

## Appleby Rest Homes Limited

# Appleby Lodge

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We carried out a previous comprehensive inspection on 12 and 15 June 2017. The service was rated Inadequate and was placed into special measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

We told the provider to make improvements to ensure people's medicines were managed safely, that the environment was checked to ensure it kept people safe, and risks associated with people's care were recorded. We also told the provider to ensure staff had the necessary training to be able to safely and effectively support people, that people's human rights were protected in line with the Mental Capacity Act (MCA) 2005, and that people's care records showed their involvement in decisions relating to their care. As well as being kept up to date and in line with their wishes and preferences. Action was also required to ensure people had enough to stimulate their social and cognitive needs, and that people's privacy and dignity was respected, particularly at the end of their life. In addition, we requested the overall management, leadership and culture of the service should be improved and asked the provider to implement an effective monitoring process, to help capture people's views and identify when improvements were required.

Immediately after our inspection, the provider told us they would stop new admissions to the service, in order for them to put things right. We also contacted the local authority safeguarding team who took prompt action to ensure people's health, safety and wellbeing.

The Commission considered its enforcement policy, and took enforcement action, which was to impose a condition on the provider's registration. This meant on a monthly basis, the provider was requested to carry out an audit of people's care plans and risk assessments, the management of people's medicines, and equipment and environmental maintenance. Submit a summary of their findings to the Commission, and demonstrate what action was being taken to improve the service and to meet regulation. Since October 2017 the Commission had been receiving and reviewing the provider's monthly returns, which had demonstrated ongoing improvement at the service. However, during our most recent inspection although we found some improvements had been made, our findings relating to people's care plans, risk assessments and medicines management showed the information which had been provided had not always been fully accurate. This demonstrated the providers auditing systems had not always identified where improvements were required and continued to require adapting.

During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures, but further improvements are still required. The Commission also made a decision to remove the providers imposed condition of registration.

We carried out an unannounced comprehensive inspection on 29 January 2018 and 08 February 2018.

Appleby Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home provides accommodation for up to 18 older people who require personal care. The provider also operates a day centre offering meals and companionship to local people. The service is on one level. There are shared bathrooms, shower facilities and toilets as well as a lounge and dining area. There were 15 people living at the home at the time of our inspection and one person using day care facilities.

Since our last inspection the manager had now registered with the Commission and was now the registered manager of the service. 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.

Overall, people's medicines were now managed safely. However, people who required medicines at particular times did not always have care plans in place for staff to follow, to help ensure they received these in line with prescribing guidelines. People, who had pain relief patches applied to their body, did not have records in place to detail where they had been applied. Meaning, people may not always receive consistent medicine support. The registered manager and provider had introduced a new audit to help highlight where improvements were required. Whilst the use of this audited had seen a positive impact in driving improvement, it had failed to identify where some improvements were required.

Overall, people now lived in an environment which was assessed to ensure it was safe. Fire checks were being carried out as required. However, some risks had not been assessed to ensure people's safety, for example hot water in two bathrooms and in one person's bedroom was found to be very hot.

People's accident and incidents were recorded which helped to provide a good overview of when a person had experienced unavoidable harm, so themes could be identified to help minimise it from occurring again. However, when a theme had been identified people's care records were not always updated. This meant the person may not receive consistent care because the information had not been recorded for staff to read.

People told us they felt safe living at the service. People were protected from abuse because the provider's processes and procedures kept people safe. People were supported by suitable numbers of staff to ensure their needs were met. People's call bells were answered promptly and the provider had created a new staffing dependency tool which would help to assist with ensuring there were, enough staff to be able to meet people's needs safely.

People lived in a clean and odour free environment. Staff received infection control training and implemented their knowledge and training. Whilst, laundry was handled in the correct manner the laundry area was found to be cluttered with flooring which could not be washed easily.

People now received care from staff who had undertaken training to help meet their individual needs. Overall, people's human rights were protected, but when someone did not have the mental capacity to make certain decisions, such as in respect of their care this was not always detailed within their care plan to enable the person to be supported effectively. People's consent to care was now obtained and was documented in care plans and people were asked for their permission prior to being supported.

People's individual communication needs were known by staff and staff knew people well. However, the

recording of this information was not always detailed in people's care plans to help ensure a consistent approach.

