Willows Care Home (Romford) Limited

Willows Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place took place on 15 February 2018. At our last comprehensive inspection on 26 April 2016, we rated the service 'Good'. After that inspection we received concerns in relation to the safety and the overall management of the service.

We looked into these concerns at this inspection and we have rated the service 'Requires Improvement'.

Willows is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Willows Care Home accommodates up to 72 people across three separate units, each of which have separate adapted facilities. The units specialises in providing nursing care to people living with dementia.

One the day of our inspection, 52 people were living in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Each unit in the home was managed by a registered nurse who was supported by the registered manager and a deputy manager. The deputy manager was unavailable on the day of our inspection.

Risks to people were identified to ensure they remained safe. However, we noted that any risks relating to people's personal equipment which helped them remain comfortable was not always assessed by the provider. This was addressed by the registered manager during the inspection.

Medicines were stored, managed and administered by staff who were trained. We noted that staff had not appropriately followed procedures following a change to a person's medicine prescription.

People were involved in the planning of their care and received care and support to ensure their individual needs were met. Care plans were person centred and contained information on people's backgrounds and preferences, including for end of life care.

Staff ensured people had access to appropriate healthcare when needed and their nutritional needs were met. People were provided with a choice of meals, although some people told us they were not always happy with the variety and the presentation of their meals. We have made a recommendation for the provider to look into maintaining good quality catering standards.

Feedback was received from people and relatives in the form of questionnaires and surveys to help drive quality improvements. People and relatives were able to make complaints and have them investigated by the registered manager. However, we have made a recommendation about ensuring all types of complaint are responded to and followed up because some people did not feel they were always listened to or shown enough respect.

The registered manager was committed to developing the service, although further improvements were required to ensure people continued to receive a caring and responsive service.

The premises were clean and regularly maintained. The environment was suitable for people who had specific needs such as dementia.

Infection control procedures were followed after a recent outbreak, which affected people in the home.

Records of accidents and serious incidents showed that the provider learned from mistakes to prevent reoccurrence.

Staff had received training on how to keep people safe. They were able to describe the actions they would take if they had any concerns about people's safety. The provider also had a whistleblowing policy, which staff were aware of and they knew how to report concerns both internally and to external organisations.

The provider had safe recruitment procedures in place and carried out checks on new employees. There were enough staff on duty to ensure people's needs were met and staff rotas were planned in advance so that staff cover could be arranged when required.

Staff were supported with regular training, meetings and supervision. Staff performance was reviewed on a yearly basis and they were encouraged to develop their skills.

The provider had systems in place to support people who lacked capacity to make decisions for themselves. Staff had received training on the Mental Capacity Act 2005.They were knowledgeable of the processes involved in assessing people's capacity.

Staff were aware of people's preferences, likes and dislikes. They also had an awareness of equality and diversity and challenged any discrimination they encountered.

People were encouraged to participate in activities and remain as independent as possible. Their choices were respected.

Staff were able to communicate with people in order to understand their needs.

Staff felt supported by the management team, who reminded staff of their responsibilities and requirements when providing care.

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. Risks to people were assessed to ensure people were safe at all times.

People received their medicines on time by staff who were trained.

The provider had a safe recruitment procedure. There were enough staff to meet people's needs.

Staff were aware of the steps to take to report any allegations of abuse. They were aware of their responsibilities to report any concerns.

The provider was able to learn lessons from serious incidents to improve the safety of the service.

Is the service effective?

Good

The service was effective.

People were supported to eat a balanced diet and their nutritional needs were met. People told us they were not always satisfied with the quality of their meals and we have made a recommendation about this.

People could see healthcare professionals when required and their health care needs were monitored.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Changes in people's care needs were updated in their care plans.

Staff had good knowledge and understanding of the Mental Capacity Act (2005). Staff were supported with training and received regular supervision and guidance.

Is the service caring?

Requires Improvement

The service was not always caring. Staff knew people well and provided care with dignity and kindness, although people's views about their care was mixed. Some people did not feel they were

respected.

People were able to express their views about how they wished to be cared for. Their relatives had involvement in the decisions made about their care.

People were supported to remain as independent as possible.

Staff supported people with end of life care sensitively and respectfully.

Is the service responsive?

Requires Improvement

The service was not always responsive. There was a formal complaints procedure and complaints were investigated by the registered manager. People and relatives were notified of the outcomes. However, some people did not feel that their concerns were addressed adequately or were unsure of how to complain. We have made a recommendation about this.

