Care Quality Commission

Speciality Care (REIT Homes) Limited

Woodlands Care Home

Inspection report

Sands Lane, Mirfield, West Yorkshire, WF14 8HJ
Tel: 01924 491570
Website: www.fshc.co.uk

Date of inspection visit: 8 and 9 September 2015
Date of publication: 26/11/2015

Ratings

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

Overall summary

This inspection took place on 8 and 9 September 2015 and was unannounced. The previous inspection, which had taken place during November 2014, had found the service was in breach of specific regulations in relation to care and welfare of people, assessing and monitoring the quality of service, safeguarding people from abuse, cleanliness and infection control, management of medicines, meeting nutritional needs, safety and suitability of premises, respecting and involving people who use the service, consent to care and treatment, dealing with complaints, keeping records and staffing. A Notice of Proposal to vary the conditions of registration was issued. Taking into account subsequent actions taken by the registered provider to resolve the breaches, the representations that were made to the Care Quality Commission (CQC) and feedback from the local authority, a decision was made on 29 July 2015 not to adopt the Notice of Proposal.

At this inspection, we found improvements were evident in many areas since the last inspection. However, we found there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to safe care and treatment.

Woodlands Care Home provides residential and nursing care for up to 87 people living with dementia or with enduring mental health needs. Accommodation is provided on two floors in four separate units. At the time

Summary of findings

of our inspection, there were 64 people living at the home; Hopton unit accommodated 9 people, Mirfield unit accommodated 11 people, Calder unit accommodated 21 people and Thornhill unit accommodated 23 people. Each unit was self-contained with a communal lounge, dining area, bathroom and toilet facilities. Bedrooms were single rooms with en suite facilities. There was a central kitchen and laundry located on the ground floor and a hairdressing salon.

The home had 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.

Staffing levels were appropriately identified, using a dependency tool. The numbers of staff deployed equated to the number of staff required. Staff were trained in safeguarding and appropriate referrals and investigations took place when necessary. Standards of cleanliness and infection control had improved since the last inspection.

Staff had been trained and understood the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people were deprived of their liberty, applications had been made in order to have this restriction authorised.

Although care plans were in the process of being developed, some people's care was not always planned and delivered in a way that was personalised to their need.

Staff felt supported and received regular supervision. Staff told us that morale had improved since the last inspection.

Most staff interactions with people were of a positive nature and were kind and caring. There were occasions, however, where staff were not as respectful of people's dignity.

Strong teamwork and clear direction for staff was evident. Staff had confidence in the registered manager. There was a culture of openness and transparency.

You can see what action we told the provider to take 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?

Requires improvement

The service was not always safe.

People told us they felt safe.

Care plans were not always updated with current risks.

Robust recruitment practices were followed to ensure that staff were suitable to work in the home.

Improved systems were in place for the receipt, storage, administration and disposal of medicines, although there were some recording errors.

Is the service effective?

Requires improvement

The service was not always effective.

Staff knew people well.

Staff were well supported and received regular training and supervision.

Records in relation to food and fluid intake were not always completed when they should have been.

People had a good understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Requires improvement

The service was not always caring.

People told us staff were caring.

On occasion, disrespectful terminology was used by staff.

Staff interpreted people's needs well, particularly when people were unable to communicate verbally.

We saw staff being kind and reassuring to people.

Is the service responsive?

Requires improvement

The service was not always responsive.

The quality of recording in people's care plans was inconsistent.

The environment was much improved since the last inspection which promoted more social interaction.

The registered manager proactively sought feedback from others and considered various means of communication to do this.

Is the service well-led?

Requires improvement

The service was not always well led.

Summary of findings

Staff reported confidence in the registered manager.

People's care was not always monitored appropriately.

The registered manager had made improvements in many areas since the last inspection.

Woodlands 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 and 9 September 2015 and was unannounced on the first day. The second day of the inspection was announced.

On the first day of our inspection, the inspection team consisted of three adult social care inspectors 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. On the second day of the inspection, the team consisted of two adult social care inspectors.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority and the clinical commissioning group as well as information we received through statutory notifications. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit, in advance, information about their service to inform the inspection.

We used a number of different methods to help us to understand the experiences of people who lived at the home. We spoke with 15 people who lived at the home, six visitors/relatives, nine care staff, a member of activities staff, a member of cleaning staff, a care quality coordinator, the registered manager and the regional manager.

