Regal Care Trading Ltd

Linden Manor

Inspection report

159 Midland Road
Wellingborough
Northamptonshire
NN8 1NF

Tel: 01933270266
Website: www.regalcarehomes.com

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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 8 June 2016. It was unannounced.

Linden Manor provides a service for up to 28 people who have a range of care needs including dementia, sensory impairment and physical disabilities. There were 11 people living in the home on the day of this inspection, although one person was in hospital.

At our last comprehensive inspection on 7 October 2015, we found that the service was in breach of legal requirements in a number of areas. The overall rating for the service at that time was 'Inadequate' and the service was put in 'Special measures'. Services in special measures are kept under close review. We also imposed a condition of registration to suspend new admissions to the service until improvements had been made and the service was no longer in breach of legal requirements.

After the inspection we had a meeting with the provider to discuss our concerns, and they sent us regular updates outlining the actions they were taking to improve the service. This inspection was carried out to check the provider had made the required improvements. We found that they had done so.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. However, a new manager had been appointed who confirmed she had begun the process to register with CQC.

Improvements had been made to ensure individual risks were managed in a safe way. However, further work was required to ensure people's risk assessments reflect their current needs, and ensure staff have adequate guidance in terms of the control measures to follow where risks are identified.

There were sufficient numbers of suitable staff. Improvements had been made to ensure robust checks were being carried out for all staff, to make sure they were suitable to work at the service.

Improvements had been made to ensure people were protected by the prevention and control of infection.

Improvements had been made in terms of the leadership and management of the home. A new manager and area manager had been appointed, who were providing effective leadership at the service.

We found that the service worked to the Mental Capacity Act 2005 key principles, which meant that people's consent was sought in line with legislation and guidance. However, improvements were required to ensure assessments of capacity were available and clear.

People were supported to have sufficient to eat and drink. However, some people required different eating

aids, to enhance their independence and overall meal time experience.

People were supported to maintain good health and have access to relevant healthcare services. Some improvements were required however, to ensure people's health conditions were consistently monitored and appropriate action taken in a timely manner.

People received personalised care that was responsive to their needs. Although, some care records needed reviewing; to ensure the care recorded met each person's current needs and also reflected their involvement.

Improvements had also been made regarding internal quality monitoring systems, to support the service to deliver good quality care. However, there was still room to improve these further, particularly in terms of auditing people's care records.

People felt safe living at the service. Staff had been trained to recognise signs of potential abuse and keep people safe.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it.

Staff had the right skills and training to meet people's needs.

Staff were motivated and provided care and support in a caring and meaningful way.

Staff listened to people and supported them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.

People were given opportunities to participate in meaningful activities.

Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

We found that the service promoted a positive culture that was person centred, inclusive and empowering.

Given the level of progress, and the provider's commitment to continue with this, we have assessed that the service should no longer be in special measures. We have also removed the condition to restrict new admissions. We will continue to monitor the service to check that the progress made is being sustained and continually improved upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements had been made to ensure individual risks were managed in a safe way. However, further work was required to provide adequate guidance in terms of the control measures to follow where risks were identified.

Improvements had been made to ensure there were sufficient numbers of suitable staff on duty at the time of the inspection.

Improvements had also been made to ensure robust checks were being carried out for all staff, to make sure they were suitable to work at the service.

Staff understood how to protect people from avoidable harm and abuse.

Systems were in place to ensure people's medicines were managed in a safe way and that they got their medication when they needed it.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems were in place to assess people's capacity to make decisions. However, improvements were required to ensure clear assessments of capacity are in place for everyone.

People were supported to have sufficient to eat and drink. However, some people required adaptive eating aids, to enhance their meal time experience.

People were supported to maintain good health and have access to relevant healthcare services. Some improvements were required however, to ensure people's health conditions are consistently monitored and appropriate action taken in a timely manner.

Staff had the right skills and training to meet people's needs.

Is the service caring?

Good

The service was caring.

Staff were motivated and treated people with kindness and compassion.

Staff listened to people and supported them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care that was responsive to their needs. However, some care records needed reviewing; to ensure the care recorded met each person's current needs and also reflected their involvement.

Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

Is the service well-led?

Requires Improvement

The service was well-led.

Improvements had been made in terms of the leadership and management of the home. A new manager and area manager had been appointed, who were providing effective leadership at the service.

Improvements had been made regarding the systems in place to support the service to deliver good quality care. However, there was still room to improve these further, particularly in terms of auditing people's care records to ensure they accurately reflect their current needs and individual preferences.

We found that the service promoted a positive culture that was person centred, inclusive and empowering.

Linden Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 8 June 2016. It was carried out by two inspectors.

We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority, who have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences.

We spoke with four people living in the home and observed the care being provided to a number of other people during key points of the day, including lunch time and when medication was being administered. We also spoke with one relative, the manager, area manager, two care staff, the cook, two domestic members of staff and a handyman.

We then looked at care records for six people, as well as other records relating to the running of the service - such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 7 October 2015, we found that the service was in breach of three legal requirements in this domain. This was because risks to people were not effectively assessed and managed by the service. We found inconsistencies in the way individual risks were assessed, and some people at risk of falls did not have a specific care plan; to minimise the chance of them falling. We also found an open bottle of disinfectant in a communal area of the home. We were concerned that someone might mistake the contents of this bottle for another type of fluid, if they were confused. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found concerns with the cleanliness of the home and the use of equipment that was intended to keep people safe. There was a lack of available individual toileting slings; to minimise the risk of cross contamination and some firefighting equipment was not in a usable condition. These were breaches of Regulation 15 (1) (a) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, we found that staffing levels were not sufficient to meet people's needs and people were left waiting for help when they needed it. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan after the inspection to tell us what they were going to do to address these concerns. We checked all these areas again during this inspection and found improvements had been made.

Staff spoke to us about how risks to people were assessed; to ensure their safety and protect them. They described the processes used to manage identifiable risks to individuals such as malnutrition, moving and handling, skin integrity and falls. We saw that people had individual risk assessments in place to assess the level of risk to them in these areas and corresponding care plan plans were also in place. These had been reviewed on a regular basis; to ensure the care being provided was still appropriate for each person. Although most assessments detailed the control measures and actions to be taken to address the identified issues, some did not. For example, depression screening and behavioural pain assessment tools had been introduced which provided a good indicator for staff that someone's needs might have changed. However, they provided little guidance in terms of the actions required, if any, dependent on the scores achieved.

We observed people being supported to walk with mobility aids or transfer between wheelchairs and arm chairs, using hoists. This was with the aim of keeping them safe and secure and to minimise the potential for falls to occur. We saw that staff took their time and talked to people throughout, providing them with reassurance and an understanding of what was happening. One person commented on the fact that they had felt safe. We noted that equipment such as wheelchairs, hoists and hoist slings were available and fit for purpose, ready for staff to use. New toileting slings had been purchased and there was an adequate supply of individually named slings, as well as some spares, for when these needed to be washed. People who had pressure care requirements had pressure cushions and mattresses provided. However, we did find one person who had been assessed as high risk of developing a pressure ulcer. Their care plan stated they

needed a pressure relieving cushion, but one was not in place. We spoke with staff who confirmed the person did not have a pressure ulcer and explained that as they were able to move position regularly, a cushion was no longer required. We were able to observe the person moving position frequently throughout the inspection. The manager told us she would review the person's care plan and ensure it better reflected their current needs and routine.

Records were being maintained of incidents and accidents that had occurred in the home, in order to identify any patterns and minimise the likelihood of a reoccurrence. Observation charts were also being used following an accident, to support staff in monitoring people for any possible after effects. Other records showed that systems were in place to ensure the premises and equipment was managed in a way that ensured the safety of people, staff and visitors. Individual PEEPS (personal emergency evacuation plans) were in place and had recently been updated, as had a business continuity plan for the service; to support staff in the event of an emergency happening and needing to move people out of the building for a while. Fire equipment such as extinguishers and fire doors had been maintained or were being used appropriately.

