Coverage Care Services Limited

Lightmoor View

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20 and 21 February 2018 and was unannounced. At the last inspection completed 30 October 2017 we rated the service as inadequate, as the provider was not meeting the regulations for safe care and treatment, by having sufficient staff, safeguarding people at risk and did not have effective governance arrangements in place.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Following the last inspection, we met with the provider on 17 January 2018 to confirm an action plan to show what they would do and by when to make improvements to meet the regulations.

At this inspection we found improvements had been made and the provider was meeting the regulations for safe care and treatment, safeguarding from abuse and staffing and governance arrangements.

Lightmoor view 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.

Lightmoor view accommodates up to 75 people across six separate units, each of which have separate adapted facilities. Most of the units provide support to people living with dementia. At the time of the inspection there were 69 people using the service.

There was not a registered manager in post at the time of our inspection. 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. The provider had recruited a new manager and they had just begun their induction process and we were assured an application for registration would be completed in due course.

The systems in place to monitor people's care delivery were not consistently effective and we could not be assured the systems were sustainable. The provider had made improvements following the last inspection, however further work was required to ensure this was sustainable.

People were supported by sufficient numbers of staff; however staff deployment required some improvement. People were supported to take their prescribed medicines, however administration recording and guidance for staff was not consistently recorded.

People had their needs assessed but further improvements were needed to how this informed people's care plans. People were supported by knowledgeable staff, however further improvements were required in supporting people living with dementia. Improvements were needed to the environment to ensure it was suitable for people living with dementia.

People's preferences were understood by staff. However this did not always inform people's care planning. People were not consistently supported to follow their interests.

People were safeguarded from potential abuse. People were supported to manage risks to their safety. People were supported by staff who understood how to prevent the spread of infection. People were supported by staff that had been recruited safely. The manager had systems in place to learn when things went wrong.

People were supported to meet their dietary needs. People were given consistent care and support. People were supported to maintain their health and well-being. People had their rights protected by staff that understood and could apply the principles of the Mental Capacity Act 2005.

People received support from staff that were caring in their interactions and they were involved in decisions and had their choices respected by staff. People were respected and their dignity was maintained.

People understood how to make a complaint. People were supported in a way that met their wishes and effectively at the end of their life.

Notifications were submitted as required and the manager understood their responsibilities. We found people, their relatives and staff felt supported by the manager and able to be involved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not consistently receive support from safely deployed staff.

People did not consistently have guidance in place for their medicine administration and medicine administration records were not consistently recorded.

People were protected from the spread of infection.

People were supported to manage risks to their safety.

People were safeguarded from potential abuse.

The manager had systems in place to learn when things went wrong.

People received support from staff that had been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed and planned for, but improvements were needed to ensure these reflected up to date information.

People were supported by staff that did not always have the knowledge and skills to meet their needs.

People's rights were protected by staff.

The environment was not assessed to see if it met the needs of people living with dementia.

People's nutrition and hydration needs were not always monitored effectively.

People did not always receive support to monitor their health.

Is the service caring?

Good

The service was caring.

People were supported by caring staff.

People were involved in making decisions and choices.

People's privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always able to follow their interests or spend time doing activities they enjoyed.

People's preferences were understood by staff however this was not consistently used to develop care plans.

People received a response to their complaints.

People received effective support with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor care delivery were not consistently effective.

People and staff felt supported by the manager.

The manager notified us of incidents.

Lightmoor View

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 unannounced inspection took place on 20 and 21 February 2018. The inspection team consisted of three inspectors, a specialist registered nurse advisor to look at nursing practices and two experts 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.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service.

During the inspection, we spoke with nine people who used the service and 11 visitors. We also spoke with the manager, the operations director, the deputy manager, two nurses, two assistant managers, two senior care workers and13 staff.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. 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 reviewed the care records of 15 people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, staff handover documents, staff rotas, meeting notes, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 30 October 2017 we found the provider was not meeting the regulations for safe care and treatment, by having sufficient staff and safeguarding people from harm. We found a breach of Regulation 12 for safe care and treatment, 13 for safeguarding people from harm and 18 for staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting these regulations but further improvements were needed.