We looked at five people's care records, three staff files, a training matrix, as well as records relating to the management of the service and the maintenance of the home. We looked around the building and saw people's bedrooms, with their permission, bathrooms and communal areas.

Requires improvement

Is the service safe?

Our findings

The people we spoke with told us they felt safe. One visitor told us, "I've never seen anything that causes me any worries when I leave." A relative we spoke with told us they thought their family member was safe, although they noted they had never been asked for any identification when visiting the home.

Our previous inspection of November 2014 found the provider was in breach of health and social care regulations, regarding safeguarding people who used the service from abuse. At this inspection we found improvements had been made. The registered manager was clear about safeguarding reporting procedures and was able to outline different types of abuse and the potential signs to look for, which may indicate if someone was being abused. There were safeguarding posters on display throughout the home. The registered manager had made referrals to the local safeguarding authority and carried out investigations when this was appropriate. Staff we spoke with understood how to identify the signs of possible abuse and the procedures to follow if they had any concerns. There was a safeguarding policy and whistleblowing policy in place and staff were aware of this. Staff were confident when describing whistleblowing action they would take if they came across poor practice. This meant that people were protected from abuse and improper treatment because the registered provider had robust procedures and processes to make sure people were protected.

Some people who lived at the home behaved in a way that challenged others. Staff intervened quickly to ensure people did not come to any harm. For example, when one person became very confused and angry at another person, staff diffused the situation by diverting their attention. Staff noticed when people became distressed and offered support and reassurance. For example, one person was anxious that staff were not listening to their request and a member of staff sat with the person and reassured them, giving the person their full attention and repeating the person's request back to them to show they had listened.

We saw staff were alert to potential hazards and individual risks to people. For example, staff were observant of one person who was very unsteady on their feet and they assisted and made sure the person was using their walking frame. Staff also encouraged people to do things for themselves where they were able to, such as walking with assistance at the person's own pace. We found some risk assessments had been developed to try and reduce risks. These helped to ensure people could maintain independence whilst minimising risk.

However, individual risks to people were not always clearly documented and known by staff. For example, one person had been residing at the home for seven days and did not have a written care plan or risk assessments in place for immediate hazards, such as the risk of falling or the risk of developing pressure ulcers. Staff were more alert to the outward sign that the person was at risk of falling, although this was not documented. The local authority assessment notes stated the person should have been seated on a pressure cushion and we saw they were not; when we asked staff about this they said they were not aware. This meant the person was at risk of receiving care and treatment in an unsafe way because delivery of care was not based on the current risk and relevant safety information was not included in the care plan. This demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection found breaches in health and social care regulations regarding safety and suitability of premises. We found improvements had been made. In one of the bedrooms we looked at, we saw the original call bell was inaccessible from the person's bed, which would have meant the person was unable to call for assistance if they were in bed. The person did not want the bed to be moved, so steps had been taken to install an extension to the call bell in order to make it accessible. This meant the registered provider had taken practical steps and made adjustments in order to provide safe care.

However, in another bedroom we looked at, water from the hot water tap in the en suite was luke warm. This meant the person could not wash their hands safely and effectively, in order to prevent the spread of infection. We pointed this out to the registered manager, who agreed that this needed rectifying and reported it to maintenance.

There was evidence that up to date safety checks had taken place at the home, for example electrical testing in relation to portable appliances, lift servicing, fire extinguishers and water checks in relation to legionella. This further helped to ensure people's safety at the home.

Requires improvement

Is the service safe?

We found there were appropriate plans in place, outlining the action to take in the event of an emergency. These plans considered possible emergencies such as the event of a fire, gas leak, power failure, flood or severe weather for example. This would help minimise risk and help to keep people safe in the case of an emergency.

We saw that accidents and incidents were recorded and analysed monthly. The registered manager showed us the electronic system used for this. The system triggered immediate actions and showed any patterns of reporting. The registered manager told us that, since the last inspection, staff had been shown how to report accidents and incidents and had been encouraged to do so. The registered manager explained they felt there had previously been under-reporting due to a blame culture. This was something the registered manager was keen to overcome. Staff told us they felt supported to report accidents and incidents promptly to ensure people were protected. Staff were aware of what could be learned to avoid a recurrence. We saw evidence that incidents were investigated and actions had resulted from some incidents, for example increased observations, and care plans being updated to reflect changes.

