Barchester Healthcare Homes Limited

Moreton Hill Care Centre

Inspection report

Standish
Stonehouse
Gloucestershire
GL10 3BZ

Tel: 01453826000
Website: www.barchester.com

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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?	Good

Summary of findings

Overall summary

Moreton Hill Care Centre is a care home for 67 people, some of whom are living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. Moreton Hill Care Centre provides accommodation with nursing and personal care. At the time of our inspection 41 people were living in the home.

At the last inspection in June 2016, the service was rated Good. We carried out a comprehensive inspection on 10 and 11 January 2018. At this inspection we found the service remained Good.

There was a registered manager in post. 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.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was effectively monitored. Staff received supervision and training to ensure they could meet people's needs.

People's medicines were managed safely and audits and checks were completed. Actions were taken when errors were identified.

Staff demonstrated a good understanding of safeguarding and whistleblowing and knew how to report concerns.

Risk assessments and risk management plans were in place. We found improvements were needed to make all risks were fully considered and appropriate actions taken to keep people safe.

Incidents and accidents were recorded and the records showed that actions were taken to minimise future occurrences.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

A range of activities were offered and provided people with entertainment both in and out of the home.

Systems were in place for monitoring quality and safety and actions were taken where areas for improvement and shortfalls had been identified.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Moreton Hill 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.

We undertook a comprehensive inspection of Moreton Hill Care Centre on 10 and 11 January 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors. An expert by experience supported the inspection on 10 January 2018. 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 visit we looked at the information we had received about the home. The provided had completed a Provider Information Return (PIR). This is a form that asks the provider for key information about the service, what the service does well and the improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 14 people who lived at the home and two visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the regional director, the regional clinical development nurse, the registered manager, the deputy manager and 13 staff that included registered nurses, care staff, maintenance, housekeeping, activity and catering staff. We also spoke with the visiting hairdresser. We observed medicines being given to people and how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at six people's care records in detail and checked five other care records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other

records relating to the monitoring and management of the care home.

After the visit we spoke with three external health professionals who had provided support to the home.

Good

Is the service safe?

Our findings

People and relatives all told us they felt safe in the home. Visiting relatives told us they didn't worry about safety and felt confident that people were safely cared for.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary. A member of staff said, "I would report any concerns I had, if dealt with that would be fine, but if I got no joy, I would take it up the chain until I got to CQC."

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "I make sure there is fair play, and everyone is treated with dignity and respect. Staff have to be mindful they could be racist or sexist and have to respect people's differences. It's important I have an ear on the ground to listen to how staff treat people."

Risk assessments were in place that identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. For most people, risks were regularly reviewed and updated when things changed so that staff always had access to up to date information about how to safely meet people's needs. On most occasions we saw that the service had responded to changes in people's needs and took appropriate and timely action to keep people safe, for example, making referrals to health professionals for treatment or equipment.

For one person, their recent distressed and sometimes challenging behaviour was not being fully assessed, monitored or reviewed. Whilst staff told us they were still finding out what triggered the person's behaviour this was not sufficiently recorded. This meant the person may not receive the support they needed to keep themselves, other people living in the home and staff, safe. Before the end of our visit, the regional clinical development nurse had spoken with staff and introduced the provider's assessment and monitoring tool to make sure the person's needs and behaviours were accurately assessed, recorded and managed. This showed the provider took appropriate and prompt actions in response to identified shortfalls, to improve safety in the home.

We checked the records for five people who did not have access to call bells in their bedrooms. The records for each person stated they did not have a call bell due to, 'Risk of tripping, slipping and strangulation.' There were no further records of other options considered to support people to call for support when they needed it. There were no records to show people were checked for safety when in their rooms, especially during the night. Staff told us that night staff completed hourly checks for everyone in the home, with one member of staff telling us, "It's routine, everyone knows the checks are done." The hourly checks were not recorded. This meant there was a risk people may not receive care and support when they needed it. We brought this to the attention of the regional director and the registered manager during our visit. They told us they would take action to ensure the checks were recorded.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. For example, one person had fallen and sustained an injury. Immediate actions were taken, medical advice was sought and the person's care plan was reviewed. Furniture in their bedroom had been moved to reduce the risk of further falls. The registered manager showed us how the provider's internal monitoring system triggered an alert if a person had two or more falls. This meant that patterns or trends were promptly identified and improvement actions taken where needed.

