Bupa Care Homes (CFChomes) Limited

Wilmington Manor Care 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

Our last inspection report of this service was published on 10 January 2017 and related to an inspection that had taken place on 14 November 2016. At the inspection in November 2016 we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to Regulation 9, Person centred care, Regulation 10, Dignity and respect, Regulation 11, Need for consent, Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse, Regulation 17, Good governance and Regulation 18 Staffing.
We asked the provider to take action to meet regulations 9, 10, 11, 13 and 18. We took enforcement action against the provider and told them to meet regulation 12 and 17 by 24 February 2017.

The provider sent us a report of the actions they were taking to comply with Regulations 9,10, 11, 13 and 18 and they told us they would be meeting the Regulations by 10 February 2017.

We returned to carry out a comprehensive inspection on 25 and 26 April 2017. The inspection was unannounced. At this inspection we found that the provider had implemented new ways of working to address the breaches from the previous inspection which had resulted in an improvement to the service provided.

Wilmington Manor Care Home is registered to provide nursing care with accommodation for up to 50 people. There were 47 people living at the home on the day of our inspection. Most people lived in the home permanently, however, some people stayed for a planned period of respite care. For example, if they were recovering from a medical procedure or health issue or if their usual carers were having a break. People living at the home had varying nursing care needs. Some people were living with dementia and some people had complex medical conditions such as diabetes or having suffered a stroke. Some people were receiving the care needed to support them at the end of their life. Accommodation was over two floors plus a mezzanine floor. A lift was available so that people could move between floors easily.

A registered manager was not based at the service at the time of our inspection. However a new manager was in post and had made an application to register with CQC and this application was in progress. 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 were now receiving a safer service. Staff understood their responsibilities in reporting potential abuse and felt confident to raise concerns with the manager or provider. Safeguarding alerts had been raised with the local authority by the provider and the manager since the last inspection.

The management of medicines had improved although this continued to progress and some further improvement was required. We have made a recommendation about the medicines administration.

Improvements had been made to individual risk assessments which were now in place to mitigate the risks of people coming to harm when they were receiving care and support. More detailed guidance was in place to give staff the advice necessary to manage the risks faced by people.

Safer procedures were now in place when reporting accidents and incidents. The manager reviewed and signed off all incident records and logged these on to the provider's electronic system themselves once they had completed their review.

There were suitable numbers of nurses and care staff across the service to provide the right amount of staff people required to meet their assessed needs. Staff confirmed they were not under pressure and had the time to give to people without rushing. Safe recruitment practices continued to be followed to ensure new staff were suitable to work with people whose circumstances meant they were vulnerable.

The provider had reviewed their care plans in relation to mental capacity assessments. People's capacity to make specific decisions had been considered and support mechanisms put in place to support those who were assessed as not having capacity. Staff now had the information they needed to support people more effectively to make choices and decisions.

People's care plans had improved to reflect their individual needs and their personal preferences. This assisted staff in delivering care that was more person centred. Although some people were happy with the activities on offer, others, who preferred to stay in their rooms, or were too ill to join others in the communal lounge areas, would have liked more one to one time.

The provider had made additional training available for all staff to refresh and update their skills and knowledge in the areas found to be of concern at the last inspection. Staff told us they found this had been of real benefit and had added to the improvements made in the service. Staff were supported to carry out their role through one to one supervision although this was still a work in progress.

People received kind and considerate care. People's care and support was provided by staff who understood people's needs, reflective of the detailed care plans written by the nursing staff, with the advice and guidance of the GP and local hospice specialist staff.

The manager held resident and relatives meetings to enable people to give their views of the service and to have a say in decisions that affected them. People were given the information they needed to make a complaint if they needed to. Some complaints had been made and these had been dealt with according to the provider's complaints policy.

Staff described an improved service where changes had been made that had been welcomed by all staff and morale was now high. People and staff were complimentary about the new manager, saying that the service had changed for the better since they started in post. We found that the manager responded to issues identified and made changes immediately.

The provider had a number of monitoring and auditing processes in place to check the quality and safety of the service and these were now used effectively. The improvements made had had a positive impact on the service people now received at Wilmington Manor Care Home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were managed by registered nurses to ensure safe administration, however some further improvements were required.

Staff were trained and kept up to date in safeguarding adult procedures, and knew what action to take to keep people safe.

Individual risk assessments were in place to protect people from harm or injury.