People and their relatives told us they had seen improvements in the levels of staff available to support people. They told us it was much better than before but there were still times when they felt there were not enough staff. One person said, "Occasionally there is not enough staff, at weekends". One relative said, "It depends on how you look at it. If there are people that are unsettled, then it can be a bit fraught, you could say there are not enough staff then to manage. Sometimes you wonder what's going to happen but they handle it well". Staff told us there had been changes to the number of staff available to support people and things had improved. One staff member said, "Things have really improved, it's not perfect yet, but it's better, sometimes people do have to wait a little while if they need something". The manager told us following the last inspection they had identified people's dependency had not been assessed correctly and this had impacted on the staffing levels available. The manager told us they had reviewed the dependency of people in the home and had increased the number of staff working to ensure that sufficient numbers of staff were deployed in the home to meet people's care needs safely. People's dependency and staffing levels were kept under constant review. Dependency needs were checked monthly, but were also be checked if someone became unwell or their needs changed. There had also been recruitment of nursing staff and additional posts of assistant managers created to enable more effective deployment of staff. This meant the provider was reviewing staffing levels and adjusting them to keep people safe.

We saw staff were available to support people with managing risks to their safety. For example, where people required monitoring due to their behaviour staff were present at all times. In another example, where people were at risk of falls, staff were available to monitor them. We saw people were not left alone in communal areas; we found where people had high levels of need they had been assessed as requiring one to one staff support this was available. This meant there were sufficient staff available to keep these people safe.

The manager told us they had undertaken recruitment of new staff and changed the management structure and how the staff were deployed. We found these changes had improved staff and nurse availability. We also found following others changes in how people were supported this had given staff more time. For example, meal times were now staggered to ensure there were sufficient staff available to meet people's needs and changes to the medicines administration system meant nurses had more time to address the clinical needs of patients.

However, there were times where further staff being available could have improved people's experience of living in the home. For example, during the morning on one unit we observed people were not engaged in conversation or activity. The staff were busy supporting people with their personal care and other needs

which meant people were bored and becoming unsettled. In another example, we found at lunchtime one person needed assistance with personal care, this meant two staff had to leave the dining area and one person became unsettled and got up from the table during their meal. After a short time staff present, in the dining area, were able to encourage them to sit down and eat their meal. We spoke to the manager about this and they said they would further review dependency and staff deployment to address this. This showed that further improvements were needed to review how staff were deployed.

People and their relatives told us they received their medicines as prescribed. One person said, "I get my medication regularly and they [Staff] never forget". At our last inspection an electronic operating system to record the receipt, administration and disposal of medicines was in use. Following the concerns we raised about the length of the medicines rounds and errors with stock control and administration the provider had taken the decision after our last inspection to return to a paper based medicines administration record. We found this had improved medicine administration and the regulations were now being met, however some further improvements were needed.

Medicine administration records were not consistently recorded. When people have medicines administered on an as required basis, records should indicate why this was given and whether this was effective. We found these had not consistently been completed for people. We spoke to staff who confirmed the electronic system had prompted them to complete these records and this was an oversight now the system had changed to paper recording. The manager confirmed they would give instructions to all staff about recording immediately to address this.

Guidance was not consistently available to staff for medicine prescribed on an as required basis. For example, one person required medicine when they displayed behaviours that challenged. There was no specific plan in place to describe when this should be given. The manager confirmed these had been available for everyone at the last pharmacy audit. They felt when the new medicines system was introduced these must have been displaced. We checked with staff and they could describe in detail what actions should be tried before the medicine was administered. The manager had ensured the guides for staff were in place on day two of the inspection.

We observed medicines rounds were now completed in a timely manner and staff were able to complete the rounds without interruption. We saw staff spent time explaining to people what the medicines were for and ensured people took their medicine as required. We saw time specific medicine was given as prescribed. We found medicines were in stock and regular checks were carried out to ensure people had sufficient medicines available to them.

Medicines were stored safely. The temperature of the medicines storage area and refrigerators were checked and maintained safely. Controlled drugs were stored safely. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

Medicines were administered as prescribed. We saw people were receiving their medicines as prescribed by the doctor. The manager told us that they had received advice from the local clinical commissioning group about patch medicines and now carried out daily checks to allow pain patches to be reapplied where people had removed them. We found there were clear plans in place to show where people required their medicines to be given mixed with food and drinks, advice had been sought from the doctor and a pharmacist to obtain guidance for doing this safely.