Overall people were pleased with the food. The chef told us there was always flexibility and people could have what they wanted. People's like and dislikes were now recorded, and the menu had been re-created by taking account of people's preferences. People were supported with their nutrition, and now had care plans in place to help guide staff to deliver the correct support. People were supported to live an active life, but many chose not to.

People received a co-ordinated approach to their care. Health and social care needs were assessed on an ongoing basis, to help ensure their care and support needs were being met in line with best practice. The GP who visited the service was complimentary of the care provided.

People lived in a service which was adapted to meet their needs. The provider had recently replaced the dining room chairs so they were easier for people and staff to move, whilst they were seated.

People's privacy and dignity was now respected. Staff spoken fondly of the people they supported and used sensitive and appropriate language to describe people's care needs. People and their families, told us staff were kind and caring. People told us they were now satisfied with the laundry service.

People's individual equality and diversity needs were known, and respected. People's care plans now demonstrated how people were being actively involved in making decisions about their own care and support.

People now had care plans in place to help provide guidance and direction to staff about how to meet their needs. Care plans were reviewed when changes occurred in people's care and/or on a monthly basis.

Overall, people would be supported respectfully at the end of their life, because staff had received training in palliative care. However, people's end of life care plans were not individualised to help ensure staff knew what people may specifically wanted.

The registered manager helped to reduce people's social isolation by consulting with people about what they wanted to do. People's comments and complaints were respectfully listened to, and used to help improve the service. The provider's complaints policy may not have been in a suitable format for everyone to understand.

The provider now had more of an active role and was visible within the service. The registered manager told us they received good support, and that the provider was at the service on a day to day basis, speaking with people and staff to ensure they were satisfied with the service.

People lived in a service whereby the registered manager and provider were continually learning which helped to adapt and improve the service. The registered manager and provider kept their professional knowledge up to date. They also told us they kept up to date with regulatory changes by accessing the Commissions website. However, they were not aware of the Accessible Information Standard (AIS). The AIS is to ensure services fully meet people's information and communication needs, in line with the Health and Social Care Act 2012, which came into effect from 01 November 2017.

People lived in a caring service, the ethos of which was reflected by the approaches taken by the registered manager and provider. Whilst this caring ethos had not been detailed within the provider's statement of

purpose or service user guide (the providers brochure and terms and conditions), it was at the heart of the service.

People and staff told us they felt the service was managed well. People and staff's views were now being obtained to help with the development of the service. The provider was responsive when things went wrong and used their learning to help improve the service. There was now a whistleblowing policy in place which encouraged staff to confidentially raise concerns about poor conduct and practice.

The provider and registered manager demonstrated an open and transparent approach throughout our inspection, for example showing us what they had identified themselves as already requiring improving. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

The Commission continued to be informed of significant events which had occurred in line with their legal obligations. For example, safeguarding alerts or deaths.

We recommend the provider takes account of the Accessible Information Standard (AIS) to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. We also recommend the provider uses the department of health guidance: prevention and control of infection in care homes to help carry out an infection control audit of the laundry area to ensure it meets required standards. In addition, we recommend the provider accesses the National Institute for Clinical Excellence (NICE) website to help find a more robust medicines audit tool. In addition, we recommend the provider researches and implements alternative health and social care auditing tools.

## 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** 

Aspects of the service were still not safe.

People's risks associated with their care were known by staff, but were not always documented to help ensure they received safe and consistent care.

Overall, people's medicines were managed safely. However, people who required medicines at particular times did not always have care plans in place for staff to follow, to help ensure they received these in line with prescribing guidelines.

People were protected from abuse.

People were supported by suitable numbers of staff to ensure their needs were met.

People lived in a clean and odour free environment.

The provider was responsive when things went wrong and used their learning to help improve the service.

### Is the service effective?

**Good** 

The service was now effective.

People's individual communication needs were known by staff, however this was not always recorded in people's care plans to help ensure a consistent approach to care.

People received care and support from staff who had undertaken relevant training to meet their needs.

People were supported with their nutrition, and had care plans in place to help guide staff to deliver the correct support.

People received a co-ordinated approach to their care. Health and social care needs were assessed on an ongoing basis, to help ensure their care and support needs were being met in line with best practice.