Accidents and incidents were monitored to help to minimise further risks to people and staff.

There were enough nurses and staff to provide the support people needed. Safe recruitment processes were in place so only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff had received the additional training they required to carry out their role. A plan was in place to ensure one to one supervision meetings and annual appraisals took place.

People's human and legal rights were respected by staff. The management team and staff had knowledge of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

A menu gave people more than one choice each meal time. People were supported with complex nutritional needs and specialist advice was taken when necessary.

Nurses were knowledgeable about people's health needs, and supported people with their physical and mental well-being.

Is the service caring?

Good

The service was caring.

A stable staff team provided a kind and caring approach.

People were involved in making decisions about their care and staff took account of their individual needs and preferences.

Staff protected people's privacy and dignity. Staff were encouraging and supportive to help people to maintain their independence as long as possible.

People were happy and told us they were well supported, giving positive views about the staff.

Is the service responsive?

Good

The service was responsive.

People's care and support needs were assessed before moving in to the service and care plans were developed, identifying how people wanted their support.

People and their relatives were given the opportunity to give their views of the service provided and these were used to make improvements.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well-led.

There was an open and positive culture which focused on people. Staff spoke highly of the management team and said many improvements had been made.

The provider had robust quality assurance and monitoring procedures in place. These were used effectively to improve the service provided to people.

Records were kept well and were clear and robust.

Wilmington Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 April 2017 and was unannounced. We returned to carry out a comprehensive inspection. The inspection team consisted of one inspector, one pharmacy inspector who was assisted by an assistant 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.

Prior to the inspection we reviewed other information we held about the service, we looked at the previous inspection report, the provider's action plan following the last inspection and notifications about important events that had taken place at the service, which the provider is required to tell us by law.

We spoke with ten people and three relatives about their experience of the home. We observed care in the communal areas on each floor of the home. We spoke with nine staff including the manager, deputy manager, four nurses, and three care staff. We asked six health and social care professionals for their views of the service before and during the inspection.

We spent time observing the care provided and the interaction between staff and people. We looked at eight people's care files, medicine administration records and three staff records as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

We asked the manager to send us some records by email following the inspection and they sent these within

the timescale we gave them.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke to said they felt safe living at Wilmington Manor Care Home. The comments we received from people included, "Yes I feel safe", "Yes, they are marvellous" and, "Very safe." People said they would tell someone if they felt unsafe, some mentioned staff names or the manager's name and others a family member or friend. One family member said, "She has a keyworker [Name]. I would go to her first then to [Named nurse and deputy manager], the two staff at the nursing station, then to [Name] the manager."

At our inspection on 14 November 2016 we found a breach of Regulation 12, Safe care and treatment. Risks to people's health and welfare were not sufficiently mitigated to keep people safe and people`s medicines were not managed safely, Regulation 13, Safeguarding service users from abuse. Systems and processes operated by the provider to identify and investigate possible harm were not effective and people were not always safeguarded from the risk of abuse, and Regulation 18, Staffing. There were insufficient numbers of suitably skilled staff available and deployed to meet people's needs consistently across all areas of the home at all times.

At this inspection we found improvements in the management of medicines, although processes were still being implemented and safe systems were not fully embedded in everyday practice. Audits were undertaken, but action plans were not yet developed fully to improve on issues identified. Medicines were being stored securely, and at the correct temperatures. Controlled drugs were stored and recorded correctly. Recording sheets were kept to ensure medicines were ordered when stocks were low so that peoples' medicines were available when they needed them.
Staff involved in the administration of medicines were aware of the service's medicines policy. People were receiving their medicines as prescribed. Some medicines were prescribed on an 'as and when required' (PRN) basis. There was guidance in place for each person's PRN medicine.

Each person had an individual medication profile that included their photo, any allergies and details of any administration difficulties; for example problems with swallowing. We observed one person who had difficulty swallowing their medicines. The nurse encouraged them to take their medicines with a drink, but the person was unable to swallow and the nurse recorded this on the MAR. This meant that the person did not receive their medicines. We checked the person's care plan which said that the person should be given their medicines with porridge. Another person's medication profile had not been updated to indicate that they had swallowing difficulties. However, the MAR had handwritten instructions against each medicine stating that the GP had advised that the medicine be crushed. One of the medicines was a slow release tablet and crushing could alter its effectiveness. The nursing staff had not checked with a pharmacist before carrying out the instruction from the GP to ensure the medicines were safe to crush or sought an alternative preparation was available for people to take. We spoke to the manager about each of these incidents. They alerted the nurse in charge straight away who contacted the GP and pharmacist to gain further advice. The advice had been implemented by the end of the day and care plans were changed to take into account the advice given. The manager included these incidents as examples to discuss with the nursing staff responsible for administering medicines at the soonest opportunity the next day.

