First Cheltenham Care Limited

Wentworth Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 7, 8 and 11 September 2015 and was unannounced.

The service cares for older people who live with dementia. It can accommodate up to 63 people and at the time of the inspection 18 people lived at Wentworth Court. The service had only opened in May 2015.

We inspected this service at the time we did because we had received concerns about how it was managed. We had also been told that there were not enough staff on duty and staff had lacked appropriate training. We found the provider had been faced with having to find a new home manager eight weeks after the service had been registered with the Care Quality Commission. Interim arrangements had been made however these had not provided staff with the leadership they required. During this time the provider had appropriately used the resources they had to monitor the services performance. They had been proactive in making sure people remained safe and that the service remained compliant with relevant regulations.

At the time of the inspection the service did not 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

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was managed by an acting manager who had been in position for two weeks, although this person had worked in the home for several months. They had the previous care home management experience which was required. Recruitment for a new home manager had been taking place since the last one left. The provider was at the point where they were ready to interview several candidates at the time of the inspection. Since the inspection a successful candidate was employed as the new home manager.

People were cared for by staff who were kind and compassionate and there were enough of them to meet people's needs. Staffing numbers were adjusted according to people's needs and as the numbers of people using the service grew. Staff had received training and further improvements to the staff training programme were planned. New staff received the support they needed to learn and to improve their skills. Staff recruited processes helped protect people from those who may not be suitable to care for them.

People's care needs were met and staff were proactive in making sure people's health needs were addressed. This was despite the new service having some problems in developing working relationships with other health care professionals. Risks which could potentially affect people's health and safety were identified and managed. People received their medicines safely and given the support needed to take them. People received help to maintain a healthy diet and where they needed help to eat their food and drink this was provided. People had opportunities to socialise and take part in activities. The staff were working hard at trying to make these more meaningful to individual people. Where people lacked mental capacity they were protected under the Mental Capacity Act 2005 because staff adhered to the Act's code of practice.

In the absence of a permanent home manager the provider's own quality monitoring systems had enabled them to remain fully aware of what was happening in the care home. They had been well informed of what shortfalls there were and what actions were needed to address these. They had then ensured these had been taken. The provider had remained open to people's suggestions and had been transparent in their dealings of any concerns that had been raised with them. Although staff had lacked consistent leadership the service had remained well-led.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected against risks that may affect them. Environmental risks were also monitored, identified and managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Staff were working hard to adopt a personalised approach to care.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. Care plans sometimes lacked detail but this did not prevent staff from being responsive to people's needs and the shortfall was being addressed.

People had opportunities to socialise and partake in activities and the staff were trying hard to make these activities more meaningful to people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Summary of findings

Is the service well-led?

Good

The service was well-led. People had been protected by the provider's own robust monitoring systems. Despite the provider having been faced with challenges to find a suitable manager, they had been proactive in making sure people remained safe and the service compliant with relevant regulations.

New management arrangements were in place and staff were behind these and committed to providing people with a good standard of care.

The management team were open to people's suggestions and comments in order to improve the service going forward.

Wentworth Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7, 8 and 11 September 2015 and was unannounced. It was inspected by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case looking after people who live with dementia.

Prior to visiting Wentworth Court we reviewed the information we held about the service. This included the information of concern as well as information about significant events which the provider must inform us about. Such as a death, serious accidents/injuries and any allegations of abuse. We also gathered information from the local adult social care commissioner. They had reviewed the service in May 2015 and had shared their findings with us.

We spoke with six people who used the service and six visitors of which three were relatives. 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 members of staff, which included care and nursing staff, housekeeping staff, catering staff, maintenance and ancillary staff. We also spoke with the acting manager, the provider representative and one Director of the company.

We inspected the electronic care records of seven people, which included care plans, risk assessments and other relevant care and health related documents. We inspected eight staff files which included the recruitment records of six staff and related training records. We also requested that the services main electronic training record be forwarded to us, which we received. We inspected documents which related to the management of the service. This included, for example, staff duty rosters, monitoring audits and accident and incident records. We inspected records relating to the maintenance of the building and equipment as well as health and safety risk assessments.

