Care Quality Commission

G & A Investments Projects Limited

Oakwood Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 24 and 27 March 2015 and was unannounced. The home provides accommodation and personal care for up to 28 people, including people living with dementia or other mental health needs. There were 17 people living at the home when we visited.

At our last inspection, on 24 and 26 June 2014 we identified breaches of 10 regulations relating to: care and welfare; assessing and monitoring the quality of service; safeguarding; infection control; management of medicines; safety and suitability of premises; respecting and involving people; consent to care and treatment; records; and staffing. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014. In September 2013, we had taken enforcement action and imposed a condition to prevent the service from accepting any new admissions. This condition was still in place at the time of this inspection.

Summary of findings

At this inspection, on 24 and 27 March 2015, we found action had been taken. Significant improvements had been made in all areas and the provider was meeting the requirements of all but one of the regulations.

The home is required to have a registered manager. 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. There was no registered manager in place at the time of our inspection. A new manager had been appointed, who was in the process of applying to be registered.

People were satisfied with the cleanliness of the home. However, we found the infection control risks associated with the laundry were not managed effectively and the hand washing sink was not accessible. This put people and staff at risk of infection. Other areas of the home were clean and hygienic.

Improvements to the environment, which the provider told us they would make, had not all been completed. Work to install additional handrails and change the flooring in the lounge and dining room were outstanding. However, some bedrooms and a bathroom had been refurbished and raised flower beds had been built in the garden.

People felt safe and staff knew how to identify, prevent and report abuse. Risks of people falling or developing pressure injuries were managed effectively. Medicines were managed safely, although one medicine that needed to be given before food was often given with or after food, so may not have been effective.

There were enough staff to meet people's needs and the process used to recruit staff ensured staff were of good character and had the skills and experience to support people appropriately. Staff were well-motivated and received appropriate support and supervision. They were skilled and knowledgeable about the needs of people living with dementia and were suitably trained.

People spoke positively about the quality of the food and received appropriate support to eat and drink. They received fresh, nutritious meals and menus were tailored to people's individual needs.

Staff sought consent from people before providing care and followed relevant legislation to protect people's rights and ensure decisions were made in their best interests.

People's privacy was protected and they were cared for with kindness and compassion. Staff spoke fondly of the people they cared for. People and visitors commented on how quiet and calm the home was and the "family feel" and "happy atmosphere" that had been created.

People (and their families where appropriate) were involved in assessing and planning the care and support they received. They received personalised care from staff who were responsive to their needs. Staff had created a relaxed atmosphere and reduced the levels of anxiety and distress people had previously displayed.

Care plans were comprehensive and were regularly updated when people's needs changed. People were referred promptly to doctors or specialists when changes in their health were identified. They had access to a range of activities which were adapted to reflect their interests.

People, their families and health care professional recognised and appreciated the improvements that had been made and told us the home was well-led. Staff also praised the management of the home. Their morale had increased and they worked well as a team, which reflected on people and the quality of care they received.

There was an open and transparent culture where visitors were welcomed and good working relationships had been built with external professionals. Care was based on a clear set of values which staff understood and followed in their everyday work.

The quality assurance system used to assess and monitor key aspects of the service, such as care planning, medicines and staff training was effective. When improvements were identified, action plans were developed and monitored to ensure they were completed promptly. Analysis of accidents or incidents was undertaken so lessons could be learnt in order to minimise the likelihood of them reoccurring.

We identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Summary of findings

2010 which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the service were safe. Infection control risks within the laundry were not managed effectively, although other areas of the home were clean and hygienic.

People felt safe, staff had received training in safeguarding adults and risks to people were managed appropriately. Arrangements for the management of medicines were safe and people received most medicines as prescribed.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable people were employed.

Requires Improvement

Is the service effective?

Not all aspects of the service were effective. Improvements the provider intended to make to the environment had not been completed. There was a lack of handrails in one of the main corridors and some flooring was badly worn.

People were given a choice of nutritious food and drink and received appropriate support. Staff followed relevant legislation to protect people's rights and ensure decisions were made in their best interests.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision. People had prompt access to healthcare when needed.

Requires Improvement

Is the service caring?

