Maples Care Home (Bexleyheath) Limited

Maples Care Home

Inspection report

29 Glynde Road
Bexleyheath
Kent
DA7 4EU

Tel: 02082986720

Date of inspection visit:
24 January 2017
25 January 2017
26 January 2017

Date of publication:
03 March 2017

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 unannounced inspection took place on 24 – 26 January and 01 February 2017. At the last comprehensive inspection on 27 and 28 January 2016 we had found a breach of legal requirements in relation to records. The provider had sent us an action plan to tell us how they were going to comply with legal requirements. We carried out a focused inspection on 24 June 2016 to check that the action plan had been completed and found that the service met legal requirements.

Maples Care Home is a large home which provides long term residential care and support, nursing care, dementia care and respite services for up to 75 older people.

Since the last inspection there had been some unavoidable changes in the management team at the home. The previous registered manager had left the home in July 2016. A new manager had been appointed and started work at the end of October 2016. They were in the process of registering as manager with the Care Quality Commission. 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 deputy manager had also left and a new deputy manager had just started at the home.

We found there were some areas for improvement in some key questions as a result of the lack of stable management there had been. These included ensuring some care records and risk assessments were consistent and up to date, the recording of some best interest decisions and the provision of suitable activities to stimulate people and meet their needs for socialisation. Staff had received regular training but supervision had not always been provided to staff in line with the provider's requirements. However, the new manager had already drawn up an action plan that had identified all the areas for improvement we found and had started work on completing this plan at the time of the inspection.

Medicines were stored and administered safely. We have made a recommendation to the provider about the safe management of 'as required' medicines and the arrangements for the administration of medicines covertly where this is appropriate.

People told us they felt safe and well looked after at the home. Staff were aware of how to raise any safeguarding issues. There were safe recruitment procedures in place. People and their relatives told us there were not enough staff at all times to meet people's needs. During the days of our inspection however we found there were enough staff to meet people's needs. The manager told us they felt problems arose when staff were not effectively deployed and they were working to address this issue. We will monitor progress with this at our next inspection.

People gave us mixed feedback about the food but said they had enough to eat and drink. Nutritional risk was monitored and plans were in place to reduce risk. People had access to a suitable range of health care professionals and staff made appropriate referrals when needed to meet people's needs. Staff sought consent from people when offering them support. The service acted to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), where people had been assessed as lacking capacity to make certain decisions about their care and treatment.

People told us they were well looked after and comfortable. People were involved in making decisions about their care and treatment. Staff knew people's preferences and respected people's dignity. There was a calm atmosphere at the home. Relatives and visitors appeared relaxed and said they felt welcome. There was a complaints system readily available and responses had been made in line with the provider's policy. Annual surveys and relatives and residents meetings were held to capture people's experiences of care and views about the home and the care provided.

There were systems to monitor the quality of the service which had identified the areas for improvement we found and action needed as a result of audits was recorded and completed.

Some people and their relatives expressed their disappointment at the unavoidable changes in management there had been. Most people and their relatives felt the new manager was making improvements, for others it was too early to be sure. We found the new manager had taken action to address issues they had found promptly and had made a number of changes. They were open to feedback; they had started to build relationships with local professionals and had ideas about how they wanted the home to develop. They were well supported by the regional operations managers. Staff were positive about the impact of the new manager and felt they were working better as a team.

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 consistently safe.

Medicines were safely stored and administered and managed. Some improvements were needed to the guidance for people's 'as required' medicines. We have therefore made a recommendation to the provider in relation to the management of medicines.

Risks to people were assessed and monitored and guidance provided to staff to reduce risk but some risk assessment records require improvement to ensure they were accurate. There were arrangements to deal with emergencies.

Staff knew how to protect people from abuse or neglect. There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were supported in their roles through relevant training. However the recorded frequency of supervision was not always in line with the providers requirements.

Staff asked for people's consent before they provided care. They understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) authorisations were applied for when needed. However best interest decisions were not always clearly recorded. These issues had been identified by the new manager and were being addressed at the time of the inspection.

