Larchwood Care Homes (North) Limited

Harmony House

Inspection report

The Bull Ring
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Warwickshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 August 2017. The visit was unannounced on 1 August 2017 and the inspection team consisted of two inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. We informed the manager and regional manager that one inspector and an inspection manager would return to complete the inspection on 2 August 2017. We were joined on our second inspection day by the lead nurse for care homes from Warwickshire North Clinical Commissioning Group.

Harmony House provides accommodation, nursing and personal care and support for up to 57 people living with physical frailty due to complex health conditions and / or older age. At the time of the inspection 35 people lived at the home. The home is split over two floors; each with a communal lounge and dining area.

The home is required to have a registered manager in post. 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 and associated Regulations about how the service is run. Since our last inspection there had been some changes in the management of the home. A new home manager had started work there during April 2017 and was in the process of becoming registered with us.

After our inspection in June 2016 we served the provider and previous registered manager a 'warning notice' because regulations had not been met and the service was rated as 'inadequate'. In January 2017 we inspected again. During this inspection visit we found improvements had been made and the home was rated as 'requires improvement'. However, there continued to be a breach of the regulations in relation to the governance of the home, and a breach of the regulation in relation to the safe care and treatment of people. The provider agreed voluntarily to restrict admissions to the home until improvements were made and send us improvement action plans each month, which they did.

At this inspection, we found sufficient improvements had been made to meet the requirements of the warning notice and regulation relating to governance of the home. The rating remains 'requires improvement' with no breaches of the regulations.

The home manager and a new regional manager, who had also started during April 2017, told us they had implemented improvements and had further improvements planned for. The manager told us a change in culture at the home was work in progress and their passion was to create a home that offered a good service to people. The manager felt supported by the regional manager who visited and spent time at the home every week. Staff felt supported and were complimentary about the management changes.

There were however some provider led changes that staff felt impacted on them. The manager and regional manager had agreed to escalate some of these concerns to senior management.

Overall, people and their relatives felt improvements were being made. People knew who the manager was and relatives described them as approachable. Systems were in place to gain feedback from people and plans were in place to provide opportunities for people, relatives and staff to give feedback during August 2017.

Improvements had been made, overall, to the safe care and treatment of people. Most risks of potential harm to people were identified. However, where risks had been assessed, actions to minimise those risks were not always followed by staff. Staff felt they knew what to do in the event of emergencies. However, the provider's fire risk assessment recommendation had not been incorporated into planned fire drills.

Safe systems were in place for recruiting staff. People had their prescribed medicines available to them and were supported with these by nurses.

Staff were trained and nurses given opportunities to refresh their clinical skills. Staff worked on both floors of the home and opportunities for effective communication between nurses, such as shift handover was not always detailed. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards on a day to day basis. However, care records around people's mental capacity was inconsistent.

People's hydration and nutritional needs were met, although people's weight was not always monitored as planned for. People were supported to maintain their wellbeing and were referred to health professionals when needed.

People described staff as kind and caring, however staff member's attention to people's personal grooming and dignity was not always consistent.

People had individual care plans in place. There were opportunities for relatives to be involved in how care was given through reviews, which the manager had plans to improve on. Activities were offered to people, though, overall, people felt further improvement was needed to meet their individual needs.

People and their relatives knew how to make a complaint if needed. Audit systems and processes to monitor the quality and safety of the service had improved since our last visit, and these were used to identify where improvement was needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks of potential harm to people were not consistently identified. Where risks had been assessed, actions to minimise those risks were not consistently followed by staff. Permanent staff knew what action to take in the event of an emergency. However, the provider's fire risk assessment recommendation had not been incorporated into planned fire drills.

The provider had a safe system of recruiting staff and checks were undertaken to make sure staff were of good character before they supported people who lived at the home. People had their prescribed medicines available to them and were supported with these by nurses.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Communication between nurses and at handover was not always detailed.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards on a day to day basis. Care records around people's mental capacity were inconsistent.

