Culpeper Care Limited

Willow Tree Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 14 May 2018. The inspection was unannounced.

Willow Tree Nursing Home is a care home registered to provide nursing care and accommodation for a maximum of 47 people. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is located in a residential part of Hillmorton in Rugby and most of the bedrooms are on the ground floor. There are seven bedrooms on the first floor. There were 38 people living at the home at the time of our visit, some of who were living with dementia.

We last inspected Willow Tree Nursing Home in February 2017 when we rated the service as 'Requires Improvement' in the key questions of safe, responsive and well-led. We found medicines were not always managed safely, care plans were not personalised and quality monitoring checks were not effective. This meant the overall rating of the service was 'Requires Improvement'. At this inspection we found improvements had been made and although further improvements were required in medicines management and infection control, the service is now rated as 'Good' overall.

The service had a registered manager. This is a requirement of the provider's registration. 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.

People felt safe living at Willow Tree Nursing Home and with the staff who provided their care and treatment. There were enough suitably skilled and experienced staff on duty to meet people's care and support needs safely and effectively. The provider checked staff's suitability for their role during the recruitment process and gave them training and support relevant to their position and responsibilities.

People's needs were assessed before they moved to the home to ensure they could be met. Staff monitored people and were responsive to fluctuations in people's health so they could be promptly referred to other healthcare professionals. People were supported at the end of their life in the home and staff worked with other healthcare professionals to ensure people had a dignified and pain free death.

Overall, people received their medicines as prescribed, but improvements were required to ensure best practice was always followed in the management of medicines.

The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence. Staff understood their role in keeping people safe and their duty to report any concerns that could compromise people's safety.

The premises and equipment were checked and maintained to ensure risks to people's safety were minimised. Generally, the environment was clean and tidy, but some infection control practices needed to be improved.

Managers and staff had a good understanding of the Mental Capacity Act 2005 and how to put this into practice. Where people required restrictions on their liberty to keep them safe from harm, Deprivation of Liberty Safeguards had been applied for and authorised.

People were encouraged and supported to eat and drink enough to maintain their health.

Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed and updated when people's needs changed. The provider was committed to equal opportunities and diversity and people's cultural, spiritual and religious beliefs were respected. Staff enjoyed working in the home and listened to what people had to say so they understood what was important to them. There were a range of activities for people to participate in and a strong emphasis on maintaining people's links to the local community.

The provider and the registered manager conducted regular audits of the quality of the service to make sure people received safe, effective care. When issues were identified, managers were open and receptive and took action to ensure positive outcomes for people.

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 mainly safe.

There were enough staff to meet people's needs safely. People felt safe with staff who understood their safeguarding responsibilities. Improvements were required to ensure safe infection control and medicines management practices were followed at all times. Risks to people's health and welfare were identified, and there were plans in place to manage the risks. Learning was taken from adverse incidents to improve the safety of the home.

Is the service effective?

Good

The service was effective.

The provider supported staff to develop their knowledge and understanding so they had the skills to meet people's needs. Managers had a good understanding of their responsibilities under the Mental Capacity Act 2005 and staff offered people choice and sought their consent before care interventions. Staff worked in partnership with other healthcare professionals to ensure people's health needs were met. People were offered enough to eat and drink to maintain their health.

Is the service caring?

Good

The service was caring.

Staff listened to what people had to say so they understood what was important to them. Staff respected people's dignity and privacy. People's diversity was respected and people's spiritual and cultural beliefs were supported. People were encouraged to maintain their relationships with family and friends.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's assessed and changing needs and guided staff in the delivery of care and support in the way people preferred. People were supported at the end of their life

in the home and staff worked with other healthcare professionals to ensure people had a dignified and pain free death. There were a range of activities for people to participate in and a strong emphasis on maintaining people's links to the local community. Complaints had been investigated and responded to in line with the provider's complaints procedure.

Is the service well-led?

Good

The service was well-led.

The provider and registered managers conducted regular audits of the quality of the service to make sure people received safe. effective care. When issues were identified, managers were open and receptive and took action to ensure positive outcomes for people. The provider worked in a collaborative way with other organisations and demonstrated a commitment to improve the quality of care people received.

