Haversham House Limited

Haversham House Limited

Inspection report

Longton Road
Trentham
Stoke On Trent
Staffordshire
ST4 8JD

Tel: 01782643676

Date of inspection visit:
18 October 2016

Date of publication:
02 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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**

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 1 June 2016. At that inspection, we identified a number of Regulatory breaches and we told the provider that immediate improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and was placed into 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We undertook this unannounced comprehensive inspection on 18 October 2016 to check that the required immediate improvements had been made. You can read the report from our previous inspections, by selecting the 'all reports' link for Haversham House on our website at www.cqc.org.uk.

At this inspection, we found that some of the required improvements had not been made. Some breaches of Regulations were still present and although the service is now rated as 'requires improvement' overall, the safe domain has been rated as 'inadequate'. As a result of this, the service will remain in special measures.

The service is registered to provide accommodation and personal care for up to 59 people. People who use the service have physical health and/or mental health needs, such as dementia. At the time of our inspection 34 people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act

and associated Regulations about how the service is run. A new home manager had been appointed and had applied to register with us.

At this inspection, we found that that new systems were in place to assess, monitor and improve the quality of care. However, these systems were not yet effective. This meant some areas of unsafe or inappropriate care were still not being identified and rectified by the manager and provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely. This meant that's people's safety, health and wellbeing was not consistently promoted.

There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe.

People's care plans did not always contain the information needed to ensure they received safe, effective and consistent care. As a result, people didn't always receive care that met their needs or preferences.

People's dignity was not always promoted, but people were now supported to be as independent as they could be.

People were supported to eat and drink in accordance with their preferences. Prompt advice was sought from health and social care professionals when people's needs changed.

Safe recruitment systems were in place to ensure staff were suitable to work at the home. People spoke fondly about the staff and at times we observed some positive interactions between staff and people.

People were protected from the risk of abuse because staff knew how to identify and report suspected abuse. Some people needed to have their freedom restricted at times to keep them safe. When people were restricted, these restrictions were appropriate and lawful.

People knew how to complain about their care and complaints were managed appropriately to make improvements to people's care experiences.

The manager and provider notified us of reportable incidents, such as suspected abuse. The home's rating was clearly displayed at the home and on the provider's website as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples care needs and preferences.

Incidents of suspected abuse were now being reported as required.

Is the service effective?

Requires Improvement

The service was not consistently effective. The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests.

Staff did not always have the knowledge and skills needed to meet people's needs effectively.

People were supported to eat and drink in accordance with their dietary preferences and their nutritional needs were regularly reviewed. Advice and support was sought from health and social care professionals when required.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being followed to ensure people were only restricted when this was appropriate and lawful.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always supported to receive care and support in a dignified manner.

Staff knew people well. However, information about people's preferences was not always recorded in people's care records for all the staff to follow.

People were encouraged to be as independent as they could be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive care that met their care needs and preferences.

Systems were in place to involve people in the planning and review of their care, but these systems were not yet effective.

People knew how to complain and complaints were managed appropriately to improve people's care experiences.

Is the service well-led?

Requires Improvement

The service was not consistently well led. New systems were in place to assess, monitor and improve the quality of care. However these were not yet effectively embedded to enable the quality and safety of care to be consistently monitored and improved.

A new manager was in post. People told us and we saw that they were approachable and were making improvements to people's care experiences.

Notifiable incidents were reported to us and the provider was displaying the home's rating as required.

Haversham House Limited

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.

This inspection took place on 18 October 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also met with representatives from the local authority to discuss the concerns they had with quality and safety at this service.

We spoke with 11 people who used the service and five people who visited the service. We also spoke with, five members of care staff, a cook, the home manager, the regional manager and two provider representatives. We did this to check that good standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of 12 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas and training records.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that effective systems were not in place to ensure people received their care in a consistently safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made. However, further improvements were required to ensure people consistently received their care and support in a safe manner.

We found that effective and prompt action was still not always taken to identify and manage people's risk of falling. For example, one person's care records showed they had fallen on at least three occasions since our last inspection. Two of these falls were unwitnessed in the garden. However, no risk management plan had been completed to ensure systems were in place to reduce the risk of this person falling again when they accessed the garden. Three of the four care staff we spoke with about this person's care needs were unaware of their recent falls history or their risk of falling. Another person had fallen three days before our inspection. Their fall hadn't triggered a review of their risk of falling again and a staff member told us, "The records have not been updated, it should have been done". This meant that effective systems were not in place to ensure people's risk of falling was being effectively managed and people continued to be at risk of potential harm as a result of falling.