Overall, people enjoyed their food and said they had enough to eat and drink, although people did not consistently receive the support they needed with their meals. People's weights were not always monitored as planned for.

People were supported to maintain their wellbeing and were referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us staff were kind and caring and

involved them in making decisions about their care. However, staff attention to personal grooming and dignity was not consistent.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always personalised to individuals.

There were planned activities that people could take part in, though people felt further improvement was needed to support them with individual hobbies or interests so that risks of social isolation was minimised.

People and relatives told us they knew how to make a complaint if needed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were work in progress to create a positive culture at the home and continue to implement actions needed.

Staff felt supported by the manager. Some provider led decisions and changes impacted on staff which caused staff some concern.

Systems and processes to monitor the safety and quality of the service were in place to identify where improvements were needed.

Harmony House

Detailed findings

Background to this inspection

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

The inspection took place on 1 and 2 August 2017. The visit was unannounced on 1 August 2017 and the inspection team consisted of two inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. We informed the manager and regional manager that one inspector and an inspection manager would return to complete the inspection on 2 August 2017. We were joined on our second inspection day by the lead nurse for care homes from Warwickshire North Clinical Commissioning Group.

The provider had previously completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, a request for a new PIR was not made. Since our last inspection in January 2017, the provider had sent us weekly action plans telling us about the improvements they had made. During this inspection, we gave the home manager and regional manager an opportunity to supply us with further information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law. The regional manager had informed us about some incidents that we followed up on during our inspection.

We spent time with people and saw how they received care and support. This helped us understand their experience of living at the home.

We spoke with 17 people and spent time engaging with people who lived at the home. We spoke with nine relatives who told us about their experiences of using the service. We spoke with staff on duty including eight care staff, three nurses, three cooks, one cleaner, the administrator, the maintenance person, the home

manager and regional manager. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for six people, ten people's medicine records, food and drink charts, wound and pressure area management plans and people's weight records. We looked quality assurance audits, accident and incident reports and feedback from people.

We left a poster about our inspection, displayed at the home which told relatives how to contact us to give us feedback if they wished to so their experiences could be included within this report.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2017 we found the service provided was not consistently safe. We identified a breach of the regulation relating to the safe care and treatment of people. Risks were not always effectively assessed and actions to reduce risks of harm had not always been taken. We rated this key area as 'requires improvement.' At this inspection, we found sufficient improvements had been made to meet the requirements of the regulation, though further improvements in managing risks were needed. The rating remains 'requires improvement'.

Most risks were assessed and actions were in place to minimise harm or injury. However, we identified two people who smoked electronic cigarettes in their bedrooms did not have risk assessments in place. While the provider's smoking policy permitted people to smoke electronic cigarettes in their bedroom, we saw the policy guidance had not been followed. The manager and regional manager took immediate action to implement risk assessments; these also took account of protecting other people from the nicotine vapour.

Overall, improvements had been made in managing risks for people identified at risk of developing sore skin on pressure areas, such as on their heels or buttocks. However, further improvement was required to ensure staff took a consistent approach in preventing risks of people developing skin damage. For example, one person was assessed at 'very high risk' of developing sore skin and had a special cushion to sit on. We saw this person was sitting on an armchair in the lounge and staff had not taken this person's pressure relieving cushion from their bedroom chair for them to use while they spent time in the lounge.

Some people had sore skin and their care records showed an overall improvement in the written information relating to skin care management. One nurse told us, "The new manager has told us we need to make sure we detail things properly and keep the information reviewed, with measurements and photos, so we can monitor a person's skin." The manager told us, "I felt people's skin care had to be high priority for improvement. For those people that cannot move themselves, I have emphasised to staff, the importance of repositioning people."

