Strathmore Care

Whittingham House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Whittingham House provides accommodation and personal care for up to 70 older people and older people living with dementia. However, the provider had placed a restriction on the provision of services. The manager confirmed that 57 was the maximum number of people they would provide a service to.

The inspection was completed on 22 and 24 November 2016 and was unannounced. There were 53 people living at the service when we inspected.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager had not been in post since November 2015. However a new home manager had been appointed in October 2016.

Arrangements to manage and mitigate against risk, so as to ensure people's safety and wellbeing, required improvements to make robustness certain. Risk assessments had not been developed and documented appropriately for all areas of identified risk such as; pressure ulcers, diabetes and people's behaviours that challenged care workers. Improvements were required to ensure that the care plans for people were detailed accurately to ensure staff had adequate information to support people. Improvements with regard to the recording of care and treatment provided had been considered by the provider and plans were in place to introduce computerised systems to increase efficiency of care workers.

The service needed to improve their quality assurance systems. Systems were in the process of being developed by the newly appointed home manager to embed robust quality monitoring of the service. Although systems were in place to make sure that people's views were gathered, feedback from people and relatives had not been acted upon to drive improvements within the service. There had been a lack of oversight by the provider with regards to ensuring leadership was present and high quality care was consistently delivered.

Improvements were needed in the way the service and staff supported people to lead meaningful lives and participate in social activities of their choice and ability. The provider advised us this had been addressed and a new activity co-ordinator had been recruited.

Staff were recruited and employed upon completion of appropriate checks as part of a robust recruitment process. Sufficient members of staff enabled peoples individual needs to be met adequately. Qualified staff dispensed medications and monitored people's medication needs satisfactorily.

The manager was making developments within the service. A new workforce was being created and effective teamwork was being promoted. Care workers were being supported to obtain further skills and knowledge and were supervised effectively to ensure consistent best practice. The service worked well with

other professionals to ensure that people's health needs were met. Where appropriate, support and guidance were sought from health care professionals, including Community District Nurses and social workers.

Assessments had been carried out where people living at the service were not able to make decisions for themselves. Care workers understood the importance of consent and ensured that people were given choice. Although care workers knowledge of Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) was variable the manager had arranged for external training to increase staff confidence around the subjects. 'Best interest' meetings were being held to ensure that people's decisions were protected and respected.

Staff understood people's needs and treated people with dignity and respect. Positive relationships had been created between people and care workers. Advocacy services were provided where needed to ensure people's voice was heard.

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.

Risks to individuals were not always managed safely by ensuring people's needs were adequately documented. Arrangements to manage and mitigate against risk, so as to ensure people's safety and wellbeing, required improvement.

Staffing levels were adequate during inspection and were adapted to people's needs.

The management of medicines was safe and senior care workers were diligent in their practice.

Is the service effective?

Good

The service was effective.

Arrangements were in place to ensure staff received the support, skills and knowledge they require to meet people's needs.

People were being supported with the decisions they made and 'best interest' meetings had been held to ensure that people were protected and respected.

People were supported by care workers to receive care from health professionals, when appropriate at Whittingham House.

Is the service caring?

Good

The service was caring.

People and relatives reported kind natures of staff and care provided was seen to be person centred and caring.

People were consistently treated with dignity and respect.

Staff were mindful of people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

People were not always engaged in meaningful activities or supported to pursue pastimes that interested them and improvements were required.

Since the appointment of the manager complainants were responded to adequately with regard to concerns and complaints raised.

Is the service well-led?

Requires Improvement

The service had not been consistently well-led.

Improvements were in very early stages and there had been a lack of leadership and managerial oversight of the service as a whole. The provider's systems to check the quality and safety of the service were not robust.

People and their relatives had been provided with limited opportunities to be involved in service improvements. When feedback from people was gained the service had not consistently responded adequately to concerns.

The culture within the service was evolving into a positive one.

Whittingham House

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.

Before the inspection we reviewed information we held about the service, including safeguarding alerts and other notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

This inspection took place on 22 and 24 November 2016. The inspection team consisted of one inspector and an Expert by Experience on the 22 November 2016. 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 24 November 2016 two inspectors were accompanied by a Tissue Viability Clinical Nurse Specialist during the inspection.