Good

Is the service safe?

Our findings

People's needs were met because there were enough staff on duty to ensure this happened. People's social and recreational needs were met as well as their care needs. Call bells were answered promptly and people who required support received this when they needed it. Numbers of staff on duty were monitored according to people's needs. As the service was new, staff numbers were also being adjusted as the numbers of people who used the service increased. An increase in care staff numbers had just taken place in the day time and less recently during the night-time. The housekeeping team told us they were about to recruit a new member of staff as more areas now required cleaning. There had been a recent turn over in staff so recruitment was also taking place to replace these staff. The service was operating on one of the two floors at the time of the inspection. When appropriate additional staff would be recruited and the second floor would be opened.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed that appropriate checks had been carried out before the staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps explored at interview.

People were safe because the provider had arrangements in place to ensure this was the case. People looked comfortable and at ease with the staff. One person told us they felt quite safe living at Wentworth Court. They said all the staff were "very nice" and "I haven't come across anyone (meaning the staff) that's a bit awkward". Staff and visitors were aware of how to contact relevant agencies if they had concerns about people, which they felt were not being correctly managed. Staff were aware of what constituted abuse and knew how to report related concerns; both inside and outside of their organisation. When discussing people's safety one member of staff said, "I would bring my Mum here". One member of staff described what abuse may look like and said "abuse is anything from neglect to rudeness and being disrespectful". Other staff were also aware of what could constitute abuse. A management on call system meant staff had access to senior management staff at any time if they needed advice or to report a concern. Staff had received guidance and training on these arrangements.

People were protected from risks which could have a negative impact on their health and safety. These had been identified, assessed and actions put in place to manage them. For example, one person's risk of potentially falling had been identified and a walking aid had been supplied. We observed staff reminding this person to use this when they attempted to walk. Another three people were at risk of developing pressure ulcers. Pressure relief equipment had been organised and was in place. For example, staff had made sure one person's pressure relief cushion had moved with them from their bedroom to the lounge so pressure relief could continue. Two other people had a pressure relief mattress on their bed. They also required their positions to be altered on a regular basis to further alleviate pressure from their skin. We observed staff carrying this out and care records showed this had been done on a regular basis.

People's accidents and incidents were recorded and these were monitored so that reoccurring themes and triggers could be identified. This helped staff put actions in to place to help prevent further reoccurrences.

People were protected from the spread of infection. All departments, for example, care staff, housekeeping, catering and maintenance played a part in this. The kitchen staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing, food was kept at appropriate temperatures and other staff had limited access to the kitchen. Housekeeping staff adhered to the colour coding system in place for their cleaning equipment. This reduced the spread of potential infection by making sure, for example, cleaning equipment used to clean toilets was not used to clean bedrooms and communal areas. They were also aware of what actions to take when people had specific infections. There were additional infection control measures in place for one person. The cleaning staff were aware of these and knew how this infection could

Good

Is the service safe?

spread and what action they needed to take. Care staff and nurses wore protective plastic gloves and aprons when giving personal care so as to reduce the risks of cross contamination. The same took place when they helped people with their food. We observed staff washing their hands between various tasks as well as using hand cleansing products. The maintenance staff took action to reduce potential risks, for example, relating to Legionella. They regularly flushed all taps and showers which were not in regular use to ensure the water was flowing through the system. They also ensured correct water temperatures were maintained to avoid systemic contamination of the system. There were appropriate waste management arrangements in place.

People lived in a safe environment. The maintenance team carried out numerous health and safety checks to ensure this remained the case. We saw well maintained records which recorded frequent monitoring and servicing of various systems and equipment. Risk assessments had been completed by the lead maintenance person who held an appropriate qualification to be able to do this. Contracts were in place with various service providers and maintenance companies. For example, a specialist company serviced and maintained all lifting equipment, which included passenger lifts, care hoists and slings. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm and fire safety equipment.

