Holy Cross Care Homes Limited

Bradeney House Nursing & Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 12 and 14 July 2017 and was unannounced on our first day.

Bradeney House Nursing and Care Home is registered to provide accommodation with nursing and personal care to a maximum of 101 people, some of whom are living with dementia. There were 95 people living at the home on the day of our inspection. The home has five 'units' which are all connected to each other. There is one female only 'unit' and one 'unit' which supports people with their advanced dementia. The other units support people who have nursing or residential needs, both with or without dementia. People's rooms are situated over three floors with stairs and passenger lift access to each floor. People have access to communal areas inside and outside the home.

A registered manager was in post, who was also the provider and was present during our inspection. The provider had recently appointed a manager who confirmed they had applied to register with us. 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 home was last inspected on 5 July 2016, where we gave the service an overall rating of requires improvement. At our last inspection, we found one breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to the provider's failure to ensure their last inspection rating was conspicuously displayed at the home and on their website. We asked the provider to send us an action plan of how they intended to address this breach. At this inspection, we found their inspection rating was displayed conspicuously at the home and on their website.

The provider had made improvements since our last inspection in the processes they used to monitor the quality of the service provided. However, although the provider had these systems in place to ensure people were protected from the risk of harm, these were not always followed by staff. People also had a varied experience of the support they received at lunchtime and we had some concerns in practice in two units. The provider had already identified shortfalls in the leadership and staff supervision within two of the home's 'units' and the provider was taking steps to address this.

People felt safe living at the home and with the support they received from staff. Staff were aware of the risks associated with most people's care and understood how to keep them safe. However, there were isolated incidents in two units where staff practice needed improvement to support people safely and effectively with their eating and drinking. In addition, the assessment of risk for some people had not been completed or kept up to date by staff. This had led to staff practice not being consistent with what some people's risk assessments stated, such as with their mobility. The provider took action to make improvements to this during our inspection.

People and relatives gave us a mixed response about the staffing levels at the home. Although there were enough staff to meet people's needs, the deployment of staff at certain times of the day needed improving to make sure staff were always available to support people when they needed it.

People's right to make their own decisions about their own care and treatment was supported by staff. However, at our last inspection we found staff did not always seek people's consent before they placed clothes protectors on them prior to their meal. At this inspection, we found this was again the case in one unit.

People were supported to take their medicines when they needed them. Medicines were stored safely and only staff who had received training and been assessed as competent, were able to support people with their medicines.

People and relatives thought staff were well trained and understood how to support them. Staff had received training to give them the skills and knowledge needed to support people's individual needs. These skills were kept up to date through regular training and staff felt supported in their roles by managers and their colleagues.

Where people were unable to make their own decisions about the specific arrangements to keep them safe, these were made in their best interests by people who knew them and other relevant professionals.

People felt they had good relationships with staff and that staff respected their privacy. They were happy with the care and support they received and gave positive comments about the staff and management at the home.

Care that staff gave was personal to each person and people were supported to spend their time how they wanted to. Most people's support needs were kept under review and staff responded when there were changes in these needs. Not everyone felt they were involved in the process of reviewing their care plans but the provider was taking action to address this.

People had opportunities to give feedback and where necessary, make complaints about the care and support they received. They also had opportunities to make suggestions for improvements at the home at meetings and through surveys. People and relatives felt involved in what happened at the home and felt staff and management listened to them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
People were not always protected against the identified risks associated with their care. Staff had been trained to protect people from harm and abuse and knew how to report concerns. People were supported to take their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.
People were not always appropriately supported to eat suitable meals to reduce the risk of choking. People were not always supported to make their own decisions. People were cared for by staff who had received training to meet their individual needs.

Is the service caring?

Good

The service was caring.
People were positive about the care and support they received. They were cared for by staff they were familiar with and had opportunity to build relationships with. Staff treated people with compassion and kindness and respected their privacy.

Is the service responsive?