People's care plans contained information about their preferences.

The provider ensured information was accessible to people in a way they could understand.

People were encouraged to participate in activities of their choice.

Is the service well-led?

Requires Improvement

The service was not always well led. Quality assurance audits took place regularly to ensure the service was safe and people's needs were being met. However, they had not identified the shortfalls we found in the service.

Staff felt supported by the management team and were encouraged to provide their feedback.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

Willows Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 unannounced comprehensive inspection took place on 15 February 2018 and was carried out by one inspector, a specialist nursing advisor 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, we reviewed all the information we held on the service such as previous inspection reports and notifications. A notification is information about events that by law the registered persons should tell us about such as safeguarding alerts and serious incidents. We also obtained feedback from the local authority for their views on the service and the local Health watch.

During our inspection we spoke with ten people and with four relatives. We also spoke with three nursing staff, four care staff, the registered manager, the training administrator, the operations manager, a facilities manager and a chef. After the inspection, we spoke with a health professional by telephone for their feedback on the home.

We looked at ten people's care plans and other records relating to people's care, such as turn charts and medicine administration records. We also looked at accidents and incidents records, seven staff files, training records, quality assurance audits, health and safety information and other records kept in the service.

Good

Is the service safe?

Our findings

During our inspection most people we spoke with told us they felt safe. One person said, "I feel safe" and a relative told us, "My [family member] is in good hands here."

Shortly before we inspected, information was received from the registered manager of the home that there had been a recent outbreak of diarrhoea and vomiting, which led to some people experiencing illness. The provider took appropriate action to ensure the infection was controlled according to their procedures. Staff we spoke with were knowledgeable about safe practices to ensure hygiene and cleanliness was maintained in the service. One staff member said, "We use PPE (Personal Protective Equipment), hand gels and dispose of waste in the right bin bag for infected items." We observed that the premises were clean and free from odour. Some people were not satisfied with the levels of infection control in the home. Comments from one person included, "Hygiene is not good, one staff was coughing when serving people's food and carried on working." People were free to move about the home as they wished, although other people living in the home were concerned that this could lead to further infections, during the outbreak. Another person said, "No, not safe. They moved residents about to other floors when there was an infection going round."

We looked at medicine records and found people had received their medicines on time and as prescribed. All people had Medicine Administration Record (MAR) charts, which contained the medicines they were prescribed and the time they needed to have them. However,
we found one person's MAR sheet for an anti-depressant medicine was altered by a member of nursing staff. The staff had written prescribing notes by hand that had been authorised by the person's GP but it was only countersigned by one other trained staff member and not both staff, as is required according to the provider's medicine policy. This meant that people's medicine records were not always maintained correctly. Staff were not always following recording procedures when handling people's medicines. We raised this with the nursing staff on duty and with the registered manager, who took action to ensure staff were reminded of procedures to follow, when making changes to people's medicines. The registered manager sent us an action plan following our inspection on further actions they had taken to prevent similar errors in future.

Medicines were stored securely in locked rooms in a cupboard and trolley. Appropriate measures were in place to make sure medicines were kept at the manufacturer's recommended range of temperatures. For people that were prescribed medicines on an "as required" basis (PRN), there was guidance in place for staff to follow, on when to administer such medicines. This helped to ensure staff administered medicines to people safely. Medicines were labelled clearly and MAR charts contained the name of the person, their personal details and a photograph to help staff identify them. We saw that dates of when medicines were opened and used by, were listed with details of any allergies people had. MAR charts were signed by staff after each dose was administered. The storage, supply and disposal of any unused or expired medicines were carried out appropriately and safely. The home worked well with the pharmacy that supplied medicines.
There were also anticipatory medicines available for people receiving end of life care, who could receive these medicines immediately and without delay, if required.

People's care plans contained specific sections on their health care needs that included any risks. Risk management plans were in place for each person, which covered falls, moving and handling, risks around medicine administration, such as high risk medicines like warfarin, pressure ulcer prevention, positive behaviour management tools and any risks relating to the home environment. For example, one person's risk assessment advised staff to ensure that a footpath was free from any obstructions or dangerous objects when assisting a person to walk. People that required bed rails to be put in place were risk assessed to ensure they remained safe. People who were at risk of choking on food also had risk management plans in place. Risk assessments included guidance for staff on how to reduce risk, in accordance with the severity of the risk. We spoke with a relative of a person in the home, who told us, "The risk management in the home is very good. The reason for bringing my [family member] to the home was due to his frequent falls at their previous placement. Since he has been admitted to Willows Care Home, there haven't been such incidents."