Most of the people we spoke with told us staffing had improved considerably in recent months. They told us staffing was sufficient and staff responded to calls for help and support in a timely manner. One person told us they had a recent fall, but that they were, "Quickly helped back to bed and checked over by the nurse." Another person told us that call bells were answered, "Quickly and efficiently". Most of the staff we spoke with told us there were enough staff on each shift with comments including, "So much better" and, "We've got enough staff now." Two members of staff commented they thought staffing was still not sufficient during the night. We checked the staff rotas and there was consistency in the staffing levels maintained each day and night. We had received concerns in June and in September 2017 about the staffing levels in the home. When we spoke with external health professionals they told us they had concerns also when they visited around that time. They told us staffing had often appeared to them to be insufficient. The provider had responded to requests for information from us with respect to the concerns raised.

The registered manager told us staff recruitment difficulties had been experienced before they started in post in October 2017. They told us staff recruitment had been successful, staffing levels had been increased and the home was currently staffed at higher levels than the providers assessment tool assessed were needed for the numbers and dependencies of people living in the home. They told us they no longer needed to use agency staff to ensure the staffing levels were sufficient.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. We did see three bedroom doors propped open, two with chairs and one with a waste bin. We brought this to the attention of the registered manager who told us they would address this issue. Personal emergency evacuation plans for each person were in place. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

We noticed the temperature in one corridor area of the home was noticeably cooler than the other areas. This had been picked up in the provider's quality monitoring programme, and actions were being taken.

The environment was clean throughout. We spoke with a member of the housekeeping team who described their role and responsibilities. They told us about the cleaning routines and how the housekeeping team were allocated to different areas within the home. We observed staff using gloves and aprons when needed which showed good infection control practices. Staff were able to describe the main principles of infection control with one member of staff telling us, "There needs to be hand washing, protective clothing, using the right soiled linen bags and cleaning up any spillages."

Overall, people received their medicines safely. We observed people being given their medicines. The nurse followed good infection control practices, spoke to people respectfully and gave people time to take their medicines. There were photographs at the front of medicine administration record (MAR) sheets which meant people could be easily identified. People's preferences for how they took their medicines were recorded. For example, 'Likes to have them in her hand' was noted for one person.

MAR sheets were checked at shift handovers by staff to ensure medicines had been signed for. We saw no

gaps in the charts we looked at which indicated that people received their medicines as prescribed. However, two MAR sheets showed that correct medicines had been given but signed by staff in columns under the incorrect date. We brought this to the attention of the registered nurses who corrected the error immediately.

Where people had medicines prescribed as required (PRN), protocols were in place. These included information for staff such as, 'Has pain in her back and knees and takes Paracetamol.' Where assessed as able to do so safely, arrangements were in place for people to self-administer their medicines.

Medicines were safely stored. Arrangements were in place for medicines that required cool storage and those that required additional security. There was a system for recording the receipt and disposal of medicines so that staff knew what medicines were in the home at any one time. This helped to ensure that any discrepancies were identified and rectified quickly. Records showed that people had their medicines reviewed to make sure medicines remained suitable and met their needs.

People's MAR sheets for topical creams (TMARs) applied onto people's skin were kept in separate folders in bedrooms. Body charts were used to indicate where the creams were to be applied. The care staff were responsible for applying the creams, then signing the TMARs. In the three records we looked at, the GP had prescribed the cream to be given as required. The TMAR sheet contained the registered nurse's instruction to apply the topical cream once a day but we found care staff were giving it more often. For example, for one person instead of once a day, the topical cream was applied three times a day for three days. This meant people may have received treatments when they were not required. We brought this to the attention of the registered manager during our visit.

One person who lacked the mental capacity to understand the effects on their health by not taking their medicines received them covertly. This meant they did not know they were being given. For this person, the medicines were disguised in food. The principles of the Mental Capacity Act (MCA) had been followed. Before it was agreed to give their medicines this way, a mental capacity assessment had been completed, discussed with the GP and the person's daughters. This was done because alternative ways of supporting the person to take their medicine was not successful. It was agreed that giving the medicine covertly was in the person's best interests.

Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council. However, in the three records we looked at interview notes had not been completed. The provider's guidance on the interview process checklist referred to interview templates being written up. The lack of recording meant there was no written record of how staff suitability for their respective posts or checks for gaps in employment had been established. The regional director told us they would address this shortfall.

Good

Is the service effective?

Our findings

People received effective care from staff who had received training and support to carry out their roles. Staff told us they felt well supported by colleagues and the management team. One member of staff commented, "The team works really well together. We help each other out and the registered manager is the best thing that has happened to this home."

When new staff started in post they completed a classroom based induction programme and then shadowed colleagues to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support. The registered manager told us they had recognised the shadowing experience for new staff needed strengthening. They had reviewed and made improvements to the provision of buddy and mentor support for new staff.

We looked at supervision records and saw they were detailed and meaningful. For one recently employed member of staff their records stated, 'Starting to settle in' and, 'Becoming more confident'. The member of staff had recognised they 'Still requires more support when hoisting residents'. It was agreed for the member of staff to 'buddy up' with a registered nurse to gain more experience and to enhance their confidence. Staff spoke positively about supervision and feedback included, "I supervise some staff. We meet every three months but informal supervision and training is a daily process," "I give staff time to talk about real situations which happened in the home, and with more formal supervision I give staff the opportunity to sit down and share any concerns or training issues" and, "We talk about our work and what we can do to improve, and if it means we need a bit of extra training we get it."

The registered manager kept a training record that showed staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. A member of staff told us, "My training is up to date either through e learning or attending external courses." In addition, where staff needed training to to meet the specific needs of people living in the home, this was provided, for example, tissue viability and wound care, syringe driver and catheterisation training.

The provider told us in their PIR they were planning to introduce a training programme as a follow up to dementia awareness training. This was designed to enable staff to further improve the care and support for people living with dementia, most of whom lived in the 'Memory Lane' areas of the home.

Registered nurses were supported to revalidate their professional nursing registration. We were told by the registered manager they were supported with clinical training and encouraged to attend additional and refresher training courses as required. Registered nurses were also being encouraged to take on additional 'champion' or lead roles in the home, initially for medicines management and tissue viability.

People had access and were referred to external health professionals. One person commented, "[Name of member of staff] is absolutely brilliant. I had a fall a while back. She immediately arranged for me to attend a

balance and co-ordination clinic and got staff to practice with me on the stairs.' A member of staff said, "We get on really well with health staff coming to the home. We work hard to build up relationships because their advice is invaluable." Another member of staff told us they had an excellent relationship with the community mental health team and the district nurses who visited regularly and provided advice, guidance and support when needed.

A relative told us they appreciated the regular calls they received from the management team that provided updates about a person's health and well-being. They told us communication was good, and they were kept informed and updated if there were changes. Another relative told us their mother had become unwell during the night recently. They praised the way the situation had been dealt with and how they had been communicated with. They told us they had been updated and informed, without causing unnecessary anxiety.

People were supported with food and fluids and we saw nutritional needs were being met. The people and relatives we spoke with were positive about the food and feedback included, "Yes there's enough and the food is really good." One relative told us they sometimes decided to stay for lunch, and this was accommodated without any fuss. They told us they always enjoyed the meals, which they described as, 'hot and generous'.

We observed meal service to people in the four dining rooms and to people who stayed in their rooms. The dining room tables were nicely laid in advance of the meal service. We heard a person in the dining room asking, "Can we have the magic music on?" A member of staff smiled and put on a classical CD which was clearly enjoyed by the people in the room and was exactly what the person had been asking for.

Most people chose their meals the day before service. We were told people could change their minds and they would be provided with alternatives. One person told us they had recently requested an omelette for lunch because they didn't want what was on the menu that day. They told us, "The chef came out and asked what kind of omelette I'd like. Now that's service!"