The service was caring. Staff spoke fondly of the people they cared for and treated them with kindness and compassion. People's privacy and dignity were respected and confidential information was kept securely.

People were involved in assessing, planning and agreeing the care and support they received and this process was on-going. Where people did not have family or friends to support them, lay advocates had been appointed to help ensure their voices were heard.

Good

Is the service responsive?

The service was responsive. People received care that was personalised to meet their individual needs. They were supported to make choices and retain their independence. Care plans were comprehensive and were reviewed regularly.

Staff were responsive to people's needs and had reduced the levels of anxiety and distress people had previously experienced.

People knew how to make complaints and complaints were dealt with promptly in accordance with the provider's policy.

Good

Summary of findings

Is the service well-led?

Not all aspects of the service were well-led. Actions the provider had told us they would take had not been taken in respect of the environment and infection control arrangements. A registered manager was not in place, as required.

Quality assurance systems for other aspects of the home were effective and had led to significant improvements. A suitable system was in place to analyse incidents and accidents and learn lessons from them.

People, staff and professionals praised the management of the home. There was an open and transparent culture, together with a clear set of value which staff followed.

Requires Improvement

Oakwood Residential 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 24 and 27 March 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in mental health and an expert by experience in dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We spoke with 16 people living at the home, three friends or family members and a visiting minister of religion. We also spoke with the manager, the deputy manager, seven care staff, the cook and the housekeeper. We looked at care plans and associated records for eight people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also received feedback from the clinical commissioning group, the local authority commissioning unit, a community nurse, a community mental health nurse and a community mental health social worker.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, on 24 and 26 June 2014 we identified breaches of regulations. Arrangements to safeguard people's property were not effective. Infection control risk assessments had not been completed and areas of the home were not clean or hygienic. Topical creams were not kept securely, some medicines were not kept at a safe temperature and medication administration records (MAR) were not always accurate. There were not always enough staff to meet people's needs. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014.

At this inspection, we found action had been taken to manage most infection control risks and people were satisfied with the cleanliness of the home. One person said, "The home and [my] room is kept clean and the staff seem to know what they are doing." Another person told us, "[My] room is cleaned every day, including the sink and toilet."

An annual statement of infection control had been completed and the provider's policy was appropriate and up to date. It was supported by infection control risk assessments and cleaning schedules which detailed how most areas of the home should be cleaned. However, the infection control risks associated with the laundry had not been assessed and there was no cleaning schedule in place for it. The laundry room was very cramped and bags of potentially infectious linen were piled on top of clothing waiting to be cleaned. There was no process in place to ensure such items did not cross infect other laundry. Bags of linen waiting to be cleaned were also found in the hand washing sink. Consequently, the sink could not be used by staff operating the laundry. This put people and staff at risk of infection and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had received training in infection control and had ready access to personal protective equipment (PPE), such as disposable gloves and aprons, which they used appropriately. Check sheets confirmed cleaning had been completed as planned. All areas of the home were clean and smelt fresh. Clinical waste was stored safely and disposed of by an approved contractor.

People felt safe at the home. One said, "I feel safe, and rested, here." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and were confident the manager would act on their concerns. One staff member told us "I know she would deal with it, but if nothing happened I could go straight to [the safeguarding authority]." The provider had suitable policies in place to protect people. For example, one person was at risk of financial abuse and appropriate arrangements had been made to prevent this from happening. Staff followed local safeguarding processes and responded appropriately to any allegation of abuse by conducting thorough investigations. Where necessary, people's risk assessments were updated and action taken to reduce the risks to themselves or others.

Other risks were also managed effectively. These included the risk of people falling or developing pressure injuries. Fall saving equipment was in people's reach at all times and staff encouraged people to use it correctly. Where people had fallen, additional measures were put in place to protect them, such as reviewing their medicines or changing the layout of their rooms to remove hazards. Pressure relieving cushions and mattresses were in place for people at risk of developing injuries. A community nurse told us staff were quick to seek advice if they had any concerns about people and "as a result we see few problems with pressure injuries".

