedures. People had the opportunity to discuss their views at monthly resident and relatives meetings.

People enjoyed their meals. People at risk of malnutrition and dehydration were provided with sufficient support to reduce this risk.

Staff were kind and caring to people, and had a desire to make sure people received good care. They respected people's dignity and privacy.

The provider recognised the importance of respecting people's human rights, and the promotion of equality and diversity in the home. The registered manager and staff understood and complied with the Mental Capacity Act regulations and Deprivation of Liberty safeguards.

The provider and registered manager understood their responsibilities to safeguard people from harm, and took action when required to support people's safety. Recruitment practice minimised the risk of employing staff unsuitable to work in the care sector.

The home was clean and well-maintained. Safety checks on fire, electric, water and gas systems had taken place, and staff understood the importance of infection control. The provider had redecorated and refurbished the home.

The provider, registered manager and their management team had worked hard to improve the service. They had made a good start. They needed to ensure the improvements made would be sustained over time and when a higher number of people used the service.

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 mostly safe.

After a challenging period of staff turnover, the home had started to reduce the number of agency staff used and people were beginning to experience more continuity of care. Recruitment procedures reduced the risk of employing unsuitable staff. Risks related to people's health and welfare had been appropriately assessed. The premises and equipment were well maintained and safety measures were in place. The home was clean, and staff understood the importance of infection control. Medicines were managed safely.

Requires Improvement ●

Is the service effective?

The service was mostly effective.

Staff had sufficient skills, or were in the process of gaining skills and knowledge to provide effective care to people. New staff had received induction training to help them understand the needs of people and all staff were now receiving supervision after a period of time where there was no management to provide this. People received the nutrition and hydration required to keep them healthy. The home worked within the requirements Mental Capacity Act and Deprivation of Liberty safeguards. People had access to other healthcare services when necessary.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff treated people with kindness, dignity and respect. The registered manager was working with staff to value equality and diversity. Visitors were welcomed at the home during the day and evening.

Good ●

Is the service responsive?

The home was mostly responsive.

People's clinical needs were responded to well, but their social and emotional needs were not as well considered and acted on.

Requires Improvement ●

Complaints had been managed in line with the provider's policy and procedures. Staff were providing end of life care to people in the home, but had not received training to help them with this.

Is the service well-led?

The home was mostly well-led.

The provider and new management team at the home had worked hard to improve the service after another period of management and staff instability after our previous inspection. The improvements were relatively recent, and had not been tested over a longer period of time and with a home at full capacity to ensure sustainability.

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.

At our last inspection the home was rated as 'requires improvement.' Because of this, we returned to the home within the year of the previous inspection's published report.

The inspection team consisted of one inspector, a specialist nursing 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.

Before our inspection visit we gathered and reviewed information from notifications sent to us by the provider; information provided by the public from our website's 'share your experience' page, and information from commissioners of the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or clinical commissioning groups.

Prior to our inspection we asked the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used information the provider sent us in the PIR in our inspection planning.

During our visit we spoke with two people and five relatives. We also spoke with three care workers, one nurse, two housekeepers, the maintenance worker, the kitchen assistant, the activity worker, the deputy manager, the registered manager, and the resident experience manager.

We looked at five care records, medicine administration records, complaints, quality assurance, staff training, staff recruitment and health and safety records.

Is the service safe?

Our findings

At our last inspection visit we rated the key question of 'safe' as 'requires improvement'. This was because medicines had not always been managed safely, and whilst the breach of the Regulation for staffing had been removed, the staffing levels had only recently become safe.

Since our last inspection the home had undergone a further period of instability. The manager at the time of our last inspection visit left the home in August 2017, and the home experienced a further challenging period of staff not staying in post. The 'provider information return' (PIR) told us 17 staff had left the home in the last year. This meant people who lived at the home were once again supported by a large number of agency care and nursing staff. During this period of time the commissioners of the service visited the home weekly to ensure people's safety was not compromised by the issues related to staffing. They regularly reported back to us what they found and any improvements made.