Some people were left with a call bell accessible to them and staff had secured the cord so it could not fall out of reach. However, other people, assessed as capable of using a call bell, had not been left with one accessible to them. Staff had supported one person to get up and into their bedroom armchair, but their call bell had been left on the floor next to their bed. Three people, who spent the morning in a lounge, all told us, "We have to bang our cup on the table and hope they (staff) hear us." We saw the lounge had a call bell point on the wall but there was no cord attached. We spent thirty minutes in the lounge and no member of staff checked on the people there which had potential to put people at risk.

During our inspection visit, most people were cared for in bed. Some people told us this was their preference and they found this was the most comfortable position for them. A few staff shared their concern with us about a potential lack of equipment which meant people could not get out of bed if they wished to. One staff member felt there was a lack of suitable wheelchairs and another staff member said they felt they lacked armchairs for people whose support needs meant they needed specialist ones. The regional

manager told us new recliner-type armchairs had been purchased and, with staff, they needed to assess if these were suitable for people's needs.

The provider had a safe system to recruit staff. One nurse told us, "I have recently started here. I applied, had an interview and then waited until employment checks had been completed before I started working here."

We looked at staffing levels on shifts and how people's needs were met. The manager told us the shift was not fully staffed on the day of our inspection as staff had given the manager short notice of their absence. However a member of staff from another department was available and deployed to support the care team at that time. Staff told us that when the planned staffing levels were met, there was enough staff on the daytime shift. One staff member told us, "Most of the time, we have enough staff and the manager gets cover for sickness. But, there are a few occasions when there are not enough staff, because we could not cover a shift." Staff told us that on some occasions this impacted on them not having sufficient time, for example, to support people who required the support from two care workers, to have a bath or shower. Staff said a bed wash was still given but this was not always people's preference.

People felt most days had enough staff on shift. However, people did not consistently feel the same about the night shift which started at 8pm. One person said, "I don't always feel safe at night because there are less staff about. I'm not sure they'd get to me when I needed them, I'd have to wait." Another person told us they did not like it when they overheard staff 'grumbling' at times, and believed this might be when they were short staffed. Relatives felt evenings and nights needed more staff, one relative told us, "The staff are kind, but there are not enough of them in the evening or night time." Another relative said, "The staff are lovely, but the night shift staff are over-stretched."

The manager and regional manager told us they continually looked at people's dependency levels to assess staffing levels and felt the planned staff for each shift met those needs. The manager felt that currently there should not be an impact on the care provided if one member of staff was absent, as the current staffing levels were above what was assessed as required. The managers also acknowledged staff sickness levels presented a challenge and those were being addressed.

Staff were trained in safeguarding people from the risks of abuse and knew how to report concerns. People that lived at the home felt protected from the risks of abuse and told us they would tell a staff member or their relative if they had any concerns. The manager and regional manager understood their responsibilities in reporting safeguarding allegations to us and the local authority.

Staff felt confident they would be able to deal with emergencies that might arise from time to time. Nurses were able to tell us what first aid action they would take if, for example if a person choked.

Permanent staff described what action they would take in the event of a fire and fire drills were recorded. However, an agency care worker on their first shift at the home told us they had not yet covered fire or emergency procedures in their induction, despite a tick on their induction form, which indicated this had been covered. We discussed this with the manager who assured us this would be investigated.

During June 2017, Warwickshire Fire and Rescue services had undertaken a fire safety compliance check of the home. They had advised the home to replace the heat detector with a smoke detector. On the second day of our inspection visit, the required smoke detector was installed.

The provider's specialist fire risk assessment, dated September 2016, recommended that fire drills should incorporate the entire evacuation of any 'zone' area, had not been included in fire drills. We discussed this

with the manager and regional manager who agreed this had not been done, and assured us fire drills would be more robust and include fire zone scenarios. These would enable the provider and managers to determine if existing procedures and staff numbers, especially at night, were suitable.