Nurses recorded on MARs that creams were applied by care staff. However, the recording was completed at the time of the medicines administration round and not at the time of the application of the cream and not always by the person who had applied the cream as this was generally done when personal care was given. There were no records of the name of the person who had actually applied the cream. We spoke to the nurse about this who introduced a recording sheet to be inserted into the daily file and completed by care staff when creams were applied.

During our last inspection we found that peoples' pain was not always managed effectively. We were told that the home was reviewing the process for how peoples' pain was recorded. Some staff were unclear as to where in the notes the pain charts were kept for them to record peoples' pain. On discussion, the nurses agreed these charts should be kept with the MAR charts so they were easily available when administering medicines. We found no evidence to suggest that people's pain was not being managed well at this inspection. Care plans for people nearing the end of their life were clear throughout that staff must check if people were in pain. It was clear from the daily records that this was something that all staff asked when they had contact with people, rather than it being the role only of the nursing staff or the staff member administering medicines. People who were in pain but required essential nursing procedures to be undertaken had regularly reviewed assessments of their pain and how to relieve it. The GP was involved in discussions and reviews, as well as local hospice care community staff. The daily notes contained regular references when people were experiencing pain and the action taken by care staff and nursing staff.

We recommend the manager ensures the Handling of Medicines in Social Care guidance from the Royal Pharmaceutical Society of Great Britain is followed to ensure people receive the best outcomes from their medicines.

There were enough nurses and care staff each day to provide the care and support people needed. The provider had a dependency tool to assess the levels of staff required to be able to provide the assessed care needs of people living in the service. The tool was being used successfully to ensure there were always enough staff deployed across the service. Staff told us they thought there were enough staff and they did not feel under pressure or rushed. Staffing roles were defined within a clear staffing structure and this supported the smooth running of the service. The deputy manager was a registered nurse who provided daily management support to the manager as well as support and guidance to the team of nurses. The provider was in the final stages of the recruitment process to employ a nurse clinical lead to take responsibility for the day to day health needs of people requiring nursing care. Registered nurses led the team of care staff including senior care workers. Senior care workers were a new addition to the staffing structure. The role was proving to be effective, enhancing the management of the service. The nursing staff told us they were pleased with the introduction of the senior care workers and thought this would have a positive impact on the professional service provided to people. A health care professional said, "I think the introduction of the senior care worker is a great idea and I have seen it working well here."

Staff had a good understanding of their responsibility to protect people from abuse. The guidance and advice staff would refer to about abuse if they had a concern to report was available through a comprehensive safeguarding procedure. Staff told us they would have no problem raising any worries they had and they were aware of who to contact outside of the organisation should this be necessary. One member of staff said, "[The manager] always listens and acts on any concern, I would have no hesitation in telling him any concerns I had." The manager had raised safeguarding concerns appropriately with the local authority since they had commenced in post. The concerns had all been investigated either by the local authority or by the manager at the request of the local authority. People were now kept safe from abuse by a manager and staff team who raised concerns appropriately to safeguard people.

The approach to the management of individual risks had been improved since the last inspection so people were at less risk of potential harm. Registered nurses identified risks to the individual, assessing the risk and how to control and manage it. The risk assessments were comprehensive with guidance for staff to follow. Moving and handling risk assessments detailed the activity and what measures needed to be put in place to carry out the task safely. For example, guidance was in place to support people with limited or no mobility to transfer from their bed to a chair, with staff support and the aid of equipment such as a hoist. The equipment needed and how it should be positioned was specified and the risks involved in using it for people and staff. Circumstances that would put people or staff more at risk when assistance was being given with moving around were highlighted. These included specific medical conditions, medicines that may affect a person's awareness or if the person was experiencing pain.