Good

The service was responsive.
People received care and support that was personal to them and that was reviewed regularly. Staff supported people to decide how they wanted to spend their time and asked for their opinions on the support they received. People were provided with opportunities to make comments or raise complaints about the care they received.

Is the service well-led?

Requires Improvement

The service was not always well led.
Although systems were in place to keep people safe, monitor, and assess the quality of care these were not always followed by staff. Previous areas of improvement identified at our last inspection continued to be found. However, the provider had already identified shortfalls in the leadership and direction of staff, which they were taking action to address. People, relatives

and staff felt involved in what happened at the home and had confidence in the new manager to make the required improvements.

Bradeney House Nursing & Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 12 July 2017, and was unannounced. We returned for a second day on 14 July 2017, which was announced.

The inspection team consisted of four inspectors and two 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection we reviewed information held about the service. We looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted representatives from the local authority and Healthwatch for their views about the home. We used this information to help us plan our inspection.

During the inspection we spoke with 10 people who lived at the home and nine relatives. We spoke with 16 staff which included the cook, nursing staff, care staff, the unit leads, the clinical lead, the deputy manager, the newly appointed manager and the registered manager. We viewed the care records for 10 people which included daily support records and the assessment of risk, five medicine records, five staff recruitment

records and other records relating to how the service was managed.

We observed people's care and support in the communal areas of the home and how staff interacted with people. 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.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we rated this key question as good. At this inspection, we have rated this key question as requires improvement. This is because we found isolated incidents where risks to people's safety had not been identified or addressed by staff.

Most people were protected against the risks associated with their care. We saw examples of staff reacting positively to potential risk. We observed a staff member take immediate action to avoid injury when a person had taken their feet off the footplate of a wheelchair. They involved the person by explaining the risk to them. With the person's permission they helped them put their feet back onto the footplates. Another person left the dining table without their walking aid. A staff member saw this and quickly prompted the person to use the nearby handrail, whilst they went to get their walking aid. These practices helped to promote people's safety and wellbeing.

We saw occasions where people were not always protected by staff practice despite the provider having systems in place. Staff knowledge around the risks associated with people's care was not always reflective of what we saw or what was recorded in their care plans. We spoke with staff about the specific support two people needed. We did this because what we observed did not reflect what their risk assessment stated. We saw one person helped into a wheelchair when their risk assessment stated they could mobilise with a walking frame. Another person did not have bed rails while their risk assessment stated they needed them. Staff gave us differing accounts of the support these two people needed which placed people at an increased risk of harm. Another person was at risk of skin damage. Staff were aware of this risk but no assessment or monitoring of this risk had been completed by staff, despite them using pressure relieving equipment with this person. We confirmed with the clinical lead the support these people needed and they took action to ensure risk assessments were up to date and staff aware of the risks.

Staff told us they recorded any incidents or accidents, which were then passed to the clinical lead and registered manager. Actions were agreed and any lessons learnt were then shared with staff to reduce the risk of further incidents of the same theme recurring. However, we found one incident that staff had not reported. One person had been given normal fluid when they required their fluid to be thickened due to difficulty in swallowing. This placed them at risk of choking. One staff member told us that as a result of this incident, nursing staff had informed care staff of the need to thicken this person's drinks and this information was now located in the person's bedroom. However, no individual risk assessment had been created and the actions taken in response to the incident had not been recorded or shared with the clinical lead. The clinical lead confirmed they were unaware of this incident. They took immediate action to ensure an individual risk assessment was put in place to protect the person and reduce the risk of this happening again.

People told us they felt safe living at the home. One person told us they felt safe because there was always someone around. Staff understood what they needed to do to keep people safe, both within and outside the home. They told us they kept people safe by ensuring they had access to call bells and that any equipment was used correctly.

Staff knew how to recognise and respond to any concerns that someone may be being abused or discriminated against. Staff we spoke with told us they would share any concerns of poor care practices or abuse with their managers. They were also aware of other external agencies they could share their concerns with. Discussions with managers identified they were aware of their responsibilities of sharing information about abuse with the local authority to protect people. This helped to protect people from the risk of abuse and discrimination.

