Mulberry Care Limited

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Inspection report

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Ratings

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

Overall summary

This inspection took place on 16 and 17 September 2015 and was unannounced. This was a comprehensive inspection which included follow-up of progress on the non-compliance identified in the reports of the previous inspection on 28 and 30 October 2014.

At the previous comprehensive inspection we identified non-compliance against Regulations10 (Assessing and monitoring the quality of service provision), 12 (Cleanliness and infection control), 13 (Management of medicines), 17 (Respecting and involving service users), 20 (Records), 21 (Requirements relating to workers) and 23 (Supporting workers), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From April 2015, the 2010 Regulations were superseded by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was meeting the requirements of the

Summary of findings

comparable current regulations. Regulations 17 (Good governance), 12 (Safe care and treatment), 10 (Dignity and respect), 19 (Fit and proper persons employed) and 18 (Staffing).

We found that the service had taken action to address the previous concerns although some further improvements were needed. Some issues were still addressed reactively rather than proactively. The service has not always maintained previous improvements in response to inspection so it was too early to be sure that recent changes would be sustained. This will be monitored going forwards and at the next inspection.

Mulberry Care Limited provides services for up to 35 people with needs relating to old age, many of whom were living with dementia. There were 24 people present at the time of this inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that people were kept safe by a staff team who understood how to do this, how to recognise potential abuse and to report any concerns. There were sufficient staff to meet people's needs although some would benefit from further training on engaging effectively with people, involving them in their care and seeking their consent. Staff were seen to be caring and to give people time to make decisions and choices.

People and relatives were happy with the care and support provided by the service and told us staff were gentle kind and caring. People were offered an improved range of activities and entertainment and further developments were planned. Care staff were actively involved in providing activities and people responded positively to their enthusiasm.

Staff training and support had improved with regular supervision and additional training provided. However, In some cases key training was not provided in a timely way and staff appraisals were not used effectively as a development tool.

Infection control practice had improved and the service had introduced a new medicines management system which enabled more effective monitoring.

Improvements had been made to the premises in terms of décor and signage. However, some further environmental improvements were necessary to maximise the usability and appearance of the building.

Care plans and other records had improved and were now more detailed. More information was included about people's individual likes and wishes. Systems for monitoring the effectiveness of the service had been improved with support from the NHS care home support team and the local authority.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to keep people safe and understood how to recognise the signs of abuse and what to do if they had any such concerns.

Infection control practice had improved and staff had received further relevant training. Recruitment records had been improved.

People felt safe and there were sufficient staff to meet their needs. Medicines management had been significantly improved.

Good

Is the service effective?
The service was effective. However staff training required further improvement to ensure all staff had all the skills necessary for their role.

Staff received regular supervision from management but their appraisals lacked sufficient depth to help staff to develop their skills.

Not all staff communicated effectively with people or sought their consent in the course of providing support. Where people were able to consent to the use of bedrails this had not always been recorded.

Additional work was required to maximise the potential of the premises in terms of accessibility.

Requires improvement

Is the service caring?
The service was caring.

Staff were seen to be caring in their approach, spoke kindly to people, allowing them time to make choices.

People were happy that staff were kind to them and respected their dignity.

Good

Is the service responsive?
The service was responsive.

People and relatives were happy that staff were alert and responsive to people's changing needs.

Improvements had been made in the activities provided and further changes were planned.

New, more detailed care plans were being introduced and included more information from people and relatives.

People's views about the service had been sought via surveys and complaints had been addressed.

Good

Summary of findings

Is the service well-led?

The service was well led.

The service had sought and acted upon advice and support from external agencies and a consultant to address the previous shortfalls. However, some further improvements were needed and in some cases changes were still made reactively rather than in a proactive way.

A number of new monitoring systems had been established to maintain an overview of the service and some included a cycle of action plans and review which should help ensure ongoing development.

However, because standards and improvements had not always been maintained previously it was too soon to be assured that the improvements made would be sustained.