Some people had bed rails in place, if they were at risk of falling out of bed. The risks associated with having bed rails had been identified for each individual and measures were in place to keep people safe. Measures such as, staff checking the safety of the bed rails every time they were in use and their continued safety every hour when people were in bed. Risk assessments were reviewed every month, unless there had been a change in a person's circumstances before this date was due. People were now kept safe by staff who better understood the importance of making sure individual risk assessments were used and kept updated.

Accidents and incidents were recorded by staff as they happened. The manager reviewed the incident as soon as possible, investigating if necessary and making sure the appropriate action had been taken straight away, such as making sure people were safe or contacting the GP or family members. All accidents and incidents were recorded on the provider's electronic system by the manager where they were reviewed by the provider and an analysis completed each month. The analysis identified trends, such as time of day, witnessed or un-witnessed incidents and type of injury. This information helped the provider and the manager to develop plans to prevent further occurrences of similar episodes. For instance, some staff had received additional moving and handling training following a recorded incident

The premises were maintained to ensure the safety of people, staff and visitors. A fire risk assessment had been carried out to ensure processes were in place to prevent a fire on the premises. The servicing of fire equipment and alarms had been undertaken and were all up to date. A personal emergency evacuation plan (PEEP) was located in the fire file and recorded within people's care plans. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. The equipment used to assist people with their personal care needs, such as hoists and bath lifts were serviced and maintained to ensure they were in good working order. Regular checks and servicing of other installations such as gas and electricity had been undertaken to ensure the premises remained safe and well maintained. Environmental risks were assessed and recorded, such as risks relating to the building and grounds. These checks enabled people to live in a safe and adequately maintained environment.

The service had robust staff recruitment practices to ensure that staff were suitable to work with people who were vulnerable because of their circumstances. Staff told us that they had been through an interview and selection process before they started working at the service. Checks had been made against the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with vulnerable people. Application forms were completed by potential new staff which included a full employment history. The manager had made sure that at least two references were checked before new staff could commence employment. There was an organised system within staff personal files which was kept up to date.

Good

Is the service effective?

Our findings

People were confident that the staff knew how to support them. The people we spoke to said that staff always supported them in the way they wanted. The comments we received included, "Quite confident. We are very lucky, the staff are lovely here. I can't fault them on care", "Very, during the night they come and help me, when I press the call bell they take five or 10 minutes to come" and, "100%. Just in general they are supportive."

At our inspection on 14 November 2016 we found a breach of Regulation 11, Need for consent. The Mental Capacity Act 2005 (MCA) principles were not followed in relation to mental capacity assessments for people who may have lacked capacity and best interest decisions were not made for people following a best interest process.

At this inspection we found the situation had improved. The provider and manager had made sure that people's rights were now being considered by staff who understood the basic principles of the MCA. The provider had added additional MCA training to the training schedule and all staff had attended since the last inspection. People's mental capacity to consent to decisions on a day to day basis were considered from the assessment stage and reviewed regularly to make sure their circumstances had not changed. Where people had capacity, an assessment of their abilities and what support they may require from others, such as family members, was documented so the right support was available if required. Care plans gave clear guidance to staff to gain people's consent to care tasks before commencing. Consent, choice and decision making was a key theme running through all aspects of the care plan. Daily records confirmed that staff were following the guidance as recordings by staff throughout the records stated that people had given their consent before any personal care was given. When consent had been refused, for example, when a person said they did not want their personal care at that particular time, or they did not want to eat their meal at the time given, this was respected and another time arranged to try again.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity showed that this had been clearly recorded and decisions had been made in their best interests, each decision being treated individually and separately assessed and recorded. The manager understood when an application for a DoLS should be made and how to submit them. Care plans demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

The new manager had made many changes since being in post and although they had commenced one to one supervision meetings with staff, they told us this was an area that had been identified as needing further input. All staff had received at least one supervision with their manager since the last inspection. The provider had taken the decision to ask a registered manager from a local service to base themselves at Wilmington Manor for two weeks to support the manager to get all staff supervisions and annual appraisals fully up to date. This work had been pre planned and was taking place at the time of our inspection. All the staff we spoke with told us they felt well supported by the new manager and said they would seek them out and speak to them if they needed any advice or support.