People were supported to manage risks to their safety. One relative said, "They have taken action to prevent my relative from falls, they have a lower bed, a sensor mat in place to alert staff and have moved furniture

out of the way which posed a risk". Staff knew people well and could describe risks to their safety. They could tell us about the plans in place to support people to reduce the risks. For example, staff could describe how they supported one person when they displayed behaviours that challenged. We saw the person had a behaviour management plan in place which supported what staff told us. We found there was monitoring in place and staff were completing this accurately when the person displayed behaviours. We observed staff following the plans in place for this person during the inspection. One staff member told us about how following an incident one person's care plan had been updated to guide them on how to reduce the risks for the person. Staff told us they had received training in supporting people and records supported this.

We found staff followed the plans in place for people to prevent falls, manage risks of choking and prevent pressure sores. Where people required food and fluid intake monitoring this was in place and reviewed daily. We found evaluations were carried out when things changed or incidents happened and care plans were updated. We saw people had been assessed to determine if they were at risk of having their skin breakdown. There were clear plans in place to prevent this and we saw staff were following these and maintaining records which included how frequently people were repositioned and body maps to show where there had been changes to people's skin. However some people's care plans had not had the out of date information about their risks removed from the plan. We spoke to the manager about this and they confirmed care plans and risk assessments were currently under review and some information had yet to be archived. We saw on day two of the inspection the out of date information had been removed. This showed people were protected from risks to their safety, but further improvements were needed to ensure regular checks on out dated information were completed.

People told us they felt safe using the service. One person said, "I feel safe, the people around me make me feel safe". Staff were able to describe the signs of potential abuse and tell us what action they would take if they believed someone was experiencing abuse. We saw staff had received training in how to safeguard people from abuse. We found where incidents had been reported to the manager these had been investigated and reported to the local safeguarding authority. We found where required risk assessments and care plans were updated to ensure people were safe following an incident. This meant people were safeguarded from potential abuse and protected from the risk of harm.

People were protected from the risk of cross infection. One relative told us, "The staff wear gloves and aprons every time they change [person's name]". Staff understood how to minimise the risk of infection spreading. They could describe the procedures in place to safeguard people. We saw there were infection control procedures in place such as staff wearing protective clothing, hand washing procedures and protective gel available. We found the home was clean and tidy and there were checks in place to ensure all areas of the home were cleaned regularly. This showed the practices in place would reduce the risk of cross infection.

The provider had systems in place to learn when things went wrong. For example, the provider had taken action to analyse the last inspection report to identify where things had gone wrong. They had shared this learning across the organisation with other locations and had formed an action plan to make changes. For example, the issues identified with care plans not being kept up to date had been considered and a new approach to care planning had been developed. This was in the process of being finalised during the inspection. In another example we saw where people had a fall or an incident had occurred analysis was carried out and this was shared with staff to help identify if there were any potential areas where improvements could be made to reduce the risk of the incident occurring again.

People received support from safely recruited staff. We saw the provider ensured checks had been carried out before new staff started work, which included checks with the Disclosure and Barring Service (DBS). The

DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the service was not always effective. People were not always supported to manage their health conditions and staff were not always following people's nutrition and hydrations plans. At this inspection we found these areas had improved but other areas required improvement.

People had assessments and care plans in place to meet their needs. One relative said, "I am asked my views on my relative's care and I was part of the planning of their care and it is re visited often". We saw people's cultural needs were considered as part of the assessment. We found people's care plans then reflected the support they required. For example, one person required specific food to be available, we saw this was on offer and staff were all aware of the person's needs. Staff could describe people's needs to us and were able to give details about peoples care plans. For example, staff could describe how specialist advice had been sought to identify people's needs and help form care plans to meet them. We found staff could tell us how individual needs were met, for example they could describe in detail the plans in place to minimise the risk of people falling.

