Barchester Healthcare Homes Limited

Forest Care Centre

Inspection report

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 17 January 2017.

Forest care centre is registered to provide accommodation for up to 20 persons, who require nursing or personal care for adults with early onset dementia, with complex needs and associated behaviours that challenge. All rooms are on ground level, single occupancy with en-suite facilities. On the day of our inspection 15 people were living at the service.

A registered manager was in post who had been registered since September 2016. 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.

Staff understood how to identify and report allegations of abuse. Risks associated to people's needs had been in the main assessed for, but risk plans were variable in detail and guidance for staff. The internal and external environment people lived in was safe.

People's emergency evacuations plans lacked specific detail and did not consider people's mental health needs.

There was a system used to review and monitor people's dependency needs. There were sufficient staff available to meet people's needs and safety. Staff recruitment for a clinical lead and an additional nurse was ongoing but plans were in place to manage these vacancies in the short-term. Staff had been appropriately recruited; checks had been completed in relation to safety and suitability before they commenced their employment.

People received their prescribed medicines safely. Some inconsistencies were found with the recording of medicines prescribed to be taken as and when required. People's preferences of how they preferred to take their medicines were not recorded. The daily stock control of medicines was found to have some gaps. An eye drop medicine were found not to be dated when opened and a cream not in use had not been removed to confirm it had been discontinued.

The principles of the Mental Capacity Act 2005 were understood by staff and had been applied appropriately. Some people experienced periods of heightened anxiety that could result in behaviours that were challenging to themselves and others. Staff had limited information and guidance available about how to support people effectively at these times.

Staff training was ongoing and areas identified that required improvements such as catheter care training and cardiopulmonary resuscitation [CPR] was in the process of being completed. Staff had received

infrequent opportunities to discuss their work and development needs. This was being addressed and improvements were underway.

People's nutritional needs had been assessed and planned for and people were supported to maintain their health. Some inconsistencies were identified in relation to the frequency of the monitoring of people's weights. However, recent weekly meetings had been introduced for key staff to have oversight of people's changing needs, and the required action to respond effectively to these. Staff worked well with external health professionals and followed recommendations made in supporting people with their health needs.

People were supported by kind, caring and compassionate staff that showed dignity and respect. Some staff were more reserved in their interactions with people. Experienced staff were knowledgeable about people's needs, preferences and routines.

People had access to independent advocacy information should they have required this support. People and their relatives, if appropriate, were involved in review meetings that discussed the care and treatment provided.

People were supported by staff to participate in activities of interest to them. Staff were responsive to people's requests for assistance and reacted well to people's comfort needs.

Systems were in place for receiving, handling and responding appropriately to complaints. People had opportunities to provide feedback on the care and support they received in order to continue to drive forward improvements in the service.

Improvements had been made with regard to the quality assurance systems in place to ensure that people received high quality, safe and effective care and support. An action plan was in place to further drive the required improvements. Whilst improvements had been made in some areas, further time was required for systems and processes to fully embed and be sustained.

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.

Staff had received safeguarding training and were aware of their responsibility to protect people from harm.

Risk plans and personal evacuation plans lacked specific detail in places or were missing.

Sufficient staff were employed and deployed appropriately and safe staff recruitment processes were followed.

Some issues were identified with medicines management.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received an induction and training and support was improving.

People's rights were protected by the use of the Mental Capacity Act 2005 when needed. Behavioural support plans to support people lacked appropriate information for staff.

People received choices of what to eat and drink and menu options met people's individual needs and preferences. The monitoring of people's weight was not always consistent as required.

People had the support they needed to maintain good health and the service worked with healthcare professionals to support people appropriately.

Is the service caring?

Good

The service was caring.

People were cared for by staff who showed kindness and compassion in the way they supported them. Experienced staff were knowledgeable about people's individual needs.

Independent advocacy information was available for people. People were involved in opportunities to review their care.

People's privacy and dignity were respected by staff and independence was promoted.

Is the service responsive?

Good

The service was responsive

People were involved as fully as possible in their pre-assessment. Care plans were reviewed regularly.

Activities were available to meet people's individual preferences and interests.

People's views were listened to and there was a system in place to respond to any complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and their relatives received opportunities to share their experience about the service. Staff told us they would be confident raising any concerns with the registered manager and that they would take action.

People who used the service and staff were positive about the changes and improvements being made by the registered manager.