Staff were recruited safely. There was recorded evidence of robust recruitment in the three files we looked at and staff had been suitably vetted. Disclosure and Barring Service (DBS) checks had been completed before staff commenced work in the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

The previous inspection of November 2014 found breaches in health and social care regulations regarding staffing. We checked at this inspection and found improvements were evident. We saw staffing levels were determined by use of a dependency tool. This provided a system to determine the level of staffing required, based on the level of dependency and taking into account certain risks such as risk of choking or developing pressure sores. We spent time with the person responsible for staff rotas in order to gain an understanding of how these were managed. We found the numbers of staff identified as being required were deployed. This helped to ensure that people's needs could be met. Staffing levels were supported by extra staff, engaged from an agency, to provide one to one support for those people who required this.

Our previous inspection found the registered provider was in breach of regulations relating to safe management of medicines. During this inspection we checked and found improvements had been made. We looked at the systems in place for the receipt, storage, administration and disposal of medicines at the home. We saw medicines were stored in clinical rooms where room temperatures were checked to make sure that medicines were stored at appropriate temperatures. In one of the clinical rooms, which had an external window, we saw that black out blinds and an air conditioning unit had been installed to make sure that hot weather conditions did not affect the storage temperature.

With the Medication Administration Record (MAR) charts we saw that each person had a list of homely remedies which had been signed by their GP to confirm these were safe for the person to take. Homely remedies are non-prescription medicines which are used for the short term management of minor, self-limiting conditions. We also saw care plans were in place for all PRN (as required) medicines. The care plan detailed the medicine, what it was for, why it should be used and what symptoms the person might display to indicate they needed the medicine. This included non-verbal signs for people not able to verbalise their need for the medicine, for example facial grimacing when experiencing pain. We also noted that pain evaluation forms were in place for use of all PRN pain relieving medicines. This helped to ensure that medicines were administered in a safe and consistent manner.

When we checked the medicines on Calder unit we were not always able to reconcile the amount of medicine available against the amounts recorded as received and administered. We spoke with the care quality facilitator who oversaw medicine management in the home about this. They found that in some cases this was down to recording error when the medicines were received into the home rather than administration error. They assured us they would look to conduct a full review of the medicines on the unit the day after our inspection visit.

When we checked the medicines stored in the main clinical room for other units in the home, we saw that staff were recording on the MAR, the balance of medicine still

Requires improvement

Is the service safe?

available after each administration. The care quality facilitator told us they had recently introduced this system and had worked with the supplying pharmacy to adapt the MAR charts to accommodate this. We checked a sample of these and found they were all correct. We checked the storage and recording of controlled drugs and found these to be correct. We saw that a system for the double checking of controlled drugs was in place and completed on a weekly basis. This meant that people's medicines were available in the necessary quantities and systems were in place to prevent the risks associated with medicines not being administered as prescribed.

The care quality facilitator told us they had requested a full review of all medicines prescribed for the people living in the home from general practitioners. They also told us that medication training for all staff had been organised for the week after our visit. We observed the administration of medicines and saw this was done appropriately and that staff supported people patiently to take their medicines.

The previous inspection found the registered provider was in breach of health and social care regulations regarding cleanliness and infection control. At this inspection, we saw the environment was clean and well maintained. There had been some improvements to the environment such as replacement floor coverings. The cleaning staff we spoke with knew the procedures to follow to prevent the spread of infection and we saw cleaning took place throughout our inspection. There were appropriate cleaning policies and procedures in place, making use of colour coded systems to help prevent the spread of infection. Staff signed to show they had read the infection control policy. There was a good supply of personal protective equipment (PPE) which staff used appropriately.

Requires improvement

Is the service effective?

Our findings

From our observations we saw that staff members knew people well and people knew staff well too. We saw appropriate interaction and engagement. One person told us, "The staff are absolutely excellent."

The registered manager told us new staff received a structured induction. This included shadowing other, more experienced members of staff and completing mandatory training such as safeguarding and moving and handling training. New staff we spoke with told us their induction had been thorough and they felt they had sufficient basic information, such as policies and procedures to support them in their new role. We looked at three staff files and saw induction booklets had been completed and signed. This showed staff had received essential information when they first started work.