Since the last inspection, the manager had assessed a bath chair in one of the bathrooms to be unsafe, as it had not been fitted with a lap belt and people were at risk of slipping, particularly when the chair was wet. This meant that there was only one working shower room for the 11 people living in the home to use. The area manager confirmed that a new bath chair was on order and would be fitted approximately two weeks after the inspection. She also told us a third bathroom was in the process of being refurbished and was likely to be fully operational within four weeks. This would provide people with accessible, safe bathing or shower facilities on each floor of the home.

The home was clean and fresh and we noted that repairs had taken place since our last inspection, to support domestic staff in maintaining a hygienic environment. This included some redecoration and new tiles in the ground floor shower room. We spoke with a domestic member of staff who confirmed the changes had made it easier for her to clean. She told us: "I look at a bed and if it looks nice I am happy. I judge things by if I wanted to stay there, then that's okay. I move out beds, wash mattresses, door handles, and tops and so on. I hoover and pull things out to make sure nothing has been put there. We have a daily cleaning schedule which goes to the manager for overview. Some of the things I do are weekly and others are daily things; all to make sure the service is kept clean."

People told us that their bedrooms were cleaned to a good standard and smelt fresh. One person told us they had noticed improvements since our last inspection and that work had been done to freshen up the service. We saw on going evidence of cleaning throughout the day of the inspection. Bathrooms and toilets were clean and people's bedrooms were free from dust and odour. Cleaning products were kept safely, and we saw that there was a regular cleaning schedule in place to make sure that all areas of the service were cleaned on a regular basis. Colour coded mops were in use for different areas of the service, for example, toilets, bathrooms and communal areas, to minimise the risk of contamination.

We found appropriate systems were also in place to ensure laundry was maintained appropriately and soiled linen washed and cleaned in a safe way. There were effective systems in place to ensure people's clothing was washed and returned to them in a timely way, so they were able to wear their own clothing. Audit systems had also been introduced to monitor the standard of the laundry.

Staff told us they had good access to gloves and aprons, which we observed them using whilst cleaning or serving meals, to promote good infection control measures and keep people safe. Toilets and bathrooms contained ample supplies of hand sanitiser and handtowels so that people and staff could wash their hands easily.

People told us there were sufficient numbers of staff to keep them safe. Staff we spoke with were also content with staffing levels in the home. One staff member told us there were enough staff on duty for the amount of people in the service at the time of the inspection. On our arrival we found 10 people actually living in the home, because one person had been admitted to hospital. There were three care staff on duty, supported by the manager, a cook, a domestic, a laundry assistant and two handymen, who were decorating parts of the home.

The manager explained that due to low occupancy levels people had been moved to bedrooms on the ground and first floor, leaving the top floor empty; to support monitoring of people and keep them safe. We did witness a disagreement between two people living in the home. Staff were not in the room at the time, but they were quick to respond and deal with the matter in a calm way. The area manager was able to show us that one of the two lounges areas was in the process of being redecorated and said a new television for this room had been ordered, which would enable people to have a choice of communal space as well as the option to watch different programmes. We noted from records we looked at that the two people had different tastes in terms of their television preferences.

We observed throughout the inspection that staff had time to spend engaging with people and were able to meet their needs in a timely manner. Ancillary staff also provided support to people at peak times, such as meal times. We saw that people received the help they needed and were not left waiting for assistance. The manager told us she would ensure staffing levels were kept under review and increase them accordingly, to meet the needs of the people using the service. She told us she had already advertised for new staff and was ready to recruit, prior to occupancy levels increasing.

The manager described the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the home. We were told that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We looked at a sample of staff records and found that work had taken place since our last inspection to ensure all legally required checks had been carried out.

People told us that they felt safe living in the home. One person said: "Oh yes, they look after me very well, keep me safe and all that." Staff told us they had been trained to recognise signs of potential abuse, and were clear about their responsibilities in regard to keeping people safe. One staff member told us: "I would always act if I saw someone in danger." They went on to say that they made sure the environment in the service was safe for people and that if they had any worries, they would go straight to the person in charge to ensure their concerns were acted upon. Other staff confirmed they would report any accidents or incidents, as well as any safeguarding concerns to senior staff or the manager, so that people could be kept safe. We observed that people were relaxed in the presence of staff and often looked to them for support and reassurance.