There were systems in place to monitor and improve the quality of the service provided. An action plan was in place to drive forward some shortfalls and further time was required for new systems to fully embed and be sustained.

Forest Care Centre

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 17 January 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a registered nurse 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service, and Healthwatch to obtain their views about the service provided.

On the day of the inspection we spoke with five people who used the service and four visiting relatives or friends for their feedback about the service provided. We observed staff interacting with people to help us understand people's experience of the care and support they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the provider's clinical development nurse, an agency nurse, a care practitioner, three care staff, the cook and the activity coordinator. We looked at all or parts of the care records of six people along with other records relevant to the running of the service. This included policies and procedures, records of staff training, recruitment and records of associated quality assurance processes. We also checked the management of medicines.

Requires Improvement

Is the service safe?

Our findings

People who lived at the service told us they felt staff supported them appropriately to remain safe. Relatives told us that they had no concerns about their family member's safety. One relative said, "[Family member] has been unsafe, had incidents with staff and residents, inquired into last year. But we are happy with the outcome." Another relative said, [Family member] is safe here, I have popped in at all times of the day and never seen anything untoward. All my family think the same."

Staff demonstrated they were aware of how to protect people from avoidable harm including abuse. One staff member said, "It's our job to make sure people are safe. We follow care plans and if we see anything of concern we would report it to the manager or outside agencies like the safeguarding team, police or you CQC."

Records confirmed staff had received adult safeguarding training. Information was on display advising people who used the service, visitors and staff, of the action they could take if they had a safeguarding concern.

The provider is required by law to notify CQC of safeguarding incidents. We were aware that there had been a high level of safeguarding's reported to us. We discussed this with the registered manager who explained why this was and the action they had taken to reduce risks to people. We found safeguarding incidents had significantly reduced as a direct result of the action that had been taken. Staff also confirmed to be correct.

People who used the service and visiting relatives told us that they felt risks were assessed and managed well by staff. One person told us that they had some risks associated with their mobility and explained how this was managed. This person said, "I've got an alarm mat, if I get up in the night they [staff] hear the alarm and they're there straightaway." A visiting relative told us that their family member had particular risks that meant they required additional staff support to keep them safe. This relative said, "[Family member] has one to one and this suits them, they are doing more now and is safer."

Staff gave examples how they managed people's risks. For example, they advised what equipment was in place to protect people such as pressure relieving mattresses, cushions and mobility aids such as hoists. We saw these were in place as required and being used appropriately.

We saw examples of risk assessments associated to people's needs that had been completed. Risk plans had been developed that advised staff of action required to reduce risks; however these lacked detail in places. Daily charts did not reflect people's needs had been met in line with their risk plan. For example, we saw two examples of people's daily repositioning charts to protect against the risk of skin damage.These records showed these people were not repositioned at the frequency stated as required in their risk plan. Two other people's care records identified they were at risk of choking. Whilst risk plans stated how to reduce this risk there was no instruction for staff about how to manage the situation should the individual choke. Two additional people were at risk of seizures but neither had risk plans advising staff what to do if a seizure should occur. A person with diabetes did not have a risk plan that gave guidance to staff on what to

do if they had high or low blood sugars and what was the normal range for that individual. This meant there was a risk that people's needs were not sufficiently assessed and planned for.

Accidents and incidents were recorded and monitored by the registered manager and we found action had been taken to mitigate risks from reoccurring. This included referrals to external healthcare professionals and additional resources provided to meet people's needs. The provider had systems and processes in place to monitor the safety of the environment and equipment. Safety check records showed these were up to date. However, clinical equipment was not recorded as being checked, the registered manager assured us this was being done but was not recorded and said that they would address this.

Personal emergency evacuation plans used to instruct staff of people's support needs in the event of the building requiring an evacuation lacked detail. For example, consideration had not been given to a person's mental health needs and how this may impact on their safety during an emergency situation.

On the whole people who used the service and visiting relatives told us they felt there were sufficient staff available to keep people safe and meet their needs. One person told us, "I feel safe, there are certainly enough staff. Don't have to wait long. "A relative said, "There are enough staff, [family member] recognises staff and is happy." An additional relative commented that they thought there were less staff available at weekends.

