Care Quality Commission

Ranc Care Homes Limited

The Withens Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on the 12 and 17 October 2017. The first day of the inspection was unannounced and the second day was announced.

Staff provided personal and nursing care for up to 33 older people. The accommodation spanned two floors and some rooms had on-suite facilities. A lift was available for people to travel between floors. There were 28 people living in the service when we inspected. People had chronic and longer-term health issues associated with ageing or illness requiring nursing care and some people were living with dementia as a secondary diagnosis.

We carried out our last comprehensive inspection of this service on 05 and 06 December 2016. At that inspection breaches of legal requirements of the Health and Social Care Act Regulated Activities Regulations 2014 were found. The breaches related to Regulation 17, Good Governance; Accurate and complete records were not being kept. Regulation 18, Staffing; Staff were not deployed in sufficient numbers. We also made six recommendations. The recommendations related to medicines audits, Deprivation of Liberty Safeguards applications, staff surveys, residents meetings and meeting people's social needs. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Whitens Nursing Home on our website at www.cqc.org.uk

At the time of this inspection the local authority in Kent had been working with the provider on an improvement plan. This improvement plan had been implemented in response to recent concerns about incident and safeguarding management in the service. The action plan and the improvements being made had been shared with CQC by the provider. At this inspection, we found that the provider had brought in a team of senior managers to implement the improvements that were required.

There was not a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The provider had employed a manager who had made an application to register with the Care Quality Commission on 21 June 2017, but they had left before the registration process had been completed. However, the provider was in the process of recruiting a new manager. At the time of this inspection the service was being managed by an experienced interim manager.

Staff protected people's privacy and confidentiality whilst delivering care, but at other times, people could be observed in bed as their doors were open. It was not clear if people had consented to their doors being left open. We have made a recommendation about this.

The risk from infection were minimised by safe systems of work by staff delivering personal care and by a planned and actioned cleaning and maintenance routines. However, two areas in the service requiring maintenance posed a risk to infection control. We have made a recommendation about this.

The provider had a system in place to assess people's needs and to work out the required staffing levels. Since the last inspection, the provider had been making changes to the way staff were deployed and simplifying recording systems to reduce the amount of time staff spent away from care task, for example completing paperwork. A recently appointed nurse deputy manager was leading on the effective delivery of nursing care.

Space in the service for the storage of confidential information was limited. However, since the last inspection, information that staff needed access to when delivering care was kept in people's bedrooms and other larger care plans were stored in locked cabinets at the nursing station on the ground floor.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. The interim manager responded quickly to safeguarding concerns and shared information with the safeguarding teams.

Incidents and accidents were recorded and checked by the interim manager to see what steps could be taken to prevent these happening again. The risk were assessed and the steps to be taken to minimise them were understood by staff.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills by maintaining their registration with the Nursing and Midwifery Council (NMC).

We observed that staff were welcoming and friendly. Activities were planned to keep people mentally active and to maintain skills or hobbies they were interested in. People and their relatives described that staff were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred.

The provider and interim manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had been tested and was well maintained.

Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The interim manager understood when an application should be made.

People were supported to eat and drink enough to maintain their health and wellbeing. People had access to good quality foods. The chef prepared foods that were seasonal and used fresh ingredients. People had

access to food, snacks and drinks during the day and at night.

People had access to qualified nursing staff who monitored their general health. End of life nursing care was supported by links to the local hospice team. People had regular access to their GP to ensure their health and people's health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the home. This included checking nurse's professional registration.

Policies were in place so that if people complained they were listened to. The interim manager held regular meetings with people and their relatives and made changes or suggested solutions to issues people raised.

The interim manager of the service, nurses and other senior managers were experienced and provided good leadership. They followed their action plans to improve the quality of care people experienced. This was reflected in the changes they had already made within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to manage risk. Medicines were administered by competent nursing staff.

Staff were committed to preventing abuse. Staff spoke about blowing the whistle if needed.

Recruitment for new staff was robust and sufficient staff were deployed to meet people's needs.

Incidents and accidents were recorded and people were safeguarded from potential harm.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well. Staff understood their responsibly to help people maintain their health and wellbeing.