Requires improvement

Mulberry Care 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 September 2015 and was unannounced. It was carried out by one inspector.

This was a comprehensive inspection which included follow-up of progress on the non-compliance

identified in the report of the previous inspection on 28 and 30 October 2014. Where applicable we have referred back to the previous inspection to report the progress made since that visit.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with four staff, the registered manager and the operations manager. We also spoke with four people using the service and a relative.

We used the Short Observational Framework for Inspection (SOFI) as well as observing care informally during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care plans and/or associated records for 5 people, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for three recently appointed staff.

Good

Is the service safe?

Our findings

At our inspection of 28 and 30 October 2014 the provider was not meeting the requirements of the then Regulations 12, 13, and 21, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to Regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured people were safeguarded from the risk of acquiring an infection through failure to maintain adequate standards of hygiene or by staff using appropriate personal protective equipment. People were not protected from the risks associated with unsafe use and management of medicines. People were not protected from the risk of being cared for by unsuitable staff because recruitment procedures were not sufficiently robust.

The provider sent us action plans in March 2015 describing the actions they were going to take to meet the requirements. The provider also worked with the local authority 'Quality monitoring' and 'Care Home Support' teams in order to address the identified concerns.

At this inspection on 16 and 17 September 2015 we found that the provider was now meeting the requirements of the current regulations. However, staff should receive training in key areas such as safeguarding within a short time of appointment to ensure they are fully aware of best practice.

Staff had attended training on safeguarding with exception of three recently recruited staff who had viewed a training DVD. These staff were scheduled to attend local authority safeguarding training between January and March 2016. Staff we spoke with knew how to respond should they become aware of a safeguarding concern. With regard to physical abuse staff told us they would clarify what they were told, record it, report to senior management and record any bruising on a body chart. Staff said they would discuss it with the team leader if the registered manager was not on duty and could always call the on-call manager. They felt the manager would act on their report.

Staff knew about safeguarding and whistle-blowing procedures. A safeguarding flow-chart, detailing how staff should respond to any concerns was posted on the staff notice board. The relevant contact numbers for the local authority safeguarding team were included. Where safeguarding issues had arisen the service had worked with the local authority to address concerns and taken steps to reduce the risk of recurrence.

Staff had been given an in-house training update on infection control. Seven of the team had also attended additional infection control training led by an external trainer. During the inspection, the training was booked for the remaining staff in October 2015. Competency assessments around infection control practice had been completed throughout 2015 on all staff. We saw staff wore appropriate personal protective equipment (PPE) and changed gloves/aprons appropriately between tasks to reduce the risk of cross infection. Hand washing instructions were posted in toilets and bathrooms. The cook also undertook care tasks when not involved in food preparation. She was able to describe appropriately the need to change PPE between tasks and told us she had separate uniforms for each of her roles. The premises were clean during the inspection.

We sampled a variety of safety checks and service records for the premises and found them to be in order. The fire risk assessment and evacuation plan had been reviewed in June 2015. People had individual fire evacuation plans detailing the level of support they would need. A range of health and safety based risk assessments including those for Legionella were present and had been reviewed within the previous 12 months. The service had a detailed business continuity plan in place in the event of a range of emergency situations arising. The information available to staff included relevant emergency contact numbers and evacuation plans. People told us they felt safe in the service. One said: "The staff are gentle and kind, I feel safe here". Another person told us: "I get on well with all the staff and feel safe here".

People were happy that there were enough staff on duty to meet their needs. One said: "there are quite a few staff". The home was fully staffed with staffing levels that were sufficient to meet people's current needs. The registered manager told us that any shortfalls on particular shifts were addressed from within the existing team, without the need to use agency staff. The team leader's hours were not included within the care hours of the service. This enabled them to focus on overseeing the medicines management

Good

Is the service safe?

and provide managerial support as well as helping with care practice monitoring. In addition they provided direct care support on shift and modelled appropriate practice for other staff.