Willow Tree Nursing 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 comprehensive inspection took place on 14 May 2018 and was unannounced. The inspection was undertaken by two inspectors, a specialist advisor and an expert by experience. The specialist advisor was a registered nurse who was experienced in nursing care. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

Prior to our inspection visit, we reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioners did not share any concerns about the service.

Before the inspection visit, 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. The PIR was very detailed and we were able to review the information in the PIR during our inspection visit. We found the information in the PIR was an accurate assessment of how the service operated.

During our inspection we spoke with the registered manager, the deputy manager and the provider's operations manager about their management of the home. We spoke with one nurse, three care staff, three non-care staff and an agency care worker about what it was like to work at Willow Tree Nursing Home.

Some people in the home were living with dementia, but some people could tell us what it was like living at Willow Tree Nursing Home. During the inspection we spoke with 13 people who lived at the home and five relatives/visitors. We observed care and support being delivered in communal areas and we observed how

people were supported to eat and drink at lunch time.

We reviewed three people's care plans and daily records in detail and specific aspects of two other care plans to see how their care and treatment was planned and delivered. We also looked at five wound management plans and 26 medication records. We looked at staff training records, records of complaints and reviewed the checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection visit we found improvements were needed to ensure people received consistently safe care. At this inspection we found the provider had made improvements to ensure the safety of the service, but there were still some areas where improvements were required.

People told us they received their medicines when they needed them. One person confirmed, "I take medicines for my Parkinson's.I get them regularly and on time. They let me know if they are delayed."

All medicines were stored securely and at the correct temperature to ensure their effectiveness. Medicines that required extra checks and special storage arrangements because of their potential for misuse, were stored correctly. The administration of these medicines was recorded accurately and showed they were being given as prescribed.

We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 26 people, speaking to staff and observing how medicines were given to people. Nursing staff supported people to take their medicines in line with safe administration procedures. When one person showed behaviours that challenged when they were offered their medicine, the nurse left this person to relax. They told us they would go back in five minutes, and when they returned, the person was happy to take their medicine.

However, we found some areas where improvements were required to ensure safe medicines practice was followed at all times. For example, handwritten amendments to the MARs had not always been signed by the member of staff making them, nor had they been counter-signed by a second member of staff, to confirm their accuracy. Some medicines need to be given 30 to 60 minutes before food and other medicines. The provider did not have consistent arrangements in place to ensure these specific administration instructions were followed. There were some missing signatures on MAR charts so we could not be sure people had received these medicines as prescribed. Following our inspection visit, the registered manager told us stock checks had confirmed that people had received their medicines, but staff had not recorded this. Individual supervisions had been carried out with staff to ensure they consistently followed best practice.

Where people were on medicines which were prescribed on an 'as required' (PRN) basis for anxiety, agitation or pain for example, there were clear guidelines in place as to when these medicines should be given. This information helped staff to make a decision as to when to give these medicines safely and consistently.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important the patches are rotated around the body to avoid people experiencing unnecessary side effects. Rotation charts were in place showing the site and removal of the patches, but these had not always been completed. There was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing

unnecessary pain.

We found where people had to have their medicines given to them disguised in food or drink, the GP had agreed and signed the appropriate documentation. The provider had also sought the advice of a pharmacist about the suitability of crushing medicines into people's food or drinks so they could be safely prepared and administered. There was some information about the safeguards in people's care plans to ensure all the medicine was taken, and only taken, by the person it was prescribed for. This is essential for people living with dementia as they can easily become distracted and leave their food or drink unfinished which could then be picked up by another person. However, it is good practice for a copy of the plan to be attached to the MAR.

People were not consistently protected from risks of cross infection. For example, when putting items into the waste food bin, staff did not consistently use the foot pedal, but picked up the lid with their hand and did not always wash their hands before continuing their duties supporting people. Some incontinence wear was stored in open packs in a communal toilet directly next to a clinical waste bin. These storage arrangements posed risks of cross infection.

Cleaning schedules were in place, but were not consistently effective because some areas of the home were not clean. One person's bedroom had thick dust on ledges and on the floor and cobwebs in their en-suite. Another person's bedroom floor was sticky, with drink patches from spillages and there was a large amount of food debris on the floor. A third person's toilet was dirty at 10.30am and had still not been cleaned at 3.30pm.