The provider had safeguarding policies and procedures in place for staff to refer to if they had any concerns about people's safety. Staff we spoke with demonstrated an understanding of how to recognise different types of abuse and what actions to take to prevent or report it. This helped to ensure people were safe. They had an understanding of their responsibilities and said they would report abuse if they were concerned about a person. They were also aware of the whistle blowing procedures. A whistle-blower is a person who raises a concern about the practice of an organisation to external organisations, such as the local authority, police or the CQC. All staff had received safeguarding training, which was refreshed annually. New staff received the training as part of their induction.

There was a procedure in place to review any accidents or incidents that occurred in the service. We noted from accident and incident reports, that the management team had ensured necessary actions were taken following incidents. Any trends that were identified, this was then used to aid staff and improve their understanding of how to respond to incidents. A recent safeguarding investigation by the local authority had identified a number of improvements that were required in the service, following a serious incident. We saw that additional training and support was provided to staff, people's needs were reviewed and there was a reduction in the admissions of people with high levels of challenging behaviour. Lessons were learned from serious incidents or errors to help prevent reoccurrence. We saw from records that issues and concerns relating to incidents were discussed during meetings.

The provider had systems to ensure only suitable staff were recruited to work with people who used the service. We looked at seven staff files which detailed their employment history, qualifications and previous experience. Pre-employment checks were undertaken before staff started working at the service. This included, obtaining references, checking if they had any criminal records, proof of identification and immigration status, to check they were legally allowed to work in the United Kingdom.

There were enough staff to ensure people received the care and support they needed. Each unit had a manager and a nurse's station and we saw that staff were available to support people when required. When the service was short of staff, processes were in place for cover staff to be called. We saw there were care staff and nursing staff on duty to respond to the needs of people living in the units. We viewed staffing rotas and saw staff were available on each shift and rotas showed if additional staff were required on particular days in the forthcoming weeks. Staff told us they did not have concerns about a lack of staff cover. Staff who worked for the provider on a permanent basis knew people well and covered sickness or leave to ensure people's needs were met. One staff member said, "Yes we have enough staff. Generally it is fine."

Where people required more intensive one to one staffing support, this was provided to ensure they remained safe. It was noted that the provider was currently using recruitment agency staff to cover any staffing shortfalls. The provider ensured that agency staff were familiar with the 'culture' of the home and

the people living there, by providing them with a thorough induction. This helped to maintain consistency in the service, although some people told us they were not always happy with the agency staff. One person said, "The good carers move to other floors. I am not sure the agency ones who come in are competent." The registered manager told us they were intending to reduce the use of agency staff in future.

The premises were regularly maintained. We saw in the kitchen that refrigerator and freezer temperatures were kept at suitably safe settings. Equipment, such as hoists and wheelchairs were maintained and serviced as per the manufacturer's recommendations. We saw checks were carried out on fire safety equipment on a regular basis to make sure they were within recommended levels. People had individual evacuation plans for staff to follow in the event of a fire and practice drills took place regularly. A facilities manager said that drills did not always require people to evacuate the building. Gas, water and electrical systems were serviced annually or when they were due.

Good

Is the service effective?

Our findings

People told us staff were helpful and provided them with the care that met their needs. One person told us "Yes, it is very good. I get the care I need." Another person said, "The staff are very nice and they know what to do."

Staff were knowledgeable of what the different needs of people were and received relevant training to help them meet their needs. Staff told us they were able to access the training they needed for their roles. We viewed a training schedule and we saw staff had completed mandatory training courses in areas such as moving and handling, dementia awareness, safeguarding adults, challenging behaviour with breakaway techniques, wound management, medicine management, end of life care and person centred care. They undertook regular refresher training sessions to keep themselves updated with the latest guidance and practice. Some staff had achieved diplomas in Health and Social Care to become qualified in certain skills. Care Certificate standards were tailored into the training, which are nationally recognised learning standards and assessments for health and social care workers. This meant that staff were provided with relevant and up to date training.