Several people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. Therefore we spoke with relatives of people who use the service as part of our ongoing inspection. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who used the service, twelve members of care staff, six relatives, district nurses, social workers, two training co-ordinators, home manager and provider.

We reviewed nine people's care plans and care records. We looked at the service's staff support records for five members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and the quality monitoring and auditing of the service.

Requires Improvement

Is the service safe?

Our findings

The home manager had identified that arrangements for managing risk required improvement and was in the process of making changes. We saw and the manager told us that although there was some information in people's care records to indicate their needs and potential risks, care records had not been sufficiently or consistently documented to reflect how risks had been or should be managed. For example, some people were assessed as at high risk of developing pressure ulcers. Pressure ulcer risk assessments had not been completed for two people and care records did not indicate how staff should be managing individuals' pressure ulcers. Additionally, discrepancies were apparent in weight monitoring documents we saw which meant the service could not ensure people's weight had been monitored safely. Two people had not been weighed for several months due to unavailable equipment to carry out the task safely. The manager had identified these concerns and attempted to acquire equipment from local authorities, however concerns were further escalated to the provider during inspection; they confirmed that these would be obtained as a matter of priority.

Additionally, care records we looked at for two people who required hoisting to be safely moved, did not contain information to specify the type and size of handling equipment or the methodology for each specific activity. Despite the lack of records, care workers were able to tell us how they safely used moving and handling equipment within the service. One care worker told us, "People don't have their own slings but I check the size and weight of the person to make sure I'm using the correct size sling for them." The importance of effective weight monitoring was reflected again with regard to correct equipment being used to support people when moving.

The manager explained to us during their six weeks in post they had addressed immediate risks to people with regard to the environment and that it was their intention to review each person's care records as soon as possible to address and manage any risks to people's health. They told us the extensive review of risks to people had begun but was not yet completed. Staff were being trained in effective care planning in order to complete the review sooner. Although risks to people were being identified and acted upon appropriately, improvements were still required to ensure sustainable, robust arrangements were in place to identify and manage risks to people. The provider had not effectively kept an overview to ensure robust plans were in place to manage risk and safety prior to the manager's appointment.

Although the manager showed some limited understanding in the prevention of pressure ulcers they were keen to acquire knowledge from external sources and apply it within the service. We saw that pressure relieving equipment was in good working order and condition. Three people's rooms contained an equipment chart with daily equipment checks completed and people were being supported to use air mattresses and cushions appropriately to relieve pressure areas. The manager and care workers had good knowledge of what to do if any skin changes became apparent. We saw district nurses visiting people to tend to their pressure ulcers.

There were adequate staffing levels at the service. People told us that there was always enough staff available to support them and that they felt safe. One person said, "I feel safe here, the carers are all nice

and I feel safe with them all." We observed that people waited under two minutes if they required a care worker to support them in their room, we also observed one care worker waiting slightly longer for assistance in the lounge during a particularly busy time of the day. The manager and provider confirmed that they were in the process of purchasing two-way radio handsets so staff could communicate more effectively with each other across the service. This would enable staff to understand and responded quicker to people's needs. The manager told us that staffing levels were determined and regularly reviewed by considering factors such as; the changing dependency levels of people, daily health appointments and staff training needs. We saw that an extra care worker was on shift to attend a hospital appointment with one person. A social worker told us, "There is a constant visible presence of staff at Whittingham House now."

Environmental changes had been made to improve communal areas and people's safety. We saw a maintenance team painting areas of the home and the provider told us of their plans to refurbish areas where needed as they were aware some rooms were tired and worn. The manager told us, "We have changed the layout of the environment and the senior care workers desk has been moved to allow more support and supervision." Three communal lounges were now in use and differentiated by people's dependency levels. We saw care workers were deployed across these communal lounges appropriately with regard to people's needs. A care worker told us, "[Manager's name] has come up with some great ideas since they've been here, like the high, low and medium dependency lounge system. There is always somebody in each lounge all the time to keep people safe." Keypads had also been fitted to doors with access to stairs to ensure people were kept safe. Although one lift had been out of service it caused little disruption. It was fixed during the inspection and there was also a second lift to ensure people and staff had continued safe access to all floors.