Since the last inspection the registered manager and operations manager had reviewed the service's recruitment records and a new system had been established to facilitate effective monitoring. The administrator had been provided with additional training on the required records of recruitment processes to help ensure the process was robust.

The recruitment records for the three most recently recruited staff contained the required evidence to demonstrate that suitable pre-employment checks had been carried out. References and a criminal records check had been obtained and evidence confirming identity was on file. An employment history was provided and any gaps had been explained. Where a reference from a most recent care-related employer was unavailable, alternative references had been sought. The recruitment process included a written comprehension test to establish whether potential staff had the necessary communication skills. Some references had also been followed up by telephone to confirm their source or content.

People all had their medicines managed by the service as no one was able to manage this for themselves. People were happy the service did this. One person told us: "they do my medicines for me, I'm OK with that".

The service had adopted a new branded monitored dosage system to manage medicines. The medicines, including liquids, were sealed in individual removable cups which could be separated from the weekly pack and taken directly to the person. In most cases, this removed the need for medicines to be handled directly by staff or dispensed into separate cups to be administered. Each weekly pack and individual cup was labelled to help ensure correct administration. Medicines were named and the person's photo was on the weekly pack. The medicines administration record (MAR) sheets included people's name and photograph. Medicines were stored securely and daily checks of storage temperatures were made and recorded. An appropriate system was in place for the return of unused medicines.

Staff had received medicines training within the registered provider's expectations with the exception of two who were booked on this training in November 2015. All of the relevant staff had their medicines competency assessed within the last 12 months. Insulin medicine for people who had diabetes was managed by visiting district nurses.

The team leader carried out daily and weekly medicines audits and the registered manager told us there had been no recent medicines errors or omissions. One staff member initialled the MAR sheet each time a medicine was administered. Where any changes were made to MAR sheets mid-cycle, perhaps for antibiotics or due to GP instructed changes, a second signatory confirmed the change. Where one person had previously made errors completing the MAR sheet this had been addressed via supervision, retraining and reassessment of competency. An error report form had been devised to record such events. Medicines information sheets were available detailing the purpose of each medicine and any potential side effects. A pain assessment information sheet was also available with the MAR sheets to assist with decision making around as required (PRN) pain medicines, together with individual PRN protocols to make clear the appropriate circumstances for administration. The instructions provided by the GP for PRN medicines were not always sufficiently clear. The team leader was addressing this with the GP where it occurred. The MAR forms contained a photo of each person and clear dosage instructions including a body map to show staff where topical creams should be applied.

Requires improvement

Is the service effective?

Our findings

At our inspection of 28 and 30 October 2014 the provider was not meeting the requirements of the then Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were not in place to ensure staff received adequate training to be able to deliver safe care and support to people.

The provider sent us action plans in March 2015 describing the actions they were going to take to meet the requirements. The provider also worked with the local authority 'Quality monitoring' and 'Care Home Support' teams in order to address the identified concerns.

At this inspection on 16 and 17 September 2015 we found the provider was now meeting the requirements of the current regulations. However further improvement was needed to provide core training as early as possible in people's employment so they began with the skills and knowledge to provide care effectively. Training records were not fully up to date or comprehensive and did not present the full picture about when staff had last attended core training. Staff appraisals lacked depth and sufficient focus on individual development. Further staff development was needed to ensure all staff communicated clearly and engaged effectively with people, explained what they were about to do and sought the person's agreement. People's consent to potentially restrictive equipment was not always documented. The premises required further development to maximise their potential.

The service was introducing the new Care Certificate induction although existing staff were completing the previous Skills For Care induction. Staff told us induction had taken place over two days during which they completed some introductory training and observed more experienced staff delivering care. Staff we spoke with told us they had received the necessary training and had also had periodical updates. The training matrix provided showed the service sought training from a range of sources including the local authority, distance learning, external trainers, computer-based courses and training DVD's. Some in house training was also provided and the local authority care home support team had further training scheduled. However, the training records were not complete or easy to follow because they were in multiple formats.