Where risks to people's safety had been recognised and planned for, we found that care was still not always delivered in accordance with their agreed care plan. For example, one person's care records showed they should sit in a raised chair to help make moving on and off their chair easier. We saw that this person was seated in a chair that was not raised which resulted in them struggling to stand from this chair. Another person's care records showed and staff confirmed that they needed support to change their position when seated every hour due to their history of suffering with pressure ulcers. This person's care records showed and we saw that they were not consistently supported to change their position every hour as planned. For example, we observed that this person sat in the dining room for a period of two hours and ten minutes without receiving support to change their position. This meant that this person could not be assured that their risk of skin damage was being managed effectively and as planned.

People who could tell us about their care told us they received their medicines when they needed them. One person said, "I've just had two Paracetamol because my back hurts". However, we found that effective systems were still not in place to ensure medicines were managed safely. Effective systems were not in place to ensure people's medicines were readily available. For example, one person's 'as required' pain medicine was not available and had been out of stock at the home for six days. This person's medicine administration records (MAR) showed they had been taking this medicine on a regular basis, until it became out of stock. Another person's MAR showed that they hadn't received their prescribed nutritional supplements for a three day period because these supplements had also run out. This meant people did not always have access to their prescribed medicines to promote their health, safety and wellbeing.

People could not be assured that they received their medicinal creams as prescribed because accurate records for cream application were not maintained. For example, one person's MAR stated their creams

should be applied three times a day, but their MAR contained gaps so we were unable to ascertain that this person had their creams applied as prescribed. This person was also unable to confirm that their creams were applied as prescribed and their care records showed they were at high risk of skin damage. This meant we could not be assured that this person was receiving their medicines as prescribed to manage their risk of skin damage.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a consistently safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that call bells were now responded to promptly. However, improvements were still needed to ensure staff were effectively deployed to promote and ensure people's safety.

People told us that they still experienced some delays in receiving care that met their preferences. For example, one person said, "I have to wait for a bath, I have to see if they can fit me in". Staff also confirmed that they didn't always have the time to meet people's care needs and preferences. One staff member said, "We need more staff so we can meet people's preferences better. For example, if someone wants a bath at a certain time". We saw staff transport one person to a communal area in their night dress at approximately 9:30am. Staff told this person that they would soon be supported to have a bath. We saw that this person waited in their night dress for approximately two hours, before staff supported them to access the bath. This person was unable to tell us their preferred time to bathe, but they did confirm they had been sitting waiting for a bath for two hours when they said, "I've been sat here since 9:30am". This showed this person experienced a delay in receiving assistance to bathe. Staff told us they had been busy supporting other people during this two hour period.

Another staff member told us one person didn't always get the support they needed to manage their risk of skin damage because they didn't always have the time to do this. They said, "We don't always get round to it because we are helping other people. There's not enough staff on in a morning". This person's care records also confirmed that they didn't always receive their agreed care as planned. This showed this person was not receiving their agreed care as staff were not always available to provide this care. This placed the person at risk of skin damage.

The home manager had completed a recent analysis of incidents at the home. One recorded action from this analysis had identified that staff were to, 'ensure all communal areas are monitored at all times'. Staff told us and we saw that communal areas were not consistently monitored as planned. For example, we witnessed two people that became agitated and were raising their voices to each other in the dining room during breakfast. No staff were present to immediately diffuse the situation which meant people were at risk of harm to their safety and wellbeing. We also saw multiple occasions where no staff were present in the communal lounge on the unit that some people with behaviours that challenged chose to spend their time in. This meant incidents relating to these people's behaviours that challenged, such as aggression may not be witnessed and acted upon to promote people's health, safety and wellbeing. We asked a member of staff who was working on that unit how they monitored people's safety in the communal area. They said, "We try our best, but this morning one person needed both of us (the two staff assigned to the unit) in their bedroom. This morning two staff were not enough". The home manager told us staff had access to walkie talkies to request additional support so that staff could be deployed appropriately, but on the occasions above, additional support had not been requested to promote people's safety.

The home manager told and showed us that staffing levels were regularly reviewed and they staffed the home at a higher level than the outcome of their staffing assessment suggested. However, they agreed that effective procedures were not yet in place to ensure the staff were deployed to keep people safe. For example, staff were not always using the walkie talkies that were in place to seek additional staffing support when needed.

The above evidence shows that staff were not always available to keep people safe or meet people's care needs and preferences. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were not consistently protected from the risk of abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had been made. Staff told us how they identified, recorded and reported abuse, and care records showed that referrals were made to the local authorities safeguarding team when alleged abuse was suspected.