Staff told us they received regular training and they were required to complete all training in mandatory areas, such as safeguarding and health and safety. Staff told us they felt supported to undertake training and they saw this as a positive aspect of their work. We saw staff training records detailed training was regular and refreshed to ensure staffs' skills and knowledge was up to date. Where staff attended moving and handling training, their competency was assessed and they were required to do this in conjunction with the moving and handling policy. We saw the registered manager had access to information technology for viewing and monitoring the staff training status. This was via a system that recorded 'strengths, opportunities, aspirations and results'. This demonstrated that systems were in place for the registered manager to monitor the training needs of individual members of staff.

Staff told us they were aware of the fundamental standards and we saw these were displayed in staff areas, such as the nurse's office. Fundamental standards are the standard below which care must never fall. Staff said they received regular supervision from their line manager and they regarded this as a supportive measure in the development of their role. We looked at supervision records and these showed meetings were regularly held, individually and in staff groups. We saw clear expectations stated in supervision records so staff were fully aware of the requirements of their role.

The registered manager told us they were working towards implementing the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

There were opportunities for staff to develop, through different qualifications. For example, National Vocational Qualifications (NVQs) and the care home assistant practitioner (CHAPs) programme. CHAPs is a career progression route for care assistants which equips staff to offer support with certain nurse duties, such as administering medication.

Our previous inspection found the registered provider was not meeting regulations regarding consent to care and treatment. At this inspection we found improvements were evident. Staff were aware of the Mental Capacity Act 2005 and how this impacted upon their work with people. Staff were able to describe restrictive practice and said they always obtained people's consent before carrying out any care tasks. We observed this in practice.

Some people living at Woodlands did not have the mental capacity to make certain decisions. We found that, where people did lack capacity, decisions were made in their best interests. This was done in conjunction with the person's next of kin and other professionals such as general practitioner and district nurse for example. We saw that, where someone did not have relatives or a next of kin, an independent mental capacity advocate (IMCA) was appointed. The role of an IMCA is to support and represent the person in the decision-making process.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Some people living at Woodlands were deprived of their liberty by the way their movements were restricted, for example due to coded locks on doors, or the way they were subject to continuous supervision from a member of staff. Appropriate authorisation had been sought and granted when people were deprived in this way. We saw that

Is the service effective?

records were kept so that new applications could be submitted when current authorisations expired. This meant appropriate safeguards were in place for people who were deprived of their liberty.

The staff members we spoke with and the registered manager told us restraint was not used at the home. Some people living at the home presented behaviour that other people could find challenging. However, staff managed this by using distraction and breakaway techniques and by trying to de-escalate situations. Staff told us they had received specific training in this.

The last inspection found the provider was not meeting the requirements of regulations relating to nutritional needs. We found improvements had been made. People were appropriately supported to have enough to eat and drink. There was juice accessible within people's reach and, for those people who could not independently access drinks, staff frequently asked them what they would like to drink. Mealtimes were pleasant and sociable with staff attending well to people's needs and offering assistance where necessary. Dining room tables were laid and condiments were available for people to use as they chose. Care staff supported people to make decisions about where they would like to take their meal, for example the dining room, lounge or their own room and whether they would like to wear a clothing protector. Comments made by people following a meal included, "I really enjoyed that" and, "I'm really full now."

We looked at menu planning and found that meals were planned on a four week rotation. People could make choices on the day, depending on what they wanted to eat. People were weighed monthly and we saw evidence of this. There was a weight loss tracker which meant that any person, who lost 2.5kg over the period of a month, would be more closely monitored and supplements provided if appropriate.

We looked at the care records for one person whose record indicated they had lost 2.3kg in weight over a three week period. Records showed that a request had been made for the dietician to attend. However no further record of this had been made for a two week period and there was no record of a visit by the dietician. When we spoke with the senior care worker about this they told us this had come to the attention of the registered manager who had already requested a further request be sent to the dietician on the day of our visit.

There were conflicting records in one person's care file regarding how the person's dietary needs were being met. For example, the progress sheet stated 'good diet and fluids' whereas actual intake of the person's food and drink was recorded as being limited. The person's risk rating for weight loss was 'low' yet they had been referred to the dietician for significant weight loss and staff had identified them as being at high risk when we discussed this person with them.

Additionally, we found evidence that it was not clear what action was being taken in relation to a person's food and fluid intake, where the person had refused or eaten and drunk very little. We spoke with the nurse in charge and they told us staff brought concerns to their attention for review, although there was no documented evidence of this.