Nursing staff monitored people's health and referred people to health services when needed.

Staff met with their managers to discuss their work performance and staff had attained the skills they required to carry out their role.

The registered manager and staff had completed training in respect of the Mental Capacity Act 2005 and understood their responsibilities under the Act.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness, compassion and respect.

People's privacy and dignity was respected by staff when they

delivered care.

Staff showed concern for people's well-being in a caring and meaningful way and responded appropriately to their needs.

Compassionate end of life care was provided by staff.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

Information about people was updated so that staff only provided care that was up to date.

People were consistently asked what they thought of the care provided and had been encouraged to raise any issues they were unhappy about.

People were encouraged to participate in activities.

People and their relatives knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was well-led.

A registered manager was not in post.

The quality of the service was monitored through regular audits were effective in highlighting areas requiring further improvement.

The management team were clear and about the vision and values of the service and led by example.

People's and relatives views about the service were sought and acted on.

Care Quality Commission

The Withens Nursing 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 12 and 17 October 2017. The first day of the inspection was unannounced and the second was announced. On day one of the inspection, the inspection team consisted of two inspectors, a nurse specialist and an expert by experience. The expert-by-experience had a background in caring for elderly people. Day two of the inspection was carried out by one inspector.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We checked that the provider had followed their action plan.

We observed the care provided for people. We spoke with two people and six relatives about their experience of the service. We spoke with twelve staff including the interim manager, the deputy manager, the provider's regional operations manager, the quality development manager, two nurses, three care workers, the chef, a housekeeper and the activity lead. We received feedback about the service from four health and social care professionals.

We looked at records held by the provider and care records held in the service. This included four care plans, daily notes; safeguarding, medicines and complaints policies; the recruitment records seven staff employed at the service; the staff training programme; medicines management; complaints and compliments; meetings minutes; and health, safety and quality audits.

Good

Is the service safe?

Our findings

People and relatives said that people were safe living at the service. One person told us, "I feel very safe, they do everything I need, when I want a bath they take me." Another person said, "I feel safe and the staff are always in attendance."

Relatives said, "Mum is always clean, the staff are always nice and polite, Mum is now very poorly but they keep her comfortable." Another relative said, "We are very pleased with the levels of safety here."

A local authority occupational therapist said, "They now have an extra nurse and carer and they have been using a private occupational therapist to carry out assements which has improved the levels of staff available."

At our previous inspection on 05 and 06 December 2016, we found the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that the provider had not deployed sufficient numbers of staff on duty to meet people's needs.

At this inspection we found there had been improvements to the staffing levels and the way staff were deployed.

There were enough staff to deliver the care people needed safely and people were protected from foreseeable risks. Our observations and discussions with staff showed that staffing deployment was based on an analysis of the levels of care people needed. We observed staff prioritising answering nurse call bell alarms and people confirmed to us they did not have to wait long for staff to assist them. People's dependency levels were reviewed at least monthly. There were enough staff available to walk with people using their walking frames if they were at risks of falls or to provide safe moving and handling.

Staffing levels were planned to meet people's needs. In addition to the interim manager, who was a registered mental health nurse (RMN), there were five or six staff available to deliver care between 8 am and 8 pm. Staffing numbers were flexible to changes in people's needs at peak times. In addition to this, two qualified registered general nurses (RGN) were available. At night, there were three care staff managed by an additional qualified nurse. Actual staffing levels were consistent with these staffing levels on the rota from the previous month and planned for the coming month. For example, on the October rota there were six care staff on shift. Staff confirmed there were enough staff. One member of staff said, "Time is given between shifts for staff to hand over". Staffing levels were backed up and any staff or nurse absences were covered by approved agency or internal staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

At our last inspection, we recommended that the provider improved the accuracy of the auditing of medicines in line with published guidance. At this inspection, we found that the provider was operating effective medicines audits.

Nurses ordered people's regular medicines using repeat slips sent to the GP practice. Nurses recorded quantities of medicines received into the home on the medicine administration records, (MAR), provided by the community pharmacy. Liquid medicines and creams had been dated with a start date and a use by date as recommended by the manufacturer of the medicines. Physical quantities of stock and quantities that should have been remaining were correct. For example, we checked that the recorded amounts matched the actual amounts left. The balances of the medicines we checked were correct.