Staff were confident that there were sufficient, qualified and experienced staff available to support people. Staff told us that new staff had recently been employed and time was required for them to gain in confidence and experience as they were new to care. The registered manager showed us a tool that they used to assess people's dependency needs. The staff rota showed that the levels of care staff were the same over a seven day period. We found the staff on duty matched the staff rota and where people had been assessed as requiring additional staff to support them this was provided.

We were aware before our inspection that the service had experienced difficulties in recruiting permanent nursing staff and this had impacted on the quality of care provided. The registered manager told us that they were still in the process of recruiting a clinical lead but had a nurse in place providing temporary cover. The registered manager said that whilst they still had to use agency staff, they were block booking agency nurses to provide consistency and continuity. We spoke with any agency nurse on duty who confirmed what we were told.

There were safe staff recruitment and selection processes in place. Staff told us told us they had supplied references and undergone checks including criminal records before they started work at the service. We checked that nursing staff were registered with the Nursing and Midwifery Council to confirm they were safe to practice. Records confirmed staff had been recruited safely and nursing staff were registered appropriately.

People told us they received their medication as and when prescribed and they felt confident this was managed well. One person said, "I get my tablets twice a day." A visiting relative told us "There are reviews of medicines and they [staff] give it all okay."

We found a person's eye drops had not been dated when opened. This is important because this type of medicine is only effective for a specific time once opened. Medicine administration records (MAR charts) did not record the person's preference of how they liked to take their medicines. Some people were prescribed medicines to be taken as and when required for pain or anxiety. We found staff were not routinely recording the reasons why these medicines were administered. This is important information to enable effective

monitoring of the medicines people were taking. We did a sample stock check on medicines. We found a cream for a person that had been discontinued was still available. Daily stock checks were completed but we found two gaps in these records. However, the stock of these medicines was correct. This told us that the systems in place to manage people's medicines were not as effective as they should have been.

We observed a nurse administering people's medicines. They followed good practice guidance and stayed with the person to ensure they had taken their medicine safely. The nurse also provided explanation to the person about the medicines they were administering.

Records confirmed that staff had received appropriate training in the administration and management of medicines and a policy and procedure was available for staff.

Requires Improvement

Is the service effective?

Our findings

Generally people who used the service and visiting relatives told us they felt staff were competent and knowledgeable about people's needs. Several comments were made about newer staff employed who they found less experienced. One person said, "They know how to look after everybody." A visiting relative told us, "I think it's fantastic, I think they are well trained and know how to support him." Another relative said, "The staff seem reasonably well trained. Lots of very new staff. They have students and that's good."

Staff told us that they were satisfied with the induction and training opportunities provided. One staff member said, "I received a good induction which prepared me for my role. During the induction we completed training that included, moving and handling and health and safety." Staff gave a mixed response about the opportunities to meet with their line manager to discuss and review their work and development needs. Some said they had met with the registered manager and others said either they had not or they had not had a meeting for a long time. The registered manager told us that supervision and appraisals meetings with staff had not been provided at the frequency the provider expected. They said that they were addressing this and confirmed all staff would receive a one to one meeting by the end of the January 2017. The registered manager also showed us a supervision and appraisal plan they had developed to ensure future meetings were booked. This told us that the registered manager was working towards improving support opportunities for staff.

We were aware from a local clinical commissioning group [CCG] audit of the service in 2016 that some concerns with staff training had been identified. This included nursing staff not trained in the management of catheter care and not all staff trained in cardiopulmonary resuscitation [CPR]. The registered manager told us nursing staff had received catheter care training and one nurse was due their observational competency check and CPR training for care staff was being arranged. The registered manager showed us the staff training plan that confirmed staff had completed training in other areas of care such as health and safety, infection control, moving and handling and choking. Two dates in January 2017 was planned for staff to receive training in dementia care as this had also been identified by external commissioners as required.

People told us that staff gained consent before care and support was provided. We observed staff promoted people's choice in all aspects of their daily living and gave explanation to people before providing care and acted on their decisions.

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. We checked whether the service was working within the principles of the MCA.

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.

Staff told us they had received training in MCA and DoLS and records confirmed this. Both staff and the registered manager had a good level of knowledge about their duties under the MCA and how to support people with decision making. People's care plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out, when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed.

At the time of our inspection four people had been granted an authorisation from the supervisory body that meant their freedom and liberty was restricted. Other applications had been made and were waiting to be assessed. Care plans were in place to advise staff of the DoLS authorisation and the impact this had on the person and what staffs responsibility was to support the person effectively.