However, there were some inconsistences with the review of these plans. We found some people's needs had been reviewed however their care plans had not been fully updated to reflect the changes in people's needs. We could see from the daily care records that people were receiving the right care and support and staff were able to tell us they knew what support people needed. This meant there were improvements needed to how people's care plans were documented. We also found there were individualised assessments of people's life histories and their preferences however the information from this assessment was not consistently used to shape peoples care plans. For example, where people were living with dementia, the assessments gave specific information about the person's history and how they liked to spend their time. However this was not used in planning the person's daily activities. We spoke to the manager about this and they explained there was work underway to review care plans. There was a plan in place which showed how the plans were being reviewed and how updates had been taking place, but this was not yet complete. This meant further improvements were needed in how people's individual assessments were used to inform care plans.

People and their relatives told us they felt staff were skilled in offering them support, one person said, "I think that the staff are good at their job and they are well trained". Another person gave the example, "My ankles were swollen, and they helped me to exercise, the swelling went down. They also advised me of insoles to wear, my heels are also better, I don't need them anymore". Staff told us they received regular training following a comprehensive induction. We saw records which supported this. We observed staff using the skills they had learnt to provide support. For example, we saw staff using equipment to safely transfer people. We found staff were supporting people safely to manage their nutrition and hydration needs. We saw staff had received training in managing behaviour that challenged and where people were resistive of personal care. Staff could describe how this helped them meet people's needs safely. However, some relatives commented they felt staff needed more training in supporting people with dementia. Some staff said they felt this would be beneficial. We observed that some people with dementia were not occupied during the day. This meant they became anxious or began walking around the home. Staff did not always

engage people in conversation or activity. We spoke to the operations director about this and they told us they were aware more training was needed and this had been scheduled to take place. The training had been commissioned to increase staff knowledge of how to support people with dementia. This showed the provider had identified improvements were needed with staff knowledge about dementia and were taking steps to address this.

People and their relatives told us they had a good choice of meals and plenty to drink. One person told us, "We have a choice of two for lunch, if I don't like what is on the menu, they would offer me something else". Another person told us, "The food is lovely and we can have a drink at any time". Staff could describe in detail the support people needed with their meals. For example, staff told us about one person who was at risk of choking. They could describe the way in which the person's meals and drinks should be served, we confirmed this was documented in the person's care plan. We saw people who were at risk of malnutrition had plans in place to address this and regular monitoring of the person's weight was undertaken. Where required concerns were escalated to health professionals including the speech and language therapy (SALT) team where people had difficulties with swallowing. The manager told us they had fortified diets available to assist where people were at risk of weight loss to avoid the need for supplements. We saw this was effective in helping people maintain their weight. Staff understood people's preferences for food and drinks and offered people a choice. Picture menus were in place to help people make choices about their meals. We observed staff were available to support people with eating and drinking and this was done in line with their care plans. This meant people were supported to maintain a healthy diet.

There were systems in place to ensure people received consistent care. We saw there were handover records in place which detailed any changes to people's needs and the care and support they had received. This ensured staff were kept up to date on any changes the person had experienced in their needs or support requirements. We found where required other agencies were involved in assessing people's needs and agreeing their care plans. For example, there were health professionals involved in supporting staff to identify how best to support people with behaviour that challenged and provide guidance for staff on how to reduce people's anxieties and offer distractions. We found this guidance was followed by staff. We saw where agency staff were in use the manager ensured this was consistent, and wherever possible the provider's own staff were used to provide cover for the home.

People and their relatives said support was available to help with people's health needs. One person said, "I can see the doctor if needed or the optician". A relative told us, "There were some concerns over coughing when drinking with [person's name] so a referral was done to the SALT team and they now have thickened fluids". Staff told us any concerns they had for people's health were referred to the nursing staff. Concerns were documented in people's daily care records and we could see nursing staff had taken action to monitor people and seek support from other professionals. For example, one person was unwell during the inspection, the nurse sought advice from the doctor and the person was prescribed medicines to assist with this. We saw regular checks were carried out to ensure people were well. For example, where needed blood sugars were tested and blood pressure readings were taken. Where people displayed changes in their behaviour nurses would undertake observations and tests to see if there was a medical reason for this such as infection which can make changes to how people behave. We found advice from health professionals was understood by staff and the guidance was followed. We saw records were kept of any visits from health professionals and where required care plans were updated. This meant people were supported to maintain their health and well-being.