People's nutritional needs were met. They were supported to maintain a balanced diet and had access to a range of healthcare services when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and consideration. People were encouraged to maintain their independence.

People told us staff treated them with dignity and respected their privacy.

People were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were not always up to date to consistently reflect the care and support given. The manager was addressing this through their action plan.

Some improvement was needed to ensure that activities were personalised and provided people with sufficient stimulation. The manager and the provider had ideas about the development of activities to meet people's individual needs, but these were not yet in place.

People had access to a complaints procedure which was displayed throughout the home. The manager had an open approach to learning from any complaints and to sharing the learning with staff.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

The home had been through a difficult period of unavoidable instability. This was recognised by the manager and operational team and they had an action plan to address the areas that needed improving.

There were a range of systems to monitor the quality of the service and drive improvements. People, their relatives and professionals feedback was routinely sought and their views were taken into account.

Staff told us they thought the new manager was approachable and that the home could start to make progress now there was a new management team.

Maples 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 – 26 January and 01 February 2017 and was unannounced. On the first day the inspection team consisted of one inspector 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. On the second day the team consisted of an inspector and another expert by experience. The inspector returned on the third day to complete the inspection. A pharmacy inspector carried out an inspection of medicines on 01 February 2017.

Before the inspection, we looked at the information we held about the service including information from any notifications the provider had sent us. A notification is information about important events that the provider is required to send us by law. 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 any improvements they plan to make. We also asked the local authority commissioners for the service and the safeguarding team for their views of the home.

We spoke with sixteen people who used the service, thirteen relatives or visitors and a health care professional. During the inspection we used the Short Observational Framework for Inspection (SOFI) on two floors at the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We tracked five people's care to check that the support they received matched their care plan. We spoke with five care workers, a senior care assistant, a permanent nurse and an agency nurse, the maintenance person, the home's trainer, the activities coordinator, the chef, an administrator, the deputy manager, the clinical lead, the provider's facilities manager, the head of care, two regional managers and the head of operations.

We looked at eight people's care records, five staff recruitment records, five staff training records and records related to the management of the service such as minutes of meetings, records of audits and service

and maintenance records.

Requires Improvement

Is the service safe?

Our findings

Medicines were administered safely but some improvements were required to ensure processes to manage medicines followed current best practice. For medicines prescribed 'as required' we found that the protocols available with the medicines administration records (MAR) did not always have all the detailed information that was recorded in the care plan which would support the consistent use of these medicines. Some people were unable to make decisions about their medicines and these people had their medicines administered covertly. This was done after a mental capacity assessment and best interests' decision had been made. However, clear protocols were not in place, for the use of these medicines supported by information from the pharmacy. We spoke with the manager and the pharmacist who told us that they were currently working with the service and the GP to establish appropriate procedures.

We recommend that the service consider current guidance on protocols for medicines prescribed 'when required' and medicines given covertly and take action to update their practice accordingly.

MAR records were accurately completed. Medicines were stored safely and appropriately including controlled drugs which require additional security and medicines needing refrigeration. We saw that weekly checks were carried out on all controlled drugs and records were kept of all medicines returned for disposal. Medicines requiring regular blood tests were managed appropriately. Regular medicines reviews and pain assessments were completed where relevant.

Nurses and senior care staff administered medicines and they could describe to us the training and competency checks which they had to undergo before being given this task. We saw nurses giving people medicines in a caring manner, allowing people time to understand what they were doing. The service did internal audits and the supplying pharmacy did a comprehensive six monthly audit. This had been done three weeks before the inspection and we saw that actions had already been taken as a result. For example we saw that the recording of 'homely remedies' (medicines that can be given to people without a prescription) had been improved. All errors were logged and actions taken were noted. We saw that this was done promptly and the actions were appropriate. The service also looked at trends and occurrences with the aim of reducing errors.

The manager had already identified the improvements needed and was working on addressing these at the time of the inspection. People told us they received their medicines on time and there were no problems with supplies of their medicines. One person said, "They are good with the medicines here, usually about the same time each day. They don't forget."