We found there were issues with the availability of paper towels and toilet paper. Paper towels were not always available in communal or individual toilet facilities which meant there was no means of drying hands. Staff were seen to wear appropriate personal protective equipment (PPE) when giving personal care, although some toilets and wash areas did not have PPE available in the dispensers.

We discussed the lack of supplies with the registered manager who confirmed stocks had become low the weekend before our visit. They told us a delivery had arrived on the day of our visit and bathrooms and toilets had been replenished with supplies. However, records demonstrated that this was not the first time that stocks had become low. The registered manager agreed they needed to review their ordering procedure to ensure such a situation did not occur again.

Communal areas, the kitchen and laundry room were clean and free from any offensive odours, apart from one corridor which had a strong urine odour. The registered manager agreed they could also smell this and arranged for the area to be cleaned. A cleaning staff member told us, "I always do my best, but sometimes we do not have enough cleaning staff if there is one of us on annual leave or some weekends there is only one cleaner working for the whole building, it's not enough."

Clinical equipment was clean and ready for use and there were suitable bins for the safe disposal of sharps and pharmaceutical waste.

The registered manager told us a nurse was a named infection prevention and control 'champion.' However, the role needed to be developed because when we spoke with the staff member, they told us they did not do anything pro-active to either model good practice or give guidance to other staff.

Following our inspection visit, the registered manager confirmed they had consulted the local clinical commissioning group who had provided them with a copy of a comprehensive infection control audit which

was based on best practice guidelines. They planned to adopt the audit to ensure the cleanliness of the home and that risks of cross infection were minimised.

People told us they felt safe living at the home and with the staff who cared for them. One person told us they felt safe because staff were available if they needed them. They explained, "I'm supposed to ask for assistance but I usually manage to go to the toilet without help but it doesn't pay to be silly, I've got a bell if I need help." Another person told us they felt safe to be as independent as possible because, "I can go to the toilet on my own as it's safe here. The bathroom is right next to my bed."

There were enough clinical and care staff on duty to support people safely. One staff member told us, "On Oak side we have enough staff to safely meet people's needs. On Cedar, things can be a bit rushed at teatime, but otherwise staffing is okay." People generally felt there were enough staff, but did say they had to sometimes wait for assistance. One person told us, "I call the nurses using the bell. They do what they have to do. They are not always very swift". Another said, "They respond to my call bell, but it depends what they are otherwise doing." This person told us they might have to wait between five to 10 minutes but said, "It doesn't cause me bother waiting."

However, there was a strong reliance on agency staff to cover staff vacancies on some shifts. The operations manager confirmed that staffing was still an issue and explained, "We have had quite a lot of agency workers and a lot of residents will probably say there are still a lot of agency." They told us they had an on-going recruitment drive and the use of agency staff had decreased by over 50% in the last 12 months. They explained this would reduce further over the coming months as they had recently recruited more permanent staff. One staff member explained how this would benefit the people who lived in the home. They told us, "If we had enough permanent staff we wouldn't need to use agency so it would be more consistent care."

Staff had received training so they understood what might constitute abuse and the action they should take to safeguard people if they had any concerns. One member of staff told us they would be aware of signs that people who could not express their concerns verbally were at risk. They told us they would be aware of, "Distress, upset, facial expressions, body language or the fear of being touched." This staff member said they would not hesitate to escalate their concerns if they felt any issues they had reported had not been appropriately managed. "I would make sure it was being followed up and if I felt there was nothing being done about it, there are quite a few organisations I could go to who would help me."

Staff told us they would not hesitate to report poor practice by another staff member, such as not using the correct equipment to support people safely. One staff member told us that if another staff member suggested such practice, "I would refuse because that is not moving and handling properly because that would be a risk to the person or yourself." They went on to say, "I would report it because if they are doing that when I'm there, what could they be doing on their own? If somebody was under my care I would protect them with my life."

The provider had a recruitment process that ensured staff had the appropriate skills, knowledge and values to provide personal care. One member of staff told us they had their references and Disclosure and Barring Service checks in place, "Before I could even step into the building."