The home had adaptations to assist people with their needs. For example there were adapted toilets and bathrooms. The home was well maintained and was decorated nicely. One relative told us, "We got all pictures of the family and they have a television and CD player in their room". We saw people were able to

personalise their bedrooms and had access to outside areas. One person told us, "We go into the garden in the summer". We saw people were free to walk around and one person was observed going outside for a walk. We saw people's rooms had their names and this helped people find their room independently. However we saw one person did struggle to identify the location of the toilet, despite pictorial signs on the doors. Many people using the service were living with dementia. We spoke with the operations director about this and suggested they consider the good practice guidance in relation to adapting the environment to help people find their way around the building. They confirmed there were plans in place to carry out a self-assessment of the environment to see if there were improvements that could be made to make it easier for people living with dementia, we will check if improvements have been made at our next inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us staff asked for their consent prior to giving care and support. One person said, "The staff do ask consent before doing things for me". Staff understood the principles of the MCA and could tell us how they asked people for their consent to care and support. We observed staff seeking consent when offering care and support. For example, where people required personal care, staff were observed withdrawing when one person refused. In another example, we saw staff seeking consent when they offered people their medicines. This confirmed staff were following the principles of the MCA.

People's rights were protected. Where people were identified as not having capacity to consent, a MCA assessment was carried out. We found these were in place for individual decisions and best interest decisions had been taken involving the appropriate people. For example, where people could not consent to their medicines and required the medicine to be given to them without their knowledge the decision to do this had involved their families, doctor and a pharmacist to ensure this was done safely and in line with the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found applications had been made to the local authority where people had been deprived of their liberty. We saw where authorised DoLS were in place this was understood by staff and where required the conditions placed on the DoLS had been met. This showed the principles of the MCA were followed where people's liberty was restricted.

Good

Is the service caring?

Our findings

At our last inspection we found people's privacy and dignity was not always observed, as the lack of staff impacted on people's dignity and staff were not always able to be caring in their approach. At this inspection we found improvements had been made.

People and their relatives told us they felt the staff were kind and caring. One person said, "I never feel rushed went they care for me". Whilst another person told us, "The staff are patient with me and others around me who are less able than myself". A relative told us they had observed staff positioning themselves on the floor to make eye contact when they spoke to people. Another relative said, "The staff are kind and considerate, when [person's name] was unwell, they were attended by the same staff member and nurse all day". Staff told us they knew people well and had time to understand their needs and get to know them. We saw some positive interactions between people and staff during the inspection. For example, we heard a staff member encouraging a person to come into the lounge and sit with other people. In another example, we saw one person bang their hand on the table during lunch; a member of staff went to them immediately and confirmed they were ready for their pudding. We saw staff speak with people as they entered the room and have conversations whilst they were supporting people. We observed people recognised staff and they were smiling and appeared comfortable. We saw staff spend time with people during their lunch and use conversations about topics which interested people to help keep people's attention. We saw records which showed that staff made contact with relatives to let them know how people were. This meant people were supported by staff were kind and caring.

People told us they were able to be involved in their care and support and could make decisions for themselves. Some people commented that staff supported them to retain their independence. One person said, "I choose what time to go to bed and go to sleep". People told us they were involved in their care plans and could influence how care and support was delivered. For example, one person told us they chose to spend most of their time in their room and they chose to have a fan on all day, which staff always put on for them. One person told us, "The staff encourage me to be independent". We saw staff offered people choices throughout the day for example, people chose when to get up, where to spend their day and what to eat. We observed staff followed people's care plans to ensure they had their choices observed. For example, one person was happier eating finger foods as this was easier for them. We saw staff provided these for the person and they appeared to enjoy their meal. We found staff offered people a choice and decisions in all aspects of their care. For example, one member of staff was asking one person where they would like them to sit whilst they offered support at lunchtime. They asked about whether the person was ready for their meal, the person said they would like a drink first and the staff fetched this straight away. This meant people were involved in decisions about their care and support and retained their independence.