People told us they felt safe from abuse, bullying or harm and that their possessions were safe. One person told us, "I'm safe because the staff are nice, they do anything I want, and they are always kind." Another person said, "I am safe and my belongings are safe here." Relatives told us their family members were safe from harm and abuse. One relative said, "It is safe here. Much safer than where they were before. [My family member] is well looked after."

There were procedures in place to protect people from the risk of abuse. Staff had received safeguarding training and were aware of the types of abuse and the signs to look for that could suggest abuse may have occurred. They were also aware to report any safeguarding concerns they had to the registered manager and told us they would whistle blow if they felt their concerns were not acted on appropriately. One staff member said, "There is nothing like that here but I would not hesitate to report or whistle blow if it was needed." The registered manager knew the procedure for making referrals to the local safeguarding team in response to any abuse allegations. They had cooperated appropriately with the local authority during investigations.

Risks to people were assessed, identified and guidance provided to staff to reduce risk. However some risk assessments records required improvement to ensure they were accurately completed, to provide an accurate assessment of risk. For example, for one person, their falls risk assessment had been reviewed but the score had not changed despite further falls. We saw appropriate action had been taken to monitor and reduce risks and respond to the changes but the risk assessment did not accurately reflect the level of risk at the time. Some choking risk assessments were not always accurately scored and we found three risk assessments may have identified a greater choking risk than may be the case. We discussed these findings with the manager and head of operations and they told us a training need had been identified for some staff in completion of some risk assessments, which they would address. They were in the process of reviewing people's risk assessments at the home as part of an overall action plan. Updated risk assessments for the people concerned were sent to us following the inspection.

Other risk assessments were completed accurately and used to guide staff with actions to reduce risk. Risk assessments and guidance were regularly reviewed to ensure they remained relevant to people's needs. Records such as wound charts, food and fluid charts, repositioning charts and observational checks were completed to track the regular monitoring of risks and ensure any concerns were acted on.

There were arrangements in place to deal with risk from foreseeable emergencies. Staff explained to us what they would do in the event of a fire or medical emergency. Staff had fire safety training and fire drills had been conducted on a regular basis and some drills involved practice with evacuation equipment to ensure staff were aware of their responsibilities in the event of a fire. People had evacuation plans to guide staff or the emergency services in the need for an evacuation.

Risks in relation the premises and equipment were reduced through a system of internal checks and external servicing. Actions related to an external fire risk assessment and legionella risk assessments been addressed or were being worked on. Equipment for example fire, gas and electrical equipment, the hoists, call bells and bed rails were routinely checked and serviced. Window restrictors and water temperatures were tested routinely to ensure people were not placed at risk.

Most people and their relatives told us there were not enough staff at all times to meet people's needs. One person told us, "I don't see many staff about there is not enough staff." Another person said, "It would be nice to have someone to talk with, the staff never have time and my relatives live quite far away, so I don't get many visitors." A relative commented, "There needs to be more staff, they are under pressure always running around." However, while staff were busy throughout the day our findings did not correspond with this view.

Staffing levels on each unit accurately reflected the staff rota. On the top floor where there were five people; there were two care workers and one nurse. On the middle floor there were four care workers, a senior care worker and a nurse to support nineteen people and on the ground floor the staffing ratio was the same for twenty six people.

We heard mixed responses to our questions about call bell times: two people told us that their call bells were not always answered promptly and another person told us, "I think there is enough staff when I press my buzzer they come quite quickly." We checked the call bell response times for the weekend, the night and during the week and saw that most call bells were answered within a couple of minutes. We did not see anyone waiting unduly for care or support when we observed throughout the home and people did not wait long to be served or supported to eat at meal times. We saw in people's care plans that people's dependency levels were reviewed on a regular basis to help plan staffing levels to meet people's needs. We noted it was mainly agency nurses working during the inspection. However the manager told us, and records confirmed, that they looked to use the same consistent agency staff wherever possible. This meant they were familiar with the support people required.