Staff told us the training provided them with the necessary skills and knowledge they needed to carry out their role. During our inspection, we saw that training by health professionals on food thickeners, had been arranged for staff in each unit. One member of staff said, "The training was very good and helped me prepare for my job." New staff received an induction when they started working in the service. We spoke with a training coordinator who told us, "Induction for new staff is for two weeks, including mandatory and non-mandatory training. We provide refresher training when it is due and staff tell me that they like the training and learn a lot from it." We saw records of staff induction and competency assessments which staff acquired through training to ensure they were able to support people.

Staff felt supported by the registered manager and other members of the management team. One staff member said, "[Registered manager] is good, very supportive and listens to us." Staff received regular supervision and we saw records of supervision meetings and annual appraisals between staff and their line managers. A supervision schedule detailed dates of when each member of staff's next supervision meeting was due. Staff were able to discuss topics such as their performance, any concerns they had and areas for professional development. This meant people were supported by staff who had received guidance and support to carry out their roles effectively.

People's nutritional needs were monitored. If staff had any concerns about a person who was at risk of malnutrition, they sought advice from relevant health professionals, such as dieticians. People's food and fluid intake was recorded to show how much people ate and drank, so their nutrition and hydration could be monitored. We noted that staff received input and guidance from speech and language therapists (SALT) for people with risks around swallowing or choking on food. The information was included in people's care plans so that all staff were aware of any guidance they needed to follow.

Staff supported people to have sufficient amounts to eat and drink in order to maintain a balanced diet.

Menus were available for each day and for the full week. We observed a lunchtime service during our inspection. The dining rooms had round tables with chairs around each table and we saw people sitting together whilst being served. Staff were observed being friendly, patient and attentive. They assisted people with their food if necessary and asked if they wanted more food. We spoke with the chef in the home, who told us they were able to cater for people with specific dietary, cultural or religious requirements, such as soft or pureed food or meals that were suitable for people with diabetes. Kitchen staff received information from staff on people's dietary requirements and we saw that these were on display in the kitchen. This ensured people were provided the correct type of meal.

Although people were able to request specific meals if the food on the menu did not appeal to them, people had mixed views about the quality of meals provided. One person said, "The meals are edible but uninteresting. The food is never hot enough." Another person told us, "The food is boring. The menus are repetitive." A member of staff said, "We try to base the menu on each season so it changes through the year." We also noted from complaint records that some people and relatives had formally complained about their last Christmas meal experience because it was "late and cold." The home had also received complaints about the breakfast service. Some people also told us that they were not happy with the meal time arrangements in the evenings. Comments from people included, "Sometimes we have to wait until 6.30pm for supper which I think is late."

We recommend the provider looks into best practice guidance on maintaining good quality catering standards in care homes.

People's needs were assessed before they started to use the service. Information was obtained from other care professionals and relatives in order for staff to fully assess whether the home would be able to meet their needs, at the time of their admission to the home.

Assessments of need contained details such as the person's mobility requirements, skin care, life style, breathing, blood circulation, mental well-being and communication levels. They contained effective outcomes people wanted to achieve in line with social care guidelines. Changes to people's needs were communicated to staff at team meetings and handovers to enable them to respond to people's current needs. Staff worked together and shared important information so that all staff were aware of any issues and what actions needed to be taken. One staff member said, "There is very good teamwork and handover practice here."

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

The registered manager demonstrated a good understanding of the MCA and DoLS. We saw they had made applications for people where there were indications they may be deprived of their liberty for their own safety. This meant people were not being restricted without the required authorisation. An up to date chart detailed all people that were assessed as needing a DoLS, with dates when they were due to expire and when applications were submitted. Staff had received training and were knowledgeable of the MCA (2005)

and DoLS. They respected people's ability to make their own decisions. Staff knew what action to take when this was not the case, such as involving relatives or other health professionals to make a decision in their 'best interest,' as required by the legislation. We saw records of capacity assessments and when decisions were taken in people's best interest. People and relatives were involved as far as they were able to with decisions about their care and support needs. Staff told us they sought people's consent before providing care and support. Where people had bed rails in place to keep them safe, we saw that they had provided their signed consent to their use.

The environment was suitable for people with complex care needs, such as dementia or physical disabilities. There was appropriate signage and adaptations around the premises, which was a large building with three levels. There were communal areas such as dining rooms, lounges for activities and a garden, which people could use to sit outside in suitable weather. People with mobility difficulties had enough space to get around. Adapted baths, showers and hoists were fitted for people to use safely.