On the second day of our visit, where people had been unable to recall their meal of choice, and were unable to verbally communicate what they wanted, they were shown two plates of food and supported to indicate which meal they preferred. One person said they were not hungry and didn't choose either of the meals offered to them. The member of staff said kindly, "If I leave this, just try and little bit, I'll come back in a while and see how you get on." The member of staff told us they would try an alternative if the person did not eat their meal. Within five minutes the person had eaten all of the meal they had been given.

Where people needed softened or pureed food this was attractively served and efforts had been made to make the meals look appetising. Care staff provided attentive and thoughtful support for people, offering words of encouragement and prompts as needed. We saw people who were unable to use cutlery and used their fingers to eat. Whilst staff observed discretely, they did not interfere if the food was manageable and people were enjoying and choosing to eat in this way.

The chef visited the dining rooms and asked people for comments, suggestions and feedback. Catering staff were knowledgeable about people needs, likes dislikes and preferences, details of which were recorded in the main kitchen.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought in a timely manner. People were referred to the GP and prescribed supplements if needed. In addition, monthly nutritional reports were completed. These provided details and

progress reports for people whose weight changes had triggered concerns. For example, for one person, the report stated, 'Has gained weight this month. To continue with the current plan of care'. For another person who had lost weight, the plan stated they were to be offered snacks throughout the day. The staff we spoke with knew each person needs and we saw people being supported with snacks such as biscuits and chocolate. One care plan recorded the person needed encouragement to take their fluids. This was being done by staff and the monitoring charts showed the person had been drinking more than the amount they were recorded as needing to keep them sufficiently hydrated.

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.

Consent to care and treatment was generally sought in line with legislation and guidance. People had been assessed for their capacity to consent to specific aspects of their care. When people lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. Throughout our visit we saw and heard staff asking people for consent with questions such as "Is it ok?" and, "Would you like us to?"

People who lack capacity 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

We found that the service had submitted DoLS applications for people, but we also found two DoLs authorisations were out of date. Other applications had been submitted and had yet to be processed by the local authority. The registered manager had identified prior to our visit, there were shortfalls in staff understanding and knowledge of DoLS and a review of applications in progress was needed. An action plan was in place to address the shortfalls.

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People told us they felt respected and that staff were considerate, kind and thoughtful. Comments included, "Yes, they do treat me with respect and I respect them as well. We discuss things and agree between ourselves how to go about things. They know I want to keep doing as much as I can for myself, so they wait for me to let them know if I need any assistance," and, "I know the staff and they know me. Once when I was coming down with something, [staff name] noticed I was ill before I did! The staff here don't intrude but they do 'keep an eye'. That's one of the best things I think."

People told us they felt that staff went 'beyond the requirements of the job'. We saw people being treated with kindness and compassion, respect and dignity. Staff were not intrusive or over-supportive but were available if needed. It was clear that staff knew people well and respected their individuality.

Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We were told that staff always knocked before entering rooms. A visiting relative told us the staff always checked with the person using the service first when they asked to be present when personal care was provided. Staff told us they made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care.

People's equality and diversity was recognised and respected. People were encouraged to maintain their independence and participate in activities of their choice. One person told us, "There's something to do every day of the week but I'm not much of a 'joiner in'. I know I sound like a snob, but I prefer to keep myself to myself." They told us they used an iPad, had a radio and television and this was sufficient for their needs.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones or snacks in the reception area. The reception area was welcoming and we saw people enjoying spending time in this area with visitors during the day of our visit. Hot and cold drinks and a selection of snacks were provided and people were able to help themselves. Newspapers and crossword puzzles were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme and health information booklets that included one entitled 'Nutrition for older people'.

Care plans were detailed and people's preferences had been recorded. For example, for one person their records stated they were very private and liked to spend time in their room, but they would, "Occasionally come into the lounge during the evening and have a chat."

We saw staff show consideration for people who were not able to fully communicate their needs verbally. One person had fallen soundly asleep in one of the communal areas. The staff gently woke the person and supported then back to their room so they could sleep more comfortably.

Staff reassured and offered support to people when needed. We heard one person asking if the member of

staff could help them. The member of staff replied, "Of course I can. Where are we going then? Along to breakfast? Here. Let me take your arm." The person smiled and said, "Thank you my love." They looked pleased to be supported by the member of staff who leaned in close to the person as they guided them to the dining room, chatting as they walked.