Most people told us they felt safe around the staff. Comments included, "I feel perfectly safe here" and, "The staff are kind". We saw that effective systems were in place to ensure staff employed by the service were of suitable character to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that improvements were needed to ensure the requirements of the Mental Capacity Act 2005 (MCA) were consistently followed when people were unable to make decisions for themselves. At this inspection, we found the required improvements had not been made as the requirements of the MCA were still not being consistently followed.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's care records did not always show that their ability to make specific decisions about their care had been assessed. For example, one person's relative had made a decision about their relation's healthcare on their behalf. This decision had meant an appointment with a healthcare professional to investigate an ongoing health concern had been cancelled. No assessment of the person's capacity to make this particular decision themselves had been completed. Therefore it was not clear if the person had the capacity to make this decision independently or if this decision had been made in their best interest if they were unable to make this decision. Some staff told us this person's capacity to make decisions varied. The person told us they were still experiencing health problems and they, "Wished they could get them sorted". This meant we could not be assured that this healthcare decision had been made in the person's best interests in accordance with the MCA.

Two of the four staff we spoke with about the MCA were unable to tell us the basic principles of the Act or how they ensured the Act was used to ensure decisions were made in people's best interests. One staff member said, "I've forgotten what it means, it's lot to take in". This meant some staff didn't have the knowledge required to ensure the requirements of the MCA were followed.

The above evidence shows that decisions about people's care were not always made in accordance with the requirements of the MCA when they were unable to make these decisions for themselves. This was a new breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the staff did not always have the knowledge and skills required to meet people's needs in a safe and effective manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found further improvements were still required.

Staff told us and training records showed they had received some training since our last inspection. For example, we saw most staff had received an update in training to enable them to move people safely. We saw that this training had been effective as safe moving and positioning techniques were observed. However, training records and conversations with staff showed there continued to be some significant gaps

in the staffs' knowledge and skills. For example, at our last inspection training records showed that only two percent of staff had competed training in the MCA. At this inspection, we found that the principles of the MCA were still not consistently followed to ensure decisions were made in people's best interests when they were unable to make these decisions themselves. At this inspection, training records showed that 38 percent of the staff still needed this training and no training dates had been set to address this ongoing training need. This meant effective, prompt action had not been taken to identify this training need. Training records also showed that 25 percent of the staff still needed training to help them to manage people's behaviours that challenged. Training plans showed training dates had been set to address this gap by the end of the year, but this meant some staff had waited up to six months for this training. One staff member who had not completed this training told us that training on behaviours that challenged, "Would be useful" to help them carry out their role.

The above evidence shows that staff did not always have the knowledge and skills required to meet people's care needs effectively and safely. This was an additional and continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that prompt referrals to health and social care professionals were not always made in response to peoples' changing needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made.

People told us they saw doctors and nurses when they needed to. One person said, "The doctor comes to me regularly". Care records showed that when people's needs changed professional advice was promptly sought. For example, care records showed that when one person's mental health deteriorated, prompt support was sought from a doctor and community mental health nurse. Another person's care records showed they had been referred to a physiotherapist following a change in their mobility. This showed effective systems were now in place to seek professional advice in response to people's changing health needs.

At our last inspection, we found improvements were needed to ensure people were supported as planned to eat and drink. At this inspection, we found the required improvements had been made. People told us and we saw that they could access sufficient amounts of food and drink that met their individual preferences. One person said, "I do like the food here". Another person who we saw was eating a different meal to the other people in the room told us they had chosen their meal and were, "Very happy" with their choice. Some people who used the service required support from staff to eat and drink. We saw that this support was offered to people as planned. Some people who used the service had special dietary needs such as requiring a diabetic diet. The kitchen staff demonstrated they knew how to cater for specialist diets such as diabetic diets whilst still meeting people's individual dietary preferences.

Care records showed that people's risks of malnutrition and dehydration were assessed, managed and reviewed. For example, we saw that people's weight was monitored and staff told us when they would seek professional advice in response to changes in people's weight.

At our last inspection, we found that people were being restricted unnecessarily or unlawfully. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had been made and people were no longer being restricted unnecessarily or unlawfully.

We saw that some people were restricted from moving freely around the home to promote their safety.

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 saw that DoLS applications had been made when restrictions were being placed on people. This showed systems were now in place to ensure restrictions placed on people were appropriate and lawful.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we found that people's right to be treated with dignity, privacy and respect was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made, but further improvements were still required to ensure people were consistently treated with dignity and respect.