The provider had put extra resources in since the last inspection to make sure staff received further training to update their skills and knowledge based on the concerns found. The new senior care workers had received additional training to increase their skills and confidence to be able to take on their new role. This was to ensure their competency in assisting the nursing staff to lead on the care and support provided to people. People living at the service had specialist nursing care needs. It was important the staff supporting them were led by qualified registered nurses who had the professional credentials to make sure people got the right care. The nursing staff were supported with their revalidation requirements with the Nursing and Midwifery Council (NMC). Some staff's training was still outstanding, however there was a plan in place with dates when this would be completed by. Staff told us they were pleased with the training they had recently attended. One staff member said, "The training is much better, we went back to the beginning. We have all said how good it is – I thought I didn't need extra training, but it made me think about things differently." Another said, "We have had a lot of training recently. This is a big part of the improvements."

People and their relatives were complimentary about the food. We received comments such as, "Yes, when it is not [good quality] I tell them I used to work as a cook. Today the broccoli was over cooked", "It is pretty good" and, "It is excellent." People had the choice of sitting in the dining room overlooking the garden to eat their meal, or to eat in their own room in privacy. Staff were available to readily assist people with their meal where needed, there was no rushing. One person had a glass of red wine with their meal, others had a drink of their choice such as juice or water.

People had their nutrition and hydration needs assessed and were provided with a diet which met their needs and preferences. Care plans made it clear if people needed support with food and drink. For example, some people were at risk of choking and what action needed to be taken to reduce the risk was identified within their individual plan. Regular referrals had been made to Speech and Language Therapists (SALT) and dieticians for their advice and guidance. Some people had been prescribed a thickening powder that needed to be added to fluids to help them swallow more safely. Others needed to have their meals pureed or cut up into manageable pieces. Full guidance was documented to make sure care staff and kitchen staff knew the correct consistency required for each person if they needed a pureed diet, or what size pieces to cut people's food into.

The nurses' liaison with other health care professionals was key to ensuring medical treatment and intervention was monitored closely. There were many examples of the professional relationships and rapport between nursing staff and visiting health care professionals during the inspection. Discussions and liaison both in person and on the telephone were seen, enhancing the care and support available to people.

A local GP was responsible for the care and treatment of the people living in the service. Communication had improved since the last inspection when treatment and advice had been found to be delayed due to the lack of timely referral. The GP visited regularly to treat their patients, advising the registered nurses regarding changes in medication or treatment. Regular entries were recorded in people's care plans, making sure an accurate record was maintained. The advice of other specialist health care professionals was

regularly sought to ensure people had the most appropriate treatment to maintain their health and well-being. For example, referrals and contact had been made with specialist diabetes nurses and there were regular visits and reviews by a hospice community team who advised on all elements of end of life care. A healthcare professional told us they had seen, "a big improvement in clinical competency. The employment of a clinical lead has made a vast improvement, they are now more clinically focused".

Registered nurses used their skill and experience to provide people's nursing care requirements ensuring their expertise informed health care plans that were used to advise and guide staff. People nursed in bed at high risk of developing pressure areas had detailed risk assessments and care plans that were well recorded by the nursing staff. Body maps were in place, highlighting the areas of concern on the body. Clear instructions were included for care staff to follow, such as applying prescribed creams, changing people's position regularly and checking the air mattress. Nursing care plans included clear detail of individual wound care, for example how to change dressings and how often. Treatment was regularly re-assessed and reviewed to track the progress of healing wounds with a photographic record to support this. Close professional liaison with specialist tissue viability nurses was evident to make sure people received expert care and advice to improve their chances of recovery. People who were not able to eat food through the mouth and therefore required an alternative such as percutaneous endoscopic gastroscopy (PEG) feeding were supported well. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medication can be given without swallowing. Dieticians were closely involved, giving regular advice and guidance. The service catered well for people's specialist health needs, good nursing care was evident.

Good

Is the service caring?

Our findings

People thought the staff were kind and caring and the comments we received were positive, which included, "Yes they look after you during the night", "I think it is very good. I have not been ill before, so far everything has been fine and okay" and, "Very much so, if I want anything I just press my orange care button". Relatives were also happy with the care their loved one received. One relative said, "Yes. She gets hourly checks, on a couple of occasions they have missed them. When you ring the call bell they come within 5 minutes".

At our inspection on 14 November 2016 we found a breach of Regulation 10, Dignity and respect. The care and support people received was not always promoting their privacy and dignity.