We spoke with the manager and head of operations about the concerns raised. They said they continually assessed and reviewed staffing levels in response to feedback. They felt the issues may lie with the way care and support to people was shared among the staff teams and now there was a management team in post they would be more visible on the floors to identify any problems in the allocation of responsibilities. They were actively recruiting for nurses to ensure consistency of staff. The head of operations told us electronic care planning was being introduced next month and they had found from its introduction in other homes that there was a time saving for staff. We will monitor this at our next inspection.

Effective recruitment processes were in place to reduce the risk from unsuitable staff. The service carried out full background checks on staff before they started work. These checks included details about applicants' employment history and reasons for any gaps in employment, references, a criminal records check, right to work and proof of identification. Agency staff provided profiles of their checks and training and received an induction before they commenced work. This helped to ensure people received care from staff that were suitable for their roles.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff were competent when they supported them. One person told us, "The staff know what they are doing." New staff told us they received an induction which included training, and a period of shadowing more experienced staff members. They told us this had been helpful in starting to learn about their roles. The head of operations told us the induction followed the Care Certificate, a recognised programme for staff new to health and social care. We saw there were checklists to confirm when new staff were ready to complete tasks on their own. Experienced staff confirmed they had regular refresher training that the provider considered mandatory and we confirmed this from records. One staff member explained how they had been given the opportunity to take up further training through the Health and Social Care Diploma

However there were some areas for improvement. Refresher training on the Mental Capacity Act 2005 was overdue for approximately quarter of the staff but this was being arranged at the time of the inspection. Staff said they received regular supervision and an annual appraisal, to support them in their roles. However records for supervision showed that not all staff had received supervision in line with the provider's requirements over the last 12 months. This had been identified by the new manager and plans had already been put in place to address this as part of the overall action plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

Staff understood the need to obtain consent before they provided care. People told us staff sought their consent before care was provided. One person said, "They always check first with me and see what I say." We saw staff asked people for their permission before care was provided. For example, one staff member asked if someone would like their chair moved nearer the table to eat and then explained what they would do support them safely. Staff understood the importance of assessing people's ability, to decide on each decision separately, and to involve relatives and professionals as necessary in making best interests decisions. However, we found some best interests decisions such as the use of bed rails for two people were not recorded in the relevant capacity assessment and this required improvement to evidence a clear record that the process had been followed.

The registered manager knew how to submit a request for DoLS authorisations. Monitoring forms were

completed when required and any other conditions placed upon the authorisation were followed.

People told us they were provided with sufficient amounts of nutritional food and drink to meet their needs. However, they gave us mixed feedback about the food at the home. Six people we spoke with were not happy with the quality or presentation of the food provided. Comments included, "The food is tasteless and is usually cold." and "I don't like to grumble, its ok I guess and I eat very little anyway." Six other people gave more positive feedback when we asked. One person said, "The food is very good chicken is my favourite. I have enough to drink they often come round with teas and coffees." Another person remarked; "The food's good, there is variety and choice."

We observed the meal time experience and found there was some room for improvement. People were offered a choice of what they wanted to eat and drink and there were pictorial menus on the tables. However on the floor where there were people with a diagnosis of dementia who may struggle to process information people were asked for their choices rather than shown the food choice available to them. We observed some people who were encouraged to eat independently would have benefitted from specialist equipment such as plate guards.

People's care plans included assessments of their dietary preferences and requirements. Any allergies were clearly recorded. Any guidance about people's eating and drinking from the Speech and Language team was available in their rooms to guide staff and in their plan of care. Catering staff were informed about people's dietary needs and these were displayed in the kitchen so that all catering staff had this information readily available. Staff showed good awareness of people's needs in this area. People's weight was monitored more regularly where any issues had been identified to identify any concerns. We observed that people had access to regular fluids throughout the day.

We discussed people's feedback about the food with the manager who was aware of the variation in views and was working to address this. They told us a new chef had come into post a few weeks previously. They had regular meetings with the chef who also attended the residents and relatives meetings. New dining equipment to support people to eat had also been ordered.