People's medicines were administered safely. We observed people receiving their medicines and they were given help to take these. Safe and secure storage arrangements were in place. Records of medicines administered were generally maintained well. We checked the stock balance of a selection of medicines and these tallied with the records maintained. Staff ensured people's medicines were reviewed by their GP when needed. For example, one person had remained in a degree of pain despite having been reviewed by a GP. Staff had been very proactive in getting this reviewed again. Another person had refused their medicines in tablet form so staff had organised for these to be prescribed in liquid form to see if this helped. Another person had been discharged from hospital without enough medicine to complete their course of treatment. Staff therefore needed to address this immediately to ensure the person did not miss a dose. They organised for the local GP to prescribe a further supply, took the prescription to the pharmacy and collected the medicines. The acting manager told us that the arrangements made with a pharmacy when the service initially opened were no longer adequate enough. They had therefore made arrangements for a different pharmacy to supply and support the service as it grew. This arrangement was due to commence soon.

Good

Is the service effective?

Our findings

One person said, "I think they're (the staff) are very good, of course they've been trained" Some staff were more experienced and more qualified than others but there were arrangements in place to support staff who were inexperienced. We observed experienced care staff supporting the new staff well.

People's needs were met and monitored by staff who had received relevant training. We had received information prior to the inspection that some staff had not received adequate induction training, had not had an opportunity to shadow existing staff when they first started and that one member of staff was not suitably qualified. We inspected relevant staff files in relation to this information. We found staff had generally received a form of induction which covered all the service's key policies and procedures as well as basic training which the provider viewed as necessary to carry out their tasks safely. The induction period included an orientation to the building and guidance on fire safety systems. The acting manager explained they personally went through, many of the basic subjects with staff so they had a better understanding of a subject. This in had included, safeguarding people from abuse, the Mental Capacity Act, infection control and safe moving and handling. The acting manager told us they could not speak for what happened before they started doing this. Staff also completed other subjects, such as health and safety, employment legislation and effective communication. The provider's chosen method of delivering training was predominantly the completion of computer based modules and workbooks.

The acting manager and provider were aware of the new care certificate which providers can choose to adopt. This lays down a framework of training and support for new care staff. Its aim is for new care staff to be able to deliver safe and effective care to a recognised standard once completed. This was not in place at the time of the inspection but the provider planned to introduce this. We were shown the provider's improved training plan for 2015. Future induction training would include a two day orientation and commencement of the new care certificate. Additional subjects would be learnt by use of the computer, workbooks and sometimes face to face training through an independent trainer.

The acting manager explained that a process was in place to determine if new staff were competent in their tasks and if they were ready to carry these out alone. The acting manager also confirmed that arrangements for staff to shadow existing staff, when they first started work, differed according to the staff member's confidence and past experience. There was no evidence to show that one member of staff, mentioned in the information we received, had shadowed existing staff. However, records showed this member of staff had been experienced in care; they had completed an orientation of the building and had signed to say they had read the services policies and procedures. They had also worked alongside another experienced member of staff when they started and subsequently completed additional training. We spoke to one recently recruited member of staff. Despite already being experienced in care, they told us they were shadowing an experienced member of staff and they were finding their induction helpful. We also inspected relevant records relating to another member of staff where the information had told us they were not suitably qualified. We found this not to be the case.

The main training record showed the majority of current staff had completed training in the subjects the provider viewed as necessary. Some new staff were in the process of completing these. The majority of staff had also completed the basic computer training in dementia care. We saw that only three staff had completed more in depth training on this subject. We were shown how the service aimed to improve this by way of staff following a dementia care training pathway.

Staff had completed some training in managing people's behaviour when they were particularly distressed and anxious. We observed one person presenting like this and they were well supported by the staff. Very few staff had received training in end of life care but this had started to be addressed and three staff had already been booked to attend a specific course at a local hospice. The service had also been given guidance by health care professionals on the end of life pathway. Some staff held national qualifications in care and had previous experience in caring for people who live with dementia and who are at the end of their life.

Staff support had been provided through individual supervision sessions. The acting manager told us these sessions had fallen behind. However, they had begun to

Good

Is the service effective?

talk with staff about their training needs and any other concerns they may have. The provider had also met with staff individually to discuss with them any concerns they had and when there had been specific performance issues.