Throughout this period, the provider, and since October 2017, the new registered manager and their team had striven to improve the safety of people in the home. New staff had been recruited, and the number of agency staff being used had reduced significantly. However, there continued to be vacancies and new staff were still becoming familiar with the service and people who lived there.

The provider's PIR, which was submitted to us one month prior to our inspection visit, informed us 15 new staff had been recruited, of whom, seven had worked for the home less than three months. To further support the safety of people, the provider had limited the number of admissions to the home. A relative told us, "It's a lot better than it was. The new manager is grasping the nettle. I'm very happy with the staff. There was a lack of staff up to a month ago. I wasn't very happy. I brought it up at the residents meeting but staff numbers have now increased."

Staff we spoke with mostly felt that the staffing situation had improved. All told us there were enough staff on duty to meet people's needs, but said there were issues if staff were absent from work and the rota was not fully covered. A relative also told us of this. They said, "Sometimes we come and don't see any staff at all. Last Saturday we only saw one staff member. We have seen six staff today which is unheard of." Another relative explained that mostly there were enough staff but told us, "There was a hiccup a week last Thursday when there wasn't enough staff to get [person] to the hairdresser."

The provider's recruitment practices supported people's safety at the home. Prospective staff could not start employment until their reference checks had been received by the provider; and the disclosure and barring service (DBS) check had been returned (the DBS checks whether people have a criminal record).

At our last inspection some of the medicine management in relation to pain management required improvement. Since then, the provider has had pharmacy visits from the commissioning team's pharmacist and from the pharmacist which dispensed the medicines to the home. The PIR told us the feedback was generally good, but there were some actions that needed to be taken. The PIR also said that the home's manager undertook daily and weekly checks and any errors were recorded on their internal monitoring

system for further scrutiny.

During this visit, we found medicines were managed safely. We looked at people's medicine administration records (MARs). We saw there were two signatures missing on the MAR sheets in the files; these should have been completed by the agency nurses on duty. We checked whether the registered manager was aware of this and knew whether people had received their medicines. Within minutes we received the internal monitoring report for both incidents which showed that a tablet count had been undertaken and medicines had been given as prescribed.

We checked the records of stronger medicines given to people, and found an accurate record of medicines administered. They also showed that two members of staff had been present when the medicines were administered. This is important to minimise the risk of drug error.

We looked at the conditions for storing medicines. Medicines were kept at temperatures within the required ranges and temperatures were checked each day to ensure this was the case. The medicine room, fridge and trolleys were clean and tidy, and there was no over stock.

Topical medicines (creams) were recorded in a separate MAR sheet kept within each person's room. These were accompanied by a body map of where the topical creams were to be applied to the person, in addition easy to understand instructions were available as well. Where people had skin patches for the relief of pain, we saw these were monitored to ensure they were being correctly placed on the person's body.

Pain scoring took place every medication round. This was important to ensure the amount of medicines given 'as required' responded to the amount of pain a person was experiencing. 'As required' medicine records gave clear guidance to staff about what the medicines were for and when to administer them. Time specific medicines where people's health conditions meant they needed to take medicines at a specific time were being administered accordingly.

People's care plans included detailed information about the medicines people received, the reasons why they were prescribed and potential side effects. This information helped staff have a fuller picture of people's needs and alerted them to signs and symptoms of ill-health which may be medicine related.

A few months after our last inspection visit we received information of concern about the way the home's staff managed risks related to skin damage. People were being admitted to the home from hospital with pressure ulcers. And whilst the skin had been damaged prior to admission to the home, there were concerns that the staff at the home were not managing the risks well, and this increased the risks of further damage.

During this visit we found the management of pressure area care had improved. We checked the care records of two people who had pressure sores. Both had acquired the pressure sores in hospital. However, on admission to the home, the staff had photographed the skin damage and put in place plans to reduce the risk of further damage and to increase the healthiness of the skin. We found the skin damage for both people was reducing.