Registered nurses administered medicines safely. Training and updates about medicines was provided by the community pharmacy. Staff had been competency assessed by the interim manager or deputy nurse manager. A medicines policy was in place and was understood by staff administering medicines. Medicines management audits had been completed. When changes in medicines had occurred the nurses had marked the medicines administration record (MAR) accordingly. Medicines were stored safely and securely in a locked clinical room. Fridge and room temperatures were recorded by staff daily and were within normal temperature ranges. This meant that medicines would remain safe and effective.

Medicines specific to end of life care were well managed with guidance from a local hospice. Some medicines were prescribed on a 'when required' basis and there were additional administration records in place detailing the indication when the medicine should be given and the directions. These were recorded on a specific sheet and each person had a homely remedy chart enabling nurses to administer homely remedies if needed. A medicines administration round was observed. The nurse administered medicines safely and as specified in people's medicines care plan. Nurses administering medicines understood how people preferred to take them. For example, in one person's care plan it stated they liked to take tablets on a spoon. We observed the nurse following the person's wishes. Another person initially refused to take their medicines. We observed the nurse returning to them after a few minutes and the person then took their medicines. The medicines were available to administer safely to people as prescribed and required.

Unused medicines were recorded appropriately and were disposed of according to waste regulations. Controlled drugs (CDs – medicines with potential for misuse, requiring special storage and closer monitoring) were stored correctly. Unwanted CDs were destroyed in line with legal requirements.

The provider's recruitment policy was followed by the management. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Before employment, all applicants for posts at this service were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the interim manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. The Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded. Our discussions with the Nurses in the service confirmed that they had the skills and experience to carry out their duties and responsibilities as shift leaders.

The interim manager followed policies about dealing with incidents and accidents. Should any incidents occur they were fully investigated by the interim manager and steps would be taken to prevent them from happening again. The service had undertaken investigations in a timely manner when requested by the local authority and used these to identify areas for improvements.

For example, staff had been trained again in moving and handling due to the risks when moving people with fragile skin. One member of staff said, "The re training in moving and handling has helped me be more

careful."

People were protected against potential abuse. The service had a safeguarding policy which set out the definition of different types of abuse, staff's responsibilities and the contact details of the local authority safeguarding team, to whom any concerns should be reported. The previous manager had not followed the provider's policy which had led to potential safeguarding concerns not being reported or investigated. For example, staff had been reporting and recording incidents which included people suffering skin tears during personal care delivery. The former manager had not acted to investigate or report these issues and had not notified the Commission. However, this had now been corrected and the safeguarding issues raised had been investigated within the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse).

Staff received training in safeguarding, knew what signs to look out for and now felt confident the management team would listen to and act on any concerns they raised. One member of staff said, "I look out for bruising or marking and changes in behaviour." Staff knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Contingency plans were detailed and professionally written to make sure people's care would continue in emergency situations. Each person had an emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The interim manager operated an out of hours on call system so that they could support staff if there were any emergencies.

The interim manager had assessed the risks and safe working practices were followed by staff. People had risk assessments that were specific to their needs. People's risk assessments addressed communication, mobility, falls, and bed rails when appropriate. Sleeping risk assessments instructed staff about the frequency of night observations and repositioning, to check that people were safe. Care plans had recorded actions to be taken to minimise risk. Staff were observed assisting people to transfer and move around and this was done in a safe way. Staff were following safety instructions in practice. Infection control risks were managed through maintenance and cleaning practices. For example, cleaning was completed following a daily, weekly and monthly schedule. This was signed off and checked by the interim manager. However, we noted that two areas could not be cleaned properly to prevent potential infection because maintenance was required. For example, the bath panel in the main bathroom was cracked and some tiles were missing from behind a communal toilet.

We have made a recommendation about managing maintenance issues that could pose a risk to infection control practices in the service.