People and their relatives told us they felt as though people were treated with dignity and respect. One person told us, "All staff are kind and they respect me". A relative told us, "My relative is treated with respect and dignity is upheld". Staff could tell us how they preserved people's dignity when offering personal care. We observed nursing staff attempt to carry out a nursing task for one person in the lounge. The person was not offered an opportunity to go to a private area. One of the staff observed this and immediately fetched a

privacy screen and explained to the nurse this would offer some privacy for the person. The manager told us they would address this with the nurse concerned and issue reminders for staff about ensuring people received dignified care and treatment. We saw staff were mindful of people's dignity when supporting them. For example, one staff member saw that one person had food around their mouth. They discreetly handed the person a napkin and helped them to wipe their mouth. We saw staff speaking with people appropriately, knocking doors and ensuring people had their dignity maintained when they were supporting them. This showed most staff were observing people's dignity and working with them in a respectful way.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found people were not always supported to follow their interests. At this inspection we found some improvements had been made but there were further improvements needed to ensure people had access to meaningful activities.

People and their relatives told us staff understood what was important to them and offered a personalised service. One person said, "I think that the staff know what is important to me". One person's relative told us, "I think that the staff know [person's name] very well". Another relative told us the staff were aware of how to support their relative and had involved them in changes to their relatives care plan. Staff could tell us about people's preferences; however some staff felt that they did not always have the time to get to know people as well as they could. One staff member said, "Sometimes we can have a chat and a drink with people, but it would be better if there was more time for this, we could get to know people better". One person said, "As far as I know the lay preacher or priest comes in once per week to see people". Staff were aware of peoples cultural and religious needs and understood how to meet these. We found some care plans included information about protected characteristics, however this was not consistent. We saw there had been detailed assessment of people's life history; however this had not fully informed people's individual care plans. For example, people's work history and past hobbies and interests were clearly identified; however this had not transferred into plans for their care. The manager told us there were plans in place to make changes to people's care plans and further improve the personalised way care was delivered. We will check this has been put in place at our next inspection to ensure the improvements identified have been made.

People and their relatives told us there were opportunities provided for people to do the things they enjoyed. One person said, "One of the staff organised reading books for me and the staff take me to the library sometimes". A relative told us, "We do have activities and BBQ's in good weather". Another relative described that their relative had not really had previous interests, staff encouraged them to do some colouring but they were unable to maintain any interest for long periods as due to the person's dementia they became distracted. We saw people were not consistently offered the chance of undertaking meaningful activity. We found although there were staff in place to provide stimulation to people this appeared to focus on a small number of people joining in larger group activities. There was a tea dance taking place during the inspection and those attending did appear to enjoy this. We saw staff did provide one to one activities for some people and these were documented in their care plans. However these were not consistently available and some people lacked the opportunity for engagement in meaningful activity. On day one of the inspection there were periods when people were sat looking around with no stimulation. There were some people that were living with dementia who became anxious and began walking around as they were not occupied. One person was known to enjoy music, walking and due to their past work history would rearrange the furniture. Although this information was understood by staff it was not used to engage the person in activity and they were left without stimulation. On day two of the inspection, this had improved and there were more people engaged in activities with staff. For example, we saw people wiping tables, doing jigsaws and having time one to one with staff. One staff member told us about a person that enjoyed assisting with cleaning the home. The staff member had bought in a carpet sweeper to enable the person to assist. This showed there were still improvements required to ensure consistency of support to people to

engage in meaningful activity.

People and their relatives understood how to make a complaint. One relative told us, "I am encouraged to raise complaints, and they do normally act upon them". Another relative told us, "I have made a complaint, it's been acted on, but prior to the last inspection it was never dealt with and I would have to complain again. Now if I complain it's acted on". We checked the provider's complaints process and could see there had been complaints made since the last inspection. We found complaints had been investigated and a response had been given in line with the policy. The manager could describe how they monitored complaints and used this to drive improvements. This showed people and their relatives understood how to complaint.

People were supported with end of life care that ensured they were comfortable, pain free and met their individual wishes. One person told us they had come to the home to receive end of life care. Since arriving they had stabilised with the support from staff and had seen improvement in their condition. A relative told us, "I find the staff approachable, they explained to me how palliative care works here". Another relative told us, "Yes they have discussed [person's name] end of life care with us and they will stay here and not go to hospital". Staff could describe how people with end of life care needs would be supported. We found where people were receiving end of life care this was documented and decisions and preferences about how they wanted to be cared for were recorded.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections we found the provider did not have effective governance systems in place. There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. At this inspection we found improvement had been made and the provider was meeting the regulation; however there was still more work to do to ensure the changes made were sustainable.