Another concern was in relation to re-positioning people who could not move on their own. When people have fragile skin and cannot move, it is important they are re-positioned in bed to stop further pressure being placed on the skin. A few months ago there were concerns that staff were not re-positioning people when their care plans said they should be repositioned. During this inspection visit repositioning records indicated people were being repositioned according to their care plan.

The advanced nurse practitioner who visited the home every week told us in early August 2017 they had voiced serious concerns about the safety of people who lived at Keresley Wood. They went on to tell us that 'patient safety' improved once the resident experience manager was involved, and regular staff were employed.

People's care plans included assessments of their individual risks and described the equipment needed and actions staff should take to minimise their risks. Care plans looked at, had been reviewed and updated when people's needs and abilities changed. However one relative told us that staff did not always ensure the risks to their relation were reduced. They told us their relation should be sat upright when eating, but on one visit they found the person was lying down. We spoke with the registered manager about this, who informed us that they had addressed this issue with the family and with staff.

The provider and registered manager were aware of their responsibilities to safeguard people from harm. Where the provider found the home had not safeguarded people from harm, they had contacted the safeguarding authorities and notified us of what they found and the actions taken to improve people's safety. There had been 10 safeguarding notifications made to the CQC from March 2017 to January 2018. Many of the safeguarding concerns were related to the care provided by agency staff employed by the service at the time. Staff also knew their responsibilities to report to senior management anything they had witnessed which gave them cause for concern about a person's safety.

We discussed 'lessons learned' with the resident experience manager who had been supporting the registered manager at the home. They told us there was now a greater emphasis on 'lessons learned' within the organisation. For example, records of accidents and incidents were analysed by the provider. If there had been an incident or a 'near-miss' in one of the homes, this experience would be shared with other homes to ensure they were aware of the risk to reduce the chances of it happening in their home. Similarly, the provider looked to see if there were any trends or patterns related to the accidents or incidents reported.

We checked whether the premises and equipment were safe. We found the required checks on fire, gas, electric and water systems had taken place and any actions required to improve safety had been carried out. Maintenance to the building was carried out in a timely way, and the building had been refurbished and redecorated. A relative told us, "In the last year they have made big changes in the decoration." The new décor and furniture gave the home a more 'homely' feel for people who lived there.

The provider had arrangements in place for staff to manage any emergencies at the home. This included each person having a personal emergency evacuation plan (PEEP) so staff and the emergency services would know what support each person would need if they had to evacuate the home.

We checked to see if the premises were clean and hygienic, and to find out if staff understood their responsibilities to reduce the risks of infection spreading. A relative told us, "It's clean and smells nice." We found all areas of the home were clean and tidy and equipment used by people was also clean. Staff understood the importance of using personal protective equipment (PPE) when undertaking personal care tasks, and their responsibilities to also wash their hands after each task.

Is the service effective?

Our findings

At our last inspection we rated this key question as 'good'. At this inspection improvements were required.

Since our last inspection visit there had been concerns identified to us about the care and treatment provided at the home and whether it met the required standards. During this visit we found people's care and treatment was delivered in keeping with evidence based guidance. Care plans included risk assessments using recognised risk management tools, in line with NICE (National Institute of Clinical Excellence) guidance. For example, universally accepted assessment tools such as the MUST (Malnutrition Universal Screening Tool) for nutrition, and the 'Waterlow' score for assessing the risks of skin damage were used.

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.

When the registered manager assessed that a person lacked capacity to make decisions about their own safety and if that meant restricting the person's liberty, they had applied to the local supervisory board for the authority to do so, in accordance with the Mental Capacity Act 2005 (MCA). Within people's care records there were capacity assessments which determined when people might have the capacity to make their own decisions and when they might need support to make decisions in their best interest.

Staff understood the importance of gaining people's consent prior to undertaking any tasks to support them, and we saw this in practice. For example, staff would ask if it was okay for them to do something on a person's behalf prior to undertaking the task, or ask what choices the person might prefer.