We saw that information was on display which contained clear information about whistleblowing procedures and safeguarding, including who to contact in the event of suspected abuse. Records we looked at confirmed that staff had received training in safeguarding and that the home followed locally agreed safeguarding protocols.

Systems were in place to ensure people's daily medicines were managed so that they received them safely. People told us they received their medication when they needed it. Staff confirmed they had received training to be able to administer medication. They demonstrated a good awareness of safe processes in terms of medication storage, administration and about the purpose of the medication prescribed for

people. Records were being maintained to record when medication was administered to people, and individual medication profiles provided clear information for staff in terms of the purpose of each medication prescribed for people. We also saw that medication was stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medication.

Requires Improvement

Is the service effective?

Our findings

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 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that systems were in place to assess peoples' capacity and appropriate DoLS applications had been submitted to the local authority for authorisation. However, we found one person's care file did not contain their actual MCA assessment, despite reviews of their capacity still taking place. As we were not able to locate the assessment during the inspection, we could not be clear about the relevance or quality of the reviews that had taken place. The manager undertook to address this and ensure another assessment was put in place. We also noted that there was limited guidance for staff to follow where someone had been assessed as having fluctuating capacity. This meant that it was not always clear within the records we looked at as to what decisions each person had the ability to consent to, and what areas they did not. Despite this, records showed that decisions had been made in people's best interests where they lacked capacity; to ensure they received the right care and support to maintain their health and wellbeing.

We observed people being given the ability to make their own decisions about their day to day care throughout the inspection. One person told us: "They always ask me if I am happy with things." Staff demonstrated a good understanding of people's needs and encouraged them to make their own choices and decisions, as far as possible. For example, giving people a choice of what to eat, and where to eat it. We noted that staff did not presume to know people's individual preferences in terms of what they usually liked to eat and drink, and we heard them checking with people whether they preferred tea or coffee, and how many sugars they would like. People were seen to respond positively to this approach.

People told us they had enough to eat and drink and that they enjoyed the food provided. One person said: "Yes I do like the food." Another person told us they always had a choice and that the cook came round and asked everybody what they wanted. A third person added: "We have a choice of food which is nice and plenty to drink." The cook had a good awareness and understanding of people's individual nutritional needs and how to meet these, for example, diabetic or soft diets. Menus were based on a four weekly rolling programme, with there being two choices at both lunch and in the evening. We observed the cook going round asking people what they wanted to eat just prior to mealtimes, so their choices were fresh in their minds. We also noted that she supported some people to make their choices by showing them the food on offer. If someone didn't want the meals on offer, then an alternative was provided.

At lunch time we noted that dining tables were laid appropriately; providing a visual clue for people living

with dementia that it was time to eat. A hot trolley was used to ensure people's meals were served at the right temperature, and the meals we saw looked and smelt appetising. People were given time to eat and drink and the pace was not rushed. People were observed to eat well and second helpings were offered.

Assistance was provided by staff in a discreet manner to those who required help with eating and drinking. Some staff also sat and ate with people; providing additional prompts for people living with dementia to eat, as well as providing a meaningful social opportunity. We observed that people took enjoyment from this. Although people were encouraged to maintain their independence at mealtimes, we did note that this might have been enhanced had some people been provided with adaptive eating aids or a bowl. For example, we watched one person trying to scoop a piece of gateau onto their spoon from a small plate. The gateau slid off the plate onto the table, and then onto the floor when they attempted to scoop it up again, which caused the person some frustration.

Throughout the day a choice of food and drinks were readily available. People, including those at risk of malnutrition, were offered snacks in between meals such as fresh fruit and biscuits on a frequent basis, and a choice of fluids including hot and cold drinks was given. It was a hot day and we saw jugs of drink left close to people which contained ice blocks, to help keep drinks cool. We also saw people being given ice creams, which they appeared to enjoy. Records showed that people's nutritional needs and preferences had been assessed, with any specific requirements such as soft options or assistance with eating outlined. There were frequent entries in people's care records about their food and fluid intake, enabling staff to monitor whether they had had enough to eat and drink.