We saw a care plan was in place for a person's nutritional needs and this included instruction for the person to receive a fortified diet. We saw this was served to the person. We also saw they were served snacks and milk shakes. The care plan stated that food and fluid charts should be completed for this person. When we asked to see these we were told they had not been done.

Staff we spoke with told us they did not always complete food and fluid charts as soon as people had eaten or had a drink and it was sometimes much later. Staff said they could remember what people had eaten, but we had concerns about the accuracy of the records and the usefulness of these.

People had access to healthcare and we saw referrals were made to other agencies or professionals, such as general practitioners, physiotherapy, specialist falls teams and district nurses for example.

We looked at the care records for a person who had developed pressure sores, one of which had been recorded as having deteriorated quite suddenly. We saw care plans, which included a photographic record of the presentation of the sores, were in place but we found these were difficult to follow as the care plans included details and reviews for more than one sore, rather than there being one care plan for each sore.

We saw a root cause analysis and action plan had been completed by the registered manager for the pressure sore that had deteriorated. We saw this included a chronology of the development and treatment of the pressure sore and

Requires improvement

Is the service effective?

included details of some occasions when staff had failed to make appropriate observations and records. However, the analysis had not included a ten day period of apparent lack of appropriate care and treatment of the sore and the results of the analysis were therefore not entirely reflective of the situation. We discussed this with a care quality facilitator who agreed with our findings. They said that the root cause analysis was a recent development and said staff had not yet received full training in the completion of them. The care quality facilitator told us that a 'No Pressure' campaign was due to start in the home, during which staff would receive training and advice about prevention and treatment of pressure sores.

In terms of the environment we found that, since the last inspection, there was improved signage around the home to help people to navigate and to identify people's rooms. People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. There were some orientation boards on display. However, we noticed that the day was incorrectly displayed. The first day of our inspection was Tuesday, but the board indicated the day was Sunday. This could create confusion and increased anxieties for people living with dementia. We pointed this out to the registered manager, who arranged for the information to be corrected immediately. On the Calder unit, there appeared to be a lack of appropriate tables for people who chose to eat their meal in the lounge. The regional manager told us they would ensure appropriate tables would be ordered.

Requires improvement

Is the service caring?

Our findings

People told us they felt staff were kind and caring. One person said, "They do alright, I'm sure they quite like me." Another person said, "They have kind hearts." One person told us, "Staff are really nice. They help me." Another person said, "It's like a five star hotel."

One relative we spoke with said they always felt welcome to visit their family member at any time. They told us that, compared to other homes their family member had been in, "This one was the best one." The relative told us they thought the staff were caring and took time to get to know their family member.

We saw staff interaction was friendly and caring throughout our inspection. We saw staff acknowledged people individually and by name, made good eye contact and said, "Hello, how are you?" then patiently waited for people to communicate how they were feeling. Staff we spoke with told us they treated people like they would wish their own family to be treated.

Staff took time to make sure people were comfortable and had what they needed. For example, one person said they felt cold and staff offered to get them a blanket or cardigan. We heard staff communicate with people respectfully and they attentively listened to what people had to say. Where people could not communicate verbally, staff used observations of people's body language to interpret what they might need. For example, one person was repeatedly opening and closing their mouth and staff asked if they wanted a drink, then brought the person some juice which they drank. Staff told us they took notice of people's facial expressions and non-verbal cues to help to meet their needs. We saw where people looked uncomfortably seated, staff asked them if they needed a cushion and helped them feel more comfortable.

We observed staff being discreet when managing people's personal care needs and heard staff speak respectfully with people when offering assistance. We saw staff knocked on people's doors and waited for a response before entering their rooms. However, staff were sometimes not recognising the need for discretion to protect people's privacy and dignity. For example a member of senior staff instructed other staff, who were in the lounge, to provide personal care to people. These conversations could be overheard by other people who lived at the home.

Additionally, a member of agency staff had assisted a person to shave. We observed the staff member discussing the personal care that he had been providing with the visitor of another person. This did not demonstrate a caring approach that respected the person's privacy and dignity.

Staff engaged in friendly banter with people and we saw occasions when people hugged staff or spontaneously danced with staff. Staff used quiet tones of voice and smiled at people, and used appropriate touch, such as hand holding or placing an arm on someone's shoulder for reassurance. Staff made encouraging gestures to people, such as a thumbs up sign. Most of the time, language used by staff was respectful, although on a small number of occasions we heard staff use less respectful terms, for example, 'feeder cup' and 'doubles' (indicating two staff were required to assist). On one occasion a member of staff called across the lounge to a colleague, "Let's start transferring them then" (indicating it was time to assist people to move).