People had opportunities to live an active and healthy life.

People lived in a service which was adapted to meet their needs.

People's human rights were protected.

### Is the service caring?

Good ●

The service was now caring.

People and their families told us staff were kind and caring.

People's individual equality and diversity needs were known, and respected.

People were actively involved in making decisions about their own care and support.

People's privacy and dignity was respected.

### Is the service responsive?

Good ●

Aspects of the service were still not responsive.

People received responsive health and social care because staff knew how to meet people needs. People's care plans continued to be developed to ensure they were an accurate reflection of how their care needs should be met.

People's comments and complaints were respectfully listened to, and used to help improve the service.

People were supported respectfully at the end of their life.

### Is the service well-led?

Requires Improvement ●

Aspects of the service were still not well-led.

The registered manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service. However, these had not always been robust in identifying areas requiring improvement.

People and staff's views were obtained to help with the development of the service.

People lived in a service whereby the registered manager and provider were continually learning which helped to adapt and improve the service.

Partnership working with other providers was important to the

registered manager to help keep on top of ongoing developments and changes in the sector.

People lived in a caring service, the ethos of which was delivered from the registered manager and provider.

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# Appleby Lodge

## **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.

We visited the care home unannounced on 29 January 2018 and 08 February 2018. The inspection team consisted of one adult social care inspector and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted Healthwatch Cornwall and the local authority quality and service improvement team to ask if they had any feedback about the service. Where feedback was provided, it can be found through-out the inspection report.

During our inspection, we spoke and met with six people living at the service, four relatives, four members of care staff, the chef, the kitchen assistant, the housekeeper, the deputy manager, the registered manager and the provider. We also spoke with a visiting GP.

We observed care and support in shared areas. We spoke with people in private and looked at eight care plans and associated care documentation. We assessed the environment for safety and looked at training records and catering records. We also looked at medicine administration records, training records, policy and procedures and quality assurance checks.

# Is the service safe?

## Our findings

At our last inspection on 12 and 15 June 2017 we rated this key question as Inadequate because, people's medicines were not being safely managed and people's environment had also not been assessed to ensure they were protected from risks. In addition, people were not always protected from risks associated with their care. During this inspection we looked to see if improvements had been made. We found most action had been taken, but improvements were still ongoing and required more time to demonstrate they continued, and that they could be sustained.

Overall, people's medicines were now managed safely. Since our last inspection the provider had changed pharmacies. As a result of this, the registered manager felt they were now being given better support. People's medicine administration records (MARs) were an accurate reflection of when medicines had been given. Medicines were stored securely, and people were assisted in a respectful manner. Medicines which were required to be kept in the fridge were stored at the correct temperature, with accurate temperature records kept.

People prescribed medicines to be taken when required (PRN), such as paracetamol now had records in place to provide information to guide staff in their administration; such as what the medicines were for, symptoms to look for, the gap needed between doses or the maximum dose. This meant people would receive their medicines when they needed them. People prescribed topical medicines (creams and gels) had these managed safely. People now had records in place to provide guidance and direction to staff about where and when to apply them, and MARs now matched the creams or gels stored in their bedrooms. People's creams and gels were now dated upon opening to ensure expiry dates were being considered.

Overall, medicines requiring secure storage were handled safely, however records did not always accurately describe the medicine which was being stored, which meant there could be a risk of the person receiving the wrong one. However, records were amended at the time of or inspection.

People who required medicines at particular times did not always have care plans in place for staff to follow, to help ensure they received these in line with prescribing guidelines. For example, one person had a specific health condition that required their medicine to be given at particular intervals. Whilst the intervals were clearly detailed on the persons MARs, during our inspection, one dose was not administered because the person had left to go for a hospital appointment. However, there was no care plan in place to guide staff about how to ensure the person still got their medicine in such a situation. This meant without the medicine, the person may have suffered from unnecessary debilitating symptoms. Two other people required pain relief patch medicines to be applied to their body. However, whilst people had received these, there was no guidance in place about where the patches should be positioned. Responsive action was taken to speak with staff and to rectify documentation at the time of our inspection.

The medicine policy had been updated to reflect best practice in line with National Institute of Clinical Excellence (NICE) guidelines. The registered manager and provider had introduced an audit to help highlight where improvements were required. Whilst the use of this audit had had a positive impact in

driving improvement, it had failed to identify where some improvements were required, such as ensuring care plans were in place for time specific medicines.