Most people told us and we saw that they were given choices about some parts of their day to day care. For example, people who could tell us about their care told us they could choose their clothing and the times that they went to bed. However, some people were not consistently encouraged to make choices about their care. For example, we saw that people who lived with dementia were not always given choices about the food that was put on their plates. In one unit people who had initially chosen to eat liver and onions for their lunch received a plate with liver, onions, potatoes and mixed vegetables. Staff did not ask people if they wanted to have all the vegetables on offer, they just plated up everyone's meals in the same manner. Staff told us they. "We give it all to them but it's their choice whether they eat it or not". This approach did not promote or enable people to make individual choices about their meals and the provider agreed that people should be asked which foods they wanted on their plates.

We saw that staff didn't always have the time to ensure mealtimes were calm and dignified. For example, on one unit lunch was served to some people before their tables were laid, so placemats were put under some people's plates as they were eating. Once all the meals had been plated up one carer shouted to the other, "Is that it now" across the room. This did not promote a dignified lunch time experience for these people.

People told us improvements had been made to the way care was provided. One person said, "They take more notice of people now". Another person said, "They treat me very well". People also told us and we saw that improvements had been made to the way their privacy was promoted. One person told us that the staff, "Don't just barge in" when they entered their room to assist them. We saw that an area of the home had been converted to a family room that people could access to spend time with their visitors away from other people and staff. However, we found further improvements were needed to ensure people's private information was consistently protected. For example, on one unit, people's care files were not stored in a locked cupboard which meant there was a risk that people's private information could be accessed or used inappropriately.

Staff showed they had a good understanding of people's basic likes and dislikes and we saw some positive interactions between people and staff because of this. For example, we heard one staff member talk to a person about their previous occupation, which enabled the staff member and the person to sustain a meaningful chat. We saw another staff member kiss a person's hand. This person lived with dementia and struggled to communicate their needs. This person responded to the gesture by kissing the staff member's hand and smiling. This showed the person was happy and content at that time. One staff member told us how they used music to help one people relax when they were agitated. They told us the person responded well to this. However, this successful intervention was not recoded in the person's care records for other staff

to follow. This meant there was a risk that other staff would not be able to respond in a positive and effective manner when the person became agitated.

We saw that people were encouraged to be as independent as possible. For example, people who needed specialist equipment to enable them to eat and drink independently were given this equipment to use.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that people did not always get care that met their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that some improvements had been made, but further improvements were required to ensure people consistently received care and support in accordance with their individual preferences.

Information about people's care preferences and care needs was not always clearly recorded in people's care plans. This meant that the staff were not always aware of people's care preferences and care needs. For example, one person had a plan in place to help to manage their behaviours that challenged, but this information was recorded in an evaluation of the person's care, rather than a new care plan. This meant the information was not clearly displayed or accessible for the staff. None of the staff we spoke with told us about this plan when we asked how they managed this person's behaviours and we saw that the plan was not being followed. Another person's care records showed they frequently displayed behaviours that challenged the staff. However, no specific plan was in place to help staff manage this person's behaviours. This had resulted in staff managing these behaviours differently which meant the person received inconsistent care. A recent incident had occurred that caused this person distress because their behaviours had not been managed effectively. This meant people did not always receive care that was responsive to their individual needs and preferences.

Some people told us they felt involved in the planning and review of their care and the running of the home. One person said, "They involve me in my care and I've sat in on interviews for new staff" and, "They respect what I tell them now, they don't wake me up in the night anymore, they know I will call them if I need them". A relative told us how they had recently been involved in a review of their relation's care and they felt their views had been listened to. For example, the staff now recorded information for them to read detailing what activities their relation had been involved in and what resources they may need bringing in, such as toiletries. However, some people and their relatives told us they did not feel as involved in the planning of their care as they could be. One relative said, "We've not had a review for a while now" and, "I don't know who [person who used the service's] key worker is". Staff told us they were still in the process of organising reviews for all the people who used the service and this was an ongoing process.

People told us some improvements had been made to enable them to participate in social and leisure based activities. One person said, "There's much more going on now". On the morning of our inspection, we saw some people were encouraged to engage in group activities, such as gentle exercise and in the afternoon an entertainer performed at the home. Evening activities were also promoted as we saw some people were encouraged to engage in more group based activities. Staff told us and minutes of meetings with people showed that plans were in place to begin to enable people to access activities in the local community. Further improvements were required to ensure people who lived with dementia were consistently engaged in meaningful activity to help manage their behaviours that challenged. For example, on the unit for people who lived with dementia, The Jeremy Kyle show was on the television for part of the morning. No one appeared to be actually watching the programme, and the programme contained shouting

which did not promote a pleasant, calm atmosphere.