We saw, when one person fell, staff were quickly attentive and offered kind words and reassurance. One member of staff noticed the person was not wearing their glasses and went to get them. The member of staff told us they did not want the person to feel frightened or disorientated if they could not see clearly.

In the lounge area of the Calder unit we observed people trying to watch a film on television. However, the lounge area was used as a corridor by staff and staff supporting people with one to one care. This meant that people sitting there could not experience a peaceful and relaxing environment. Our observations were that staff failed to recognise they were in a person's home, as opposed to their place of work. We fed this back to the registered manager and regional manager.

Some staff did not recognise the effect that loud music could have on people sitting in the lounge area. On several occasions different music was playing loudly in different rooms. For people with cognitive impairment, this could be confusing and disturbing. We observed a person's facial expression change in a negative way when a member of staff turned the music on loud. We asked the person if it was too loud for them and they said it was. We then asked the staff member to be mindful of this and they turned the volume down.

Requires improvement

Is the service responsive?

Our findings

People who we spoke with told us they felt staff responded well to their needs. One person told us, “We can go out every day and there is a bus now.”

The previous inspection found a breach of health and social care regulations relating to people’s care records which lacked person-centred planning. We saw evidence at this inspection that the regional manager had been involved in developing new care plans in order to rectify this. We looked at some of the new care records and found they were mostly personalised to the individual. They included information relating to consent and capacity, medication, mobility, nutrition, continence needs, sexuality and personal hygiene for example.

We noticed however, that some risk assessments, for the use of call bells for example, were generic and had not been completed to reflect the needs of the individual. Additionally, there was some old documentation in the new care plans which could make it difficult to find relevant information. We discussed our findings with the regional manager who agreed to ensure the new care plans were developing as intended, prior to continuing to develop them further.

We were shown evidence that some people had been involved in their care planning and had been asked questions such as whether they had any new preferences in relation to activities or whether dietary needs had changed for example. However, we saw there were differences in the quality of the recording of people’s care plans and it was not always clear if people had been involved in their plans of care, or whether they knew there were any plans in place. In some plans we saw there was laminated information about people’s social history for staff to know their interests and life story. However, this was not always available in every person’s care record. Although it was acknowledged this work was ongoing, this meant that some people were at risk of receiving care that did not reflect their specific needs or preferences.

Staff we spoke with told us they tried to enable people to have as much choice as possible in their daily routine and consulted with them about decisions involving their care. We saw staff respected people’s choices and decisions in their everyday routine, such as what to wear and what to eat.

We spoke with one member of staff who told us they were responsible for activities and we saw they spent time engaging in conversation or communication with people on a one to one basis.

There were three people employed to promote activities within the home; although two of the three were on leave at the time of our inspection. The registered manager told us activities were planned around each individual, depending on their interests. Some people we saw did not have much influence over the quality of their day or the activities they engaged in. For example, people who were unable to verbalise their needs or wishes, or those who could not mobilise without the assistance of staff, did not always engage in purposeful activity.

We saw that, since the last inspection, the environment had been improved to facilitate more social interaction; chairs were arranged in smaller clusters so people could chat with one another. We saw there were more resources, such as rummage bags, dolls and books. One person enjoyed looking through a photograph book with staff and talking about what they could see. People who were able to communicate verbally were encouraged to choose the music they wished to listen to and staff knew people’s favourite singers. A recent addition to staff resources was a driver. This meant more activities off site could be planned, for example, weekly trips to the local public house and shopping.

The home had an electronic device in the reception area that people could use to provide feedback. We discussed with the registered manager different ways of engaging people and relatives to become involved in the running of the home and providing feedback. The registered manager had planned a relatives meeting two weeks prior to the inspection but nobody had turned up. The registered manager told us they would consider other ways of engaging people. On the second day of our inspection, the registered manager showed us a questionnaire that would be sent in the post to relatives, in order to try and gather their views. It is important that providers try to obtain and respond to feedback because this can be used to drive improvements in service.

Our previous inspection found the registered provider was not meeting regulations in relation to responding appropriately to complaints. We checked during this inspection and found improvements had been made. The complaints procedure was displayed on the notice board

Requires improvement

Is the service responsive?

and in communal areas. Staff we spoke with told us people's complaints were taken seriously and if people were unhappy with anything they would try to help them resolve the problem. The relatives we spoke with said they would not hesitate to speak with staff or go to the manager's office if they had a cause for concern and they felt confident that action would be taken to their satisfaction. There was evidence to show changes had been made in response to complaints, for example, following investigation.