Staff had received training, but the registered manager was still in the process of devising ongoing competency assessments which would be used to help monitor staffs ongoing skills and competence.

We recommend the provider accesses the National Institute for Clinical Excellence (NICE) website to help find a more robust medicines audit tool.

Overall, people now lived in an environment which was assessed to ensure it was safe. Fire checks were being carried out as required, staff had received fire training and people had up to date personal emergency evacuation plans (PEEPs) in place. PEEPs help to provide information to emergency service about how people should be supported in an emergency. However, cleaning products were found in one bathroom, the cleaning trolley was left unattended in a corridor and hot water in two bathrooms and in one person's bedroom was found to be very hot. Whilst the registered manager told us they did not feel there was a risk to people, they had not carried out a risk assessment to determine this. The registered manager told us they would take immediate action to carry out a formal assessment of risk, and that they would start checking water temperatures on a monthly basis.

People's accident and incidents were recorded which helped to provide a good overview of when a person had experienced unavoidable harm, so themes could be identified to help minimise it from occurring again. However, when a theme had been identified people's care records were not always updated. For example, it had been identified that one person had been falling because of having frequent urinary tract infection (UTIs). Whilst action had been taken to seek external advice to help mitigate ongoing risks, the person's nutritional and mobility risk assessments and care plans had not been updated to reflect the changes to the person's care. This meant the person may not receive consistent care because the information had not been recorded for staff to read. The registered manager told us they would immediate change the way in which this was recorded, to help prompt changes to people's records.

People told us they felt safe living at the service, commenting "I feel safe enough here. I feel the people have been trained to do what they do", and "I feel very safe and secure here".

People were protected from abuse because the provider's processes and procedures kept people safe. There was a safeguarding policy in place and the registered manager understood their responsibilities about raising alerts. All, staff had been trained and were confident about what action to take if they suspected someone was being abused mistreated or neglected. Following our last inspection, the provider had worked positively and in partnership with the local authority safeguarding team to ensure people were safe.

People were supported by suitable numbers of staff to ensure their needs were met. People's call bells were answered promptly, with two people telling us, "I have an alarm by my side, they're pretty good, I don't have to wait long" and "I have used the alarm and they came quickly". The provider had created a new staffing dependency tool which would help to assist with ensuring there were, enough staff to be able to meet people's needs safely, and in line with their individual needs.

People lived in a clean and odour free environment. Staff received infection control training and implemented their knowledge and training. For example, handling soiled washing in a suitable manner to reduce the spread of infection. Whilst, laundry was handled in the correct manner the laundry area was found to be cluttered with flooring which could not be washed easily.

We recommend the provider uses the department of health guidance: prevention and control of infection in care homes to help carry out an infection control audit of the laundry area to ensure it meets required standards.

The provider was responsive when things went wrong and used their learning to help improve the service. For example, a safeguarding alert which had been raised in respect of one person's medicines had resulted in a change of practice across the service.

# Is the service effective?

## Our findings

At our last inspection on 12 and 15 June 2017 we rated this key question as Requires Improvement because, people did not always receive care from staff who had undertaken training to help meet their individual needs, and people's human rights were not protected by legislative frameworks. In addition, people's care plans were not always reflective of how their nutritional needs should be met and the meals being provided were not always in line with people's preferences. During this inspection we looked to see if improvements had been made, and we found action had been taken.

People now received care from staff who had undertaken training to help meet their individual needs. The registered manager had ensured staff undertook training the provider had deemed as 'mandatory'. Some of which included, moving and handling and person centred care. Training specific to people's needs was also completed, such as Parkinson's and Dementia. There was a rolling programme for training within 2018, with one member of staff telling us "There is loads of training opportunities". The registered manager had devised a new training record so they could easily see what training staff had completed and what was outstanding. One to one supervision of staffs practice and appraisals of performance, were now being undertaken with staff telling us they felt "supported".

There had been no new staff who had joined the organisation since our last inspection, but the registered manager told us any new member of staff would undertake an induction, and when necessary it would incorporate the care certificate. The care certificate is a national induction, and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff had a good understanding of the legislative frameworks. One DoLS application had been made and was awaiting authorisation by the relevant authorities.