People and relatives had mixed opinions about the staffing levels at the home. People told us they were not kept waiting for their care and support. Whereas one relative told us, "There's not always enough staff. It's fairly random. It's not regular but it happens." Other relatives told us there were "plenty of staff". Staff thought they were able to safely meet people's needs because there were enough staff.

We saw that call bells were responded to in a timely manner and people were not kept waiting for support. There was a staff presence in the communal areas of the home and staff also supported people in their rooms. However, when we tried to get help for one person after lunch we were told by a staff member that they could not help because they were on their own. Other staff members had gone on their breaks. This left the staff member supporting people both in the lounge and outside on the terrace. We also saw another occasion where the allocation of staff had an impact on the emotional state of a person. We saw one staff member from one unit support people from a different unit, in a communal lounge. This staff member did not have access to information about what might trigger changes in people's behaviour or how to support them when this happened. We saw one person start to become anxious and agitated and the situation started to build to a point of conflict before another staff member diffused the situation. We shared this information with the manager who acknowledged it was unacceptable for staff not to be available to support people when needed. The manager told us they had identified there was an issue with the allocation of staff at break times and assured us action would be taken to address this. This would ensure that staff were always available to assist people when required.

People were supported by staff who had received appropriate checks prior to starting work with them. Staff we spoke with confirmed they were not allowed to start work at the home before employment checks had been completed. The provider followed safe recruitment practices and requested previous employers to provide references for them. Further checks included past employment histories, identification and criminal checks on staff's backgrounds. These criminal checks are called Disclosure and Barring Service checks and help to ensure potential new staff were suitable to work with people living at the home.

People were supported by staff to take their prescribed medicines. People told us they were happy with how supported them and they received their medicine when they needed them. We saw that staff checked with people that they were ready to take their medicines and made sure they had a drink to take their medicine with. We saw staff support people to take their medicines safely and in a way that promoted their dignity. Where people had medicines on an "as required" basis, such as pain relief, there were clear instructions for staff on when this should be given. These medicines are prescribed to be taken only when needed. However, we found there was no information provided for when one person may have required medicine for their anxiety. This placed the person at risk of not receiving their medicine when they needed it. One staff member told us there was no information in place because this person had not required this medicine for three months, even though it was still prescribed. We shared this information with the clinical lead who took immediate action and ensured this information was provided. We found systems were in place that ensured medicines were ordered, disposed of and stored safely within the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated this key question as requires improvement. This was because we found some staff could not communicate clearly with people due to their first language not being English. People's meals were often not hot and they felt there was a lack of choice and quality in their meals. We also found that staff did not always ask people's permission prior to supporting them. Although there was no breach of regulation, we asked the provider to make the required improvements. At this inspection, we found some improvement had been made. This key question remains as requires improvement.

We found that most people were supported to make decisions about their care and treatment. People and their relatives told us that staff asked the person's permission before doing anything. We saw people were offered choices of what to eat, what to drink, where they wanted to sit and how they wanted to spend their time. Staff we spoke with recognised that people could become upset and frustrated if they could not express how they felt and what they wanted. We saw that in most areas of the home, people living with dementia were asked for their consent. Staff sought people's agreement and this was often given with a smile or a nod of the head that staff recognised. However, at our last inspection we found staff did not always seek people's consent before they placed clothes protectors on them prior to their meal. We found this was again the case in one unit and observed some staff place these over people's heads without any explanation to them. We also saw one incident where one person had their walking aid moved away from their armchair when they tried to stand up. This person's agreement had not been sought and their freedom of movement was restricted as a result. We shared our observations with the manager who acknowledged this was unacceptable. They acknowledged further training and increased supervision of staff was needed in some areas of the home. They had started to take action to address this, to improve staff awareness and promote good practices.