Risks to people's personal health and safety had been identified and actions to minimise those risks were recorded in people's care plans. The actions, however, were sometimes contradictory. For example, one person's emotional support plan told staff to ask them to go to their room or the garden until their "anger was under control". Another part of this person's care plan told staff not to challenge this person when they were angry as they would shout and show behaviour that challenged. This did not give clear guidance to

staff in how they should manage this person's and others personal safety.

Another person had a health condition which meant their blood glucose (sugar) level should be monitored. Whilst there was a recording sheet in place for 'random tests' there was no guidance available to staff to say how frequently the test should be undertaken. Records showed no consistency to testing and despite one low reading being recorded, the next test was not undertaken until three days later.

Some people were at risk of skin damage and their risk management plans stated they required pressure relieving equipment to reduce pressure to vulnerable areas of their skin. Where people needed special equipment such as airwave mattresses or pressure relieving cushions, we saw these were in place. Pressure relieving mattresses need to be set at the correct weight setting for the person to be effective. Mattresses we checked were at the correct setting to prevent the risk of skin damage. Where people needed to be regularly re-positioned to alleviate pressure, records showed this was being done in accordance with people's risk management plans.

A member of clinical staff told us care staff were trained to routinely check the condition of people's skin when providing personal care. One member of care staff told us, "When we wash people in the morning or in the evening we glance over their skin and check everything is okay, because if we see an area that is sore, we can prevent it from getting worse so we need to be vigilant." They told us they would report any concerns to the nurse or senior member of staff on duty.

Our specialist nurse advisor checked the care records of three people who had wounds or tissue damage to their skin. Each person had a treatment plan and wound chart, and wounds were photographed on a regular basis to support evaluation of the treatment plan. All wounds were showing improvement, despite people having underlying physical conditions which can hinder the healing process, such as diabetes.

Two other people had venous leg ulcers for which the main treatment is compression bandages. One person declined the treatment, but records showed staff were managing this because the person's ulcers had not deteriorated any further. The other person's legs were healing well.

People who were at risk of not eating or drinking enough to maintain their health had their food and fluid intake recorded. Fluid charts had the target amount for what people should drink each day recorded at the top of the chart. We checked the fluid charts for one person. The charts were fully completed and totalled each day and evidenced that the person normally exceeded their daily fluid intake target. The registered manager checked the charts regularly to ensure the needs of people at risk of dehydration were met.

The provider's policies to keep people safe included regular risk assessments of the premises and regular testing and servicing of essential supplies and equipment. There were procedures to keep people safe in the event of an emergency which meant people had to be evacuated out of the home. Each person had a personal emergency evacuation plan (PEEP) and there was a summary of what assistance and equipment each person would need to evacuate the building, in the entrance to the home. There was an allocated first aider and fire officer on each shift.

Accidents and incidents were recorded by staff and information showed actions had been taken to address any injuries. The registered manager analysed these to identify if appropriate action had been taken and any action needed to prevent them happening again, such as extra training for staff.

The provider shared any patient safety alerts in respect of medicines or equipment with the registered manager. This included any learning taken from incidents that had occurred in other homes within the

provider group to ensure people's safety was maintained.

Good

Is the service effective?

Our findings

At our last inspection we rated 'Effective' as 'good'. At this inspection people at Willow Tree Nursing Home continued to receive good, effective care.

Before people moved to the home, their needs were assessed to ensure they could be met by staff with the appropriate skills and knowledge. Care plans had been developed from the assessments and covered people's physical, mental and social needs. One person explained how the support they received had enabled them to regain some of their independence. They told us, "I'm moving better now than I was when I came here." A relative told us staff effectively monitored their family member to ensure they received the support they needed. They said, "[Person] has periods when they are not very hungry. Staff keep an eye on their weight."

All staff received an induction when they started work which included working alongside experienced members of staff. Induction courses were tailored to meet the needs of people who lived at the home, and the different roles each member of staff performed. The induction was linked to the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. The registered manager told us all staff had completed the Care Certificate, including existing staff and senior staff. They explained this was a decision made by the provider so, "Corporately, everybody has the same standard."