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). Care workers consistently told us how they attended their interviews at Head Office and had to wait for all relevant checks to be completed before they commenced working at Whittingham House.

People and relatives told us and our observations showed that medication was administered safely as prescribed. One relative told us, "They [care workers] are very on the ball, they discuss all about [relative's name] medication to make sure they are given to them correctly. Makes you feel safe." Senior care workers who had received training in medication administration and management, dispensed medicines to people. We saw that senior care workers were diligent in their daily practice. For example one relative had provided unclear information regarding the administration of one person's medications. We saw that the senior care workers discussed concerns together and acted appropriately in order to ensure medications were administered safely. Information was passed onto other senior care workers and recorded clearly to ensure that safe administration was consistent. We reviewed medication administration records (MAR) and found these to be in adequate order. The service carried out daily and weekly audits of the medication. The manager told us they had further plans to develop the robustness of medication audits which assured us that the service was checking people received medication safely. The training co-ordinator provided documentation to show that senior care workers competency had been observed and we saw competency assessment documentation in staff support files.

Staff received training in how to safeguard people from abuse. Care workers were knowledgeable of the signs of potential abuse and they knew how to protect people from harm and keep people safe. The service had a policy for staff to follow on safeguarding and whistle blowing and staff knew they could contact

outside authorities such as the Care Quality Commission (CQC) and local authorities. One member of staff told us, "If I thought there was an issue I'd go straight to the senior or manager. If I thought they weren't listening to me I'd go higher to Head Office or straight to safeguarding teams." The manager had a good understanding of their responsibility to safeguard people and had experience of referring concerns to the local safeguarding authority to investigate further.

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Good

Is the service effective?

Our findings

The manager confirmed that all newly employed staff received a comprehensive induction. Staff told us they received an effective induction over two weeks depending on their role and responsibilities. This included an induction of the premises and training in key areas appropriate to the needs of the people they supported. Staff told us that in addition to the training they were given the opportunity to 'shadow' and work alongside more experienced members of staff. This was so that they could learn how to support individual people effectively and understand the specific care needs of people living in the service. The manager told us that suitable new staff had been enrolled on the Care Certificate. This is an industry recognised set of minimum standards to be included as part of the induction training of new care staff. One care worker told us, "I'm doing the Care Certificate at the moment I'm on module 7 and have 15 to do. [Training co-ordinator's name] is supporting me to complete it."

Staff training records showed us that a considerable number of new staff had been recruited since the appointment of the manager. During the inspection we saw that inductions and mandatory staff training was taking place internally by the training co-ordinators. Staff training records revealed that existing staff members were due to undertake refresher courses in various mandatory subjects. The staff we spoke with felt confident that they could care for people effectively however told us that they would appreciate further training to increase their confidence in specific subjects such as skin integrity. The provider confirmed that arrangements were in place for staff to accrue hours which allowed for staff training days. We also spoke to the training co-ordinators who explained the training programme that was underway to ensure that all staff were receiving adequate knowledge and skills. We saw a scheduled training programme was in place to allow the manager time to cover shifts so that the majority of care workers would complete their refresher training. The training co-ordinator also provided us with a schedule detailing that care workers practice was being observed. Competency checks were being undertaken and documented.

The training co-ordinators and manager had also identified additional subjects that the people and care workers would benefit from. For example dates had been arranged for staff to attend training on behaviours that challenge, pressure area care, continence and catheter care. The manager expressed the importance of knowledge and how they wanted to support staff to have the knowledge to confidently care for people. During the inspection we heard from advocacy services and local authorities that arrangements had been made by the manager for further external training to enhance care workers knowledge around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and various other subjects.

The MCA 2005 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 DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had an understanding of the principles and practice of the MCA and DoLS. The manager informed us that they worked hard to ensure that people's needs and rights were respected. We spoke to an advocate who confirmed that actions had been and were continuing to be taken in people's best interests. Multi-disciplinary meetings had taken place for people in order to review their circumstances and ensure that everyone acted in their best interests in line with legislation. One relative told us that they had been involved in meetings to discuss their relative's mental capacity and expressed to us that they were confident that they could work with the manager and care workers to support their relative's decision making.