We looked to see whether staff had the skills, knowledge and experience to support people at the home. The increase in the number of staff employed directly by the provider, had given the registered manager more control over staff training, and knowledge of their previous experience. The registered manager told us they had just recently achieved stability with nursing; and now only used agency staff for emergency cover.

Some of the nursing staff were qualified as registered mental health nurses (RMN's) and not general nurses. The registered manager informed us those nurses would receive further training to support them with general nursing, in order to care for people's physical care needs; as well as support from the clinical lead

(deputy manager) and the other nurses on duty.

We spoke with one of the new RMNs. They told us they had received training to use a syringe driver (this is used when people require quick relief from pain at the end of life); and were going to attend catheter and venepuncture training. They told us the deputy was 'hands-on' and this was helpful.

We looked at the training provided to all staff to ensure staff knew how to maintain people's health and well-being. We found most of the staff had attended the training provided by the home.

We checked whether staff new to care work undertook Care Certificate training. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people. The registered manager told us new staff were working towards this.

At our last inspection staff told us they had received regular meetings to discuss their performance, and they had yearly appraisal meetings scheduled to attend. Because of the management issues in the home and the turnover of staff, supervision meetings and appraisals have not been provided over the year. The registered manager acknowledged this had been an issue. They had 'flash' supervisions to discuss any immediate issues in relation to practice; however in the last month staff had received planned meetings to give them the opportunity to discuss their performance and training needs. Appraisal meetings were being planned.

We checked whether people received the food and drink they wanted and needed to keep healthy. A person told us, "Overall the food is good, we chose on the day;" and, "I do like the food." The meals looked and smelled appetising and there was plenty available for people to eat. People were offered choices of drinks at lunchtime, and we saw drinks provided throughout the day. A person told us, "I get drinks when I like." However, a relative of one person who required thickeners in their drink (thickened drinks are often used for people with dysphagia, a disorder of swallowing function. The thicker consistency makes it less likely that an individual will choke while they are drinking) told us they had to speak with staff because sometimes the drinks were too thick, and they had found one occasion the drink had gone cold and was no longer drinkable. They said they had informed the home's management who were dealing with this.

We saw that people who were prescribed 'thickeners' in their drinks, had the thickeners stored in their rooms. We discussed the potential risks with staff, of people with limited capacity, opening and eating the thickening agent. The home agreed to make sure the thickeners were stored more safely.

We looked at how the home's staff supported people on specific diets, and those who required specialist equipment to help them receive the nutrition they required. The kitchen assistant showed us the system they used to inform them of the type of diets people who lived at the home had. At the time of our visit the home provided fork mashable, soft food, pureed, fortified and high protein diets.

We had mixed feedback from people or the relatives of those receiving these diets. One relation told us their relative had pureed food when it should have been fork mashable, but this had since been resolved. Two others told us their relations were currently being assessed in relation to their food intake to determine the safest way for them to eat. One informed us there did not appear to be a system to feedback views about the soft food diet.

We checked that those at risk of malnutrition were being appropriately supported. We saw where people had lost weight they had been monitored more closely to see if further weight loss occurred. Where this happened, referrals to the right healthcare professionals had been made. We saw that people had gained

weight as a consequence of the home's monitoring, and intervention of specialist services.

Where people required specialist equipment to receive nutrition such as a PEG (a feeding tube inserted into the stomach which enables nutrients to be delivered without the need to be swallowed) the PEG was being used effectively to provide the nutrients; and staff had a good understanding of what action to take if the PEG was not able to be used.

We checked that people were receiving access to other healthcare services. A relative told us, "[Person] is much improved since they've been here. The doctor saw them in January, they're doing very well."

We saw good links had been made between the home and the GP practice used by the service. During our visit the GP visited the home to consult with people who lived there. The advanced nurse practitioner from the GP practice told us there was a period of time where they visited the home every day because they had concerns the home was not ensuring people's health needs were being addressed. They said this had changed for the better and they now had resumed their once or twice weekly visits.

We saw by looking at records that other services had been contacted to meet people's needs. These included tissue viability nurses (for skin damage), opticians, and speech and language services.