We saw that people's weight had been regularly monitored, to support staff in recognising potential health problems associated with weight loss or gain. However, these had stopped for one person almost four weeks before the inspection, with no explanation. In addition, we noted the person's weight had been quite erratic prior to this, with them losing over six kilograms in a six week period between March and April 2016. When we spoke with staff there was no clear guidance for them in terms of when to make a referral to a specialist healthcare professional where someone had lost or gained weight, and they confirmed this had not yet taken place. The manager took immediate action to address this and confirmed an appointment would be arranged for the person to see their GP. She also advised that she had taken advice from a local nutritional specialist, and an agreement had been put in place that in future staff would seek external professional help where a difference of three kilograms was identified in someone's weight.

People confirmed they were supported to maintain good health and have access to relevant healthcare services. A relative also told us that staff had acted quickly when their relative's needs had changed and they had needed antibiotics prescribing. Staff told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support.

Records demonstrated that referrals were made to relevant health services when people's needs changed for example, the local falls service, or a GP for a medication review. A record of visits to and from external health care professionals was being maintained for each person, and records we saw showed that people were in regular contact with external healthcare professionals. We did note in one person's records that they were diabetic. We saw that staff had previously been checking the person's blood sugar levels, but this had recently stopped following a visit to the person's GP. A member of staff explained the person's levels had not been cause for concern for a while and they found the procedure of daily testing painful. Although staff had written this up in the person's notes to the best of their understanding and recorded that 'regular (daily)' checks were no longer necessary, the person's diabetic risk assessment stated that they were at risk of a diabetic coma if their diabetes was not controlled correctly. We therefore queried whether there should have been some testing still in place; to monitor the stability of their sugar levels. Again, the manager took

action immediately to confirm with the GP that six monthly checks had now been agreed and the person's care records had been updated accordingly.

People received effective care from staff with the right skills and knowledge. Staff told us they received regular training which gave them the skills and knowledge they needed to support people. One staff member said: "I have all the training I need." Another staff member told us: "I do all the on line training, infection control, safeguarding, fire, everything." A third staff member added: "We have e-learning courses and face to face training, in house and practical. I have done my dementia training and have the right skills to support people."

A training matrix had been developed which provided information to enable the manager to review staff training and see when updates / refresher training was due. This confirmed that staff had received training that was relevant to their roles such as induction, safeguarding, dementia, moving and handling, nutrition, continence, skin care, challenging behaviour, ageing and depression, medication, diversity and equality, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Further training had also been planned. We saw that non care staff received relevant training in areas such as safeguarding and dementia, which provided them with important knowledge and an understanding of the needs of people they came into close contact with on a regular basis. From speaking with staff and observations throughout the inspection, we found staff, in all roles, to have the right knowledge and skills to meet people's needs. For example, we observed staff using their training effectively in respect of supporting people to mobilise and to react appropriately if they became agitated.

Records showed that staff meetings were being held on a regular basis; to enable the manager to meet with staff as a group, and to discuss good practice and potential areas for staff development. Staff also confirmed that they had received recent supervision, which provided them with additional support in carrying out their roles and responsibilities. Records we looked at supported this.

Good

Is the service caring?

Our findings

People confirmed that they were treated with kindness and compassion. They spoke positively about the care and support they received. One person told us: "I do like it here; they are kind to me and help me, like friends." Another person told us they liked all the staff because they were always there for them. A third person said: "She's alright she is." This was in reference to the cook, with whom they were observed to be enjoying meaningful conversation throughout the day of the inspection. The same person also told us that the other staff looked after them well too.

Staff demonstrated that they were caring and had a person centred approach. We observed many positive interactions between staff and the people living in the home. For example, when one person became anxious about the time of day, believing they had missed a train or bus, a staff member reassured them and went to fetch some train tickets, which they gave to the person. We saw the person visibly relax and they became less distracted by what time it was. Staff were seen to sit with people and pass the time of day, maintaining eye contact. We also saw staff going round and saying 'Hello' when they came on duty and letting people know when they were leaving. They responded promptly to requests for support, and when they could not provide instant support, the staff were true to their word and returned within the timescale they had told the person. There was a relaxed atmosphere and we heard lots of light hearted but respectful banter being exchanged between people and staff.