People were supported to have a balanced diet and risks relating to people's nutritional in take were managed. When talking with one person they said, "It's (the food) okay, chicken is my favourite". One visitor said, "The food's very good" and another said, "The food's excellent, (name) has put on weight". People were given hot drinks at set times and helped to drink these. One morning the lounge felt quite warm and very few people were offered additional drinks in between their set cups of tea or coffee. There were no glasses of drink put alongside people when they arrived in the lounge. On this occasion we did not observe anyone looking particularly dehydrated and we saw, at other times and in other places, people were given plenty of drinks.

Staff used a nutritional assessment to determine levels of risk and to guide them on what action should be taken. Referrals were made to GPs when for example, people lost weight. Care staff and kitchen staff worked together to address people's nutritional risks. Kitchen staff were aware of who needed extra calories and fortified their food accordingly with whole milk powder, butter and cream. Other diets were also managed, for example, people with diet controlled diabetes as well as reducing diets. Each day, one cook attended the morning staff hand over meeting. Issues relating to food and mealtimes were discussed. For example, in the meeting we attended problems with a person's dentures were discussed. Staff talked about how they would address this and what actions they could take to maintain the person's appetite and weight.

We observed people receiving patient and kind support at mealtimes. Seven people out of seventeen required staff to feed them. This was carried out a way that maintained people's dignity. We also observed staff allowing people to eat their meals independently but they provided support when needed. People were able to choose what they wanted to eat and if people were hungry between meals then snacks were available. A visitor informed us that their relative got up very early in the morning. They said, "But it doesn't matter the staff just sit with them and they have a cup of tea and some toast and marmalade". We arrived to carry out the inspection at 7am and three people had woken up early and were sitting in the lounge. All had already had several cups of tea, toast or biscuits.

People were protected under the Mental Capacity Act 2005 but there had been confusion about what needed to be documented. We found the principles of the Act had been followed but documents such as mental capacity assessments and best interest decisions had not always been completed. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The acting manager explained that most people lacked mental capacity but that some were able to make simple day to day decisions with support. Where we would have expected to have seen a completed mental capacity assessment showing that the two steps of this had been completed, this was not always the case. Where people were unable to give consent for their day to day care and understand what was recorded in their care plans, there was not always a recorded best interest decision.

We checked to see if any significant decisions had been made on someone's behalf without a best interest decision having been made. This had not been the case. This would include, for example, giving someone their medicines hidden in their food because they were refusing them and were unable to consent to taking them. Where a Do Not Attempt Resuscitation (DNAR) order was in place a best interest decision had been recorded. In some cases a best interest decision process had taken place prior to admission. This related to a decision about where the person should live. In these cases Deprivation of Liberty Safeguards were place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had also already submitted seven referrals to the local authority under DoLS where they suspected someone's

Good

Is the service effective?

liberty had been deprived. Others were being assessed and the acting manager told us they would complete additional referrals as needed. We were not aware of anyone's liberty having been deprived without this process taking place.

We observed staff asking people for their agreement before, for example, they helped them to use the toilet, have a wash, sit down to a meal or have their tablets. When speaking with staff about this they were aware it was unlawful to force someone to do something they did not want to do. For example, staff told us where people refused personal care, they left them and tried again later when the person was more able to agree.

People had access to some health care specialists but where some referrals for health care support was needed, this was proving difficult for the care home to access. Staff told us they had needed to be more assertive than they had expected to ensure people's health needs were reviewed. Working relationships with some community professionals were proving difficult for the new service to initiate and develop. People had access to mental health care professionals, chiropodist and eye and dental care. Arrangements were in place for a GP to visit the service fortnightly but for various reasons this had not recently been provided. The acting manager was taking action to try and resolve these issues on behalf of those who lived at Wentworth Court.

Good

Is the service caring?

Our findings

One person told us they liked living at Wentworth Court. When we asked what it was they liked about it they said, “Everything, I get on alright with everybody”. One visitor told us their family “Couldn’t be happier” with the care given to their relative. They said that all the staff were “very, very friendly" and they told us that all the staff knew their relative by their name. Another visitor said, “Staff are fantastic”.