Although care workers knowledge of the MCA and DoLS was variable they were aware that people had to give their consent to care and had the right to make their own decisions. Care workers told us that they supported people in making day to day decisions and always offered people choice. We saw staff offering people choice. For example, we saw a care worker ask one person if they would prefer to eat their meal in the dining room or in the lounge. Everyone was shown and offered a choice of food at meal times and drinks throughout the day. One person said, "Oh yes, I'm given choice of drinks but I like tea so that's what I have." We also saw one person walking to their bedroom wishing everyone good night at the time of their choosing. This told us people's rights were being protected.

The manager told us that when they started in post they had identified that people's nutritional needs had not always been met in a way personal to them or in a way that would ensure their safety and wellbeing. For example the manager had reviewed people's nutritional needs with the input of family and health professionals and informed the kitchen staff of any changes. The cook showed us a list of people's specific dietary requirements which was also easily accessible for care workers to refer to at meal times to ensure people received the correct diet and support. The manager also told us that they had made changes to the environment to make mealtimes a more pleasurable experience for everyone. We did see that many people chose to sit together in the dining room where there was lots of interaction between people. Although the majority of people reported to us positive experience's some had slightly negatively weighted views of mealtimes. One person told us how they would like more vegetarian options. Another person told us, "You don't always get what it says on the menu." The manager advised us they would talk to the kitchen staff to rectify these identified concerns immediately.

We saw healthcare professionals visit Whittingham House throughout the inspection. Care workers responded to people's immediate and ongoing care needs and were consistently confident about how they would respond positively to people's health needs. One care worker told us, "I would tell the senior on shift if I think someone needs to see a doctor, we would call 111 or 999 depending on what the problem is, then call their family." Relative's told us that they were contacted if an incident or accident had occurred or if it was necessary for someone to attend hospital. One relative told us, "I was so grateful to the staff, they went to hospital and sat with [relative's name] until I got to hospital so they [person] weren't on their own." We saw care workers respond to people's immediate health needs by calling the emergency services at the appropriate time. A district nurse told us, "They are good here for reporting any changes on the skin for residents and usually call us or catch us when we're here if they are concerned."

Good

Is the service caring?

Our findings

People's comments about the care and support they received were positive. People told us, "There are nice girls here, lovely, really lovely," and, "They are all lovely staff here, I have a real laugh." A relative told us, "They don't treat people like children here, [person's name] is happy here and that's the main thing." Another relative spoke kindly of the care workers and how they felt reassured their relative was cared for while they lived some distance away.

Our observations showed that staff interactions with people and relatives were kind and caring. On several occasions we saw care workers laughing and dancing with people. One care worker told us, "I love it here, wouldn't want to leave because I feel like I'm making a difference to people's lives." Relative's we spoke with were positive about the care being received. One relative expressed to us, "[Care worker's name] really understood my concerns and went out of their way to reassure me. They called me in the evening again to reassure me [relative's name] was ok which meant I was able to sleep that night." We were assured the attitude of care workers towards people was positive and caring relationships had been created.

The manager told us they had identified the need to gain people's views about the service they were receiving. They had implemented a tool called a listening sheet. We saw care workers using the listening sheet to record conversations between themselves and people regarding matters such as; how they felt living at the service and what they felt could be improved for them personally. For example one person expressed an interest in local trips being arranged. The manager reviewed the listening sheets with the view to improve the service in collaboration with the provider based upon people's feedback.

We observed that people were being treated with dignity and their privacy was being respected. One person and their relatives chose to have a lock on their door which was documented in care records. We observed that care staff respected the person's wishes and ensured the lock was used in accordance with wishes. Care workers showed a regard for people's dignity when people lacked their own self-awareness. We saw care workers behaved respectfully and respond quickly to ensure people's dignity in very challenging situations.

Advocacy information was available within the service. An advocate provides support and advice to people and is available to represent people's voice and interests. The manager had good knowledge when we asked them about the purpose of advocacy services. One person told us that they had an advocate to discuss personal affairs with. We saw the person talking with their advocate in a comfortable and private area within the service.

People were supported and encouraged to maintain relationships with their friends and family, this included supporting trips home and into the community. Staff confirmed people's relatives and friends could visit whenever they wanted. One person told us, "I love the fact that we are encouraged to visit at any time."