People told us they were supported to maintain good health and had access to support from health professionals when needed, for example a chiropodist, and optician. We saw advice was recorded in people's records to ensure all staff were aware. Staff were quick to respond to changes in people's behaviours and alerted health professionals when needed. For example, contact with the GP if someone was unwell. The deputy manager told us that they were redeveloping stronger links with health professionals to ensure they worked well together. A health professional told us that staff were attentive to people's changing needs. Feedback from a professional survey we saw stated; "A friendly home with staff who are motivated to improve the service given."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person remarked, "They are kind and caring and helpful to me." Another person said, "Staff treat me well, they talk to me and they are caring." A relative commented, "The staff are very good, whatever [my family member] needs they get it. Staff know [my family member's] needs; they are very good they really do try to do their best." Another relative told us, "The staff are very caring here."

There was a calm atmosphere throughout the inspection on all units at the home. We observed staff supported people in a relaxed and friendly way. For example, staff shared a joke or joined in conversation as they supported people. Permanent staff demonstrated a good understanding of the needs of the people they supported and could describe people's preferences and routines; this enabled them to provide personalised care. We observed staff showed awareness of people's changes of mood. For example, when a person became distressed, we observed how staff reassured them and distracted them. Agency staff had a profile of people's needs and the manager told us and we confirmed from records that agency staff had an induction before they started work at the home so that they were informed about the routines and procedures at the home. Agency staff told us they felt they had enough information to meet people's needs.

People confirmed they were treated with dignity and respect and we observed this to be the case. One person commented, "The staff are respectful and polite." We observed staff speaking to and treating people in a respectful and dignified manner. They were aware of the need for confidentiality and spoke discreetly to people about their care and support needs and ensured doors were closed when they delivered personal care. A care worker told us, "It's really important to keep people's information confidential and to show respect by knocking on people's doors before I enter."

Staff were knowledgeable about people's needs with regard to their disability, physical and mental health, race, religion, sexual orientation and gender, and they supported people with their individual needs. For example, people were supported to practice their faith and staff told us any cultural needs with regard to diet or personal care would be supported.

People and their relatives, where appropriate, told us they were involved in making decisions about their care. People said they were consulted about their day to day care needs and their views were listened to. For example, one person told us, "Staff ask for my opinions about if I want to get up, or have a shower, or if I'm tired in the evening. It's up to me." We saw people were consulted about joining activities or where they wished to spend their time. Relatives told us they were kept informed about any changes to their relatives health care or support needs. One relative said, "They do let me know about any changes. They are good like that." People and their relatives told us they were involved in reviews of their care plan. One relative told us, "We have talked about the care plan together. I like to know what is happening and if there are any changes."

People's independence was encouraged, for example where they could manage aspects of their personal care; this was recorded in their care plan, so that care staff were aware which aspects of care people could

manage for themselves. One person told us, "The staff do encourage me to do what I can manage. It's nicer that way."

Relatives confirmed they were free to visit whenever they wanted and told us they felt welcome at the home. A notice area in reception provided information to staff and visitors about the home and information guides about aspects of care for older people. Feedback from surveys completed by professionals was positive about the care provided. One comment stated, "Very clean home, friendly staff, residents appear happy. Well decorated for those with dementia."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they had a written plan of their care and support needs and that their needs were discussed before they came to the home. An assessment of people's care needs was completed before they moved in to ensure the home could meet their needs safely. Care plans detailed people's needs across all aspects of their care and support. For example their needs at night, communication needs, personal care needs, mobility and eating and drinking. Care plans were written to guide staff on how to address people's individual needs and preferences. For example, they explained what people felt able to manage independently and which aspects of care they needed support with. There was information about people's life history for staff to understand important facts about them and the significant people in their lives. Care plans were reviewed on a monthly basis or in response to any changes in people's needs. Staff also recorded daily notes and observations where relevant, to show that people were supported in line with their individual needs and wishes.

Most care plans were up to date but we found some improvement was needed to ensure care plans consistently reflected people's current care needs. For example one person's wound care plan had not been updated to reflect the change in frequency of dressings, although the wound was being dressed in line with the new guidance. Information about two people's dietary needs was on the handover sheet but the changes had not been updated consistently in the care plan. We tracked their care and saw that they received the correct diet. Their care plans were updated to ensure consistency of information following the inspection.