The provider had taken immediate action to assess the levels of staff required after the last inspection. They told us they had checked the levels of dependency for people using the service and were now keeping these under review. Where required people that had high levels of need were receiving one to one care from staff and some people had moved to a more suitable placement which had further improved staffing availability. We saw the provider was assessing the deployment of staff and changes had been made to make more staff available at times when they were most needed. For example, nursing staff were now deployed alongside assistant managers; this allowed the assistant managers to support with medicines administration and gave nurses more time to manage people's clinical needs. There had been other changes which had helped to improve deployment, such as staggering meal times which meant people were supported to meet their dietary needs effectively. There were some areas in the home where deployment required further analysis the manager was aware of this and said the work was on going. We will check if these further improvements were made and the sustainability of these changes at our next inspection.

The provider had developed systems to audit people's care plans and ensure they were accurate, up to date and had been reviewed. We found where these audits had been completed they had not always identified some of the concerns we found with people's care plans. For example, where people's needs had changed we found out of date information was still showing in their care plans, despite some aspects of their care being reviewed and an audit taking place. This meant if people were supported by staff that were not familiar with their care, such as agency staff, they were at risk of receiving care and support that was no longer required. We spoke to the manager about this and they told us the clinical lead, who had been newly appointed would be asked to make immediate changes and remove out of date information. The operations director confirmed further work would be carried out to ensure the audit process was identifying these concerns in the future. We will check the changes have been made at our next inspection.

The provider had taken the decision to revert to a paper based recording system for medicine administration records (MAR) following the last inspection. The system meant new audit processes had been introduced, which were not yet fully completed at the time of our inspection. We found some concerns had been identified with medicines recording. For example there were missed signatures for some medicines on people's MAR charts. The manager was able to confirm these had been identified and checks had been carried out on the person's stock of medicine to confirm this was a recording error only and the people had received their medicines. However, there were some other concerns which had not been identified at the time of the inspection. For example, there were medicines which had been administered on a as required basis, without a record of why this was given and the impact for the person. There were also some gaps in the guidance for staff on administering as required medicines. The manager took immediate action to address these concerns and assured us these issues would have been picked up in the monthly

audits; however these had not yet been undertaken at the time of the inspection. The manager said they would consider more frequent checks on medicines being introduced until they could be assured the new system was operating as it should be. This meant there were improvements required to medicine administration audits.

People and their relatives told us they felt that they were listened to and things had improved since the last inspection. One person told us, "There are resident's and relative's meeting". Another person said, "You can speak to staff about anything, I am happy here". One relative said, "We had no support previously, generally we are happy now". We were told that there were opportunities to share views about the service. One relative said, "They do try to get the residents involved, which wasn't happening before". People, relatives and staff found the manager was accessible. One relative told us, "I do know who the manager is and they are approachable". A staff member told us, "There is support from the manager through supervision. There is more support now over the last few months it's really improved now we have the assistant managers". We saw there were regular opportunities for people relatives and staff to be involved in discussions about the service. The manager told us they had spent time ensuring they addressed individual concerns from people and relatives. This showed the manager was responsive to people, relatives and staff.

The provider had made changes to the audit systems in place to check the quality of people's care following the last inspection. For example, the handover system had changed and now included information about any changes to people's needs. The handover document required staff to make checks on daily care records and ensure care had been delivered, for example the charts for when people were repositioned were checked to ensure people had received the pressure care prevention they required. We saw that where people had a food and fluid balance chart in place these had been checked daily and totals confirmed with any additional actions recorded for example if someone needed to have an increase in fluid intake. We found where issues required escalation to a health professional this was done promptly and we could see the advice given had been included in people's care plans and followed by staff. This meant the provider had systems in place to ensure people received the care and support they needed.

The manager had introduced systems to analyse accidents and incidents to help identify changes that could be made to reduce incidents. We found this had enabled changes to some people's care plans and had identified where changes to staff deployment could further reduce incidents. For example, a pattern had emerged around a time in the day where people were falling. It was identified that there were less staff available to monitor people at this point in the day which may have contributed to the falls. So changes had been made to address this.

The manager had submitted notifications to CQC in an appropriate and timely manner in line with the law. Services that provide health and social care to people are required to tell us about important events that happen in the service, we use this information to monitor the service and make sure the service is keeping people safe.