People's preferences and choices for their end of life care had been recorded for one person with the input of their lasting power of attorney. Care records clearly documented where the person did and did not want

to receive treatment and what pathways should be used. The manager told us they understood the importance of clearly recording and reviewing people's wants and wishes for future care towards the end of people's lives, so they could support people in accordance to their views. Although this information was not yet contained within all care records the manager had plans for key workers to discuss these sensitive issues with people already living at the service and would broach the subject during pre-admission assessments if people were happy to. This assured us that the service was making sure staff knew how to manage, respect and follow people's choices and wishes for their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People had not been consistently supported to have care plans that reflected how they would like to receive care, treatment and support. We identified that people needed support with behaviours of anxiety and health needs such as Diabetes. However, people's care plans required more information that described what staff needed to do to make sure personalised care was provided. We saw from complaint records that one relative had reported concerns about how care was being provided and documented. We also spoke a social worker who also advised that they had identified some areas of development with regard to care records. For example; limited information was seen within care plans which needed to be more person centred.

People's care records did not consistently show that their healthcare needs had been recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. For example, two people's care records contained letters of referrals and routine health care appointments. We could not see from care records if the people had attended the appointments or what the outcomes were. Although care workers had good knowledge of the people and their associated needs they confirmed that outcomes of appointments were likely recorded in Ongoing Care Recording Booklet (OCRB) which had been archived. Therefore it was unclear from records what action had been taken and what further action was planned to involve the necessary healthcare professionals.

When we asked care workers about people's specific needs and how they responded to them, they were consistently knowledgeable about how to care for and support each individual appropriately. The manager advised us that they were aware of the need to review care plans to ensure they were person centred and current. They had devised a schedule to ensure that everyone's care plans, OCRB, listening sheets and medication documents were reviewed and updated as soon as possible. This process had begun and several reviews of people's care had been undertaken with the inclusion of families, advocates and social workers since the manager's appointment in post. The manager assured us people's care records would continue to be updated and reviewed regularly in the same manner. The manager also advised us that they wanted to support and encourage care workers to continually familiarise themselves with the care plans. We observed care workers requesting people's care plans to refer to during inspection. We also saw one senior request a comprehensive handover from the manager as they had been on annual leave and explained it was important to be aware of any new or changed needs for people.

Care workers told us they felt the way provision of care was recorded was not effective for the service or people. One care worker told us, "We follow the guidelines for the manager but there are too many places to record the same information. It's possible to make mistakes." Another care worker told us, "There seems to be a lot of paperwork, it should be more streamlined. That way we might be able to spend more time with people than writing paperwork." The manager and provider supported the care workers views and agreed that the way care and treatment was recorded required improving. The provider expressed to us during inspection that they had found OCRB's to be an effective recording tool in the past however was no longer appropriate for the service. They told us of their plans to introduce a computerised system for care workers to record care and support provided, which could be monitored by the manager more robustly in real time.

In addition, to aiding staff to spend more time with people throughout each day.

The manager told us of the improvements they wished to make to ensure people received responsive care. They told us how they wanted to learn from people's experiences and respond to concerns. They showed us a one page checklist for monitoring people's personalised needs. For example, pillow positioning, equipment check, repositioning, food and fluid intake. These checklists had been created for people in response to concerns of poor recording raised with the manager. The manager told us how the checklists would allow people's health to be audited more effectively and to provide health care professionals with relevant information readily.

One relative told us how staff were responding to one person's communication difficulties, "I have had recent meetings with social workers and the manager and we have discussed how I can help with creating communication boards to help [relative's name] communicate what they want easier." We also saw in one person's records how a key worker had contacted a relative to discuss how they could make the person's room more personable to them with photos and personal items. One care worker told us, "[Manager's name] has just started a key worker system. We check what people's needs are and have direct contact with the families of the people we are responsible for." The manager also told us how they had introduced a system to benefit people who were bedbound. Each shift one care worker was allocated to individual service users who were bedbound to ensure their individual needs were met throughout each day and night. Although developments were being implemented they had not yet been embedded into the service to ensure a consistently responsive service.