The manager showed us their overall action plan that had identified the need to review all the care plans and ensure they reflected people's current needs prior to the introduction of electronic care plans. The operational manager told us the electronic plans had been successfully introduced in other homes and enabled staff to update records more efficiently. We will check on this at our next inspection.

Arrangements to meet people's need for socialisation and stimulation required some improvement and this had been the case at the previous inspection in January 2016. There had been a number of changes in activity coordinators and managers since the last inspection which meant there had been limited progress made.

We received mixed feedback about the activities provided at the home. Five people told us there was enough to do; one person said, "I like the activities we all come together for them regularly." Another person told us, "There's an activities chart that informs you what is on. There are things to do and we have entertainers from outside and dogs come in too." However, other people and some relatives said they did not feel there was always enough to do. One person commented, "The activities are alright, but quite boring so I prefer to stay in my room." A relative told us, "There needs to be more activities. It would be good if the activities were more physically and mentally stimulating." Another relative said, "The activities could be better planned and include a wider range of things to do."

During the inspection we observed an outside entertainer provided a music and exercise session on two

floors of the home on different days and some people came from other units to participate. People were observed to enjoy the sessions we saw. One of the activities organisers took a group of people to a local community activity and held a quiz on one day and a singing session on other days. However there were periods throughout the day when people lacked stimulation and meaningful activity.

There were three activities organisers now employed at the home; although one had only very recently started. We spoke with the lead activities organiser they told us the provider had paid for them to attend training on activity provision for people with dementia and that they also attended regular support meetings for activity coordinators from other homes. They tried to provide some activities for people nursed in bed or in their rooms on a weekly basis. On one floor we observed care staff engaged in ball games or other activities at points in the day. However the activity folders recorded very limited information about people's interests and the range of activities did not always reflect people's interests and preferences as outlined in their care plan. The manager had identified the activities as an area for improvement and we saw they had started to address this in their action plan. We will monitor progress on this and check on this at the next inspection.

People and their relatives knew how to complain if they needed to and were confident any problems would be dealt with. Most people and their relatives told us they had not needed to complain. Three relatives told us they had raised concerns and were happy with the response they received from the manager. One relative said, "I have complained and it's all been dealt with quickly. I am happy the matter is resolved." There was information displayed about the home on how to make a complaint. This included guidance for people on the timescale for a response, as well as information on what to do if they were unhappy with the outcome of any complaint investigation. We checked the records and found complaints had been responded to in line with the policy and most complaints had been resolved.

The manager told us they would be reviewing the complaints to identify any common themes. They had an open approach to identifying any concerns and we saw they shared any learning with staff for example a complaint about entertainment at Christmas had been investigated and discussed with relevant staff to embed learning. Two relatives told us they felt their complaints were listened to and acted on but that the actions identified were not consistently implemented over time. We discussed this with the manager who told us they were working to maintain consistency and now there was a complete senior team at the home this could be more readily achieved.

Requires Improvement

Is the service well-led?

Our findings

Most people and their relatives told us they had met the current manager and felt they were available and had responded to issues raised in the short time they had been at the home. One person said, "I think it's well organised. I know who the manager is. They do come by and say hello. I have no concerns at the moment." A relative said, "I've met the new manager, they come up here quite a bit and often have a chat." Another relative commented, "I think I will get on with the new manager. I went to see them and they sorted my problem out quickly." Some relatives told us they had not met the new manager and two people and three relatives and told us, "It was a bit early to tell."

Due to a number of unavoidable circumstances the home had experienced some changes of manager or registered manager since the last inspection in January 2016. Some people and their relatives expressed their disappointment with the number of changes. The previous registered manager had left the service unexpectedly in July 2016 and the home had been managed by an operations manager since then. We were aware from our monitoring that the provider had acted appropriately to reduce the impact of the changes and appointed a permanent manager as soon as they were able to. There had been regional and operational management support during this period. The current manager had been working at the home since the end of October 2016. They had applied to become registered manager with CQC. They understood their responsibilities as registered manager and had submitted notifications to CQC as required.