At this inspection we found the situation had improved. Staff were respectful of people's privacy. The people we spoke to who could tell us, said that staff were respectful towards them and knocked on their door before entering. People's room doors were closed when they were too ill to get up and were being nursed in bed, unless they had requested their door be left open. Care plans recorded people's wishes, for example, one person liked their door open through the day and ajar at night and another person liked their door to be wide open through the day and at night. One person told us, "I get frightened if the door is closed. It was closed when it was a fire drill, it is frightening and I don't want it closed." Staff described how they preserved people's privacy and dignity. They were able to tell us who liked to have their door open, who liked to have the door closed and what people's likes and dislikes were. Staff gave individual examples of how people chose their clothes for the day and how staff supported them, depending on their ability to choose. Staff also described how they communicated using body language or eye contact with those who could not verbally communicate.

Care plans for those people who were approaching the end of their life were written respectfully and recorded the detail that was so important to make sure people got the care they and their family expected. References were made by staff in the daily records that 'Tender loving care' had been given. Care plans included giving people time each day to express how they were feeling and to allow plenty of time for people to be able to talk of their condition if they wished and be able to say if they felt their condition was changing. As part of the care planning, people and their family members were asked about their future decisions, such as funeral arrangements. End of life plans were discussed with people when possible and they were able to decide when they wanted to discuss this. The plan included detail such as pain relief and who they wanted to be present in the final days of their life. People were involved in all aspects of their care and the planning of this to make sure their care was provided in the way they wanted.

Family members were contacted whenever there was a concern or if people's circumstances changed, such as if their condition worsened.

Care plans included a section setting out what people were able to do for themselves so that staff could continue to encourage and therefore support people to maintain their independence.
People's likes and dislikes were recorded so that staff were able to continue to do things in the way that people wanted. For example, their favourite toiletry products or the toiletries they did not like, as this could

have the effect of a good or bad start to the day.

Staff told us they had time to sit and chat with people, particularly in the afternoon, listening to stories about their life, employment or families.

Good

Is the service responsive?

Our findings

People told us they were generally happy with the activities on offer in the service, although people nursed in bed or in their room did not have as many opportunities. One to one time was available to people in their rooms, however, people would have liked more than the time given. The comments we received included, "Some I do some I don't do [activities]. I like singing and talking, sometimes we have a little dance but I am not keen. I like the dog Baloo, he comes on a Thursday", I can't do activities. I can't get up on my own. I sat in the garden once but it was too cold, I see staff only when they bring me the food – sometimes I feel lonely. I read the paper and watch the TV" and, "I go to the lounge. I join in most of the activities. For example, this morning they had exercises. If the weather is suitable we go out in the garden."

At our inspection on 14 November 2016 we found a breach of Regulation 9, Person centred care. People received care and support which didn't always take account of their likes, dislikes and preferences.

At this inspection we found the situation had improved. People's care plans were more person centred, describing the person, their likes and dislikes and personal information about them.

Staff told us there had been a lot of changes since the last inspection around their understanding of person centred care. One member of staff said, "There have been a lot of changes recently, for the better. Paperwork is much better and this makes it easier for staff, and the people we are caring for."

An initial assessment was undertaken with each person, by the deputy manager or one of the registered nurses, to assess their needs before they were accepted to move in to the service. People and their family members where relevant, were fully involved in the assessment process. When people were admitted from a hospital setting, a nurse on the hospital ward was also involved in providing information for the assessment. The manager reviewed the assessment and signed their approval before a person was accepted and a date agreed to move in or start a period of respite. The assessment led to the development of an individual care plan. People's care plans were set out well in a style designed by the provider called, 'My day, My life'.

Care plans were now detailed to ensure people were supported and assisted in the way they wanted and to make sure their needs were met by staff. All the areas of daily living where people may require care and support were included. Such as moving and handling, skin care, life style and healthier happier life, senses and communication, choices and decisions and personal care. For example one person used a hearing aid to be able to hear what was being said to them. This sometimes did not work well enough to assist the person. The care plan stated that the person would tell staff if their hearing aid was not working correctly. Others documented when people preferred to stay in their room and not socialise with others. For some people this may be a sign they were felling unwell, for others they preferred to have their own space and privacy. It was therefore important this information was recorded to capture the individual's preferences within the care plan. Care plans provided the detailed information staff required to support people as they wanted.