Records showed that people were encouraged to share their life story; to enable staff to know them better and understand their individual preferences and personal histories. We saw life story booklets that had been completed by people or their families, which provided information about each person's family and friends, past jobs and significant memories. We heard a member of staff using this knowledge to remind someone of their age, when they asked, in a kind and gentle way.

People were involved in making decisions about their care and day to day routines. We noted that staff listened to them and provided information in a way that was appropriate for each person. We saw them giving people time to respond and also heard them check that people were okay with the support and care provided to them. When care and support was provided, staff gave thorough explanations beforehand and offered encouragement and reassurance where needed.

People's privacy and dignity was respected. We observed staff ensuring people were comfortable and their dignity was maintained at all times. We observed that people were supported to use the toilet throughout the day, or when they requested to do so. Staff supported people to protect their clothing at meal times by offering them an apron to wear. When food was spilt, people were supported to change their clothing or have their face and hands wiped, in a timely manner. We saw that staff supported people to take a pride in their appearance. We also observed staff knocking on people's doors before entering and ensuring that doors were closed before the delivery of personal care. We noted too that people's records were stored securely, meaning that confidential records could only be accessed by those authorised to do so.

At our last inspection, we noted that the building was looking tired in places, in terms of the facilities

provided and some of the décor. During this inspection we saw that work had started to provide people with more dignified surroundings. We saw that some redecoration had taken place and a new shower and toilet fitted on the ground floor. Efforts were being made to make the service more dementia friendly; through signage and by replacing bold colours on walls with more neutral tones. The area manager also spoke about possible future plans to enhance the location and useable space of communal toilets within the home. We saw that people were encouraged to bring in personal possessions to enhance their feeling of well-being, and pictures and ornaments created a feeling of homeliness in communal areas.

People were encouraged to maintain relationships with friends and family. Information that had been developed for people using the service and prospective users, confirmed that visitors were able to visit without restriction. We spoke with a relative who told us they visited at different times of the day, and felt welcome to do so.

Requires Improvement

Is the service responsive?

Our findings

Staff talked to us about how people were able to contribute to the assessment and planning of their care. They told us that before people used the service, they were asked for information about their needs. This information was then used to develop a care plan that reflected how each person wanted to receive their care and support. We reviewed care records and found that people had been asked for information prior to moving in.

Care plans we looked at provided some useful information for staff to enable them to meet people's care and support needs. They had been evaluated regularly; to ensure the care and support being provided to people was still appropriate for them. However, the evaluations were sometimes meaningless, as they were not always relevant to the related care plan. For example, one person had a care plan in place relating to their social interests which recorded that they enjoyed watching sport and movies. The evaluations undertaken by staff had recorded that they continued to enjoy watching television, which did not correspond with their actual preferences.

We found that falls care plans had been introduced since our last inspection. Although it was positive that there was now guidance in place for staff to follow in the event of someone having a fall, we noted that they sometimes lacked detailed information in terms of what caused each person to fall, and the steps that needed to be taken to minimise the risk of this happening for each individual person. Another person, who was registered blind, had a care plan in place that instructed staff to show the person pictures, to aid their communication. Staff confirmed that although the person could make out shapes and colours, showing them pictures would not really aid their communication or ability to understand. Some plans were also not clear enough for care to be provided in a consistent way. For example, one person had a catheter care plan in place. We found this lacked important information about who was responsible for changing the catheter, and when this should be done by. There was also no information for staff in terms of potential problems such as signs of an infection and what to do. Staff were verbally able to give a good account of how the person's catheter was managed, but the manager acknowledged that this information needed to be in the person's care plan too.