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. We saw that where required, people's capacity to make specific decisions had been assessed. Relevant healthcare professionals, including family, were involved in making decisions on people's behalf and in their best interests. This included the arrangements that needed to be put in place to help people stay safe. Staff understood and had received training in the MCA and its use.

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 application 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. The provider had submitted applications to legally deprive some people of their liberty and these were kept under review. These applications were deemed necessary because some people could not consent to the arrangements to keep them safe within the home. People's care records contained the reason for the DoL and most staff we spoke with knew who had a DoL in place and the

reasons for this. We spoke with a DoLS assessor who was completing an assessment in one of the units. They told us staff at the home were knowledgeable about people's needs, their current situations and knew them well.

We spent time observing the care that staff offered people over meal times and how this was managed to ensure people received their meals in a way that met their nutritional and care needs. We found people had a varied experience of the support they received at lunchtime and we had some concerns in practice in some units. Some people received personalised support from staff. They were asked if and how much support they wanted and were told what their meal was. They were offered choices and were not kept waiting for support. People told us the food was good and they had a choice of meals. They told us if they did not like what was on the menus they were always offered an alternative. One person told us, "Sometimes they do me beans or cheese on toast. I had a sausage sandwich for my lunch today." We saw staff encouraged people to drink throughout the day. Snacks were available and people had access to fresh fruit.

Some people were not always supported appropriately by staff to eat suitable meals. Risks associated with people's ability to eat and drink had been assessed, and staff told us they had access to information about suitable meals but this not always followed. For example, we saw one incident where a person who required a soft diet was given a meal of roast meat, roast potatoes and vegetables. We had to intervene on two occasions to ensure this person received a meal that was appropriate to their needs. A number of people ate their meals whilst sat in armchairs rather than at dining tables. Staff told us that it was people's preference not to eat at a dining table, but we were unable to confirm this with people. The arrangements for people to eat their meals whilst sat in armchairs, was not always appropriate and for some, had a negative impact on their ability to eat their meal. One person had their plate placed on their walking trolley and others had theirs placed on high drinks tables. These were awkward to reach and caused people to have to stretch to reach their plates so food dropped into their laps, which caused some people to lose interest in eating their meals. Staff told us they did not have enough appropriate tables for people to eat their meals whilst sat in their armchairs.

We spoke with the registered manager and manager about our findings. They assured us they would look into why so few people ate at a dining table as the manager had asked senior carers, at the 11am meeting that day, to encourage people to sit at the dining tables for their meals. They told us they were disappointed so few people had been encouraged to sit at the dining tables. The manager also took immediate action in response to one incident to ensure staff knew the correct dietary requirements of this person.

People and their relatives told us they felt staff were well trained and knew how to do their job. At our last inspection we found communication between people and staff was compromised because some staff's first language was not English. At this inspection, we were informed staff had been provided with English lessons. One person confirmed this and said, "The staff have had English lessons and I've seen a big difference. It's not an issue with me at all." Relatives were complementary about staff's abilities. One relative said, "They're confident and competent. I find them very helpful."

People were supported by staff who had received training to meet their specific and individual needs. Staff told us the training was now more person centred because it focussed on the people they supported. One staff member said, "There are improvements since last inspection. We have better training now, they've employed a trainer and the way they explain things is thorough." One staff member told us about the dementia awareness training they had completed. They said, "Training helped me understand how to talk with people and to not rush them. It helped me to understand their views." New staff completed an induction period where they worked alongside more experienced staff to get to know people's needs. One

staff member said, "My induction has enabled me to understand people's needs and know how to meet them."

People were cared for by staff who were supported in their roles. Staff told us they received the support they needed through one to one supervision meetings. One staff member told us, "These supervision meetings review the standard of my care practice and my training needs. It helps me understand what I need to do better." Nursing staff were supported to keep their clinical skills up to date in areas such as catheter care, wound care and end of life care. One staff member said, "We get observed by the managers to ensure the skills we have learnt are put into practice." Senior staff attended a daily 11am meeting with the manager. This was newly introduced and was designed to be a swift meeting to share required information throughout the home. Senior staff shared the information from the meeting with staff on their respective units. The manager said, "It's all about communication. We use it to keep everyone updated on what's happening across the home."