The premises met people's individual and diverse needs. The home is a two storey building with one communal lounge, a communal dining room, and a larger communal lounge and dining room located on the ground floor; with individual bedrooms located on both floors. Passenger lifts provided people with access to both floors and the corridors were wide enough to support people using wheelchairs and frames. The communal lounge and dining room was used by people the most, but the other communal areas were available if people wanted a quiet space or to have time with their families. All bedrooms were single rooms, and so people were also able to see visitors in the privacy of their room.

Is the service caring?

Our findings

This key question was rated as 'good' at our last inspection. We continue to rate it as 'good'.

We were aware from some of the notifications sent to us by the provider, and through discussions with other professionals, that during the time since our last inspection people were not always cared for in the way the provider had wanted. This was in part due to there not being enough staff or staff with the right skills and experience. However, during our visit we found improvements had been made and we found people's care was delivered by staff who were kind and compassionate.

People and their relatives told us, "They are all quite caring. They do a thankless job." And, "The staff interact very well with people. I've not seen staff with a scowl on their face, they are all very nice."

During our visit we saw all staff respond respectfully to people who lived at the home. This included the maintenance worker and housekeeping staff who worked around people ensuring their privacy and dignity. Care and nursing staff were calm and measured in their responses to people as well as being seen to enjoy friendly banter with some people. A relative told us, "They talk to her very respectfully." And, another said, "I get the feeling that the interaction is good. No-one shouting, they talk nicely".

During the day we saw people's privacy was respected. For example, doors were closed when personal care was provided, and we saw when one person used a communal toilet and forgot to shut the door, a staff member made sure their dignity was maintained by shutting the door behind them.

We saw friends and family visited people throughout the day and evening. Visitors were welcomed in the home and could see their loved ones in the person's own bedroom, and in the communal areas of the home. Visitors were able to help themselves to drinks. One said to us, "We are offered drinks and snacks."

Where people were less able to communicate because of health conditions, sensory or physical disabilities, we saw staff support them to reduce the barriers. For example, people who experienced memory loss were supported to choose their meal by looking at two plated examples instead of staff choosing for them. A person with a sensory disability was supported by staff with bible readings. This was important to them and they were not able to do this for themselves.

Care records showed the provider had engaged with people and their families to find out their personal histories, preferences and backgrounds. The provider's policy 'Valuing Diversity and Promoting Equality in Clinical Practice Policy' set out the provider's commitment of fostering a culture that actively valued differences and recognised the importance of using this information to enhance the way they worked. The registered manager informed us in their PIR that they were going to make this policy a 'policy of the month' to further embed the policy into staff practice.

We looked at whether the service used external advocacy support for people. The registered manager told us this was not necessary at the present time because all people who lived at the home had families who

were acting as their advocate. However they would ensure external advocates were sourced for anyone who did not have a friend or family member available to advocate for them.

Staff we spoke with all had a positive view of the work they undertook with people. One said, "I feel the care is good. There has been staff who haven't had patience but they're not working here anymore. We make sure they're happy, comfortable, well cared for and well-fed." This member of staff was asked whether the home passed 'the mum's test' (would you place your relative here?). They told us they thought it would, and added 'I've never said yes to that question in the past'.

None of the staff we spoke with had concerns about the way people were cared for. They all thought people were treated well. However there was an anxiety expressed about future staffing levels and worries that they might reduce to the detriment of people who lived at the home.

Is the service responsive?

Our findings

At our last inspection visit this key question was rated as 'good'. During this visit we found improvements were required.

We looked at the involvement people, or those acting on their behalf had in contributing to planning people's care and support. Relatives told us they had been involved in reviewing their relation's care and had worked with the home to make sure they received the care required. However, one person we spoke with who had been at the home for a month told us that whilst the staff 'seemed to know' what they needed; they had not discussed their care needs or interests with staff in the home.