The provider had checked that the environment was safe for people. Equipment was serviced and staff were trained how to use it. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. Other environmental risks were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, to minimise the risks from water borne illnesses. There were up to date safety certificates for legionella, gas appliances, electrical installations, portable appliances, lift and hoist maintenance. Staff logged any repairs in a maintenance logbook and the maintenance staff monitored these until completion. The maintenance staff carried out routine health and safety checks of the service including regular checks of water temperatures, fire safety

equipment and fire drills. Comprehensive records confirmed both portable and fixed equipment was serviced and maintained.

Good

Is the service effective?

Our findings

People said that staff responded to their needs and their health needs were met. One person said, "The staff are good, they look after me very well." Another person said, "I like the staff here, they are very good."

People said they liked the food. People told us there were good choices and that the food contained vegetables and they could always have fruit. One person said, "I have food when I want, we have roast, puddings and supper if we want." Another person said, "The food is nice and varied, I have vegetables and fruit too."

Relatives said, "We have had a history with other homes, but this one is very good, we feel assured that our loved one is looked after well." Another relative said, "The staff keep in touch with the family regularly and always tell us if our loved one is unwell." And another relative said, "My mother is bed bathed, her continence pads are regularly changed, I have not noticed any bad hygiene practices either."

People at the service were being supported by staff to attend routine health visits and were getting support with routine optician, dental and GP checks and their health and wellbeing was protected. One relative said, "Mum used to get lots of urine infections, (UTI's) but the care she received has stopped these happening." Staff were managing pressure ulcers and wounds effectively. Referrals to the community tissue viability nurses (TVN's) were made promptly. For example, one person with a recurring ulcer had been referred to the TVN's on the same day staff had reported the issue. The interim manager had documented the action taken to manage the person's ulcer and staff followed the recommendations made by the TVN. There were 21 people identified as at risks from pressure ulcers developing and others were at risk from skin tears. These skin/pressure areas were being managed by staff using prescribed creams, body repositioning and air flow mattresses to minimise the risks of serious ulcers developing. The correct settings for people's air flow mattresses were recorded in care plans. These matched the actual settings on the mattresses we checked. Documentation was kept up to date showing when people had been repositioned. Wound care plans showed frequent review. People's care plans had a Waterlow Score. A Waterlow score gives an estimated risk for a person to develop a pressure ulcer and these were reviewed monthly. Records showed that staff were identifying any pressure ulcers at the early stages and were recording their healing appropriately with pictures and body maps. For example, dates were being recorded along with any health care guidance from people's GP or Tissue Viability Nurse (TVN). This meant that it was possible for staff to identify the person if the picture was separated from the care plan or to monitor any deterioration or improvement effectively.

The provider ensured that people's nutritional and hydration needs were being met. Care plans had nutritional risk assessments. One person's nutritional assessment told staff that the person liked to eat independently using a plate guard. (A plate guard sits on the edge of the plate to make it easier to pick up food with a fork or spoon.) Staff used a Malnutrition Universal Screening Tool (MUST). MUST is a five step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. The MUST in care plans identified if people were at low, medium or high risk. The MUST care plans were reviewed at least monthly. This minimised the risks of changes in people's MUST scores being missed. People were being weighed on a monthly basis or weekly when there were any concerns. People's records showed when

referrals were made to a GP, dietician or speech and language therapist. Care plans identified when people were on specific diets, such as soft or diabetic diets. Risk assessments were in place for those who were diabetic. Referrals to other health professionals were done in a timely manner by nursing staff following assessment and observations by staff. For example, staff had referred one person to a speech and language therapist (SALT) who created a risk assessment and care plan to minimise the risk of the person choking on food. Staff had kept a record of the actions they had taken to comply with the SALT care plan.

The chef had introduced a menu that was responsive to people's likes and needs. The chef showed us how they constructed the menus to provide balanced and nutritious foods and how they knew which people had specific dietary requirements. They said, "Before I arrived they used mainly frozen foods, now most of the food is freshly cooked with seasonal vegetables, we use very little frozen or pre-packaged foods now." Menus were displayed in pictorial formats in the dining room. Staff and the chef had diet sheets that identified what diet people required and what options they had selected. People could make comments about the food on a daily basis either by talking to the chef, or recording their thoughts in a comments book in the dining room. Medical information was recorded where this impacted on the persons eating and drinking. For example, if the person was a diabetic or had an allergy to any foods.