After induction, a new on-line training programme ensured staff received regular refresher training to keep their skills up to date. This included training in areas such as manual handling, first aid, nutrition awareness and end of life care. The registered manager told us staff had worked hard to complete their training and explained, "It will give them more understanding of why we are asking them to do things." One staff member confirmed they had completed, "Lots of refresher training since the last inspection." Overall, our observations confirmed staff had the skills they needed for their job role. However, we saw a couple of occasions when staff failed to put their knowledge about good infection control and how they recorded medicines into practice. The registered manager assured us they would take action and later confirmed they had signed up for the local clinical commissioning group's accreditation in 'Say No to Infection'.

The provider encouraged and supported staff to gain further qualifications and attend external courses provided by other organisations. The registered manager explained this was to increase staff knowledge and understanding so they could share it with rest of the staff team. For example, two staff members had recently achieved a qualification in Falls Prevention Awareness and another was completing a course around supporting people with behaviour that can challenge. Other staff had enrolled on the local authority's 'React to Red' training to increase their understanding of managing and minimising skin damage caused by reduced mobility.

Staff had opportunities to meet with senior staff to discuss their training and development. One staff member told us they felt confident to ask for support outside of these formal meetings and explained, "Even if I am not sure of something now, I will go to a team leader or any of the managers."

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 are called the Deprivation of Liberty Safeguards (DoLS).

The managers had a good understanding of MCA and how to put this into practice. The registered manager told us about one person whose needs they were no longer able to meet at the home. The registered manager and operations manager had involved a multi-disciplinary team to ensure this person's 'best interests' were met. They explained they were working closely with healthcare professionals to ensure a suitable new placement was found for this person. Where people required restrictions on their liberty to keep them safe from harm, for example, if they left the home alone, DoLS had been applied for and authorised.

Staff had training in and understood the principles of the Mental Capacity Act 2005. Staff knew the importance of obtaining people's consent and during our inspection visit we saw staff asked people if it was alright with them before they carried out any tasks or care. One staff member told us how they balanced the right of people to decline assistance with ensuring their health and wellbeing was maintained. They explained, "If they refused (personal care) I would document it and go back half an hour to an hour later and offer again. If it was a continual thing, I would speak to my team leader or line manager and discuss what we are going to do because it is in the person's best interests to freshen up."

People were encouraged and supported to eat and drink enough. People had a choice of meals and could eat in the dining area or their own bedroom if they wished to. Meal options were displayed in words, which people living at the home did not always understand. However, when meals were served, staff explained what was on offer. They also showed people the plated choices so they had a visual prompt to help them choose what they wanted to eat. At lunchtime people received support and assistance from staff to ensure they ate and drank enough and enjoyed their meal.

Mid-morning and mid-afternoon snacks were offered to people with a choice of drink. Staff knew which people were identified as being at risk of malnutrition and required high calorie snacks. They encouraged and prompted people to finish their drinks to prevent the risk of them becoming dehydrated. One person told us they were regularly offered snacks which pleased their relative because, "[Person] has stated to put on weight since they have been here."

The cook had information about people's nutritional needs and made a fortified (high calorie) milkshake for people who required extra calories in their daily diet. The home currently used a 'cook-chill' system where pre-prepared meals were delivered to the home. People had mixed opinions about the quality of the food. Comments included: "The food; we have our good days and our bad days", "They give you two options with the food. It's quite good" and, "All the meat tastes the same." However, plans were in place to return to home cooked food. A catering and hospitality manager had been recruited to work across three of the provider's homes to develop menus and people's mealtime experience.

The provider worked in partnership with other organisations to ensure people's needs were met and responded to. Staff monitored people and were responsive to fluctuations in people's health so they could be promptly referred to other healthcare professionals. For example, people were supported to attend appointments with doctors, opticians, dieticians and speech and language therapy. During our inspection

visit, dental services visited some people and gave them health checks.

The registered manager explained how they encouraged good working relationships between their own clinical team and community health professionals so information could be shared effectively. Each person had a 'hospital pack' which went with them if they were admitted to hospital. This informed other health professionals about all the care the person had received in the previous seven days, including their nutritional intake.