People and their relatives knew how to complain and they told us their complaints were listened to and acted upon to improve the quality of care. One person said, "I have complained and they are looking into it". We saw that complaints were recorded, investigated and acted upon appropriately and in line with the provider's complaints procedure. This procedure was clearly displayed at the home.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvements had been made. However, further improvements were still required.

Safety incidents were not always appropriately reported to the manager. For example, the manager was unaware a person had recently fallen three times as one of their falls had not been reported to them. This meant appropriate action had not been taken to reduce this person's risk of falling again. The manager told us they planned to complete more training with the staff to address this reporting issue.

Safety incidents at the home were now being analysed to identify emerging patterns and themes. However, the action plans in place to address these emerging risks were not followed as planned. For example, the manager had identified that the number of falls had increased, so they planned for communal areas to be monitored at all times to help manage people's risk of falling. We saw that communal areas were not always monitored as planned and no effective system was in place to monitor the staffs' compliance with this action plan.

Risks to people's safety were not always managed effectively. A health care professional had visited the home and completed an assessment of the safety of the homes environmental risks in relation to preventing falls. The professional had made a number of recommendations to help improve the safety of the environment to reduce falls. However, some of the recommendations had not been acted upon to promote people's safety. For example, it was recommended that bathrooms should be free from clutter. We saw a wet floor warning cone was in place for just under three hours in one bathroom, blocking access to the toilet. The floor was dry during this time, so the warning cone was not needed to promote people's safety. This cone was therefore 'clutter' and presented a trip hazard. This meant an effective system was not in place to ensure this professionals advice was followed to promote people's safety.

Care plan audits were now taking place. However, these were not always effective in driving the required improvements needed to ensure people's care records were accurate and up to date. For example, a recent care record audit had identified that people's bed sensor alarms were not being checked as often as planned. A memo had been sent to staff asking them to complete and record these checks. However, this memo had not been effective as the records we looked at did not show that these checks were not being completed as planned. The manager and provider told us they planned to introduce new care records to make them more user friendly for people and the staff.

Some staff told us they had received training and supervision since our last inspection, but other staff said they had not. The manager showed us they had plans in place to address the staffs' supervision needs as every staff member now had a supervision sessions scheduled. We saw plans were in place to address some of the staffs' training needs, but some training gaps were yet to be planned for. This showed some further improvements were needed to ensure training gaps were promptly planned for.

The manager and provider showed they were committed to improving people's safety and care experiences. A service improvement plan was in place outlining how they planned to make the required improvements to people's care. However, we saw some of the improvements the provider had identified as needing to be completed by a set date had not been completed and sustained. For example, the plan recorded that people who needed plans in place to help staff manage their behaviours that challenged should have these in place by the end of June 2016. We saw that some people did not have these plans in place as required. This meant although the provider had identified and planned to make improvements, systems were not yet in place to ensure these improvements were made as planned. This compromised people's quality of care.

The above evidence shows effective systems were still not in place to consistently assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management records showed that general feedback from people and their relatives about the care and the home was now being sought and acted upon. For example, relatives had reported that there were not enough chairs for them to use when they visited their relation's at the home. We saw that new chairs had been purchased and these were being used by visitors. A 'you said, we did' board was also on display in the family room showing how feedback was being used to make improvements to the care. The manager told us they planned to place this board in a more accessible area of the home so more people could see how their feedback was used. This showed people's feedback was now being sought and used to make improvements to people's care experiences.

A new manager had been appointed and had applied to register with us. People and staff spoke positively about the new manager and the improvements they had made. One person said, "The new manager is lovely". Comments from staff included, "There have been lots of improvements, we know people better as we are designated to work in certain areas of the home now", "We are starting to set goals for people now, based on what they want to do" and "Things are getting more organised". This showed the new manager was approachable and was making improvements to how care was provided.

People and their relatives told us and we saw that the atmosphere of the home had improved. One person said, "It's much quieter now. I would recommend it now to others". A relative said, "The whole atmosphere is much better". Staff also told us their morale had improved. This showed people felt the home was improving.

At our last inspection, we found that the provider was not always informing us of notifiable incidents, such as alleged abuse. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found the required improvements had been made. The provider was now reporting all notifiable incidents to us as required.

At our last inspection, we found that the provider was not displaying their inspection rating as required. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that the provider was now displaying the home's rating as required at the service and on the service's website.