In addition, care plans did not always demonstrate that people's individual needs and preferences had been taken into account. For example, people had nutrition care plans in place, which provided staff with need to know information about their specific dietary requirements and any allergies. However, they did not always reflect people's personal preferences such as their food likes and dislikes, or how and where they liked to eat. We also saw one person's life story contained clear information about their preferred choice of name. We heard staff addressing the person with the preferred name at all times however, the name had not been transferred to their care records. Despite this, there was no evidence that people's individual preferences were not taken into account, as we observed staff to have a good knowledge of each person's needs. We also observed them consistently encouraging people to have as much choice and control as possible.

Electronic records were being maintained on a daily basis; to demonstrate the care provided to people. Staff talked to us about one person's preferred daily routine, and we could see from these records, that this was

followed on a consistent basis. This showed that people were involved in day to day decisions about their care routines. We also noted that people and their families, where appropriate, had been involved in reviews of their care, but care plans did not demonstrate their involvement in the actual planning of their care. Again, the new manager and area manager acknowledged this and told us that they would make sure everyone's care plans were properly reviewed to ensure they reflected people's current needs clearly and accurately, with their involvement as far as possible.

Staff talked to us about people's hobbies and social interests. The area manager explained that an activity coordinator had been employed, but due to low occupancy in the home, they were dividing their time between this service and another local home run by the same provider. Despite this, and due to the current occupancy levels, staff were able to provide a more 'ad hoc' activity schedule, which helped to reduce potential social isolation. Staff we spoke with were able to describe the activities that people enjoyed, for example, going for a walk outside into the garden, playing games and listening to music. The activity coordinator was not on duty on the day of our inspection however, we saw that care staff involved people in activities; for example, we observed staff playing a board game with two people, and then later on, dominoes with another person. Another person was observed enjoying a 'pamper session' with their nails being painted, and we saw them engaged in conversation with the staff member whilst doing this.

During the inspection the use of the television was kept to a minimum in the main communal area, and we heard appropriate music being played, which people were heard singing along to. People were also asked what else they might like to do, such as read a book or watch a specific television programme. This demonstrated that staff understood the importance of a variety of meaningful and stimulating activities for people and did not just view this as the role of the activity coordinator. In the afternoon, a local gospel choir came to entertain people, and staff told us they visited the home on a regular basis.

Daily records showed that activities were offered to people and these were tailored to people's needs on occasions. For example one person enjoyed watching sport on television, so staff had engaged the person in a sports quiz, which they had enjoyed. The manager showed us a copy of the home's business plan, which referred to the need to build on and improve activity provision in the home as occupancy levels increased. This showed that the provider had recognised the importance of supporting people to follow their interests and take part in meaningful social activities.

Staff gave us examples of how they provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. However records did not always support this knowledge for example, pre-admission assessments had not always been completed fully in terms of people's sexuality preferences. We also noted that care plans relating to sexuality referred more to people's appearances and their preferred clothing and hygiene routines. One person's care plan used the words 'sexual behaviour', which suggested negative behaviour rather than simply recording their sexual preferences. There was no evidence that they were at risk to others.

Staff enabled people to be as independent as they could be, in a supportive way. People were encouraged to do as much for themselves as possible such as transferring from one chair to another, pouring drinks from a jug and eating without assistance. We did observe one occasion when someone wanted the volume turning up on the television. They were unable to do this independently because they needed help to mobilise and there was no available remote control. The manager acknowledged this and told us that if the remote control could not be found, a replacement would be sourced.

Everyone we spoke with told us they knew how to make a complaint or raise a concern. People told us they felt the staff team were approachable and that they would feel comfortable speaking with a member of staff

if the need arose. A relative echoed these comments and told us they would be happy to speak with staff if they had any concerns. We saw clear information had been developed for people outlining the process they should follow if they had any concerns.

The manager showed us that a record of complaints and compliments was being maintained. We noted from this that concerns were taken seriously, and updated to record any actions taken in response. We also noted that records clearly detailed where legally required action had been taken in response, such as notifying us (CQC) or the local authority, for potential safeguarding concerns. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints. We were able to read a recent written compliment from a relative too. They had written: 'A huge thank you to you all for the amazing care and support you gave…we know he appreciated the love and kindness given to him at all times. You are a brilliant team, keep up the good work'.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on 7 October 2016, we found that the service was in breach of legal requirements in this domain. This was because we were not assured about the effectiveness of internal monitoring audits that had been carried out to check the quality of service provided. We found a number of areas identified as requiring action during the October inspection which had also been identified within the service's own audits. However, action had yet to be taken to improve the service. This was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan after the inspection to tell us what they were going to do to address this concern. We therefore checked the leadership, monitoring and oversight of the service again during this comprehensive inspection and found improvements.