People received caring and compassionate care. We witnessed a caring approach by all staff. Comments such as, “Would you like some of your coffee?" and "Shall we put your legs up?” demonstrated that staff wanted to help people and make them comfortable. One particular situation was managed with compassion and a real understanding for the person’s feelings and distress at the time. The member of staff made comments such as, “I’m so sorry you feel like this” and "Please don’t cry, take a deep breath”. This member of staff sat with this person for a considerable length of time giving them reassurance.

Caring and positive relationships had been built between staff and those they cared for. People looked well cared for and staff showed affection towards the people they looked after. People in return looked very comfortable and relaxed in the staffs’ presence. Terms of endearment were used by staff several times; such as “my darling” and “my sweet”. People were unable to tell us whether they minded this but on each occasion people reacted favourably and at other times staff used their Christian names.

People were involved in making daily decisions and had opportunities to make choices. One person told us they dressed themselves and had a say in choosing their clothes. They said, “You’ve done it yourself for many years so you just get on and do it yourself”. They went on to tell us that the staff helped them by getting clothes out of the wardrobe for them to choose. We complimented another person on the way they were carefully applying their make-up. They said, “It makes me the person I am; I love lipstick”. We noticed that staff had put her large make-up box on the shelf of her walking frame so that she could do her face and hair whenever she wanted to. We saw staff giving people opportunities to make choices about how they spent their time. For example, some were asked if they would like to get some fresh air and were supported to do this and others had opportunities to partake in conversation and activities inside the care home.

One member of staff explained the staff learnt about people’s interests and preferences by talking with them and their families. People’s biographies were kept in the staff room so staff could read these. The plan was to include these on the computerised care records system. Work was also in progress to have a document called ‘My Life Story’ available in each person’s bedroom. This would be used as a prompt to help staff have meaningful conversations with the person they were delivering care to.

People who mattered to those who lived at Wentworth Court were made to feel welcomed and involved. One visitor said, “The staff make you very welcome; day and night. If you’re here at a mealtime, they will give you a meal and they always offer you a drink”. This relative had recently been able to celebrate their relative’s birthday with a family party which was organised by the kitchen staff and held in the care home. Another relative who had experience in dementia care had been asked to represent relatives in the forthcoming home manager interviews.

People’s privacy and dignity was maintained. Personal care was delivered behind closed doors and therefore in private. One incident which took place in a communal area required the person’s dignity to be maintained under difficult circumstances but this was well managed by the member of staff present. Where people could not maintain their own dignity any longer staff did this for them in the way they delivered their care and spoke with them.

Good

Is the service responsive?

Our findings

One visitor said, “Care staff are good, some better than others but none less than good”. This relative was very involved in the care of their relative and had meetings with senior staff about their relative’s care and where they thought it could be altered or improved. They told us they felt their relative’s care had improved and become more consistent in the way it was delivered over the past two weeks. They also said, “The staff are exceptionally responsive to all questions and feedback”. Another visitor said, “All staff are very approachable” and “I would talk to the Nurse on duty about health issues, someone in the office about finance, and anyone’s who’s around about any other issues”. In terms of how people and their relatives contributed to the planning of care and activities, one member of staff said, “It’s a good team and we’re asking peoples opinions so that we can have it running the way it should be; for the residents, not for us”.

People’s care needs were assessed and care plans outlined how this was to be delivered. An electronic care records system was used to record all relevant assessments and care plans. One visitor had been involved in the planning of their relative’s care, but had not realised until very recently, that a hard copy of the care plans could be provided for them to read. They had now seen these and were satisfied with them. The acting manager told us they had gone through three people’s care plans with relatives who were acting as their representatives. They told us they planned to do this with others so that they had an opportunity to represent their relative. One person who lived at Wentworth Court told us they were unaware of having a care plan but indicated they were happy with the care they received.