Some people were at Willow Tree for a period of assessment before moving back home or on to other nursing or residential homes. The registered manager told us how important it was that those people returning to their own homes had the appropriate support in place to ensure it was managed effectively. They told us, "We always stamp our feet that they (community providers) come here and meet the residents and go through the care plans." Staff made sure people had all their medicines and discharge letters so information was shared with all those involved in the person's care.

The home was spacious with two separate communal areas and a quieter lounge where people could spend private time with their visitors. There was a garden area with a central courtyard which people could sit in and enjoy in the warmer weather. There were challenges in the home such as some corridors were narrow which made it difficult for people to pass each other in wheelchairs. However, staff assisted people so they could get to where they wanted to go.

We found the environment was not always considerate of how people living with dementia might perceive their surroundings. For example, whilst flags and pretend hot air balloons gave colour and brightened up communal corridors and lounges, some people could find these confusing and they could impact on their spatial awareness. However, the provider had already identified that the environment needed to be changed so it was more supportive of people living with dementia. They had recently recruited a 'care co-ordinator' who had previously worked in an accredited dementia care home. The operations manager explained, "The care co-ordinator will work with the nurses to provide a more dementia friendly environment because we know we are not there yet." The operations manager was confident the improvements would provide a more effective environment where everyone would feel safe and comfortable.

Good

Is the service caring?

Our findings

At our last inspection we rated caring as 'Good'. At this inspection we found people continued to receive care and support from an understanding and caring staff team.

Staff told us they enjoyed working in the home and some staff particularly showed a real commitment to ensuring people's social and emotional needs were met. For example, one staff member regularly completed sponsored challenges to raise money for the 'Residents Outing Fund'. This staff member told us, "I just want to make sure our residents have the best life they can have in this home. I want them to get the best out of life." Another staff member told us, "I care for these people as if they were my own family and that is the best support I can give them."

Staff listened to what people had to say so they understood what was important to them. For example, one person was born and raised in another country. When a staff member visited the country, they went to the person's home town and took a photograph to show them. Another person proudly spoke about having worked in the oldest sweet shop in England. Staff had researched the shop and obtained a picture which was now used as a 'memory plate' on the person's bedroom door to help them find their room more easily.

Staff were aware of people and responded to people who were anxious. For example, one person became uncomfortable in the company of another person. A staff member noticed and went over, spoke to the person and offered them reassurance. Another person became agitated during lunch. A staff member supported them out of the room to give them space. When they returned a few minutes later, the person was relaxed enough to finish their meal. A staff member offered to close the curtains for one person when they noticed the sun was in their eyes.

However, we found some staff would benefit from further dementia care training so they had a greater understanding of how best to actively involve people living with dementia in making decisions. For example, one staff member listed five choices of snacks for people and we saw some people were confused by the length of the verbal list. This varied from the lunchtime approach, when people were visually shown two items to help them make a decision. We also saw that whilst staff undertook tasks in a polite way that met people's needs, they were sometimes focussed on the task rather than the person.

We discussed this with the registered manager who told us the provider had recognised this was an area which required improvement. They had engaged an external company which specialised in dementia care. The company were going to provide in-house training and workshops to support staff to recognise and explore opportunities for meaningful engagement with people throughout their working day.

People were assigned a specific member of staff called a keyworker as well as a named nurse. Keyworkers were responsible for maintaining a special relationship with each person they supported, ensuring their social and practical needs were met. The registered manager explained how they invited staff to share information about their interests and hobbies so they could ensure people were allocated a keyworker who had the same, or similar, interests. The registered manager told us this had been particularly successful for

one person who had formed a trusted relationship with their keyworker. This person could become very anxious during personal care so some interventions, such as weighing the person, were planned for when their keyworker was on duty. One person told us, "My keyworker is [name]. He'll get me anything I want." Another told us, "My nurse is [name]. She's lovely, she brings my tablets. No, she doesn't plan my care, but she helps the carers put me to bed sometimes" However, one relative felt the keyworker scheme could be more actively promoted and said, "The keyworker and nurse are advertised in [person's] room, but it's not a rigorous scheme."