Some staff had not yet received training in core areas. For example first aid training and moving and handling. One person had not had practical moving and handling training, although they had completed an e learning computer based introduction. They were supporting people with moving and handling alongside trained staff although not trained to do this. The remaining staff had received practical moving and handling training however their refresher training had been a DVD which was not specific to the needs of the individuals they were supporting, the equipment used or the environment within the service. The manager had completed moving and handling competency assessments on the current staff in 2015. Whilst we saw no evidence of poor moving and handling practice during the inspection, this situation could present a risk to both people using the service and to staff. Following the inspection the registered manager conformed that the majority of staff had been booked to attend a practical moving and handling training and also a first aid course within the next 6 weeks.

Records showed and staff confirmed they attended one to one supervision approximately every two months. The supervision matrix also included scheduled dates for future supervision meetings. In addition to supervision meetings staff had some "Job chat" meetings to address specific issues or discuss performance. As with supervisions, a record was kept of the discussion. Staff had also received annual appraisals. However, the completed individual appraisal records we saw were very basic and lacked sufficient details around staff development or future goals.

The registered manager told us most people had a degree of capacity to make decisions for themselves apart from two people for whom this would be limited to making day-to-day decisions. Assessments under the Mental Capacity Act 2005 (MCA) had been completed for both people. The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests. Best interests decisions had been made and

Is the service effective?

recorded for some people where relevant. An Independent Mental Capacity Advocate (IMCA) had been obtained for two people to support best interests decision making. These best interests decisions had been reviewed to make sure they were still appropriate.

Appropriate applications had been made under the Deprivation of Liberty Safeguards (DoLS) to safeguard people's rights. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. A meeting had been held with people and relatives to explain the changes in legislation around capacity and consent. Copies of Power of Attorney authorisations were present to evidence where relatives had decision-making authority on financial matters on people's behalf. No one had appointed relatives with decision-making powers for health and welfare.

The level of staff interaction when supporting people varied between staff. Some were very good at engaging people and involving them. For example one person was being supported to eat lunch by a staff member who sat with them one to one, encouraged them through conversation and gave them time to process what was said to them. However not all staff engaged in this way and they sometimes began supporting people with limited engagement or explanation about what was going to happen. Staff were aware of the need to seek people's consent and described some of the ways they would go about this. However, consent or agreement was not obtained on every occasion prior to providing care support.

Where equipment was used which could restrict people's freedom of movement, like bedrails or wheelchair lap-belts, appropriate consultation had taken place with the occupational therapy service and the wheelchair clinic. In two cases where bedrails had begun to be used while people had capacity, no evidence of consent for their use had been documented. In another case where the person still retained capacity, their consent to the bedrails was also not recorded. The operations manager told us the person was unable to sign but had given verbal consent and this was noted in their file during the inspection.

Risk assessments had identified people at risk of malnutrition and dehydration, and those who required a specific diet. The service had sought advice from the local care home support team, the speech and language team, dietitians and an independent consultant in developing the dining experience for people. The level of meals choice available to people had been improved. Precise nutritional information was available if required from the external catering company. Standardised portion measures and drink sizes had been introduced to enable accurate records of dietary and fluid intake to be kept.

When specialised diets were provided they were presented well and provided variety of texture and appearance. People were placed on fortified diets where necessary and the details were on file. Each person's dietary and fluid intake were recorded and monitored. However the fluid monitoring charts, although well completed, did not include a daily target to ensure that any shortfall below this would be picked up. Where a nutritional concern had been identified, people were weighed weekly rather than monthly to monitor this. We observed staff offering fluids regularly to people to encourage sufficient intake.

People told us the food was generally good and they had a choice. One person said:" They do the food very nicely, you have a choice on the day". Another told us: "it's alright here and the food is alright, we get a choice". The registered manager had introduced a meal and nutrition forum to involve people in the choice of catering and menus. One person told us they would prefer to eat a vegetarian diet but a vegetarian option wasn't available daily. The registered manager and operations manager were aware the person enjoyed vegetarian food, but said they often seemed happy to eat one of the two daily options. Arrangements had not been made to have a vegetarian option available to meet this person's wishes on days when they might want this. The registered manager agreed they would arrange for a daily vegetarian option to be available in future.