The care records we looked at had recently been improved by the acting manager. Some additional information had been added and the detail of some care plans improved. The acting manager explained the care plans had not been overly personalised and had required improvement. They also explained this work was still in progress. Some care plans we read still needed to be personalised, for example, one person’s continence care plan said, “Ensure toileting programme is adhered to”. It gave no detail about what this programme was or what the person’s particular needs were around being helped. We checked to see if this person was in receipt of appropriate continence care. The lack of a personalised care plan had not prevented staff being responsive to the person’s needs. Another person had no care plan or risk assessment in relation to their infection. The person was however receiving the correct care and staff were aware of the associated risks. The acting manager described this as an oversight and these records were completed before the end of the inspection. Another person’s care plan did specifically state how the person should be cared for. On one morning we found this care plan had not been followed in practice and the person had been left in an uncomfortable position. Staff addressed this as soon as we pointed it out. This was the only example of a care plan not being followed that we identified.

We spoke with staff about how they provided people with social stimulation and activities. There was a weekly activities programme as well as spontaneous activities and social opportunities taking place. We observed the start of a movement activity where eight people and five staff participated. The leader spoke to each person individually, asking their names and if they had any particular aches and pains. They gently encouraged people to take part and explained why the exercises were beneficial. Staff participated alongside people and it became a shared experience. Several people, at various times, were supported to go out; to the local shops. One other person enjoyed the inner courtyard with their relative. One member of staff explained this was a safe and popular place to sit. The scented herbs planted in this area had been used as a topic of conversation recently and people had reminisced on how they had used these in their cooking. The service had one activities co-ordinator who worked four days a week and another was being recruited. We were told the care home had a ‘whole home’ approach to activities. This meant every member of staff was involved in the provision of activities. For example, kitchen staff had helped people to bake, housekeeping staff encouraged people’s involvement in dusting and care staff took people out into the community. Both the provider and activities co-ordinator were keen to develop links with the local community; schools, churches and shops for the benefit of those who lived at Wentworth Court. Work was in progress to promote this.

People’s past work and their hobbies were explored with them and their families so staff could try to tailor activities to the person making them more meaningful. The maintenance person had been involved with one person and had supplied plastic piping so the person could spend

Good

Is the service responsive?

time joining these together. This activity had been meaningful to this person as they had worked as a plumber. The activities co-ordinator said, "We have to be flexible, people's needs change, interests change". We observed staff talking with people in the atrium area when they were not delivering personal care. Two people enjoyed a came of skittles with one member of staff. Other activities were not overly personalised but people enjoyed them. We found the people seated in the lounge did not receive the same level of interaction from staff as those who sat in the busy atrium. The television was on in the lounge each time we visited and people were rarely engaged with this. We found different people responded to staff in different ways and some were easier to engage than others. The activities co-ordinator told us they had managed to connect with one person by singing to her. They spoke of another person's communication improving since their admission. They said, "You can always get through to people in some way, it's just about listening and watching".

People's complaints and concerns were taken seriously, listened to and action taken to try and resolve the issues raised. The services complaints procedure was explained to people and their representatives on admission. It was included in information they received at this point. The acting manager told us they operated an open door policy and people were able to and did chat to them about simple concerns or queries they had. They informed us that they had not received a formal complaint since in being the role of acting manager. We spoke with one visitor who told us they had spoken with senior management staff about the concerns and queries they had about their relative's care and about the management of the service. This person confirmed they had felt listened to and some changes had taken place as a result of this. They told us they had put forward ideas which they felt would improve the service and that the management staff were considering these. They said staff had been, "Exceptionally responsive to all questions and feedback". The provider told us they had been involved in these discussions and were considering the person's suggestions.

Two complaints had been recorded in the services complaint log. One related to a visitor not being able to find staff when they visited at the weekend. Actions taken to resolve this included staff taking their correct allocated breaks, staff not taking breaks at the same time as others and the introduction of at least one of the company's own senior members of staff being on duty over the weekend to oversee this. The acting manager also explained that senior care staff had become more proficient in their roles and this had ensured staff were deployed correctly. The other complaint involved concerns about unexplained bruising on a person. This was investigated and it was found that records about the bruises and what had been done about them had not been thorough enough. Arrangements were put in place to rectify this. In this inspection we saw reference to bruises when they had been found and what the follow up had been. Both these complaints had been managed within the provider's stated time frame for acknowledging and investigating complaints. A Director of the company told us they would rather be aware of people's concerns/complaints so they can consider them, investigate them and hopefully resolve them.