Some people had do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. This is important information to advise staff of the person's end of life wishes or the best interest decision made on behalf of a person who lacks mental capacity to make this decision. These were found to be appropriately completed. Some people had advance directives in place in their care records to instruct staff of their wishes. An advance decision [sometimes known as an advance decision to refuse treatment, an ADRT, or a living will] is a decision you can make now to refuse a specific type of treatment at some time in the future.

Some people were living with dementia and experienced periods of high anxiety that affected their mood and behaviour. Experienced staff were found to be knowledgeable about people's individual needs, including triggers and what their coping strategies were at these times. A member of staff told us about the different techniques used to distract and support people and we saw how they supported a person effectively to reduce their anxiety.

We found behavioural care plans for people with particular needs with their mental health lacked specific detail in places for staff of how to support people effectively. One care plan stated that the person had challenging behaviour but no explanation of what this meant for the person or guidance for staff of how to support the person at these times. Another care plan though did give some detail in regard to challenging behaviour and strategies on how to deal with it. For one person It had been recommended in January 2017 by a consultant psychiatrist that a behavioural care plan should be put in place however, this had not been provided. The lack of clear written guidance for staff meant that people could not be assured that staff fully understood their needs. There was a risk people did not receive a consistent and effective approach from staff at periods of increased agitation.

People received a choice of meals and were supported to have sufficient to eat and drink. People described the food as good or at least alright. They added that there was enough offered and they would be asked if they wanted more. One person said, "Promising food, most of the time it's very nice, other times it's not." Relatives were positive about the food provided. One relative said, "Food looks good, [family member] did lose a lot weight due to illness but now seems to have picked up."

We spoke with the cook who was knowledgeable about people's dietary needs and preferences. They told us how they provided meals that were appropriate for people's individual needs. For example, some people required a soft diet due to concerns about their swallowing. Other people required a fortified diet due to issues with weight loss. Some people were living with diabetes and needed a particular diet. Kitchen staff had written records of people's needs including likes and dislikes and allergies.

We observed the lunchtime experience for people. People were shown two plated meals to choose from. This was good practice because it supported people to make an informed choice. Some people required assistance from staff and we saw staff were attentive, explaining what people were eating and engaged people in conversations as fully as possible. Adapted eating and drinking utensils were provided that supported people's independence. We observed people were offered drinks and snacks throughout the day.

Care records demonstrated people's dietary and nutritional needs had been assessed and planned for. These plans showed us that consideration of people's cultural and religious needs was also given in menu planning. People were supported to have their weight monitored so action could be taken if changes occurred.

We were aware that there had been some concerns identified by external commissioners, that the monitoring of people's weight and action to respond to concerns had not been effective. We found an example where a person was at risk of malnutrition, care records showed they had been weighed weekly and a referral to a dietarian was completed in a timely manner. However, two other people's care plans stated that the individuals were required to have their weight taken each week but we found some gaps in the recording of their weight. The registered manager told us that they had just introduced weekly internal meetings that included the nurse, clinical lead and care practitioner to improve how people's needs were assessed and managed.

People told us they were supported to access external healthcare professionals and health services. One person said, "The doctor would come, no problems."

We received feedback from a visiting healthcare professional. They told us that referrals made by staff were appropriate and timely and staff followed any recommendations made.

Care records confirmed people were supported to access external healthcare when required. This included the GP, dietician, speech and language therapists, physiotherapists and the opticians.

Good

Is the service caring?

Our findings

People told us that they found staff to be kind and caring. They said staff were friendly and cheerful. One person told us they always felt comfortable with the staff. One person said, "A lot of the staff are really nice." Another person told us, "I'm quite taken with it [the service], there's a good atmosphere."

Visiting relatives told us staff were caring, they appreciated the way in which their family member was cared for and found staff friendly and helpful. One relative said, "I've observed caring staff. [Family member] likes physical contact and I do see them [staff] holding their hand, chatting to them and doing activities with them." Another relative told us, "Staff are always pleasant and helpful, any problems I'm confident staff would help if I mentioned it to them."

Staff spoke positively about their work and felt they had developed positive relationships with the people their cared for. One staff member said, "I love my job, there's been lots of improvements here recently and I think this is really positive for people who live here."