Staff respected people's privacy. Staff knocked on people's bedroom doors before entering. We saw one staff member gave a person privacy whilst using the toilet. The staff member stood outside the closed door and asked the person to call them when they needed support.

The provider was committed to equal opportunities and diversity. People's cultural and personal preferences were respected within the home when it came to receiving gender specific care or engaging in cultural or religious activities. The provider developed relationships with faith organisations to ensure people's spiritual and cultural needs were met. People could attend a regular faith service and were supported to attend events at the local church. For people who did not have specific religious beliefs, a pastor visited the home regularly to provide pastoral care to people and spend time with them on a one to one basis.

People were supported to maintain relationships with those that mattered most to them. Visitors were encouraged to visit when they wished to.

Good

Is the service responsive?

Our findings

At our last inspection visit we rated the responsiveness of the service as 'requires improvement' because care plans were not always personalised and did not always demonstrate people's involvement in developing their plans. At this inspection we found improvements had been made the rating is now 'Good'.

Since our last inspection visit the provider had introduced an electronic care planning system. The registered manager and provider could audit the system to identify any gaps in care delivery so action could be taken.

Care plans reflected people's assessed and changing needs and guided staff in the delivery of care and support to people. The care plans were personalised stating how people liked to dress, the food they liked and preferences for bathing, washing and sleeping. This information was taken from the detailed profile completed on admission to the home, either with the person or their family members.

The nurse we spoke with talked about people in a very person centred way demonstrating that they knew people's individual routines, likes, dislikes and preferences. They explained how this knowledge enabled them to respond to people's changing needs. "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right."

Staff were responsive to people's communication needs. People's sensory needs were assessed and recorded in their care plans and what support or equipment they needed to enhance their ability to communicate. One person had an eye condition which meant they had no central vision. There was pictorial information for staff about how this impacted on what the person was able to see and how staff should approach them. Another person whose first language was not English had 'cue cards' to help them communicate. A third person had a 'communication pad' to call for assistance and to change the channel on their television. The registered manager told us information could be produced in larger print or in a different language to make it accessible for people's differing needs.

People were supported at the end of their life in the home and staff had received training in end of life care. The provider worked with other healthcare professionals such as district nurses and the local hospice to ensure people had a dignified and pain free death.

There was some information in people's care plans about their wishes at the end of their life. For example, about any decisions that had been taken should they experience a cardiac arrest. However, the registered manager acknowledged they needed to seek people's views about how they would prefer their care to be delivered in their final days while they were still able to express them. They explained, "The end of life care plans are still not as great as we would want them to be. We do broach the subject all the time but there is still a taboo with people not being able to talk about it." They told us they planned further training to give staff the skills and understanding to have these conversations so they had the information to meet people's preferences for their end of life care.

The provider arranged activities for people to participate in. The service had an activities co-ordinator who led group and individual activities, both inside and outside the home. Among the activities provided were bingo, dominoes, quizzes, afternoon teas and visits to local areas of interest. The activities co-ordinator told us they helped serve breakfast every morning so they had the opportunity to speak with every person and ensure their social needs were met. They explained, "I like them to be happy and smile. I don't want them to be bored."

A major initiative the activities co-ordinator had introduced was a 'wish tree'. Each person was invited to share a wish and hang it on the tree. For example, one person wanted to have a Chinese meal and another person wanted to 'take a walk in the fields and scrump apples'. The activities co-ordinator was working through the list to make sure everyone's wishes were met. They had already arranged a trip to Blackpool for a person who wished to go to the seaside and a narrow boat trip for another person who wished to go on the river.

There was also a strong emphasis on building and maintaining community links so people could still remain a part of the local community. For example, a local playgroup was invited to join in with some of the activities in the home and people could visit the playgroup if they wished to. The provider had also established links with another residential nursing home and shared their transport facilities and arranged joint activities. People who lived near the home were invited to attend activities including the regular faith services. During recent elections the registered manager had worked with the local council to ensure people maintained their right to vote. Some activities were to support other national and local charities. For example, a McMillan coffee morning and a Christmas shoe box appeal. The registered manager explained this was important because, "It is helping another area of the community."