A member of staff said, "People here get the care they need" whilst another commented, "We try to work well with residents and their families as it's a vital part of our job. We want people to be happy, relaxed and safe, as this is their home."

We read recent compliment cards and letters received in the home. They included the following, 'Thank you for all the care you gave Dad and all the support you gave also' and, 'Thank you to all the staff and especially [names of two staff] for all the care and kindness that you showed to [name of person] during his time with you. It was a very difficult time for us and we really do appreciate all you did for [name of person]. We also read 13 reviews entered onto the carehome.co.uk website in 2017. The reviews were mainly positive and the home scored highly for the services it provided.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans showed that people and their relatives or advocates were involved in the initial care planning and the care planning review process.

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. Care plans were designed to reflect individual needs, choices and preferences. Care records were checked and reviewed by registered nurses or senior care staff and signed every four weeks. Care plans were formally reviewed every six months with involvement of people and their representatives to check the care plans were still current and make changes if needed.

Staff demonstrated that they knew people well and supported people to have choice and control over their daily lives. For example, one staff member told us, "[Name of person] loves to chat and sing, she's got a lovely voice." They proceeded to compliment the person who was sat nearby.

We spoke with one person who was supported to move with a hoist. They told us they felt quite comfortable that staff knew what they are doing. The person said it was exceptionally important to them that they were correctly positioned in the sling as they were not able to reposition themselves. There was one occasion when they were supported by two new, unfamiliar members of staff. They told us this initially made them feel nervous. However, they told us they had been pleasantly surprised. The members of staff listened attentively to the person and took great care. The person said, "They worked with me and understood why I was worried about it. They didn't try to rush me and were very reassuring".

Most care plans reflected people's physical, mental, emotional and social needs. For example, one person's sleep plan provided detail of their preferred time to go to bed, what they liked to wear in bed and, 'Likes her curtains left open a bit.' For another person their care plan noted when they were awake during the night they needed reassurance they were safe 'several times.'

We saw a range of activities were provided. During the week of our visit, the programme included flower arranging, poetry reading, cooking, pottery and quizzes. People were also supported with one to one support in their rooms. A Sunday afternoon film club invited people, in addition to the showing of the film, to 'Have a glass of sherry and a bowl of popcorn'.

We observed tai-chi taking place in one of the lounges. Ten people joined in this physical activity. We heard one person telling a member of staff as they were helped into the room it was their first time and they were a little nervous they may not be able fully participate. They were reassured by the member of staff who told them, "Don't worry it's your first time. Just do what you can. You'll be more confident next time." They added, "If you want to go at any time just let me know." One person who participated in this activity told us, "It's the social side of it as much as the exercises. We all have a laugh together while we do our stretches." The instructors and the activity staff encouraged and enabled people to participate as much as they were able. There was laughter and camaraderie throughout with another person commenting, "Joining the activities is the best way to make friends."

We heard people and staff talking about areas of the home that were in the process of being renamed. This included one of the lounges and two areas of the home currently referred to as 'level one and level two.' People had been asked for their ideas, opinions and suggestions and we were told the most popular names would be chosen. Regular meetings were held to discuss the activities programme and to discuss ideas and suggestions. We read the minutes from the most recent meeting. People had requested more availability of cookery classes, which, we were told, were being planned.

People were sensitively supported to communicate in ways that were meaningful to them. For example, one person with cognitive difficulties was supported by a member of staff. The member of staff clearly understood how to communicate effectively with the person who they supported to participate in a group activity.

Links had been developed within the local community. The activity staff told us about their plans to work with the local council to support the local area to become 'A dementia friendly town.' They also planned to involve local schoolchildren in the 'Pond project'. The pond in the provider's grounds was being upgraded to make it safer and more accessible for people, children and visitors.

A minibus and pool car were available to take people out. The activity staff told us, "The transport is useful for group and for smaller, more personal outings. We took one of our resident's out to visit his wife's grave which was a really nice thing for us to be able to do for him."