People had their prescribed medicines available to them and nurses supported people to take them. In November 2016, the provider had moved to an electronic medicine administration system. Nurses used a hand-held 'well pad' electronic Proactive Care System (PCS) to scan medicines and record those given. One nurse told us, "I am new here and I like the 'well pad' system. I feel confident in using it now." Two other nurses who had used the system since its implementation felt it had reduced risks of them making any medicine errors, one nurse said, "It's got reminders and shows me what medicine I need give, when, how much and to who. It's a good system."

Guidance was available for nurses to refer to when people were prescribed 'when required' medicines. Care staff applied topical preparations, such as creams, to people when needed and we saw a 'body map' was available to show staff where creams should be applied. Care staff signed a cream application record kept in people's bedrooms so staff were consistent in where creams needed to be applied.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in January 2017 we found the service provided was not consistently effective. Staff did not consistently follow professional healthcare guidance when supporting people to eat. Care records lacked detail and did not always show whether healthcare referrals had been made. Staff did not always put their training into practice. We rated this key area as 'requires improvement.' At this inspection, we found some improvements had been made and further improvements were planned for. The rating remains 'requires improvement'.

All of the staff spoken with were positive about the management changes and felt supported in their role. One care staff member told us, "The new manager is supportive; things are changing for the better here now." A nurse said, "We are now being offered more training, clinical updates and overall more support in our work. It is improving. I now feel happier coming to work and it is a better atmosphere for the people living here."

Nurses and care staff felt some communication needed to be improved on. One nurse told us, "If there has been an agency nurse on the night shift, the written handover sheet is very basic." We saw this contained single word entries such as 'ok' for people who had high dependency levels and complex healthcare needs. In addition to the written handover form, nurses and some care staff attended a fifteen minute verbal handover before their shift started. There was also a daily report written during each shift on each person who lived in the home, and this was handed over to the next shift on duty.

The manager told us about their daily 'ten at ten' meeting which gave staff an opportunity to raise any issues. Nursing, kitchen, cleaning and maintenance staff representatives attended and felt the meeting was useful. However, nurses felt this was not always an appropriate setting to discuss people's individual clinical and support needs. One nurse told us, "We used to have frequent nurse meetings, and would benefit from these again to improve communication between nurses." Another nurse told us, "The meetings would be really useful to keep in touch with everyone's needs. At the moment, we change between working on the ground and first floor and may not always be up to date with people's needs." The manager told us they would respond to this and schedule nurses' meetings which would promote effective communication. However, in addition to the daily meetings and general staff meetings, two nurses meetings had already been organised in the home within the last three months.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

Staff told us further training was planned for so they could refresh their knowledge on the MCA. One staff

member said they felt a bit 'muddled' about the MCA and the further training would be beneficial. Overall, staff worked within the principles of the Act on a day to day basis explaining what was happening to people, such as when the hoist was being used to transfer them, and told us they would not force people to do anything they did not wish to do. However, people's care records showed staff were unclear about the MCA. For example, one person had a 'Do not attempt cardio pulmonary resuscitation,' (DNACPR), in place and had been assessed as not having mental capacity. During the same month that their DNACPR was written, a care plan review stated this person had full mental capacity and could make decisions. The manager assured us immediate action would be taken to ensure this person's decisions were accurately recorded.

Care plans did not reflect people's mental capacity. For example, when capacity fluctuated and what type of decisions people may be able to make. The manager and regional manager said that when staff had completed their planned MCA training update, they would add further information to people's care records.

The manager told us they understood their responsibilities under the Act and gave us examples of when they would refer a person for a 'best interests' meeting. They added that 34 people who lived at the home had a DoLS in place. The manager told us most people's DoLS had already been in place when they started to work at the home. They assured us they would review all of the DoLS for people that lived at Harmony House to ensure people's freedom was not being restricted unnecessarily.