People had a 'Daily file' in their room with the documentation staff needed to hand for ease of recording and

access to day to day information about each person. For instance, the daily file held all regular daily check charts such as food and fluid recording, position change charts and bed rail checks. The daily check charts were not always completed as they should have been. For instance, there were gaps in the hourly check record for two people nursed in bed and gaps in the positional change charts. One person's positional change chart had not been recorded by staff for five hours when they should have had their position changed two to four hourly, even though we could see the person had actually had their position changed since that time. Food charts recorded the meals given but not always the amounts actually eaten and did not record snacks given through the day to accurately measure a person's daily food intake. Charts on some previous days were accurately recorded.

An activities coordinator was in post who planned and organised all activities in the service by liaising with people to find out what they wanted. Activity timetables for the week were distributed around the service so that people had the information they needed about the activities on offer so they could plan their involvement. The activities coordinator spoke to those who were not able to read or understand the timetables. Regular weekly activities were planned such as bingo, music for health and fitness, and the recent addition of a gardening club. 'Customer feedback boards' were in prominent positions around the home. These centred on two questions asked of people, 'What you said' and, 'What we did'. People said they wanted to do some gardening and also they wanted to go out more. 'What we did' stated 'We have a regular gardening club on a Wednesday afternoon weather permitting' and 'We are planning a trip to the local pub'. Both these activities had started. Staff told us that there had been a marked improvement in the activities available for people to choose from. One member of staff said, "There has been a massive improvement in activities, it was not like this before. The activities coordinator is fantastic, they have loads going on."

Resident and relatives meetings were held to provide updates and news and to receive feedback from people about the things that were important to them within the service. At a meeting with both residents and relatives on 24 February 2017 the agenda included an open discussion about the last CQC inspection report and the provider's response to this, with the action they were taking to address the concerns found at the time. Some people said they had been asked their views of the service so they felt listened to and others said they had not. When asked, one person said, "Yes, I can't complain about the service the girls who do it are absolutely lovely" and "Yes I had a questionnaire two days ago".

The provider had a complaints policy in place and details of how people could make a complaint was given in the service guide for people and their relatives. This gave clear details of what people needed to do, and what people could expect in terms of responses and time scales. The policy also gave the contact details of the local authority, Care Quality Commission and Local Government Ombudsman. A health care professional told us they had cause to complain recently. They said they were happy with the response and the issue got dealt with and responded to quickly by the present manager. We checked the complaints log and this showed that the investigation the manager had undertaken and the action taken to address the complaint, which led to better liaison with other professionals and better outcomes for people. One person complained about the dining room being cold in January 2017. The manager took action straight away, purchasing heaters and moving the dining room furniture around to avoid draughts. The provider and manager had responded to complaints in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

Most people thought the home was well run and had noticed improvements since the new manager had started in post. The comments we received included, "It is lovely and the manager is wonderful", "Very well, the management has improved, there is a new manager, you can talk to him and we all like him a lot", "I have been here for 4 years. Ooh yes, since [Manager name] came the place is lovely. It is amazing what he has done. He brought the staff into line, but they didn't need very much" and, "Yes the staff seem a lot happier since [Manager name] came. He was quiet at first but he has come out his shell."

At our inspection on 14 November 2016 we found a breach of Regulation17, Good governance. The provider failed to monitor and mitigate the risks relating to the health, safety and welfare of people. People`s care records were not always accurate or contemporaneous in reflecting the care and treatment they received. The provider`s quality assurance systems were not effective in identifying all areas in need of improvement.

At this inspection we found the situation had improved. Staff told us there had been many improvements in the service since the last inspection. They said staff morale had increased significantly. Comments we received from staff included, "The last inspection was right, there were issues then", "[The provider] sent managers to put things right, so it [the last CQC inspection report] has really benefitted everyone", "There have been a lot of changes and improvements since last time, things are much better", "There has been a lot of improvement in how the home is run" and, "Staff morale is much better. We are all on the same page."

We spoke to the manager and the regional director about the inconsistency found in recording people's daily charts. They said that they had taken a lot of time with staff impressing the importance of accurate recording. Staff did tell us this was the case. The manager went to speak to the nurses and care staff on duty straight away to remind them of their responsibilities in making sure records were accurate at all times. The manager was keen to address recording issues straight away with staff to make sure improvements made were maintained.