Records demonstrated there were systems to monitor the quality of the service and actively drive improvements. The areas we had identified at the inspection had already been identified by the new manager through their auditing and had been included in their action plan for making improvements at the home. Regular audits were conducted across aspects of the home and the care provided; these included areas such as infection control to minimise risks from infection, people's clinical care, care records, equipment and the building to ensure these were safely maintained. The manager had introduced a new accident and incident report to more readily identify actions taken to minimise risk and check for any trends. There was a new electronic tool to record any incidents that involved changes in risks for people and gave the provider more oversight of the risks individuals faced. The manager conducted a daily walk around the home and we saw that actions identified from the walk around were completed. For example a staff member not using personal protective equipment was identified as an issue on one unit and this was discussed with the staff member concerned and at the next staff meeting. The manager sent weekly reports to the operations manager that allowed them to monitor the care across aspects of the service. The new manager told us they were well supported by the operations team and head of operations.

Relative and residents meetings had been held regularly to keep people up to date with changes and discuss any issues. For example feedback about the food at one meeting led to the chef attending a further meeting to hear feedback about the food. Some residents and relatives had also been involved in the recruitment of the new manager. A meeting was due to be held in February 2017 for people to raise any issues and to discuss the new electronic care plans being introduced and provide other updates about improvements being made.

The provider sought the views of people, relatives and professionals through surveys and used the feedback to work to drive improvements. The most recent surveys had been completed in November 2016; we saw that the overall scores from the 12 people who had completed the surveys were not as positive as the feedback from relatives and professionals. The satisfaction score for people at the home at that time was 51per cent, for relatives it was 82 per cent and for professionals it was 91 per cent. The manager was addressing the feedback within their action plan. There was a regular newsletter that provided articles of interest and information for people and their relatives about past and future activities at the home.

We observed the new manager had taken steps to promote an open environment and a culture of learning for staff and was motivated to provide good quality care. For example where we identified a possible issue about manual handling on one unit the staff concerned were supported with immediate supervision and additional training. The manual handling risk assessment and care plan for the person concerned was also reviewed to ensure it continued to meet their needs.

The manager was actively recruiting permanent nursing staff and had met with the agency to discuss expectations about the staff they sent to improve consistency of care for people at the home. The manager had met with commissioners and the safeguarding team at the local authority and was reinforcing links with health professionals to ensure there were effective communication paths when needed.

Staff told us they had found the changes in managers difficult although they had been supported by regional operations managers. They said the new manager was visible, approachable, fair and consistent. They felt comfortable talking to them if they had any issues or concerns. One staff member said, "The new manager is right for this home. They listen to what you have to say and makes you feel your views are counted but they won't stand any nonsense." Another staff member commented, "The manager is always at handovers which is good so they know what is happening. They check to see everything is running properly. I did see them about a personal issue and they were very helpful and supportive."

There were a series of meetings across the home to aid communication and help deliver effective care. Regular handover meetings were held between shifts to ensure staff had up to date information about people's needs. Daily meetings were held with the nursing staff to ensure people's clinical needs were being monitored and any changes identified. Staff meetings had been held regularly and staff told us they felt able to bring up any issues that concerned them. Records of staff meetings showed staff were involved in discussions about the operation of the service and how people were supported. One staff member said; "The team work is better now. Most staff work well with each other."

While we found there were areas for improvement in the home the new manager and the operational manager's demonstrated openness about the challenges there were and a commitment to honesty, accountability and driving improvements. There was a willingness to learn from any feedback. They showed us a copy of an action plan they had already drawn up to address issues they had recognised needed improvement. They had started to work on this prior to the inspection; for example they had started to introduce champions across key aspects of care such as dementia, falls or nutrition to drive improvements. They had acted in response to concerns identified about care at night and a schedule of night spot checks had been put in place. Any quality concerns or safeguarding issues had been reported appropriately to relevant bodies. They told us now they had a management team they could begin to address issues more quickly and that they were well supported by their regional and operational managers.

There was evidence of some of the characteristics of good in this key question. However, here had been instability at the home and people's experiences were not consistently good. This has therefore affected the

rating in this key question at this inspection.