Staff were aware of people's preferences and mobility support needs. We observed staff assisting people appropriately, such as when transferring them using equipment or helping them remain comfortable in their beds. People's weights were monitored and any risk of malnutrition or dehydration was assessed to make sure they maintained their health. Observation charts were in place and they were up to date, such as for people who required turning to avoid pressure sores, as well as fluid and diet charts. There was also a behavioural chart for people with challenging behaviours to help staff monitor them so that they and other people remained safe. The staff used malnutrition universal screening tools (MUST), which identified people at risk of under nutrition. These helped staff monitor people's health and wellbeing and take action when necessary if their health or needs changed.

Records showed people were supported to maintain good health. Their health care needs were checked daily and referrals were made to healthcare professionals if they became ill or had sustained any injuries through falls or pressure sores. One person said, "Yes, I get to see the doctor when I need to." Staff had a good knowledge of people's health conditions and communicated with health professionals. Outcomes of appointments or treatments was recorded, for example the results of blood tests and tissue viability checks to treat wounds or skin tears. We found people who required warfarin, which is a medicine to prevent blood clots, regularly attended an anticoagulant clinic and the home ensured they complied with any guidance or advice relating to the person's warfarin prescription.

There were records of prompt intervention and the involvement of other health professionals such as palliative care nurses, dieticians, optician, physiotherapists, diabetic nurses, the local GP and mental health teams. We spoke with the GP who visited the service weekly and checked on the health of people living there. They told us, "I work well with the staff and nurses at the care home. They are helpful and provide good care." The registered manager told us the GP was always available and could be contacted when necessary.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives told us staff were kind and caring. One person said, "Yes, the carers are caring and friendly." Relatives were mostly satisfied with the level of care received by their family members. A relative told us, "Yes, my [family member] is well looked after. They help them be groomed and dressed neatly. [Family member] is happy here." However, some people did not feel they were treated with respect by staff and said, "No they do not respect me. They can be rude." Another person said, "It's ok here. The staff behave like they are doing me a favour when taking care of me."

We found that most staff were attentive and did not wait too long before checking to see what help a person required. People could call for assistance by pressing a call bell attached to their beds. One person told us, "When I ring my bell, the staff come promptly to see me." However, another person told us, "I had to wait for a long time to go to the toilet once. They didn't come. I was upset and embarrassed." These concerns meant that some people did not feel that all staff treated them with kindness, compassion, dignity and respect.

We fed back to the management team that responses from people were mixed so that they could look into any concerns and ensure staff remained caring and respectful in their attitudes towards people.

During our inspection, we observed how staff interacted with people throughout the day and we saw that they were polite, caring and cordial. Staff were respectful when communicating with people, were supportive and told us they knew people and what their needs were. Staff were patient and considerate when supporting people, such as when assisting them to eat their meals. Other comments from people included, "The carers are kind and helpful. One carer brought me my own bottle of ketchup, so I am never without it for my meals" and "I can talk to the staff. They are generally good."

Staff knocked on people's doors before entering their rooms and spoke to them politely, addressing them by their first names. Staff had received training in equality and diversity. This helped them understand how to treat people as individuals and respected their human rights. They understood how to treat people equally regardless of their race, sexual orientation or religion and were respectful of people's cultures, beliefs and backgrounds. A relative told us, "My [family member] requires cultural meals and they provide this."

There was a calm and relaxed atmosphere in the home which helped to make it a comfortable place for people to live. We saw that people were appropriately dressed during the day and they were free to spend time in their rooms or in the communal areas. People and staff engaged in positive and respectful interaction.

Staff told us they ensured doors and curtains were shut when providing people with personal care, to ensure people were given privacy and their dignity was maintained. A sign was placed outside on the person's door for them to not be disturbed while they were receiving personal care. Staff also encouraged people to remain as independent as possible. One staff member said, "I make sure I knock on the resident's door first and when care is in progress, I let them know what I am doing. I give them choice as well and encourage

them to do things for themselves if they can."

People and relatives told us they were involved in developing and reviewing the care plans for people. A relative told us, "Yes, we are involved and we are always in contact with the home." Relatives told us they could visit the service at any time, were made to feel welcome and we saw they were involved in meetings, which allowed family members and people to provide feedback to staff.

Requires Improvement

Is the service responsive?

Our findings

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. Staff we spoke with were not fully aware of the AIS but told us they communicated with people and relatives well and used gestures or signs for people who were less able to communicate, so that they could understand each other. One staff member said, "We speak to people slowly and clearly so that they understand us. We listen to people and make sure they have what they need."