The provider had a range of audit and monitoring systems in place to check the quality and safety of the service and these were now used effectively. A 'clinical daily walk around' the service was undertaken by various members of the clinical nursing team, but usually the deputy manager, and recorded on the provider's electronic system. The manager reviewed the walk around notes, and the actions taken, at the end of each week and signed to confirm their review. Where concerns were noted these were recorded and actioned. For example, where the GP had requested blood or urine samples be taken, a named nurse was given the responsibility and a record made that samples had been sent. A 'clinical risk' meeting was held every week following the GP's routine weekly visit and round of the people living at the service. The manager, deputy manager and nurses on duty planned people's medical care and the interventions required. In addition, other topics were also discussed and action agreed, including pre admission assessments, new admissions, safety, challenging behaviour, nutrition and hydration and tissue viability.

An audit of people's care was undertaken every month by a member of the management team. A sample of care plans were scrutinised, the findings recorded and an action plan in place to address any areas that

required improvement. Each area was scored to show the level of compliance through a rating of red, amber or green. Those areas scoring red were placed under further scrutiny by the provider as the expectation was that all areas should be green.

The manager completed 'quality metrics', recording the information the provider wanted to monitor on a monthly basis. Such as the numbers of pressure ulcers acquired by people, weight loss of 2kgs or more in one month, the number of deaths and the number of medicines incidents. The provider used the information to check these indicators against other services to compare and raise concerns if found to be performing worse. The manager was expected to make comments and provide action where they noted trends or changes within the service. The information was developed into graphs to give a quick and clear indication of increases and decreases in numbers leading to investigation where necessary. For example, in March 2017, three medicines errors had been reported and it was noted these were all relating to one staff member. An investigation was undertaken, supervision was put in place and disciplinary processes were used. The other areas monitored every month within the auditing process included a 'first impressions' audit to check the environment and premises.

Quarterly audits carried out every three months included health and safety and infection control. Areas had been identified for improvement and actions recorded. For example, it was noted that some people did not have their own identified hoist sling. An action point was made to order new slings and the date recorded when this had been done.

In addition to the monitoring and audits undertaken by the service management team, one of the provider's quality monitoring team carried out an independent audit each month to check the management team were adhering to the provider's monitoring systems. They carried out a comprehensive audit highlighting areas for improvement and positive practice seen, as well as providing their own rating of red, amber or green. The findings of all audits were electronically recorded and the results sent straight to the provider's head office where they were analysed and checked by senior management. Actions and recommendations from all audits were added to the manager's home improvement plan (HiP). The HiP was monitored by the provider's regional director to ensure actions were undertaken within the timescales agreed.

The manager told us they had found the provider's local senior management team to be very supportive since they had commenced in post. Members of the senior management team visited during the inspection to offer support as the new manager had not been in post at the last inspection.

The manager told us they had noticed that staff morale had grown in recent months and they felt that people and their families were happier since changes had been made to improve the service. This was borne out by the feedback we received. A health care professional told us, "We have noticed a change in the staff recently. They appear happier and are enjoying their work more."

The manager recognised the importance of good communication amongst the staff team to support positive outcomes for people. They held regular clinical meetings with nurses and senior care workers to discuss people's health and clinical needs. Daily 'take 10' meetings were held with all heads of department, for example, nursing staff, kitchen, housekeeping and maintenance, to aid the communication flow through the service. Staff meetings were being held. A staff meeting held on 5 March 2017 was the first for all staff since the manager had commenced in post. The manager used the meeting to listen to staff concerns and address each in turn. One member of staff said, "Communication is much better, he [the manager] interacts well. Everyone knows what is happening and what is about to happen." One member of staff gave an example. They said that all staff now knew when new people were going to be admitted to the service. This was something they were not told before. They told us that staff were now ready and prepared for new

people moving in or people staying for a short period of respite care.

The provider had undertaken a staff survey since the last inspection. An obvious trend upwards was seen around staff morale and contentment since the previous survey. Staff consistently spoke positively about the new manager and the senior management team. The comments received included, "[The manager name] is a very good manager, he knows what he is doing. He lets you know if he is not happy, but in a good way", "Staff are now happier – with [manager name]. We talk amongst ourselves and all feel that way", "Senior managers are very good,[senior manager's name] is always here and always doing something" and, "Everything is improved and [manager name] has had a big influence on this. He has been inspiring."

On carehomes.org.uk six reviews had been received about Wilmington Manor. Of the six, four had rated the service excellent overall, one good and one satisfactory. Four reviewers had said they were extremely likely to recommend the service and two said they were likely to recommend the service.