People were happy that their health was looked after by the service. One person said: "They call the doctor in if I am unwell" and others confirmed this. Records showed that healthcare professionals were consulted when necessary. We saw instances where people's care needs had changed or staff were asked to alter how they recorded events and this was noted on care plans. However, these amendments were not always dated and signed to enable the changes to be tracked or clarify the date a change had been made.

A relative said of the service that: "they had made lots of improvements recently" and some new furniture had been provided. They were happy that an area of garden had been made more secure and said their family member was: "quite happy here". One person felt some rooms could do

Requires improvement

Is the service effective?

with brightening up in terms of their décor and bedding. They thought the home preferred them not to have pictures up in their room. The registered manager clarified they were happy for people to have pictures up but wished to put them up on people's behalf to ensure this was done safely. The manager agreed to clarify this at the next resident's meeting. Another person told us: "I am happy here, it is a nice room".

Some areas of the building were dated and in need of refurbishment. The operations manager explained that there was a refurbishment plan in place. The dining rooms and the lounge in the old wing had vinyl flooring. The new wing lounge was carpeted but the carpet was stained and creased in places. The operations manager told us it was due to be replaced with vinyl flooring. People commented on the difficulty presented by the number of doors throughout the ground floor. We saw that negotiating these was often difficult even with staff assistance and the width of some doorways presented some risk of injury particularly for wheelchair users. One person said: "The doors are difficult for me, there are a lot of doors".

Part of the garden had been fenced off to provide a more secure area for people to be able to use without the necessity for staff supervision if they could do so safely. There was a level patio area adjacent to the building provided with some seating. Other areas of the garden could be improved to make them more accessible to all of the people being supported.

Good

Is the service caring?

Our findings

At our inspection of 28 and 30 October 2014 the provider was not meeting the requirements of the then Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were not in place to ensure people's privacy and dignity.

The provider sent us action plans in March 2015 describing the actions they were going to take to meet the requirements. The provider also worked with the local authority 'Quality monitoring' and 'Care Home Support' teams in order to address the identified concerns.

At this inspection on 16 and 17 September 2015 we found that the provider was now meeting the requirements of the current regulations.

A relative was happy that staff were caring and said: "The care is fine here, the staff seem perfectly alright with [name]". They added that the staff would chat with their relative and that other family members had also visited and felt the care was good. They described the care support their relative needed and how this was provided by the staff.

One person said: "Two staff help hoist me from bed, they talk me through it" and added: "they encourage me to do what I can". Another person told us that staff: "check in the nights, check how I feel, and added: "they help with my weekly shower, they are patient and give me time". They added that staff: "ask me about activities". Staff were also described as: "very gentle" and: "very nice" and people said they got on well with the staff.

A poster was displayed in a staff area to remind staff about supporting privacy and dignity. Additional external training on supporting dignity had been provided to about half of the staff and others had watched a training DVD on dignity since the last inspection. Staff competency around respect and supporting dignity was being assessed and about half of the team had already been assessed. Discussions of specific scenarios had been used to illustrate how dignity should be afforded to people.

The service had taken part in the local authority "Dignity in Care" initiative. "Champions' had been appointed to take a lead within the team on specific aspects of care including dignity, activities provision, and dementia. It was too soon to see how their roles would be developed and whether they would have a sustained impact on care practice.

Issues previously raised about the premises in relation to dignity had been addressed by the provision of obscuring or blinds at certain windows. People told us staff were: "respectful and look out for privacy". One told us staff always knocked and closed doors and curtains before supporting them. One person told us: "The staff are gentle and kind and look out for my privacy, they close the door [before providing care]".