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines. Medication administration records (MAR) confirmed that people received most of their medicines as prescribed. However, the MAR charts showed that one medicine, which should be given half an hour before food, was often given with or after food, so may not have been effective. When we raised this with staff, they took immediate action to ensure this medicine would be given before food in the future. Some people were living with dementia and were unable to communicate when they were in pain. Information was available to help staff identify when these people needed pain relief, but this was generalised and a pain assessment tool was not being used to assess people's individual needs for pain relief.

Staff were suitably trained and knew how people liked to take their medicines. They were clear about how to

Requires Improvement

Is the service safe?

escalate any concerns they had about people's medicines, for example if they were not achieving the desired outcome and we heard them do this for one person. They also had the confidence to question GPs and pharmacies when medicines were not prescribed clearly or provided as required. A recent audit conducted by an external pharmacist confirmed medicines were managed safely.

There were enough staff to meet people's needs at all times and people were attended to quickly when they pressed their call bells for assistance. One person said, "There always seems to be plenty of staff around. I don't normally use the call bell but when I have, it has always been quite prompt in its response." A staff member told us, "If a care assistant goes off sick the staff all pull together and come in or swop shifts so the residents' needs are seen to." A community nurse said, "Staffing levels are good; they always open the door to us, no hanging around. It is much better than before." A community mental health social worker confirmed this, saying, "Staffing levels are good, there are always lots of staff around when I visit."

Staffing levels were determined by the manager who assessed people's needs and took account of feedback from people, relatives and staff. They were clear about the need to have staff with a mixed skill set on each shift and had provided additional training to some staff to achieve this. A staff meeting was planned for the week after our inspection where staffing levels were due to be reviewed, to ensure they continued to meet people's needs.

Records showed the process used to recruit staff was safe and ensured staff were suitable for their role. The provider carried out the relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. Staff confirmed this process was followed before they started working at the home.

There were plans in place to deal with foreseeable emergencies. The provider had a sister home nearby, and arrangements had been made to share resources if the need arose. An emergency bag and file had been prepared containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support they would need if they had to be evacuated, which were linked to a system of symbols on people's doors for easy reference in an emergency. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, on 24 and 26 June 2014 we identified breaches of regulations. People's nutrition and hydration needs were not always monitored or met effectively; The environment was noisy and not adequately maintained to promote people's wellbeing. There was a lack of handrails and doors giving access to the garden were not safe. Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014.

At this inspection we found improvements had been made to the environment, but not all of the work identified in the provider's action plan had been completed. For example, there was a lack of handrails in the corridor between the lounge and the dining room, which meant people who did not use walking aids did not have access to support. The laminate flooring in the lounge and dining room was heavily worn which did not enhance the environment. The doors giving access to the garden could not be secured fully, although planters had been put either side of them to restrict their opening and help people negotiate a ramp down to the garden more safely. A new action plan was in place for these works, which the manager told us would be completed within two months.

Other work had been completed fully, including the replacement of flooring and re-decoration of some of some bedrooms. The communal areas of the home were bright, with pictures and photographs on the walls that were appropriate and relevant to people living there. Colourful notices about events and information for people and their families were also prominently displayed. Previously unpleasant noise levels had been reduced and calm, soothing music was often played. This created a positive environment for people and their families. A mental health nurse told us, "The environment used to be over-stimulating for people, but it's much quieter and calmer now."

People and their relatives spoke positively about the quality of the food. One person said, "The food is excellent here, the cook is very good and the meals are very tasty". Another person told us, "The staff always bring round a hot drink in the morning and afternoon and leave a jug of juice; the food is always hot tasty, and nutritious." A family member confirmed this saying, "[The person] was very up and down before [they] came here, but now [their] appetite's good. The chef is very good at celebrations, buffets and cakes and things."

People received appropriate support to eat and drink enough. They were offered varied and nutritious meals including a choice of fresh food and drink. The cook was aware of people's likes and dislikes and, if something was on the menu a person didn't like, they would visit them in the morning to offer alternatives. For example, one person had been refusing food frequently, so the chef had supported them to design a menu that suited their particular tastes.