In the morning we spoke with a person who was having breakfast in their room. They told us they weren't asked if they would like to get up for breakfast, and would have preferred to do so as they found it easier to eat their food at a table. The resident experience manager, who was with us when the person told us of this, said they would make sure the person's requests were acted on in the future. A person who told us they had been at the home for less than a week said they had been washed by male care staff, and their preferences were to be washed by female care staff. This person also told us they stayed in bed more than they would like to and felt they were getting back ache because of it. They had not yet had an opportunity to inform the registered manager or deputy of their concerns.

The care records we looked at provided a lot of detailed clinical information to support staff in their knowledge of people's physical health and treatment requirements. The clinical response to people's health needs was good. For example, one person had been admitted to the home on an end of life pathway with a very short life expectancy. The person was now recovering and their family was very pleased with the care which facilitated this recovery.

However, whilst the clinical care planning was good, the social and emotional support provided to people needed further work as it was not always clear or as person centred as it could be. For example, one person's care plan said the person did not like sitting uncomfortably in bed. It did not say what made the bed comfortable for the person. Another's told us the person could get distressed and agitated when moved with a hoist, but didn't inform staff what measures to take to reduce the person's agitation.

In a separate journal we saw information about people's histories, likes and dislikes but this had not transferred into care plans to provide a more individualistic approach to people's care. Similarly, the registered manager had introduced a 'handover sheet' which was provided to staff at the shift change 'handover' meeting. This sheet provided staff with a quick reference to ensure people were safe but did not give a quick reference guide about people's preferences. For example, it made sure staff knew what type of food regime people required, but did not say whether the person preferred to eat in the dining room or in their room; or whether they preferred to be out of bed, or stay in bed.

At our last inspection, although the key question of 'responsive' was rated 'good', we had some concerns that people who were cared for in bed, did not have access to meaningful activities or interests which met

their needs. We spoke with the activity worker who told us that part of their responsibilities was to make sure people received one to one engagement with them. One person told us, "The young lady talks to me sometimes which is quite nice." We saw that journals reflected this had happened but not on a daily basis as there were gaps in the recordings. We were concerned that people were not having their individual needs met when the home was less than half full. We asked people and their relatives about the activities available. They told us, "There seem to be a few things happening. There was a band last week I think." And, "They play some games in here (lounge) and there was music last week."

We saw there was an 'activity schedule' on display in reception. On the day of our visit the schedule was for 'one to one' activities to take place from 9am to 12noon and 'golf' and 'skittles' activities from 2pm to 3pm. We saw the afternoon activities took place in the morning, but this was not well organised. During the activity session the music was playing but people were facing the TV. The sound was turned down but the TV images were still showing on the screen and were distracting. The music was not age appropriate for the people in the room. There did not appear to be a clear relationship between the activities on offer and the interests of people. However the few people participating appeared to enjoy it.

Later on in the day we saw a movie had been put on the TV for people to watch. A person felt secure in telling the activity worker that they did not like the movie. This was then changed, but the worker did not check with the person whether they liked the new film they put on.

On the day of our visit a visiting clergyman provided a religious service to those who wished to take part. They arrived at the home at the time the other activities were being provided. These then ended to enable the religious service to go ahead. There appeared a lack of organisation.

We checked whether people's concerns or complaints were listened to and acted on. People and their relatives told us they felt they were listened to. One said, "Our concerns are now being managed for the better. We haven't been advised of any procedures on this. We just take them up with the management." Another said, "They did advise complaints information when [person] arrived." Complaints made were logged by the registered manager onto the provider's monitoring system. This meant the provider could see what complaints were being made, and ensure the registered manager was responding to them appropriately. We saw the four complaints which had been made in the last year had been responded to in line with the provider's complaints policy and procedure. The registered manager told us that any learning from complaint investigations was shared with staff through staff team meetings.

Since the registered manager had been in post, there had been two resident and relative meetings. By looking at the notes of the meetings, we saw people and their relations were provided with opportunities to share their concerns and to get answers from the home's management. However, the concerns raised at the meeting had not been transferred to the provider's complaints log to enable the provider a more robust understanding of the complaints and concerns raised at the home.