We observed the atmosphere was quiet and calm with staff responding well to people's comfort needs or if they became distressed. A relative told us their family member had improved since having additional support and was now doing more and seemed more settled. We saw and heard staff talking to people with good humour and kindness. For example, one person was walking round with a member of staff, giggling and evidently enjoying the company of the staff member. We observed staff trying to distract and refocus a person who had become distressed calmly and quietly. Another person was seen to be restless and walking up and down the corridors. A staff member walked with them at times, talking to them and offering objects for them to focus on.

Whilst on the whole staff used good communication and listening skills. Such as talking with people at the same eye level and encouraging them to engage in interactions, some staff were more relaxed and confident than others. For example, some staff missed opportunities to engage with people at times, not always picking up on communicative cues. We found experienced staff were informative about people's needs, including their preferences and personal histories.

People or their relative, when appropriate, had been involved in the care planning process. The registered manager told us they were in the process of reviewing people's care plans and had arranged meetings to enable people and their relatives where appropriate, to participate in the meeting. On the day of our inspection care reviews were taking place and we saw people and their relatives were involved in these meetings. One relative told us how much they appreciated the opportunity to meet up with their family member's named nurse and to check through the care plan. Another relative said they were able to raise anything at review meetings and they were confident these were met.

Information about independent advocacy support was available. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. This meant should people have required additional support or advice, the provider had made this information available to them.

People were positive that their privacy, dignity and respect were maintained. One person told us, "The staff treat me with dignity and respect and I feel comfortable with them."

Staff gave examples of how they respected people's privacy when providing personal care and that they were discreet and sensitive in maintaining people's dignity at all times. Our observations confirmed what staff told us. We saw staff were polite and courteous to people, they knocked on people's doors before entering and were discreet when providing support to people.

People told us that there were no restrictions about when their family and friends visited and this was confirmed by a visiting relative.

The importance of confidentiality was understood and respected by staff and confidential information was stored securely.

Good

Is the service responsive?

Our findings

A relative told us about their first visit to the service when looking for a placement for their family member. They said, "We got a good response when I came to visit to choose which home, they gave us leaflets and encouraged us to ask other questions."

People and their relatives where appropriate, had been involved in the person's pre-admission assessment. We saw records that confirmed this. These assessments are important to ensure the provider can meet people's individual needs before admission to the service to enable staff to provide a responsive and personalised service. Care plans were then developed to support staff to understand what people's diverse needs were and how to respond using a person centred approach. We found care plans provided information about people's routines, what was important to them and the support they required from staff. We saw these were regularly reviewed to ensure they reflected people's current needs.

People who used the service and visiting relatives were positive that staff provided a person centred approach to the care and support they provided. A relative told us they had discussed their family member having a daily bath and shave, they confirmed that this was always adhered to. People told us that they felt staff responded in a timely manner to calls for assistance and this was confirmed in our observations, we also noted that people were not left in communal rooms unattended.

Another relative told us staff recognised their family member's needs. They said staff understood their family member did not want to sit and watch television but preferred to be active and so was offered jobs they enjoyed such as sweeping, polishing and dusting. This relative added, that they appreciated staff had asked them about his family member and they were able to fill in their history for them. We saw records confirmed what we were told.

We found some examples where people were supported appropriately as stated in their care records. For example, one person's care plan stated the person liked to sit outside the office and eat their meals there. This was apparent on the day of our inspection and we found staff were aware of this and resepected the person's wishes.

We also found example where people's care plans either lacked specific detail or was not followed. For example, some people living with dementia were uncooperative with staff with aspects of their personal care. One care plan stated the person's preference to either male or female care staff whist the other did not. This may have been important to the person. Another person's care plan stated that they required support to wear their glasses and shoes. This person was seen walking around without these. We noted this person's care records included a recent incident, whereby they had sustained an injury to their foot whilst not wearing shoes. This should have been picked up on and staff reminded to support the person as their care plan instructed. We discussed this with the registered manager who agreed to discuss this with staff.

People's interest, hobbies and pastimes were recorded and we saw people were being supported with these. For example, one person liked to be active by going on walks, visiting parks, going to the cinema and

listening to music. On the day of our inspection we observed this person was supported by staff to go for a walk in the local community. Later in the day we saw them listening to music. Their care records showed that this person was supported during January 2017 to go to the cinema and a community country park.