People were supported by staff to access healthcare services and receive the on-going support they needed to maintain good health. Arrangements were in place for people to receive visits from chiropody and optician services and appointments with people's doctors were arranged when needed. One person said, "The GP comes here every week and we can ask to see them." One relative told us that staff organised transport for their family member to go to their hospital appointments. Staff offered to go with the person, but the relative accompanied the person. Referrals to other healthcare services were made in a timely manner where people's health needs changed. Staff had recognised a change of behaviour in one person who had become quiet and withdrawn. The GP was called and the person started treatment immediately. On another occasion staff were prompt in recognising when a person required urgent medical attention and an ambulance was called. This demonstrated that people were supported to access relevant healthcare services when needed.

Good

Is the service caring?

Our findings

At our last inspection we rated this key question as requires improvement. This was because staff did not always respond to or refer to people appropriately or in a timely manner when they were distressed. At this inspection we found improvements had been made.

People spoke positively about the care and support they received. They were complimentary about staff and told us they felt staff were caring and supportive towards them. One person said, "I'm very happy here. If I had to choose a place to live I would choose here." Relatives felt their family members were supported by staff who were kind, thoughtful and caring. One relative said, "My family and I come at different times in the day and evening. We have seen nothing but kind and caring staff."

Staff knew people well and spent time talking and engaging with them in a way that made them smile and laugh. One staff member told us that since our last inspection staff tried harder and had improved the way they interacted with people. We saw there was a relaxed atmosphere throughout the home. People appeared comfortable with the staff that supported them and staff took time to stop and chat with people when they had the time. Staff encouraged communication with people by the use of touch, eye contact and body language.

We observed gentle, kind and thoughtful interactions between staff and people. One staff member gently woke a person up so they could get ready for their meal. As they were assisted we heard this person start to shout at the staff member and become anxious. The staff member remained calm, reassured the person and held their hand until they calmed down. We heard this person say to the staff member, "Thank you, you are very good to me." One staff member noticed a person had slumped over in their chair. They gently woke the person and asked if they would like a pillow and went and got one.

People told us they had choice and staff involved them in making decisions about their care. People and relatives told us they had discussed wishes and views when they first arrived at the home. One relative said, "Sometimes [person's name] likes a lie in. They have choice." Staff supported people to be involved in making day-to-day choices whether it be what they wanted to do with their time, what clothes they wanted to wear or what they wanted to eat. People and their relatives felt that staff listened to them and their wishes about their care and that these were responded to. One relative said, "I have discussed these things with the staff."

People had access to an independent advocate who visited the home regularly to talk with people and their relatives. They supported people to express their wishes and make sure they were involved in any decisions relating to their care. The registered manager told us, "They feel open and relaxed with [advocate's name] because it's a face they know." An advocate is an individual, independent of local organisations who represents people when they unable to, or have difficulty in expressing their views. They ensure people's rights and views are protected in any decisions made and speak on people's behalf.

People told us that staff respected their privacy and dignity. One person said, "They always knock and say

who they are and what they're going to do, before they start." We heard staff speak with people in a respectful way. Staff understood the importance of respecting people's dignity and privacy. Staff understood the importance of keeping people as independent as they could be. One relative said, "They encourage [person's name] to do things for themselves." People had access to specialist cutlery and crockery to promote their independence whilst eating and drinking. This included the use of cutlery with thickened handles. We saw staff encouraged people to help with domestic tasks such as helping to clear up after drinks and take items back to the kitchen.

Relatives told us they were always welcomed by staff and there were no restrictions on when they could visit their family member. One relative said, "I'm welcome to stay as long as I want and at the times I want." Another relative said, "They (staff) made me so welcome. They say, "You come in whenever you want, we're open 24/7." We saw there were plenty of communal areas where relatives could visit their family member. As well as people's own rooms, there were also rooms available for private meetings if needed.