People's physical health and mental wellbeing was protected by staff who were qualified and trained to meet these needs. Registered nurses were available who had qualifications in mental health and adult nursing. The interim manager provided us with further information about how the provider supported qualified nursing to maintain their skills and NMC registration as part of the revalidation process. For example, the interim manager monitored the dates when nursing staff NMC registrations needed to be renewed so that they could plan this in with the training nurses received.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The nurses on shift told us they had received training to carry out their roles. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Nurses had training in life support, first aid and the management of diabetes. The first aid training had provided them with information on how to manage/support people who may be bleeding or choking. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. For example, 21 staff had recently attended refresher training in the safe moving and handling of people. The training plan identified a further moving and handling course and a wound care coursed had been booked for November 2017. The staff records we saw contained information about recent training staff had attended and information confirming staff had received an induction. Training gave staff the opportunity to develop their skills and keep up to date with people's needs.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Four new staff had started recently. They confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised. Staff were encouraged to complete a Diploma/Qualification and Credit Framework (QCF). To achieve a QCF qualification, staff must prove that they have the ability and competence to carry out their job to the required standard.

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's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. Where people did not have the capacity to consent, a decision specific MCA had been completed and best interest decisions were recorded. For example, if people required bed rails. Staff talked us through in detail about how they sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

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 services 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 decisions had been made in their best interests. The management understood when an application should be made and how to submit them. A log of DoLS applications and renewal dates was held and monitored in the service. There had been 18 DoLS referrals made and recorded in 2017. This 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.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. One person said, "The staff are kind and pleasant."

Most people and their relatives spoke positively about the staff that provided care. One relative said, "Although Mum is bed fast (cared for in bed), the staff do not treat her any differently, they come in and have a chat, give her a cuddle and show her photographs that she likes." Another relative said, "The staff are attentive, Dad is hard of hearing on one side and when they come in to turn him in bed they speak to him on his good hearing side. They say to him what they are doing so he is prepared."

A visiting social care professional from a local hospice commented, "Whilst the service has suffered with staff recruitment issues which can affect the consistent delivery of end of life care, my impression of the service is that overall it is a good home with hardworking staff."

At our previous inspection on 05 and 06 December 2016, we found the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that the provider had not kept information about people secure.

At this inspection, we found that the provider had made some improvements to protect people's confidentiality.

Areas in the service for securely storing paperwork were limited. The interim manager had reviewed the care plan system so that 'working files' such as repositioning charts and staff daily care logs were stored in people's bedrooms. This meant that staff could complete the required information without any other people nearby. When staff completed paperwork this was either stored in people's bedrooms or kept at the nursing stations to maintain confidentiality. Information about medicines were securely stored in clinical rooms between medicine rounds. Care plans were kept in locked cupboards at the nursing station near to the main lounge. We observed how staff dealt with the paperwork and noted that information needed for completion had been separated out into discrete folders. This meant that if staff completing paperwork were interrupted they could close the folder and others could not see the information or identify the person the record concerned. We observed that staff returned care plans and other paperwork to the locked cabinets at the nursing station when not in use, with access restricted to staff.

Staff spoke kindly to people, did not rush them and addressed them in the way they preferred. Staff knew people well and understood what care they needed. Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. Staff were seen to be kind and compassionate towards people. One member of staff told us, "I love working with elderly people, the time we get to chat varies, but we do like to sit and talk to people when we can." And, "I find the interim manager is very caring towards people." Throughout our inspection we observed care that was kind and respectful. When staff spoke with people who were sitting down, staff were lowering their position so people who were seated could see them at eye level and talk in a clear way to make themselves

understood.

People's dignity and independence were respected. All people reported that staff knocked before entering their rooms and closed the door for personal care. One relative said, "As far as we are aware the staff close the door when they give a bed bath." However, we noted that some people's bedroom doors were routinely left open which meant they could be observed from the passageways. People's preferences about their privacy in relation to their doors being open or closed had not been routinely recorded in their care plan.

We have made a recommendation about the recording of individual preferences in relation to people's privacy when doors should be open or closed.

Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff, nurses and management team.

People and relatives told us that they were involved with the planning and reviews of their care plans. One person told us, "We know that Mum had a care plan and we were involved in the discussions about this." Another relative said, "We think (our loved ones care) is well managed, we are involved in regards to decision making." Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for.

Good

Is the service responsive?

Our findings

We observed staff were responsive to people's needs and relatives told us the service was responsive to people's needs.

Relative's said, "We have noticed that the staff are regularly in touch with the interim manager." Another said, "We are confident that anything we ask for will be sorted out." Another said, "We attended the residents and relatives meeting. We did raise an issue and this was sorted out by the interim manager."

At our last inspection, we made two recommendations. Firstly, that regular activities are made available and secondly, that the provider puts in place systems so that regular meetings take place where people could express their views about the service.

At this inspection we found the provider had made improvements. The interim manager told us there was more of a focus on meeting people's social needs. The number of staff hours available had increased so that there were now two activities co-ordinators. They had introduced a 'Resident of The Day' scheme during which staff reviewed people's care and provided social and pampering support. Staff from each department, the chef, the housekeeper, the senior carer, the nurse, the maintenance person and the interim manager all had their part to play in recording what they have found when visiting the resident of the day and any changes that are required to be made. For example, the maintenance man may find that a lamp needs a new bulb or the curtain may be coming down. These things will be documented, actioned and signed off. The cook will talk to the person if possible about their diet, if there is something that they really do like but it is not on the menu and perhaps this can be considered and the person have their favourite dish. The domestic staff deep clean that persons room on the day and document that this has been done.

Other people pursued hobbies they liked, for example knitting. This helped people maintain movement and dexterity. People told us that external entertainers visited them in their rooms and would sing for them as part of a monthly music for health programme. There was an established activities program. This was advertised for people to see. People who were more able contributed to the activity plan and staff did their best to enable people to continue with any activities they enjoyed prior to coming into the service. This information is now part of the initial assessment. For people who were less able to say what they liked to do, the activity coordinators spent time with individuals on a one-to-one basis so that they had a good idea of what activities they would like to join. For example, the activities lead was now developing tactile activities for people who were more frail. A monthly sparkle magazine was circulated for news about events past and planned and information about the activities available. This gave people the chance to see and share information and get involved if they wished.

The interim manager had also produced action plans to improve people's satisfaction with the service at The Withens. This included holding effective monthly 'Resident and relative forum meetings.' These had been taking place to capture people's views and minutes of the meetings were circulated and displayed for people to read. Future meeting dates were advertised within the service. Quality feedback surveys had been sent out in early September but the feedback received had not yet been collated. There had been a

'Resident and relative forum meeting' on 15 September 2017. This had been attended by nine people and included discussions about the new winter menu with the chef. The interim manager had produced a list of actions from the meeting and proposed to feed back the results at the next meeting. These meetings were providing people with an opportunity to comment and influence the service they received.

The provider had a compliments and complaints procedure in place which was followed by the management. The interim manager had a complaints log in place to record all complaints received, relevant investigations, their outcomes and how this was communicated to the people involved. There had been five complaints since May 2017. These complaints had been dealt with in line with the providers policy. Complaints were reviewed by the provider's regional manager and included having face to face meetings with people who had complained to try and resolve complaints. The six compliments received were available for people and staff to view.

People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing or residential service was suited to the person's needs. Each person had their health and care needs assessed in depth. People received care from staff who knew their needs, their individual likes and dislikes and their life stories, interests and preferences. One member of staff said, "I feel I know the residents well, I read their care plans and ask them about their backgrounds." Another said, "I have a good relationship with people, I speak with them asking about their lives and families."

Daily clinical governance handover meetings were held by the interim manager for nurses and senior staff. People's care needs were discussed and recorded with follow-up actions delegated to staff. The daily meetings minimised the risk of changes in people's care needs not being responded to.

Changes in people's needs had been responded to appropriately and actioned to keep people safer. For example, a person living with dementia had been aggressively refusing to go to their bedroom at night. This person was being enabled to stay calm by staff making up a bed in one of the lounges at night. The person had been referred to other services that may be in a better position to meet the person's accommodation needs. This change in behaviour had presented some challenges for the staff, but they had adapted the care they provided to meet the persons needs for this short term crisis.