We looked at whether peoples' nutritional and hydration needs were met and asked people what they thought about their meals. Overall, people said they enjoyed their meals and felt they had enough to eat and drink. Three people described the food to us as 'lovely,' and a further person said, "The food is mixed, some I like and some I don't." Staff told us people had two choices for their lunchtime main meal, but had to make this the day before. Some people could not recall what the menu was or what their choice had been. One person told us, "Yes, we do have choice. Yesterday, I chose jacket potato for today." However, we saw this person was unhappy when they were given stew and vegetables. After some delay, this person was offered their jacket potato.

Some people required support to eat and drink. We saw one staff member was attentive and kind while they supported one person to eat their meal. Another person later described this staff member's support to us as "absolute gold." However, staff did not consistently assess where support was needed or where a person might have benefitted from different cutlery. For example, we saw one person struggled to place food onto their fork and often placed an empty fork into their mouth. Much of this person's food has slid off their plate but staff did not offer them support, a spoon or plate guard.

Some people were identified 'at risk' of dehydration and malnutrition. People had food and fluid (drink) charts and staff completed these to record what people ate and drank. People had individual target amounts of fluid and these were totalled. We looked at the past eight entries for one person's fluid intake and each showed they had not met their desired target. The two latest entries showed staff had taken action to encourage the person to drink and a GP review had been arranged.

Throughout the day opportunities were taken, by staff, to encourage snacks when food intake had been low. For example, mid-afternoon cakes and yogurts were offered to people. Plans were in place to monitor people's weight; however, these did not always take place as planned for. For example, one person's care plan said they should be weighed weekly or have their upper mid-circumference of their arm measured. Entries on this person's record were not weekly, as planned for, and of the six entries only one arm measurement was recorded. Another person's monthly weight record recorded 'refused' four out of seven entries and a weight loss was recorded in the weights recorded. However, no alternative means of

monitoring this person's weight had been put into place.

People's care records showed they were supported to access healthcare professionals when needed. One nurse told us, "One GP surgery we use for people visits on a weekly basis. We use other GP surgeries as well and they come out on a 'when needed' basis." Optician, dental and chiropody services also visited people at the home.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found the service provided was not consistently caring. People were not supported by consistently kind and compassionate staff. People's dignity was not consistently promoted in respect of their personal appearance. We rated this key area as 'requires improvement.' At this inspection, we found improvements had been made and further improvements were planned for. The rating remains 'requires improvement'.

Since our last inspection, there had been some staff changes along with changes in the management of the home. Overall, people felt the changes were positive and improvements had been made. One person told us, "The staff are happier now in their work, it's a better place, so that makes it better for me." People said staff were kind and caring toward them. One person told us, "The nurses and care staff are very good here. I think the new manager is very caring, she talks to me and acknowledges other people that live here too." Another person said they felt 'well looked after' and a further person added, "I've made friends here and feel settled."

Throughout our inspection visit, the home had a calm atmosphere. While nursing and care staff were, overall, task centred, people and their relatives were keen to tell us the staff were cheerful, caring and welcoming. We overheard a staff member singing in the corridor and friendly chatting between staff and people.

Relatives felt staff were caring, though at times their task orientated approach at the home impacted on the care they provided. For example, two relatives gave us an example of their family member asking to be supported to the toilet at 11.30am, but a staff member had replied the person had been previously asked if they needed the toilet at 9.30am. The manager and regional manager acknowledged they were working to change the culture of the home and to support all staff toward working in a caring, person centred way.

Most people's personal appearance reflected they had received the support they needed from staff to maintain their dignity, however, this was not consistent. One relative told us they sometimes had to clean dirt from their family member's finger nails. We saw two people in the lounge had dirt embedded under their fingernails despite their care notes recording they had been supported by staff with personal care.

Staff involved people in making decisions about their day to day care and support and how they spent their time. For example, one person told us, "The activities staff member comes to see me in my bedroom and asks what activities I like. Being hoisted put me off going to the lounge, but [staff name] was kind and encouraged me and I went to join in the singing."