The provider had a complaints procedure which people and relatives understood. One staff member explained how important it was for people to feel listened to and explained how they would support people if they had any concerns.

We looked at the complaints register and found 10 complaints had been received since our last inspection visit. There was detailed information about how the complaint had been investigated and whether there were any recommendations or action that needed to be taken to prevent similar issues in the future. For example, an issue around dirty clothing had been subsequently shared with staff at a meeting to ensure learning was shared.

Good

Is the service well-led?

Our findings

At our last inspection we rated the provider as 'requires improvement'. This was because quality assurance checks were not sufficiently robust. At this inspection we found that significant improvements had been made. Where we did identify areas which still required further improvement, the registered manager was open and receptive and took immediate action to address the issues. The rating is now 'Good'.

The registered manager walked around the home every morning to greet people, speak to staff on duty, and assess the environment. The provider's operations manager visited the home regularly and the registered manager told us the provider was very supportive of developing the service to ensure positive outcomes for people. For example, the provider had demonstrated a commitment to improve the quality of care provided to those people living with dementia. They had engaged an external specialist dementia training provider to review dementia care throughout the home, identify where improvements were required and support staff in developing their knowledge and skills in supporting people living with dementia.

The registered manager told us that one of their biggest challenges had been to recruit a permanent staff team and raise the morale of staff to ensure people received person centred care. They explained, "We needed to work with the staff to understand the needs of the residents, where we were and where we need to be. We have more of our own staff now and nurses, so there is more stability." The provider had introduced initiatives to recruit and retain staff. This included a 'refer a friend' bonus scheme for new staff and overtime incentive payments. Where staff needed support with training, for example with IT skills, the provider had referred them to a local organisation who provided them with support to complete the training modules.

One member of staff explained that communication had improved in the home because, "Since your last inspection, the manager has started an 'office open door' hour every weekday between 2-3pm. This is for staff, we can go and raise any concerns. If I was concerned about anything, I'd see the manager." Staff told us they felt more able to raise issues and had been encouraged to provide feedback about agency staff to ensure people received a consistent standard of care.

The provider and registered manager conducted regular audits of the quality of the service to make sure people received safe and effective care. They also maintained a regular schedule of health and safety checks of the premises and equipment. Some audits had not identified some of the issues we found, for example around infection control and gaps in medicines records, which was acknowledged by the registered manager. Following our inspection visit, they confirmed they had introduced a new infection control audit tool which was based on best practice guidelines and had supervisions with staff who gave medicines.

The operations manager explained there had been changes in the governance of the home since our last visit which meant quality assurance had improved. They told us, "I think we have made masses of improvements around clinical governance and provider governance. We now have monthly leadership and management meetings." Each month, the registered manager completed a report which gave detailed clinical information about any wounds in the home, people who had lost weight, any falls or accidents and

incidents. This was analysed by the provider's operations director who was a registered nurse to identify any areas which needed to be improved. This then fed into the business improvement plan. Two areas where improvements had been identified was nutrition the prevention of falls. A catering and hospitality manager had been recruited to improve the mealtime experience for people and the provider had signed up to a national 'Fallsafe' initiative to reduce the number of falls within the home.

People and relatives were invited to provide feedback about the home. The provider had introduced a new questionnaire which was sent out every two months. Each questionnaire was based on the key questions of safe, effective, caring, responsive and well-led to identify any suggested improvements in each area. Following completion of the surveys, the provider had invited people and relatives to an 'annual quality review event' to share what they had learnt from the surveys and audits. The registered manager explained this was to promote transparency and openness and said, "It was a good thing to share what we had achieved and identify what are strengths and weaknesses are." People had been invited to share their feedback, both positive and negative, during the meeting.

The registered manager understood their responsibilities and the requirements of their registration. For example, they had completed a 'provider information return' as requested, understood what statutory notifications were required to be sent to us and the ratings from the last inspection were displayed in the home.

The provider worked in a collaborative way with other agencies. In particular the registered manager liaised with the local clinical commissioning group, healthcare services and other organisations within the local community. At the time of our visit, the activities co-ordinator had recently received a community award for 'customer care' in recognition of their work with people who lived at Willow Tree Nursing Home.