Care plans and risks assessments evidenced monthly reviews. These gave guidance to staff and maintained continuity of care. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care.

Requires Improvement

Is the service well-led?

Our findings

People told us they were satisfied with the service they received. One person said, "I am very happy with my care." And "I feel at home."

A relative said, "The home is managed well, the staff speak to people fondly and they are efficient." Another relative said, "The quality of the service is exceptionally good. Our loved one is cared for really well, everyone goes out of their way to do things. Even the chef enquires with residents on what they like and don't like to eat." Another relative said, "It's a really friendly place, everyone is given choices and asked what they want to do, which is really important."

At the time of inspection, there was no registered manager in post and there had been no registered manager since November 2014. There had been an interim manager in post who started the role in October 2016 and they had made an application to CQC to register as the manager in June 2017, but they had now left without completing their registration. The provider had appointed an experienced manager from another of the nursing homes in their group of services to act up as the interim manager for The Withens. This was a temporary measure whilst the provider took steps to recruit a manager who would register with the Care Quality Commission.
It is a condition of the providers registration to have a registered manager in post. The provider had recruited several managers since November 2014, but had not supported their timely registration with the Care Quality Commission. For example, the last manager had been recruited in October 2016, but had not applied to register as the manager until June 2017. This was a ratings limiter and meant that the rating in this domain could not be better than requires improvement.

At our last inspection we made three recommendations. That records and assessments included people's social needs, that effective systems should be in place to ensure that DoLS authorisations are notified to the Care Quality Commission and that staff views should be captured, recorded and acted on.

At this inspection we found improvements had been made. The provider had provided additional management resources for the service to assist with their improvement plan. The interim manager and regional operations manager had been completing the actions on their development plans showing what improvements they had made and what they intended to make. There were still some areas to be completed. We checked the actions taken on the improvement plan against what had actually been achieved and found the management had made good progress. For example, a DoLS application tracker was now in place and care plans had been updated to a new format to include social needs assessments. A recruitment drive had taken place to increase the number of staff care hours, nursing hours and activities hours. This had improved the assessment, care planning and service delivery for people.

There had been recent issues around notifications, not only to CQC but also social services. Previously staff had been informing the former manager of incidents that had caused people in the service to suffer skin tears and bruising. On investigation it had found that poor manual handling had been the issue. The investigation also found that health professionals, such as GP's had not always been asked for their advice.

This has now changed and all issues that need to be notified to CQC and the social services safeguarding team were being reported. The interim manager had met their legal responsibilities. They sent us (CQC) notifications about important events at the home.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about poor practice within the service.

The provider's policies and procedures relating to safety were implemented effectively. The interim manager's approach to risk management and their response to issues was effective. For example, staff had been retrained when their performance fell short of the standards expected. General risk assessments affecting everybody in the home were recorded and monitored by the interim manager. Quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service.

A health and safety maintenance checklist was in use and other periodic risk management systems were in place to check for hazards that may cause harm, for example checks on bed rails, furniture and wheelchairs. If faults were recorded these had been responded to and the hazard repaired or removed. Risk auditing and periodic maintenance checks minimised the risk of accidents and harm.

Staff described the care values of the service. They said, "It's 100% about care and compassion." And, "It's about care and quality of life for the remaining years of people's lives." We observed staff delivering compassionate care. Staff told us they felt supported by the interim manager. There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings and monthly team meetings. These meetings were recorded and shared. The team meetings supported the improvements in the service. For example, to check that staff understood how nutrition affects people's wellbeing and skin integrity they were being asked questions and having discussions at staff meetings to confirm their learning. Information about how staff could blow the whistle was displayed and understood by staff. A member of staff said, "I get on well with everyone, I feel comfortable raising any issues I may have with the interim manager." Staff told us about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings and handover meetings. Staff felt that they could speak up at meetings and that the interim manager listened to them. This meant that staff were fully involved in how the home was run.

The provider's regional operations manager was often on site. They had assisted the interim manager to develop the service systems and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area of the service and on their website.