Drinks were available to people and within reach. People were encouraged to eat well and staff provided one to one support where needed. When people did not eat their meal, staff offered alternatives, such as sandwiches or soup and gave people time to eat at their own pace. The lunch time experience was calm and relaxed. Staff had made arrangements for people who took a long time to eat their food by providing dishes that retained the heat so food stayed warm. People were also able to eat at a time that suited them rather than set times.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff showed an understanding of the legislation in relation to people living with dementia. Before providing care, they sought consent from people using simple questions and gave them time to respond. People who had capacity had signed their care plans to indicate their agreement with it. Where people lacked capacity, best interest decisions had been made and documented, following consultation with family members and other professionals. Three people did not have family members to represent their interests, so lay advocates had been appointed to support them.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain

Requires Improvement

Is the service effective?

decisions and there is no other way to look after the person safely. DoLS authorisations were in place for five people. Staff were aware of the support these people needed to keep them safe and protect their rights.

People were cared for by staff who were motivated to work to a high standard and were supported appropriately in their role. They received regular one-to-one sessions of supervision with a senior member of staff, which provided opportunities for them to discuss their performance, development and training needs. Dates had been set for staff to receive appraisals in the near future, although these had not started yet. Most staff had obtained vocational qualifications relevant to their role or were working towards these.

Staff were skilled and knowledgeable about the needs of people living with dementia and how to care for them effectively. New staff 'shadowed' senior staff until they were assessed as competent to work unsupervised and followed national induction standards. Records showed staff were up to date with all the provider's essential training and this was refreshed regularly. Where staff needed additional support, this was provided. For example, one staff member was given extra training when it was identified they were struggling to administer medicines correctly. A community nurse said of the staff, "I work with them on a one-to-one basis every day and have delivered training. They really understand people and morale is much better now."

People were able to access healthcare services. Relatives told us their family members always saw a doctor when needed and were admitted to hospital promptly if investigations or treatment were required. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified, for example if they started to fall, lose weight or showed signs of increased levels of confusion or anxiety.

Good

Is the service caring?

Our findings

At our last inspection, on 24 and 26 June 2014 we identified breaches of regulations. A person's preference to have a male member of staff was not being met and staff did not always knock before entering people's rooms. We set a compliance action and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014.

At this inspection we found action had been taken. People's privacy was protected and they were cared for with kindness and compassion. One person told us, "I've had nothing but kindness. I'm very fortunate, very lucky." After some friendly banter with staff, another person said, "Well, you can see how we get on here. We have a laugh!" A third person described staff as "homely, kind, conscientious and polite." People and visitors also commented on how quiet and calm the home was and what a "family feel" and "happy atmosphere" had been created.

Staff spoke fondly of the people they cared for and described them as "like one big family". Regardless of their role, they expressed a shared view that they were responsible for meeting people's needs and making life as pleasant and comfortable for people as possible. We heard conversations between staff and people, where they talked about each other's families and interests, showing they knew people and their backgrounds well. Care and non-care staff visited people when they were in hospital and supported them to access the community, for example to go shopping or for a walk. A care staff member supported another person to visit an elderly relative. Shortly after the visit, the relative died and the staff member helped the person plan and attend the funeral. This helped build positive relationships.

When medicines were administered, staff were patient and chatted with people while waiting for tablets to dissolve, for example. When a person was reluctant to take their medicine, they were coaxed gently and slowly to finish the dose, which they did without any distress. Another person was allowed to finish their food first, to prevent it going cold. The staff member returned shortly afterwards to administer the person's medicine.

Staff spoke with people in ways that showed they knew them well and understood their support needs fully. When it was difficult to understand what people were saying, they used facial expressions, body language and touch to reassure people and make them feel listened to. When they met in passing around the home, staff always acknowledged people and made friendly comments. A relative told us, "Staff never just walk by; they always give [people] a kiss or a hug and spend time with them."

One person chose to sit in a chair in which they became uncomfortable when they fell asleep. Staff accepted this was the person's choice and made them comfortable by placing cushions carefully around them to provide support. Another person liked to mobilise with a walking frame, but sometimes became tired. We observed staff walking behind the person with a wheelchair in case they needed it. They explained that allowing the person to walk as far as they could, helped them remain independent and active. Another staff member told us how they promoted one person's independence by encouraging them to wash themselves. They said, "Sometimes all they can manage is washing their face with a flannel, but they feel a sense of independence by being able to do that still." This also showed staff helped maintain people's dignity.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided they ensured doors were closed and curtains pulled. People had been asked whether they had a preference for male or female care staff; their preferences were recorded, known to staff and respected. For example, one person would only allow a particular staff member to help them with personal care. The staff member made it a priority to support this person whenever they worked, to ensure they received personal care as often as possible. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured conversations could not be overheard.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members were kept up to date with any changes to their relative's needs. Three people did not have family members or friends to support them, so staff had

Good

Is the service caring?

obtained the services of lay advocates to help communicate with these people and represent their interests. This helped ensure people's wishes were sought, heard and acted on.