We saw that staff were generally attentive to people's need and responded to indications of unease or distress. Staff paid attention to people who were quiet and tended not to initiate contact, offering activities, drinks or a chat. At lunchtime we saw people supported appropriately by staff who maintained their dignity and focused on their individual's needs. For the most part people were treated with respect. However, we saw a few occasions where staff weren't respectful in subtle ways. On one occasion a staff member was involved in a one to one activity with a person. A colleague summoned her assistance elsewhere and she left the room without explanation to the person with whom she had been working, which left them looking confused about the abrupt ending of the activity.

Several staff engaged people positively in activities and offered ongoing encouragement to maintain their focus. When one person had completed a puzzle they were offered a replacement so they didn't become bored. We saw examples of evident warmth in the interactions between staff and the people they were supporting and people smiled at staff who took time with them.

When wheeling people around the building in wheelchairs, staff took particular care negotiating narrow doorframes and offered verbal reassurances. Sufficient staff were available to meet people's needs without undue haste, which allowed them to spend a little time over most interactions.

The registered manager told us and care plans showed, that people and their families had contributed some information to help staff provide individualised care. Some information about people's lives, employment and family was recorded in their support plans which helped staff engage with people in the course of providing support.

Good

Is the service caring?

Activities people had previously enjoyed or still liked to pursue were noted as were individual likes and dislikes, to enable staff to offer relevant support. We saw examples of these reflected in the support provided.

Good

Is the service responsive?

Our findings

At our inspection of 28 and 30 October 2014 we found that the service required some improvements to ensure they were consistently responsive to people's needs and preferences. Some records were not fully up to date or lacked detail particularly about how people spend their days and their physical and emotional wellbeing. The service had engaged with the local care home support team to develop their activities and the equipment and items available.

People said that staff responded quickly when they wanted support either through the call bell or a verbal request. No one said they had been kept waiting too long. One person said: "They respond to the buzzer quickly". Another told us that it was: "sometimes quicker than others, depending on how busy they were, but they were not left too long".

A relative felt staff were responsive to people's needs. They told us when they had mentioned any health concerns, staff had listened and responded promptly and appropriately and had involved the GP. The relative felt the staff kept them informed of changes in wellbeing such as illness, and said they had been texted to update them of these events. They had also contacted the home and found staff helpful and forthcoming.

The new care plans contained clear sections relating to the core areas of care including nutrition and hydration, skin integrity and continence. Records of people's care were individual and detailed and showed ongoing monitoring and review of their needs. They also included a section recording people's interests, past employment and family relationships. They were reviewed by the registered manager at least every two months although the level of involvement of people or their representatives in care plan review was not always clear from records. The registered manager said she, the team leader and the keyworker sat with the person (and/or their representative), to discuss their plan. Feedback from people and a relative did not always confirm this involvement.

People and relatives were aware that new care plans had been devised but did not always feel they had been fully consulted during the process of improving them. A relative told us they had seen a copy of the old care plan and felt that if they had any queries they could discuss them with the manager. One person told us staff: "didn't really ask about their care plan", but said staff tended to respect their preferences. They gave the example of the time staff offered them breakfast, which suited them and said they had the option of going back to sleep afterwards if they chose. A relative was happy that they were kept informed of changes in wellbeing.

Staff told us they referred to the care plans for information about people's needs. They told us they spent one to one time with people who preferred to be in their bedrooms. Staff felt the home was moving in the right direction and described recent improvements in records, activities and staff engagement. One said: "the care plans are better written now" and added that all staff tended to join in with activities now. An example was given of improved detail within the care plans. It related to one person who didn't like crowds and became agitated and would be calmer and more settled when it was quieter. The staff member felt this type of information was good as it helped them respond to people's individual needs.

Where people could behave in ways that put them or others at risk behaviour management plans were on file and the advice of community psychiatric services had been sought. Five people had individual behaviour management plans. One person had been prescribed medicine (as required) to calm them when they became agitated. Records showed this was not used often. For the others, staff interventions were designed to reduce agitation and divert people to more positive activity, which was usually effective. We saw staff responded promptly to people when necessary and most readily instigated interaction with people to engage them. A few staff did not appear as confident to do this.