After the last inspection, we were notified that the registered manager and area manager had both left, and a new manager and area manager appointed. Both were present during this inspection. They acknowledged there was more work to be done, but there was evidence of real progress being made and they demonstrated that they understood what was required of them. The new manager, who had taken up her post in March 2016, also confirmed she had begun the process to register with the CQC, which is a legal requirement.

The manager and area manager talked to us about the monitoring systems in place to check the quality of service provided. New provider level audits had been introduced, which corresponded with the CQC's five key questions which we focus on when inspecting services - is a service safe, effective, caring, responsive to people's needs and well-led? We saw that these were being carried out regularly, and there was evidence that areas identified for improvement were being acted on. Areas where checks had taken place recently included catering, staff files, the environment, activities, infection control, fire, falls, medication, training, and care plans.

In addition, we found there were a range of internal audits and systems in place and carried out by the manager. These included reviews of medication, infection control, the kitchen and laundry areas. The manager also undertook spot checks and management checks, which were overviewed by the area manager. This showed that arrangements were in place to monitor the quality of service provided to people, in order to drive continuous improvement. The manager recognised there was still more to do in terms of the audits undertaken, particularly in regard to people's care records, and ensuring these accurately reflected their individual needs and preferences.

The manager told us there were opportunities for people to be involved in developing the service, which included attending resident and relative meetings, and completing satisfaction surveys. We also observed less formal methods for example, staff were seen asking people if they were okay or if they had enjoyed their lunch; providing them with the opportunity to provide immediate feedback. We saw some minutes of a recent resident meeting where people had been asked to provide feedback about their care, the food, and activities. We saw that positive feedback had been provided. The manager confirmed that satisfaction

surveys had recently been sent out to relatives, but these had not yet been returned and collated. We were therefore not able to review these on this occasion.

We saw useful information around the home for people, staff and visitors including safeguarding arrangements, fire safety and the Care Quality Commission (CQC) last report and rating. Clear information had also been developed for prospective users of the service, setting out what they could expect from the service, their rights and also information about fees and the cost of any extra services. This demonstrated an open and transparent approach in terms of how information was provided to and communicated with people.

Systems were in place to ensure legally notifiable incidents were reported to us, the CQC in a timely way. Our records showed that this was happening as required.

The service demonstrated good management and leadership. One staff member told us they were happy working at the home and said: "I left as it was so bad and then came back when the new management was in place, it's so much better now. I get supported and have all the training I need." Another staff member told us: "It's a completely different feel now, we have new equipment. It's a different environment now, happier; a better atmosphere and staff are happier. People are happier too. [Name of Manager] is approachable, very nice." A third member of staff added: "Everyone has tried hard since the last inspection to pull things together. [Name of manager] is supportive, she will be an asset, and she treats everyone nicely, all the same and is very approachable and amenable to requests. Staff morale has been low but is now getting better." A relative told us they felt things had improved recently too.

During the inspection we saw that the manager spoke with people to find out how they were and was involved in their support and wellbeing. The manager and area manager knew people's names and interacted with them on a personal level, making them feel at ease and sharing a laugh and a joke. Staff made positive comments about the open culture at the service and told us they were supported by the manager rather than being made to feel unvalued. Staff we spoke with were clear about their roles and responsibilities across the service. One staff member said: "We all pull together for the benefit of people." We observed staff working cohesively together throughout the inspection and noted the way they communicated with one another to be respectful and friendly. We also found the management team to be open, organised and knowledgeable about the service - they responded positively to our findings and feedback. The area manager confirmed they were well supported by the provider and confirmed appropriate resources were available to continue with driving improvements in the home.