We spoke with the activity coordinator who told us that they asked people about activities they wanted to do. They showed us an activity timetable they had developed based on people's choices and known interests. This included fortnightly community trips, recent trips had been to the country park and a museum. The activity coordinator said that they had plans to improve activates further for people and this included supporting people with memory boxes. They were also due to receive training to support them to develop meaningful activities for people. In addition dementia training had also been arranged all of which would support them in their role in providing stimulating and interesting activities for people.

We observed activities taking place during the day, these were mostly with one or two people and a member of staff. These included table top activities and arts and crafts. There were brightly coloured activities available that included sensory and tactile objects and equipment for people to engage with. The week's activities were displayed using pictures which made the list accessible for people who may have found reading difficult.

Some people told us they knew there was a complaints process and that they knew who to speak to if they needed to make a complaint or had a concern to raise. One person said, "I've not got any complaints, think it's one of the best places I've been to." Another person told us, "I'd go to the lady in the office, not made a complaint. Not often that sort of thing happens, the manager would listen."

Relatives were confident they could make a complaint and that this would be listened to and acted upon by the registered manager. A relative told us, "If I had a concern they would do their best to fix it. I would speak to the named nurse and then to the manager."

Staff were aware of the complaint procedure and what their role and responsibility was in responding to any issues or concerns. The provider's complaint procedure was available for people if they wished to make a complaint. We saw that one written complaint received during 2016 had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

We were aware that external commissioners had visited the service in September 2016 where concerns were identified in a number of areas about the quality and safety of care and treatment that was provided. In response to these concerns the provider completed an action plan, this has been monitored by external commissioners to ensure improvements were being made. We saw this action plan and found examples where improvements had already been made. This included some improvements in how medicines were managed, how people's needs were monitored more effectively and improvements to staff training, competency and deployment. Whist we acknowledged the registered manager who had been in post since September 2016, had made improvements; further work was required for all the required improvements to be completed, fully embedded and sustained.

We saw that all conditions of registration with the CQC were being met. We had received notifications of the incidents that the provider was required by law to tell us about, such as any safeguarding any significant accidents or incidents. A registered manager was in post and they had a clear understanding and plans in place to continually improve the service. We found they interacted well with people who used the service, clearly demonstrating they knew and understood people's needs. They were also seen to be responsive to visitors and staff. They told us they had an open door policy and was always available when requested. Through our observations we saw this was the case. People who used the service went into the office to see the registered manager and relatives and staff alike.

The registered manager had introduced daily walk arounds where they assessed such things as staff engagement with people, activities being provided and health and safety issues. Records confirmed what we were told and what action had been taken if required. They worked hours that enabled them to be present for staff handover meetings and had introduced additional meetings for staff to discuss people's needs to improve the quality and effectivness of care provided. A variety of daily, weekly and monthly quality assurance audits and checks were in place. This included areas such as health and safety, staffing issues and care records. In addition representatives of the provider conducted two monthly quality assurance visits. Night spot checks were also completed by the registered manager to ensure people received a safe, caring and responsive service at all times. The registered manager said no concerns had been identified during night checks.

People who used the service and visiting relatives spoke positively about the registered manager. They told us they had confidence in the registered manager, they found them to be approachable and friendly. The registered manager was around throughout the day of the inspection and several relatives told us they appreciated their hands on approach. People also told us the home had improved under the leadership of the registered manager.

People and their relatives were invited to attend meetings and complete surveys by the provider to give their views and experience of the service. This information was then analysed for any themes and patterns to make required improvements. We saw a resident survey results dated 2015 that showed that people were very positive with the service they received. We also saw feedback received in 2016 by people completing an

on-line questionnaire, that gave the service a high rating score in areas such as facilities, being treated with dignity, care and support.

Staff were positive that improvements had and were being made to the service. One staff member said, "The manager is trying really hard to make improvements, they listen and involve us. We were concerned about lunchtime being loud and chaotic. We suggested using a second room for meals, we started it last week and it's made a massive difference, so much better." Another staff member told us, "There have been big improvements, we are trying to be more person centred and new documentation has been introduced which is much better. I would describe it as definitely an improving service."

Staff were aware of the provider's whistleblowing policy. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation. Staff told us that they would not hesitate to act on any concerns and were confident their concerns would be addressed.

The provider's statement of purpose and service user guide provided information about what people could expect from the service. This included the provider's vision and values. We found staff understood these and demonstrated them in their day to day work.