Although one person told us, "They don't put any pressure on me to do things. I'm happy doing what I want." Our observations throughout the inspection showed that there were few opportunities provided for people in regards to planned social activities. There was an activities co-ordinator in post, but people reported to us that they did not enjoy or weren't interested in the limited activities available to them. One person told us, "Why do I want to play with kids skittles and balls – stupid." We also observed that people were not interested in playing skittles. People repeatedly told us there was nothing to do. The activities co-ordinator told us they regrettably were unable to continue employment at Whittingham House; however the manager advised us that another person had been recruited to fill the post and would be starting in approximately two weeks' time. The provider informed us that there would be emphasis placed on developing meaningful activities for people by finding out people's life history and incorporating their own personal skills around the home in person centred daily activities.

Information on how to make a complaint was available for people to access. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Relatives stated that they felt able to express their views about the service. We saw that they had raised concerns and that the manager had responded in good time and taken concerns seriously and explored them further.

Requires Improvement

Is the service well-led?

Our findings

The quality assurance arrangements and processes which assessed, monitored or improved the quality of the service required improvement. Although systems were in the process of being reviewed and updated to ensure people's current needs were met, it had not been demonstrated during inspection that these monitoring systems and processes were robust and effective as they had only recently been implemented by the manager. This was with particular regard to people's care records.

The service had not delivered consistent high quality care. The quality assurance manager was able to demonstrate to us the arrangements for gaining people's views of the service. This included the use of questionnaires distributed to people who used the service and those acting on their behalf. However, we were only provided with the outcome of questionnaires for 2014 as the 2015 and 2016 analysis had not been completed. Only three questionnaires had been returned for the 2016 analysis. Additionally some of the key highlights identified within the 2014 report had not been actioned to drive improvements. For example; the providers quality assurance report 2014 had identified that people wanted more activities in the home and more frequent support meetings to discuss any changes in the home.

The quality assurance manager informed us that the identified improvements had not been actioned within the home due to a lack of leadership. However a lack of oversight from the provider had meant that people's feedback had not been responded to effectively for almost two years. Since the manager had been in post we saw they had held a residents meeting, were planning relatives meetings, applied listening sheets to gain regular feedback directly from people and implemented a key worker system to provide people with an immediate contact to address issues. One relative told us, "[Person's name] keyworker is so lovely, really goes out of her way to understand what [person's name] needs." Although the provider had failed to drive improvements within the service over a considerable period we were assured that the manager was striving to deliver good quality care.

The provider and quality assurance officer told us that the service had lacked leadership in the past and support to staff had been intermittent from management. The manager, quality assurance manager and the provider were aware that the lack of leadership had impacted negatively on the quality of care that people had been provided. However the provider expressed confidence in the leadership abilities of the newly appointed manager. This expression of confidence was echoed by people, their relatives, professionals and staff alike. One relative told us, "[Manager's name] introduced herself to me as the new manager, she seems very approachable." Visiting professionals told us how the service had made visible improvements since the manager's arrival. We were told, "So many positive changes have been made since [manager's name] has been here. Used to dread coming here but it's so much better now. I know I can discuss concerns with [manager's name] and they will be acted on." We also saw compliments from agency staff with regard to Whittingham House's improved atmosphere and enthusiastic manager. This demonstrated that the provider had responded to the lack of leadership and had recruited a manager who understood what improvements needed to be made.

The manager had made initial plans to positively change the culture of the service. The manager voiced the

importance of ensuring that a good team was in place to carry out the necessary improvements. We were told how a recruitment drive had taken place and it was ensured that new recruits working at the service were passionate about care and good practice. One care worker told us what the Commission expect from services that provide care, they said, "We must look after people correctly, care for them and be responsive to their needs. Everyone has different needs in here so we need to look after people as individuals and make sure they are happy and comfortable." We saw minutes of meetings attended by staff to discuss ways they could improve the service together. The care workers and manager all expressed their keenness to deliver a high standard of care and support to people using the service and developments were being made. We saw care workers openly talk with the manager and offer their extra time to support with people's needs. We were assured that a positive culture was being promoted.

The manager had only been in post six weeks at the time of inspection and there had not been a registered manager in post since November 2015. Although we saw positive changes with regard to the culture within the service and deliberate intentions to improve the quality of people's care they received, the quality assurance and governance processes required improvement and although they were being developed the manager needed time to ensure effective and sustained improvements for people living in the service.