Staff knew how to maintain people's privacy. Most people cared for in bed chose to keep their bedroom doors open, however, we saw staff knocked on the bedroom doors before entering and ensured doors were closed when people were supported with personal care.

People told us their relatives could visit them whenever they wished. Relatives told us they were not aware

of any restrictions when they visited, one person's relative told us, "I feel welcomed by all the staff whenever I visit." Another relative said, "I feel it's been great since the new manager started. If I have any concerns I can take them to her and she gets on with sorting things out."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found the service provided was not consistently responsive to people's individual needs. People's individual needs were not consistently prioritised over non-care tasks. Planned activities did not always meet people's needs. Improvements made, following complaints from relatives, were not always sustained. We rated this key area as 'requires improvement.' At this inspection, we found improvements had been made and further improvements were planned for. The rating remains 'requires improvement'.

People and their relatives were involved in a pre-admission assessment before they moved into the home. People's care plans contained information about their personal history, their likes and dislikes, and what interests they had. Care plans were lengthy and the manager agreed that developing 'at a glance' care plans would be useful for care staff to refer to, these would make it easier for staff to know what a person's needs were.

Care plans were reviewed, however, reviews had not always identified inconsistencies that had been recorded about people. For example, one person was described as having mental capacity and not having mental capacity to make the same decisions, and the entries were both dated the same. The manager told us about their plans for further improvement to care plan reviews. They added that all care plans had been reviewed and they had involved relatives in these reviews. Where relatives could not attend the review in person, they discussed the person's needs on the telephone with the manager. The manager had also documented where relatives had power of attorney for health and welfare decisions and / or financial decisions for their family members as they had identified this was not always clearly documented.

We saw that despite the lower occupancy level at the home, of the 35 people that lived there, staff told us people needed a high level of support. Staff were constantly busy meeting people's needs, however, there was not a sense of rushing and staff maintained a calm atmosphere as they went about meeting people's needs. This helped people feel relaxed, one person told us, "The girls (staff) during the day are very good, they help me when I need some help, they don't rush me."

At our last inspection, some people had told us they enjoyed the planned group activities but other people were either unable to attend these as they were cared for in bed or did not wish to join in group activities. Overall, people had felt their social and activity needs were not met and we found people at risk of loneliness and social isolation. During the first day of this inspection visit, some people had their nails painted. On the second day, some people joined in an armchair exercise session and later sang along with a visiting music entertainer. Other people continued to tell us they felt 'a bit lonely at times' and 'bored.' One person was watching a television programme in their bedroom and told us, "It's not interesting, but there is nothing else to do."

The manager told us they had identified further improvements still needed to be made in the provision of planned group activities and also with individual time spent with people supporting them with their interests. An electric piano had been donated to the home and used at a recent fete, that one person

described to us as being 'very good.' A Wii and x-box (games consoles) had been purchased with the view to these supporting armchair activities such as bowling. The manager told us they planned to develop reminiscence groups for people and make use of two lounges that were currently rarely used by people.

People who wished to practice their faith felt supported to do this. One person told us, "We have a church service here, I like the singing." One relative said, "I go, with my family member, to the church service they have here. We can have Holy Communion and join the singing." One person told us they did not wish to join the home's church service but wanted someone to pray with them. We discussed this with the manager, who told us they felt able to support this person themselves. The activities staff member also took immediate action to contact local churches to explore whether visits might be possible for this person.

Information about how to make a complaint was displayed in the entrance area of the home. Staff told us they would support people to make complaints. Speaking with us about what they would do if someone told them they had a complaint, one staff member said, "I would listen and reassure the person, I'd sort it out if I could or tell the manager."