We looked at end of life care provided to people. We found that people's clinical needs were supported and appropriate documentation had been completed. The advanced nurse practitioner told us, "They're very good with end of life care." They explained the deputy manager and permanent, experienced nurses understood when people were moving towards the end of life. These nurses contacted the GP surgery to make sure anticipatory drugs were in place to ensure that if the person developed symptoms they had the necessary medication at hand to promote comfort.

In the two months prior to our inspection the home had experienced a higher number of deaths than was usual. This was because of people's complex health conditions. The home's staff had managed this well and

the registered manager told us relatives had been pleased with the way the staff had supported their loved ones through their last days. However, the recently recruited registered mental health nurses and new care staff had not received training in end of life care, and were not yet fully equipped to deal with complex end of life nursing and care needs. There were no 'end of life' care plans which provided staff with information about the person's individual preferences in how they might want to spend their last hours or days.

Is the service well-led?

Our findings

At our last inspection visit we rated this key question as 'requires improvement'. At this visit we found the home continued to require improvements.

At our previous inspection the home was improving after a period of instability. There was a new manager in post who had started work at Keresley Wood in January 2017 and who registered with the CQC in June 2017. A new deputy had also been recruited and there was stability in the home. By August 2017 both the registered manager and the deputy manager had left the service, and another period of instability commenced as other staff also left.

Another new manager was recruited but they only stayed at the service for a short period of time. The home was managed by interim managers until the end of October when the current registered manager was recruited. In December 2017 the new deputy manager for the home commenced employment.

During this period of instability the provider had been candid with us and commissioners of the service about the issues they had faced and provided us with updates about the actions they were taking to improve the situation. One of these was to limit the number of new admissions to the home.

Since the recruitment of the current registered manager and deputy manager, stability had returned to the home. Commissioners of the service had been closely monitoring the service and were satisfied that improvements were being made. The management team had overseen a recruitment drive to increase the number of nurses and care workers to the home; had worked on care records to make sure they contain the right information to provide safe care; and had worked hard to ensure medicines were managed correctly.

They continued to work on improving staff morale and ensuring there was the right skill mix to meet people's needs. They were also working to improve relations with relatives of those who had not experienced good care during the periods of instability. The registered manager told us they had received good support from the provider and the senior management team.

People and their relatives told us they had seen improvements. Two relatives whose relations had lived at the home for a long time said, "We know the manager, he is visible and approachable now," and went on to tell us, "I can honestly say it is now good here." The other told us, "The new manager is very approachable. I feel he is listening, there are improvements I am pleased to say." They went on to say they felt the manager needed to walk around the home more to check what was happening in the home. Two people who lived at the home who had not lived there long told us they did not know the manager but one told us they thought there was a nice atmosphere in the home, and the other felt there were no improvements needed.

We asked staff whether they felt supported by the provider and manager. One member of staff told us they thought the registered manager was approachable and there was no such thing as a 'stupid question'. They told us, "I don't feel they look down on you." Another told us the registered manager had been 'good for this place.' They told us the registered manager and deputy manager had worked hard to improve the home. A

third told us it had been a challenging time working with three different managers in the past, but they felt the current manager and deputy were 'lovely' and 'great'.

The advanced nurse practitioner told us the registered manager was very approachable, listened and acted on advice. They also said the senior management team had worked hard to improve the home, particularly the provider's resident experience manager who had worked hard to support the new management team and who had been 'open', 'honest' and 'approachable.'

The provider had a responsibility to send us notifications of events that happened in the home; to send in the provider information return when requested, and to inform the public of the CQC's most recent rating of the service. The provider sent us the expected notifications and often followed these up with discussions to provide further information. The PIR was comprehensively completed and reflected what we saw during our visit. The rating of the home's performance and the link to the inspection report was on the home's website and was visible in the home.

Whilst there had been improvements to the home, these had again been for a short period of time. The registered manager and senior management team needed to be able to demonstrate the improvements could be sustained over time and with a higher number of people living in the home.