Good

Is the service responsive?

Our findings

At our last inspection, we rated this key question as requires improvement. This was because we found people's preferences were not always known or respected by staff. We also found that the complaints procedure had not been followed consistently. At this inspection, we found improvements had been made and we have rated this key question as good.

People told us that staff supported them and provided their care the way they wanted it. They told us they received care that was personal to them and met their preferences and wishes. One person said, "The care that I want is being delivered." Another person told us that staff knew what they liked and what they did not like. Relatives told us they were aware that their family member's preferences were respected by staff.

Staff told us that since our last inspection the provider had introduced 'resident of the day'. Once a month people were 'resident of the day' where staff reviewed and discussed all aspects of the person's care. Their care plan was then updated as needed. Staff told us that where people had capacity they were involved in the review of their care records. However, not everyone we spoke with felt they were involved in this process. The registered manager told us that people and their relatives were given care plans for them to review but acknowledged that staff did not always sit and discuss these with them. They already had plans in place to ensure people and relatives had the opportunity to view care plans with staff. This helped to ensure care provided was kept up to date and people were able to contribute fully.

People and their relatives told us that staff discussed people's needs with them and kept them up to date with any changes that were needed in their care. They felt staff responded to changes in people's needs which contributed to positive outcomes for people. One relative told us how staff had supported their family member upon their discharge from hospital. They said, "I think staff understood what [person's name] could do, rather than what they couldn't do." They went on to tell us that staff had worked to change an aspect of their family member's care. This had meant they could now go for a walk, with their family member, in the home's grounds when they visited.

Staff in each unit knew the people they supported well in terms of their preferences and personalities. Staff told us one person expressed their preference to wear their traditional dress and was supported to do so. People were supported to attend their preferred place of worship and eat food that was traditional for them. One person's first language was not English. Although they spoke English, due to living with dementia they reverted back to their first language on occasion. Because of this, staff who were able to speak their first language were assigned to work with this person and we heard conversations taking place between them. This helped the person to maintain their communication skills and kept them relaxed if they started to become anxious.

People were supported to spend their time how they wanted to. We saw improvement in how staff supported and interacted with people to maintain their hobbies and interests throughout the home. One person played an indoor golf putting game with their visitor, which caused much interest from other people and staff, who all engaged with each other. We saw a staff member helping a person to dance during some

musical entertainment. Staff later told us this person loved to dance. We saw a staff member entertain people by playing their guitar and encouraging people to participate in singing. People were encouraged to chat about the age of the songs which led to reminiscence and more song requests. We saw people had smiles on their faces and were engaged in this entertainment. We saw people supported to take part in soft ball games, darts and listen to music. People and staff told us they also went on day trips, helped with domestic tasks and had the opportunity to help in the garden and grow fruit and vegetables.

People and their relatives had opportunities to and were encouraged to give their feedback about the service provided. They were encouraged to complete questionnaires and attend regular 'resident and relative meetings'. These meetings were led by the home's independent advocate. The registered manager told us that this meeting was alternated with a 'tea and chat meeting' where relatives could share and discuss their experiences with other relatives. The registered manager attended the 'resident and relative meetings' and would only attend the 'tea and chat meetings' if requested. As a result of these meetings improvement had been made to the decoration of the home, laundry arrangements and the introduction of a fruit platter each day for people.

People and relatives told us they felt comfortable to raise concerns with staff and managers. However, they felt their issues were dealt with more efficiently if reported direct to management rather than care staff. One person said, "If you've got any problems it gets sorted." Relatives we spoke with were happy with how issues raised were responded to. One relative said, "At the beginning, cleaning of dentures was an issue. I mentioned it and since then, they're always done." Two relatives told us they had commented on the poor state of carpets in their family members' rooms. They told us the management had been responsive and replaced the carpets without delay. Where complaints had been received we saw evidence these were responded to as per the provider's complaints policy. Complaints were acknowledged in a timely manner and, following investigation, the complainants were given explanations of actions taken and the outcome.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated this key question as requires improvement. We had found that although quality assurance systems were in place these were not monitored efficiently in order to identify issues. At the time the provider told us there had been changes to the management arrangements within the home, which had had an impact on the monitoring of the service.