Information people receive, will also tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. The provider had a complaints procedure in place for people and relatives to make formal complaints if they wished. An easy to read complaints procedure was available. There was a system in place for receiving, logging and responding to complaints. We saw that the registered manager investigated all formal complaints that were received. They were acknowledged and responded to appropriately, with explanations by the registered manager and details of action they were taking to resolve the complaint.

However, some people we spoke with did not feel they were supported and encouraged to raise any issues they were not happy about, either informally or formally. One person told us, "One carer was rude to me. I would like to complain about this carer but I don't know how to complain." Another person said, "I complained to the manager about something and she got cross with me."

Some people also told us they were not happy with the care staff and the management team. They did not feel they were listened to or that their concerns were addressed appropriately. Other comments from people included, "They don't listen to my opinions and I feel ignored" and "I was told off by staff when I said something they did not agree with." A relative we spoke with told us their family member found the wheelchair they were using uncomfortable. We asked if they raised this with the staff and they told us they had but no action had been taken to look into why the wheelchair was uncomfortable or whether it was suitable. Another relative said, "I would prefer if staff encouraged my [family member] to leave their room more often and join the other residents."

We recommend the provider reviews its procedures to ensure all formal and informal complaints and verbal feedback are looked into and responded to appropriately.

Most people and relatives told us the service was responsive to their needs. People received care from staff who were aware of their individual care and support requirements. Comments from people included, "Staff are nice and they know me" and "I get what I need and I like it here."

When a person started to use the service, a personalised care plan was developed to meet their individual needs. Each person's care plan contained information about their personal histories and care needs in an electronic format. Care plans were person centred and contained detailed information on people's backgrounds, needs, choices and preferences. They were reviewed and updated monthly or when people's

needs changed. People and their relatives were involved in discussions about the care they received. However, we found that due to care plans being stored electronically, it meant the service was reliant on systems to be operating effectively. One person's care plan was mostly missing and important information, such as their risk assessment, specific needs and support plan, was unavailable on the day of the inspection. We raised this with the registered manager, who was not aware of this and they took action to look into and resolve the issue with the software. However, there were printed copies of risk assessments and assessments available if required. People and relatives were able view the care plans online when they requested to ensure they remained involved in any key decisions.

Staff actively used technology in their day to day work. They completed daily records of what care and support people had received using their individual smartphones and tablets, supplied by the provider. The devices updated automatically, so that all staff received the information immediately on their own devices. We saw this in operation during our inspection. A key worker system was in place for each unit in the home, where people were allocated a member of staff, who took responsibility for arranging their care needs and preferences. Relatives were notified of who the key worker was for their family members, as well as the named nurse on the unit they lived on, so that they knew who to contact if they had any concerns.

Each person had their own room and had the required adaptations in place according to their needs. People's rooms were clean and had been personalised with their pictures and belongings. There was an activity programme in place and notices of activities were on display in the home. People had the opportunity to take part in activities of their choice, such as games, puzzles, singing and bingo. An activity coordinator worked in the home and devised activities based on people's interests and preferences. We noted that people liked to be seen by a hairdresser who visited the home and we saw that a number of people during the day had appointments with the hairdresser. We saw a group activity take place during the day which people enjoyed. One person said, "There's plenty to do. The activities are good." Another person told us, "I prefer my own company or going out with my family."

People's wishes for end of life care were respected. These were expressed in their care plans and staff ensured people were comfortable and any pain was managed sensitively and carefully. When required, advice and support was provided to people, relatives and staff on pain management for those on end of life care. Some people had DNACPR (Do Not Attempt Cardiac Pulmonary Resuscitation) forms where applicable, which meant that they did not wish to be resuscitated should they fall into cardiopulmonary arrest. Records showed that support was received from health professionals, who provided advice to staff on managing people's end of life care sensitively and in accordance with their wishes.

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance systems to monitor and improve the quality of the home. The registered manager and other senior staff carried out daily, weekly and monthly audits to ensure the home remained safe for people, was meeting health and safety requirements and improvements were made where necessary. Records showed that nursing staff on each unit met every morning to discuss concerns and notify staff coming on to the shift of any important information. Nursing staff were also required to complete 24 hour reports which detailed any significant activity across the whole home, such as hospital admissions or discharges. The registered manager was supported by a deputy manager and the operations manager, who visited the service weekly to assess the performance of the home. We saw that they checked on any follow up actions such as updating staff training, care plans, responding to complaints and updating notice boards for people and relatives. The management team monitored the service, during the day and at night, through observations and discussions with people, staff and relatives. Staff told us they knew what precautions to take in order to ensure that people were safe and received the necessary care.