Good

Is the service responsive?

Our findings

At our last inspection, on 24 and 26 June 2014 we identified breaches of regulations. Staff were not aware of key information about some people and care plans were not personalised. There was no system in place to analyse comments and complaints from people or to identify learning from them. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014.

At this inspection we found action had been taken. People received personalised care from staff who supported people to make choices and were responsive to their needs. One person said, "I like the way things are here." Another person told us, "It's very nice here; the people are very good. I sleep well, eat well, and I like my room." A family member told us, "For me, it's simple. If [the person] is happy, I'm happy. His care here is excellent." People also felt listened to. A family member confirmed this, saying, "If I'm not happy with something, I mention it and it's sorted out." A community nurse told us, "The residents are well looked after. Staff know what to do and want to do well, which in turn reflects back on the residents." A community mental health nurse said, "Staff are more engaged with people and have a good understanding of people's needs. Care is much more person centred now."

Care plans provided comprehensive information about how people wished to receive care and support. For example, they gave detailed instructions about how they liked to receive personal care, how they liked to dress and where they preferred to spend their day. Staff confirmed the care plans provided all the information they needed to care for people appropriately and enable them to meet people's needs effectively. One staff member said, "They're really good. The more you know about [people] the more you understand their needs, what they can do for themselves and what they need help with."

All staff contributed to developing people's care plans. For example, one staff member had highlighted that a person was at risk of pressure injuries as they spent a lot of time in bed. The manager then arranged for the person to be given a pressure relieving mattress. An occupational therapist had recommended a person with advanced dementia was given certain equipment. The chef felt the suggested equipment was not very dignified, so researched and found a more suitable product. It achieved the same purpose, but was more appropriate to the age of the person. The person showed us the equipment and gave a big smile, indicating they were very happy with the product.

Reviews of care were conducted regularly by key workers. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. As people's needs changed, their care plans were developed to ensure they remained up to date and reflected people's current needs. People and their relatives were consulted as part of the review process.

Records of daily care confirmed people received care in a personalised way in accordance with their individual needs and wishes. By understanding people's needs and creating a relaxed atmosphere, staff had managed to reduce the levels of anxiety and distress people had previously displayed. As a result, people were visibly more relaxed and smiled more. A person who had been reluctant to leave their room now used the lounge and mixed with other people more often. A community nurse said, "All the staff seem happy and the residents seem calm." A community mental health social worker confirmed this and said, "Staff are doing the best they can for [people]."

People had access to a range of activities which were adapted and personalised to reflect their interests. They were encouraged to identify wishes, goals and activities they wanted to undertake and staff found innovative ways of achieving them. We heard people taking part in a sing-song which they clearly enjoyed and a film afternoon, showing a classic film was well attended. Photographs showed events, such as birthday parties had been celebrated. Some people and their family members had also become involved with planting and developing the garden. Staff spent time on a one-to-one basis with people who preferred not to engage in group activities. They also made occasional use of a hand held computer to find topics of interest, such as operas for one person. They had been successful in encouraging these people to take some of their meals in the dining room, which had helped reduce the risk of them becoming socially isolated.

People knew how to complain or make comments about the service and the complaints procedure was prominently displayed. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy. For example, a family member had raised

Good

Is the service responsive?

concerns about one person's care. Their concerns were documented and investigated thoroughly, which reassured them that the person was receiving appropriate care. Staff had then worked with the family to help them understand their relative's condition better and explained how the family could help the person by supporting them in a different way.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, on 24 and 26 June 2014 we identified breaches of regulations. The quality assurance system was not embedded in practice or working effectively and record keeping by staff was not always accurate. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 31 August 2014.