At our last inspection we found the provider had failed to conspicuously display their last performance ratings at the home and on their website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found action had been taken and the provider's ratings were displayed at the home and on their website.

People and relatives were positive about the care and support they received at the home. They found staff and management approachable and felt able to openly discuss any concerns with the independent advocate and management. People and relatives commented on the improvements made throughout the home since our last inspection. They felt involved in what happened within the home and were kept updated with changes that affected the service.

Since our last inspection, the provider had made improvements to existing quality assurance systems and introduced new systems. However, although the provider had these systems in place to manage risk, we found these were not always followed by staff. This included one person where there had been no review of the risks associated with their care. We also found one incident that had not been reported to management, despite staff being aware of the accident and incident reporting procedures at the home. We also saw occasions where staff would have benefited from improved leadership and clear direction to inform their practice. The registered manager had recognised there was a lack of clear leadership on some of the units at the home. Since our last inspection, they had introduced the role of unit lead for all units within the home. They said, "There was a lack of stability on the units and we needed to make staff more accountable for each unit." Not all units had a unit lead in place yet as this recruitment was on-going. The registered manager and the new manager acknowledged this was a key priority in driving improvement within the home.

People's information was not always stored confidentially. We saw people's daily records were kept in communal areas so that staff had easy access to them. However, staff were not always present to ensure their confidentiality. We also observed, in another unit, that records were kept in an office. We saw that on one occasion this office door was left open which meant these records were accessible to anyone who walked past. We spoke with the manager about what we had seen. They agreed this was not good practice and they took action to address this.

The registered manager and new manager were receptive to all feedback we gave them throughout our inspection. They took action to address all the issues we identified in a timely manner and we saw evidence of this when we returned for our second day. We need to be certain that the improvements put in place are able to be sustained within the home.

The registered manager monitored information they obtained from quality and safety checks, which they used to help drive improvement within the home. Managers and senior staff had responsibility for completing audits on areas such as care plans, complaints, equipment, DoL applications, health and safety and infection control and prevention. The registered manager told us they analysed this information to look for any trends and areas for improvement. Recent improvements, and improvements put in place since our last inspection, had been started for the redecoration of the home, improving and creating new reminiscence areas for people and improving staff training. They told us they completed a daily 'walk around' of the home, where they asked people and relatives about their opinions of the home. They also now completed random meal sampling and invited relatives to take part in this. One unit lead told us the provider had discussed the last inspection report with staff and what they needed to do to improve. They said, "We're open to criticism if it improves the care for people."

The registered manager is also one of the owners and provider of the home. They have been in post since 2015 after the last registered manager resigned. Since this time there have been changes to the management structure of the home. At the time of our inspection a new manager had been in post for three weeks. They had applied to become the new registered manager of the home. Since our inspection their application has been accepted.

People and their relatives told us they were impressed with the new manager. One person said, "[Manager's name] is very good. They always pop their head in to check that everything's ok." Another person said, "The new manager is a whirlwind. They've made such a difference in such a short time." Staff were equally positive about the new manager. One staff member said, "[Manager's name] is nice. They are putting their foot down. They have good ideas and are changing things that need to be changed. Very approachable." Another staff member said, "[Manager's name] has jumped straight in and hit the floor running. I have confidence in them. I know they will lead to good things happening. They've taken the time to get to know people, relatives and staff and have been completing spot checks on us all." The manager told us they had a clear direction they wanted to take the home. They had the full support of the provider and had resources available to make the required improvements. They said, "Everything I've asked for over the last three weeks, I've got. I want to ensure staff are competent and suited for their roles. We have to support and guide the staff and manage from the floor up."