The home had an activities coordinator who worked 10am-4pm, Monday to Friday who led on activities provision but we saw that other staff also engaged in activities with people once personal care or other tasks were completed. Since the last inspection, staff had all completed computer-based training or viewed a DVD on providing activities for people living with dementia and the care home support team had also provided input on activities. Staff had also received training input on dementia, person centred care and other relevant subjects in the same period to support them to provide a service responsive to people's needs.

We saw people engaged in various activities including catching a ball, skittles and puzzles. People told us they

Good

Is the service responsive?

also like to complete word searches and enjoyed the visiting entertainers. Around the home we saw some interactive equipment such as clothing, scarves, costume jewellery and soft toys had been provided for people to engage with if they wished. There were photographs of various events and activities on the lounge walls. Various colouring books had been obtained as these can interest and provide activity for some people living with dementia. Some of these had appropriately adult themes such as wild animals, but a couple were aimed at children. Following discussion the registered manager agreed to replace these with more adult themed alternatives.

The home held periodic themed events and during the inspection a Hawaiian themed afternoon took place with appropriate music. Several staff and some people dressed in floral garlands and some staff dressed in Hawaiian themed clothes. This was enjoyed by quite a few people as shown by the smiles on people's faces and promoted some humour between people and staff. People could opt out of joining in if they wished and some did so. Staff told us the level of activities had improved and there was now a good variety of options, including some outings. They mentioned creative sensory ideas like bringing in flowers for people to smell and asking people to identify fruit with their eyes closed from its smell. Outings included garden centre cafes and shopping and there were social events and entertainers too. People's spiritual needs were addressed by visiting clergy. The registered manager told us they had held two activities forum meetings this year in January and April and was intending to hold these on a six-monthly basis going forward.

We saw that two people who smoked could do so in the garden, without direct staff supervision. One person spent the afternoons listening to the radio having taken part in some morning activities. The registered manager said people chose whether to eat in the dining room, the lounge or their bedroom and some people confirmed this. One person told us the staff encouraged them to do things for themselves when they could but: "provide support when I need it and they arrange care to suit me".

A relative was happy activities were provided for their family member and felt these met their needs. They were aware that some outings had taken place, such as to a local garden centre. They also knew that outside entertainers had visited and said their family member had enjoyed that. One person had been taken out to visit their old place of work the day before the inspection and photos had been taken to help them recall their visit and past working life. Others had been taken shopping one to one with staff previously. Another person said they were happy with the activities provided and gave some examples of the ones they enjoyed. They said they were not aware of any resident's meetings, although records showed these had taken place. People told us staff asked them if they would like to join in with activities but they could choose not to.

The registered manager told us people and their relatives had been given a copy of the service's complaints procedure which was also posted in the entrance hall. A suggestion box was available but there was no simple comments/complaints form available there for people to take without having to ask staff. A relative said that another family member had raised a complaint in the past and it had been addressed appropriately. The relative told us they felt happy that if they raised a concern with the manager it would be sorted out. One person told us they hadn't had any cause to complain but hadn't specifically been told how to. They said they would talk to the registered manager and: "she'd sort it out". Another person said they had never had to complain and was happy the staff always called the doctor if they needed them. They said: "If I was concerned I'd tell a carer or the manager, they'd sort it out". They added they would tell the team leader if they had a complaint and: "He'd sort it out" and gave an example when this had happened.

The service had a complaints log, in which the manager had listed the quality issues raised by the local authority as part of their monitoring process since the last inspection. The log also referred to the action taken to address them. The registered manager gave examples of changes that had been made following complaints. Laundry labelling had been improved and was now done by a single staff member to provide consistency. The fenced area of garden had also been provided in response to a relative's suggestion.

Requires improvement

Is the service well-led?