We looked at how information was shared, for example between one shift and another, to ensure continuity of care. We saw that handover report templates had been developed, and staff were expected to complete these in order to pass on relevant information. This included information in relation to medication, choking risks and falls. However, we found these were sometimes not completed by staff. Other information was sparse, for example, some simply stated where people were and if they had a settled night, rather than highlight any concerns or pertinent information. One member of staff we spoke with said they did not think the handover information was sufficient for staff taking over from the previous shift. This could mean that important information was not shared between staff and this could impact on people's care and safety. We highlighted this to the registered manager and regional manager, who agreed to look at this.

Requires improvement

Is the service well-led?

Our findings

Relatives we spoke with told us they thought the home was run well. One visitor we spoke with, however, who was the friend of a person who lived at the home, felt they were not kept fully informed at times. This had already been raised with the registered manager and was being dealt with appropriately.

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since August 2015.

Staff we spoke with reported improvements in the standards of care in the home and the quality of the leadership. Staff told us things were, "Much, much better than before," and said morale had improved. One member of staff said, "There has been a massive improvement. There are new carpets, new tablecloths and decoration, and staff are much happier. It's a friendly homely place, much more than it was before."

We saw there was clearer direction and leadership given for staff than at the last inspection. Staff were complimentary in their views about the registered manager and they said they felt supported in their work. We noted a positive and welcoming atmosphere with strong teamwork and motivated staff.

We saw staff meetings were regularly held and there were clear directives for staff as well as words of encouragement. Staff were reminded about the need to be honest, open and transparent. We saw action plans were shared with staff following the previous inspection and all staff were aware of what was expected of them. There was a clear emphasis about the need to support the well-being of people through interaction and this was discussed in staff meetings, with a reminder that, 'This is the residents' home, not just the staff workplace.' Staff were reminded that, 'Good documentation is part of good care, not an optional extra.' A staff member we spoke with told us the agenda for staff meetings was displayed in the staff room, so members of staff could add their own items for discussion.

The registered manager attended quarterly independent sector care home manager meetings, which were held by the local authority. These meetings provided a forum for the registered manager to discuss issues and receive support around learning and organisational development. This demonstrated the registered manager was engaging with other professionals and stakeholders in order to develop the home.

We asked the registered manager about community links and whether the home engaged with external groups. The registered manager told us the home had developed a relationship with two local universities, with a view to working together and assisting with placements for students.

The registered manager told us the vision for the home was to provide the highest quality care and that this was done through investment in staff. We saw that staff had been invested in, for example, through staff training and development.

Our previous inspection of November 2014 found the registered provider was not meeting regulations relating to assessing and monitoring the quality of service. We found improvements had been made. We looked at systems and processes in place for auditing and monitoring the quality of the provision. We saw routine monitoring in place for the maintenance of the premises and equipment and where actions were identified, these were addressed and recorded. Additionally, regular daily, weekly and monthly audits took place and we saw these were planned in a structured way. We saw evidence of daily walk arounds, where the registered manager looked at areas such as whether the home was clean and tidy, if staff were engaging positively with people and whether people were happy and felt safe. We saw evidence of health and safety audits and medication audits. We could see that action was taken when necessary.

The registered manager told us they were working closely with the Infection Prevention and Control team to secure improvements and they had recently had positive comments from a support visit made by the team.

We saw the registered provider had due regard for the duty of candour, which meant they acted in an open and transparent way. The most recent inspection ratings and report were displayed and shared on the noticeboard for anyone who wished to see it.

We found the registered manger and staff team to be open, transparent and receptive to feedback.

Requires improvement

Is the service well-led?

The registered provider had taken many positive steps to address the areas of concern highlighted at the last inspection and staff reported improvement in the quality of care for people. However, there were still areas for improvement in the monitoring of how people's care was assessed, planned and delivered. For example, risk assessments were not accurately completed to ensure people received safe care and audits were not yet robust enough to demonstrate how quality of care was being monitored and improved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care was not provided in a safe way for service users because risk assessments relating to the health, safety and welfare of people using services were not always completed. Delivery of care was not always based on risk assessments. Regulation 12(2).**