A complaints procedure was in place that was readily available to people and relatives. The procedure was displayed in the reception area and given to people as part of their welcome pack when they moved into the home. We looked at the complaints file and saw that complaints managed in accordance with the provider's policy. We read the details of a recent complaint and the actions required had been checked and followed up by the registered manager at one of the daily head of department meetings. The people and relatives we spoke with had not had a reason to make a complaint, but felt confident they could do so if needed. One relative arranged a meeting with the registered manager, during our visit. They told us the homes' management team were available to them when needed.

Arrangements were in place and we saw from the records that people had the opportunity to discuss their end of life wishes and preferences.

Good

Is the service well-led?

Our findings

Everyone spoke positively about the management arrangements and knew who the new registered manager was. Feedback included, "This manager is really on the ball. She is thoughtful and listens to what the residents have to say. Some things might seem unimportant, but they are important when your life is quite restricted, which is the case for a lot of us here. Things like food, music and entertainments take on a big significance. She understands that and does her best to keep us happy" and, "The new manager has made a big difference and is very approachable."

People's views and those of their relatives were sought as part of the quality assurance process to make improvements to the service. There were a variety of ways in which they could give feedback. These included annual surveys, residents' and relatives' meetings, care reviews and through the complaints process. Concerns had also been shared directly with CQC. The main themes had been concerns about staffing levels. In response, the provider had reviewed and increased staffing levels. They continued to use their assessment tool to make sure there were sufficient staff to meet people's needs. We acknowledge in this report that the home was just 61% occupied at the time of our visit. The provider must ensure when they increase the numbers of people living in the home, they are sufficiently resourced to manage the changes and sustain the improvements they have made.

Systems were in place that identified shortfalls, a range of audits and monitoring checks were completed by the registered manager, staff in the home and representatives for the provider. For example, the regional clinical development nurse visited the home on a regular basis to review performance and care quality provision. During our visit the clinical development nurse took action in response to a shortfall we had noted. They explained what was needed to staff who supported the person, and introduced monitoring records to provide evidence of the care given.

Other audits and checks included food monitoring, infection control and health and safety. Required actions were incorporated into an action plan. Recent actions included introduction of weekly checks for people with diabetes, a monitoring record for staff to complete at the end of each shift to make sure MARs were fully completed and all medicines signed for to confirm they had been given, actions to further enhance the dining experience for people who could not verbally communicate their wishes and reminders for staff to attend refresher fire evacuation training.

We found further improvements were needed to make sure shortfalls, such as those we reported on in, mainly in the safe section of this report, were identified and acted upon. For example, the quality assurance system had not identified the incomplete recording for one person with distressed and challenging behaviours, and full and complete risk management plans were not in place for people who did not have access to call bells. However, we did find the provider took action to address the shortfalls with some actions completed before the end of our visit.

A daily meeting was held with the registered manager and heads of each department in the home. Each department representative provided an update about what was happening with their team on the day.

Following this meeting a clinical meeting was held with the registered nurses and team leaders. The registered manager checked who was unwell, if any accidents or incidents had occurred and actions being taken, and other clinical or care issues. The registered manager or person in charge also completed a structured 'daily walkround' of the care home. They recorded their findings and actions to be taken when areas for improvement were noted.

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and circulated. Staff told us they felt able to express their views and felt listened to. A member of staff commented, "I think we go the extra mile, we do what we can to make sure the care is good. We do feel listened to and can speak to our unit managers or the manager." Another member of staff told us, "Yes I would recommend here, and would be happy for one of my loved ones to be cared for here."

Staff told us that staff morale had improved and the home was now 'more settled'. A member of staff said, "[Name of registered manager] is moving things in the right direction. We're seeing improvements every day since she arrived. Things are better for us and better for the residents as well. I go home at the end of my shift feeling that I've been able to make a difference."

The provider's values and mission statement had recently changed. All staff were being supplied with individualised cards with the values stated, in addition to the posters on display in the home.

The registered manager was able to tell us how they kept up to date with current practice. They also told us they were provided with information and guidance from the provider. The provider also ran corporate induction and supported managers to attend 'Igniting leadership.' Registered managers were invited to attend a 'Quality First' conference which was held twice each year. In addition the register manager told us they read nursing journals and planned to attend local provider forums.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.