Prior to the inspection we had received concerns from people, predominantly about the services management arrangements. Where appropriate we had asked the provider to respond to these using their complaints procedure. They had done this by responding quickly and fully to the issues raised. The provider had also offered people the chance to contact them personally to talk through their concerns. They also held a meeting where some relatives were able to discuss their concerns. In this meeting the current management arrangements were explained as well as an update on the actions being taken to resolve this.

Good

Is the service well-led?

Our findings

Prior to the inspection we had received concerns which were about the management of the service. The service had been registered with the Care Quality Commission in May 2015 and a registered manager had been in position. This manager stopped managing the service on 20 July 2015. Despite the provider having been proactive and putting interim arrangements in place, these had not provided the necessary leadership required for the service to run smoothly. One member of the senior nursing team, also previously experienced in care home management, had agreed to be the temporary acting manager. They had been in this role for two weeks when we inspected the service.

They were supported on a day to day basis by a representative of the provider who had previous experience at senior management level within the care industry. Their role with this provider was to complete all audits and report their findings to the provider. They also had an additional role at Wentworth Court which was to oversee the final commissioning of the new building. This representative had not been involved in any nursing or care tasks. They were not involved in or made any decisions which related to people's care or health needs. The acting manager had full control over who was to be admitted.

The acting manager told us their initial priority had been to improve the care records. Senior care staff now had access to these and were able to adjust and add certain information. This was improving the information held about people for staff to read and follow. The other main priority had been to ensure the service was adequately staffed. The acting manager had made it clear to staff that the rosters would be managed in a way that benefitted the service and the people who used it. Some actions had been taken to ensure this were the case. Added complications had included a lack of senior management staff so the acting manager had limited staff they were able to delegate responsibilities to. However, there was a committed group of senior staff who the acting manager had confidence in. Some had begun to take on additional responsibilities and tasks. Staff had confidence in the acting manager's ability and wanted the service to succeed.

The acting manager told us their main responsibility was to the people who used the service. They expected them to receive a good standard of care. They had voiced this expectation to the staff. One incident which occurred just prior to us arriving had not ensured this. As soon as other staff had become aware of this the person's needs were addressed. During the inspection an investigation in to what had happened commenced and appropriate action was taken in relation to the members of staff involved. The acting manager and provider told us they had no problem in taking appropriate action to protect people even if this meant losing staff if they were not providing people with the best care.

To ensure all departments within the care home were working together the acting manager had commenced a weekly meeting with all heads of departments; the first one had already taken place. Senior care staff were involved in these meetings also so they could feed back to the care team generally. The provider had already met with staff and had explained the current management arrangements and future plan.

The recruitment of a permanent home manager had started straight after the previous registered manager left. It had taken some time to find suitable candidates for interview. We were told that final interviews were due to take place soon after the inspection. One relative had been invited to be part of the interview panel so that relatives and people could be represented. Following this inspection a permanent candidate was successfully identified and started in post as the new home manager.

Despite the above challenges the provider had been fully aware of what was happening in the service and how various areas were performing. This was because the representative carried out extensive and detailed audits and monitoring checks on their behalf. We looked at these and saw that they recorded the representative's findings and where necessary proposed actions. The actions were given dates for completion. The findings of any audits which related to areas of care or nursing processes, such as care planning and medicines, were shared with the acting manager and it was their responsibility to address these. For example, the care plan audit had picked up a lack of detail in the care plan content and this had been handed to the acting manager to address as a priority. A monthly report was prepared for the provider by the representative, which included the audit findings and proposed actions. The acting manager also added to this report from a nursing and care perspective. The provider then carried out

Good

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visits to the service and signed the actions as completed once they had confirmed this to be the case. The process then repeated itself ensuring improvements were identified and planned for. In the last few months, where there had been a gap in a suitable home manager, people had been protected by this process.

People's views on the service to date had been monitored by the provider's representative. Three reviews by relatives had been posted on the Care Home UK website and these had all been positive. The service had also directly received three compliments about the services provided. The provider's first satisfaction survey was to take place in November 2015.