At this inspection we found action had been taken. Quality assurance systems and record keeping had improved. The provider had completed most, but not all the actions they told us they would take to ensure they met the requirements of the regulations. They had not completed all the environmental improvements and had set a new action plan for outstanding work. The provider had not identified a solution to on-going concerns about the laundry and was seeking advice from an infection control specialist.

Auditing of other aspects of the service, such as care planning, medicines and staff training were effective. Where changes were needed, action plans were developed and changes made. These were monitored to ensure they were completed promptly. In addition the manager and the deputy manager spent time working with staff and observing care being delivered to ensure staff were working effectively. The chef monitored people's nutritional intake by taking time out of the kitchen to observe how well people ate. As a result, they identified improvements that could be made. They had changed the type of food provided to people, which resulted in people managing to eat more easily. The manager was aware of key strengths and areas for improvement at the home and had put an improvement plan in place, together with a new plan to improve the environment of the home.

The home is required to have a registered manager as a condition of their registration, but there was not one in place at the time of our inspection. The previous registered manager had left the home in October 2014. A new manager had been appointed immediately and they had started the process of applying to become registered with CQC.

The new manager was receiving support from the Clinical Commissioning Group (CCG) to develop their skills and took every opportunity to attend as many courses as possible. The provider had employed the services of an external consultant to support the manager further and the manager regularly sought advice from an experienced registered manager at one of the provider's other homes. A deputy manager had been appointed to act in the manager's absence and they too were seeking every available training opportunity.

People and their families told us the home was run well. One person said, "It's an excellent home. There's nothing I'd change." A family member said of the management, "We get on like a house on fire with them. It seems well run. If I ask a question, I get an answer. I can't think of anything that could be improved." A community nurse told us, "We can walk in anytime; they're open and happy for us to be supporting them. They've been on a roller coaster, but it's different now, things are much calmer."

Staff also praised the management of the home. Comments included:, "[The manager] lets us use our initiative, is approachable and very supportive"; "If we go to [the manager] with a problem, she sorts it out there and then"; "People enjoy coming to work; they smile more and are happier, which makes the residents happier too"; and "[The manager] is very good, the residents are much happier and there's more of a community feel as we're involved with the families more".

There was an open and transparent culture within the home. The previous inspection report was available for people and visitors to read in reception, together with the responses from people to a survey conducted by the provider. Visitors were welcomed, there were good working relationships with external professionals and the provider notified CQC of all significant events. There was a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. There were links to the community through two local churches, visitors and advocates. A local school was also working with the home on a project which brought people and children together.

Brightly coloured display boards promoted the values of the home, which were cited as: 'Privacy, dignity, independence, choice, fulfilment and rights'. One display said, "Treat us with respect, smile, listen to us, laugh with us, dream with us, get to know us." This encouraged an inclusive approach towards people by staff and visitors.

Requires Improvement

Is the service well-led?

When we discussed the displays with staff, they fully understood the values and described actions they took to reflect these values in their everyday work. These actions were confirmed by our observations.

The manager felt proud to have changed the culture of the home and said, “People and staff are happier. Morale is much better and the atmosphere is calmer.” They engaged with staff through daily contact and by running staff meetings. These provided an opportunity for staff to discuss concerns and make suggestions for improvement. Records of the meetings showed these were productive and had led to better outcomes for people. One staff member told us, “We know what’s expected and we all work as a team now.” The manager also conducted staff surveys and used the result to assess how satisfied staff were with their work. Results were positive and confirmed morale was high.

An effective system was in place to analyse incidents and accidents and learn lessons from them. An improved recording format had been introduced. Accidents, such as falls, were reviewed monthly by the manager to identify any common themes or patterns. Action was then taken to minimise the risk of them reoccurring. For example, furniture in bedrooms was moved around to minimise trip hazards and people had been offered more suitable rooms on the ground floor. In addition, staff made good use of a communications book to pass on information or concerns about people to their colleagues. This helped ensure all staff were aware of current risks to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider is failing to ensure that people are protected from the risk of infection. Regulation 12(1) and 12(2)(a). This corresponds to Regulation 12(1) and 12(2)(h) HSCA 2008 (Regulated Activities) Regulations 2014.