Relatives were positive about the manager and gave us examples of them seeking their feedback. One relative told us, "The new manager has changed the times for the 'resident and relative' meetings. It is now much better and easier for people to attend." Relatives felt the manager was approachable and listened to them and acted on any concerns they raised. The manager told us, "There is a lot still to do, though I feel progress is being made in making the service more responsive to people's needs and supporting their relatives."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, during January 2016, we found insufficient improvement had been made to the governance of the home. The requirements of the warning notice served on the provider and previous registered manager, following our inspection in July 2016, had not been fully met. We found a continued breach, which dated from March 2015, of the regulation relating to the governance of the home. Staff did not feel supported and quality assurance systems were not always effective. We rated this key area as 'requires improvement.' The provider agreed voluntarily to restrict admissions to the home and send us improvement action plans each month, which they did.

At this inspection, we found sufficient improvements had been made to meet the requirements of the warning notice and regulation relating to governance of the home. There had been a change in the management of the home since our last inspection. A new home manager and regional manager had started working there in April 2017. They had continued to send us improvement action plans and had taken action to implement improvements and identified further areas where improvements were needed. The rating remains 'requires improvement'.

All staff spoken with were complimentary about the new manager. Staff told us the manager was supportive and listened to them. Staff said they felt appreciated in their work and gave us examples of this, one staff member said, "The manager thanked us and brought a box of chocolates for the staff team." Another staff member said, "I've had six managers here in the five years I've worked here. I feel this manager is supportive and I feel happier coming to work."

We were told that the provider had made some recent changes to one of their catering suppliers without consultation with cooks. One cook felt the quality of some items had deteriorated, and gave an example of draining a lot of liquid from a meat product. We saw cooks had to change the menu on both days of our inspection visit because items for the planned menu were not in stock. After our inspection visit the manager and regional manager told us there were systems to monitor the quality of service provided by suppliers and for staff to give their feedback. They had not received feedback that there were any concerns with this supplier, however they would follow up on these concerns.

Staff working in the kitchen felt cleanliness was not as good as it could be due to a recent change where kitchen assistants managed the morning and afternoon drinks trolley, giving out drinks and supporting people with them. One cook told us this had happened without discussion and they believed it was a provider decision. While the kitchen, overall, was clean, we saw some tasks needed to be done, such as the freezer needed defrosting from a very thick layer of ice. Items in the fridge were not always stored in the safest way; to prevent possible cross contamination. One member of staff felt this was not due to a lack of knowledge but because staff rushed, as time was more limited.

The manager and regional manager told us the decision to have the kitchen staff take the trolley out to people was made with the purpose of kitchen staff getting to know the people they were catering for and to promote a person centred care approach. This decision was made together with the Head Chef a few weeks

before our visit and they considered this as good practice.

Staff felt the manager was having a positive effect on the overall culture of the home. A staff member said, "The atmosphere and culture of the home are changing for the better, it is improving for the people that live here." Another staff member told us, "The manager is more supportive and wants us to be able to make decisions and use our initiative. This is quite new to us as a staff team, it wasn't like that before. We just got told what task to do. It is taking us time to change to being like that, but we want to get there." The manager told us a new deputy manager was due to commence employment at the home soon and this would enable further improvements to take place, plans included one to one supervision meetings with staff.

The provider had systems and processes in place to assess, monitor and mitigate risks to people's health, safety and wellbeing. We looked at infection prevention and control, medicine and environmental safety check audits. Overall, these had identified where actions were needed to make improvements.

The manager showed us their accident and incident reporting system. There had been 12 recorded accidents this year to date. The manager told us these were used to identify the actions needed to minimise the risks of reoccurrence. The manager undertook spot checks to ensure staff used their training in practice on a day to day basis.

Systems were in place to seek feedback from people, their relatives and staff. While feedback surveys had been made available to people since our last inspection, the manager and regional manager felt the response was very low and not representative of people's views. For example, only one survey from the staff team had been returned. The regional manager told us they planned to undertake a new feedback survey during August 2017 and were happy to share feedback with us and any actions needed to improve, following their analysis.