Our findings

At our inspection of 28 and 30 October 2014 the provider was not meeting the requirements of the then Regulations 10 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been safeguarded from unsafe or inappropriate care because the provider had not had effective systems to assess and monitor the quality of services provided. The registered person had not ensured that records relating to service users and staff were kept securely.

The provider sent us action plans in March 2015 describing the actions they were going to take to meet the requirements. The provider also worked with the local authority 'Quality monitoring' and 'Care Home Support' teams in order to address the identified concerns.

At this inspection on 16 and 17 September 2015 we found that the provider was now meeting the requirements of the current regulations. Action had been taken on all of the issues raised. However, given that the service had not consistently maintained standards or sustained improvements made in the past, it was too soon to be certain the changes introduced would be sustained effectively. A number of developments had taken place in response to the advice and input from other agencies. Additional improvements were required in some areas and it remained to be seen whether the service would continue to make proactive changes. This will be further reviewed at the next inspection. The service had sought advice and support from the local care home support team, the local authority quality management team, an external consultant and other external professionals to support development. Recent feedback from external agencies had been positive.

Most of the records we examined had been improved and contained more detail. For example care plans, which were now more detailed and person centred. However, people said they had not been fully involved in the recent improvements made to care plans. A relative felt that the registered manger and senior staff managed the service effectively and listened to the views of people and relatives. People's current care records were secured appropriately and archived records were now secured in a locked cupboard.

The training records initially provided were not up to date or comprehensive and did not present the necessary overview to enable effective monitoring. This had potentially contributed to various training having not been delivered or refreshed appropriately.

Regular monitoring reports were now completed by the registered manager (monthly) and the operations manager (bi-monthly) which sampled records and recorded observations of care. A system of additional bi-monthly monitoring visits by another of the provider's registered managers had also been established. Where issues were identified the necessary actions were recorded and signed of when completed, by the registered manager and operations manager. The main focus since the previous inspection had been on addressing the non-compliances identified in the previous inspection and the action plan from the local authority rather than ongoing service development although we saw that some development had begun following the input from the local authority and the care home support team, which the home will need to maintain once their support is no longer provided.

The registered manager's audits included a sample of recent staff recruitment files, care files, and medicines records. The operations manager oversaw and checked these areas and in addition monitored the provision of staff supervision and appraisals as well as signing off the manager's actions in response to previously identified shortfalls. Both reports included some observations of direct care and noted some direct feedback from people. Action taken in response to complaints had also been monitored. Feedback about the service was also sought from relatives meetings and surveys.

We saw that senior staff like the team leader worked alongside care staff to deliver care as well as taking the lead in areas such as medicines management. This meant they would be aware of staff practice and could model appropriate care and techniques. A wide range of competency checks had been introduced across many of the aspects of care addressed through training, including infection control, safeguarding, manual handling, respect

Requires improvement

Is the service well-led?

and dignity. The relationships within the team appeared positive and staff reported a good positive team spirit. Staff told us they could go to the seniors or management if they had any concerns and would be listened to.

Staff were consulted at staff meetings and kept informed through leaflets about changes in legislation and current best practice. However, no recent staff survey had taken place to seek their views about the developments in the service and identify their level of ownership of the changes made. Staff felt the service was improving and told us there was a more constructive atmosphere, better staffing, more resources and equipment and more effective monitoring. One staff member said there was: "more involvement of service users, they are asked now". Another said things were: "going in a good direction".

A relative's survey had been carried out in February 2015, to which a dozen responses were received. Responses were varied but the majority were positive. Individual comments had not been sought so the detailed reasons for people's comments were not available. Some people were critical of the standard of décor in the home, activities, the laundry service and cleanliness of the building. Action had been taken since then to address these issues and was ongoing with regard to the standard of décor. A food survey had also been carried out in August 2015. The results showed that people were happy with the meals and the choice and support provided with all responses being either excellent or good. Meetings had been held with residents and relatives and were minuted. The notes indicated positive feedback re the improvements in the home in terms of people's wellbeing, activities and care.