However, the provider's systems did not adequately identify the issues we found at the inspection. We found there was not always an effective handover system in place to ensure that previous staff, who had assisted people with their care, had communicated with current staff. They did not always inform them of important information, prior to no longer working in the home, which meant some staff were not aware of a person's needs. For example, there were no handover records on how to assist one person with using their personal care equipment, to ensure continuity of care. Some staff we spoke with had not received any instructions about a particular device or information on what actions they should take to prevent any risks. Despite the relative safety of the equipment, they had also not sought to ask the person's relative about it, despite the device being visible on the person. One relative told us, "I am concerned that staff don't always enquire about what assistance my [family member] needs, especially as some staff I knew have left." The person's risk assessment or care plan did not contain details and guidance for staff on possible risks when using this specific equipment, to ensure they were safe at all times. It is good practice for providers to ensure that any type of equipment used for health reasons is included in people's risk assessments and care plans. The registered manager took action to address and updated the person's risk assessment shortly after our inspection.

A recent quality audit within the home identified that MAR charts were checked and medicines that had been administered, were required to be signed by two nursing staff. Despite this, we found that people's medicines were not always appropriately signed off and staff did not follow the correct procedures, according to the provider's medicine policy. Although a future medicine audit would have identified this issue, we were concerned that staff, who had been trained, were not fully aware of procedures to follow. The concerns above were resolved after our inspection, only after we had identified them.

People and relatives were generally complimentary of the home. One relative said, "Yes, it is a nice place, well maintained and welcoming." However, some people and relatives we spoke with felt that they did not know the registered manager very well and did not have much interaction with them. One person said, "I think things have deteriorated. The managers always change. I have not even met the new manager and

don't have much confidence in them." Another person said, "The manager dismissed my concerns when I brought them up." The registered manager told us that they knew all the people staying in the home and attended meetings with people and relatives to listen to their concerns.

The registered manager had been in post for six months prior to our inspection. Since our last inspection in April 2016, the previous registered manager had left their post and the home was managed by interim managers for almost one year. The registered manager told us, "It has been a difficult start but I aim to get a more stable staff team so we can provide consistently good care."

Staff told us they felt supported by the registered manager and felt confident they had the skills to meet the day to day challenges of their work. They were aware of their responsibilities and told us they were knowledgeable of people in the home, their care plans and how to access them. One staff member told us, "The manager is very supportive." Another member of staff said, "I am happy working here in my job. The managers are always available when we need them. Their communication is very good and there is an open culture."

Staff felt they worked well with their colleagues and told us meetings were held regularly. The management team and staff shared learning and best practice, so they understood what was expected of them and what their responsibilities were. Records showed that if staff did not follow correct procedures or had breached terms of their employment, then disciplinary action was taken when necessary by the management team. Incentives such as Employee of the Month were introduced by the management team to encourage staff in their work, make them feel valued and promote a positive culture. Meetings took place between the nursing staff and topics of discussion included housekeeping, staffing, training and professional codes of conduct for staff to adhere to. Care staff meetings also took place and agenda items included safeguarding, incidents and recruitment.

The home also held 'residents and relatives' meetings where participants were able to express their views about the service, air any concerns and provide feedback. We noted that people's requests or suggestions were responded to and outcomes were displayed on a notice board to show what people told the provider, and what the provider did in response. For example, additional activities were requested by people and relatives and we saw that improvements to the activities programme were in progress. This meant that the provider took action to ensure people were satisfied with the service to make further improvements. The home had established links in the local community, such as with schools and places of worship, which meant people were able to engage with community groups through visits and outings. Annual questionnaire surveys were sent to people and other stakeholders, such as relatives. We looked at the results from the most recent survey and noted comments were mainly positive. Compliments received from people and relatives included, "Thank you for looking after and caring for [family member]."

The registered manager notified us of serious incidents that took place in the service, which providers registered with the CQC must do by law. People's personal information and care plans were stored in secure online systems that were password protected. This showed that the provider recognised the importance of people's personal details being protected. Staff said they were aware of confidentiality and not sharing people's personal information. They adhered to the provider's data protection policies.