However, when someone did not have the mental capacity to make certain decisions, such as in respect of their care this was not always detailed within their care plan to enable the person to be supported effectively. For example, one person's care plan stated they were "sometimes confused", so they had a mat in place beside their bed that would alert staff if they got up during the night. However, their care plan did not provide any further information about how their confusion impacted on their other day to day decision making processes. The registered manager told us they would take action to update the care plan.

People's consent to care was now obtained and was documented in care plans and people were asked for their permission prior to being supported. When people had mats in their bedrooms to alert staff of their movements, the reasons for why these were in place had now been documented, and people had consented to having the restrictive monitoring equipment in place.

People's individual communication needs were known by staff and staff knew people well. However, the recording of this information was not always consistent in people's care plans. For example, one person's care plan detailed clearly how they communicated without speech that they were thirsty. But another person who was very deaf and reluctant to wear a hearing aid did not have recorded information in their care plan about how staff should support them. The registered manager told us they would take action to update the person's records.

Overall people were pleased with the food, commenting "The food is good. They would always get me something else if I wanted them to. They ask what I'd like on the same day". However, one person told us "The food is pretty good, sometimes better than others. I like most food but there's not always a choice". The registered manager told us there were always choices available and the chef told us there was flexibility and people could have what they wanted. The chef also explained they would cater for any special cultural or religious diets. People's like and dislikes were now recorded, and the menu had been re-created by taking account of people's preferences.

People were supported with their nutrition, and now had care plans in place to help guide staff to deliver the correct support. One person told us, "They keep an eye on what I'm eating to check it's enough". Any changes to people's nutrition was communicated by staff to the chef, so that catering records could be amended and meals could be adapted, for example if someone was losing weight.

People received a co-ordinated approach to their care. Health and social care needs were assessed on an ongoing basis, to help ensure their care and support needs were being met in line with best practice. One person told us, "If there was anything wrong they would call the doctor". There was a weekly GP visit to the service, to help ensure continuity and consistency with people's care. The GP who visited the service was complimentary of the care provided and explained they were not contacted unnecessarily, demonstrating staff were competent in their roles.

People lived in a service which was adapted to meet their needs. The entrance to the service had wheelchair access, and bathrooms and toilets had assisted equipment to help people with mobility difficulties. The provider had replaced the dining room chairs so they were easier for people and staff to move, whilst they were seated.

# Is the service caring?

## Our findings

At our last inspection on 12 and 15 June 2017 we rated this key question as Requires Improvement because people were not always treated with dignity and respect. During this inspection we looked to see if improvements had been made, and we found action had been taken.

People's privacy was now respected. The registered manager had introduced a 'butterfly scheme'. This meant, each person had been consulted about whether they wanted their bedroom door to be left open and/or whether they wanted any visitors to enter their bedroom for a chat. Each person's choice had been respected. Staff spoken fondly of the people they supported and used sensitive and appropriate language to describe people's care needs.

People's dignity was promoted. One person told us, "They are respectful of my dignity... everything is good". People's medical provisions and incontinence aids were now discreetly hidden. Staff described how they made sure people's dignity was respected when assisting someone with personal care by covering up their bodies when they could. With one member of staff telling us, "You do what you would want for yourself". People were also now being asked on a frequent basis if they felt staff provided care which was dignified, respectful and compassionate. To help increase staffs awareness and ongoing competency with regards to dignity, the registered manager had arranged for staff to attend dignity and support training in October 2018.

People and their families, told us staff were kind and caring. Commenting, "The staff are brilliant – everything is done like in my own home", "People look after me here. I'm happy", "My aunt is very happy here" and "Nothing is ever too much trouble. When we take my aunt out they will always help take her to the car".

People's birthdays were recognised with one person telling us, "When someone has a birthday here we have a special tea and birthday cake". People's families and friends were welcome at any time, with one relative commenting, "Very welcoming. There is always a tray of tea, it's more like hotel service really".

People told us they were now satisfied with the laundry service, commenting, "They have a good laundry service" and "Laundry is done here except for woollies, my sister takes them to wash".

People's individual equality and diversity needs were known, and respected. For example, people's cultural and spiritual needs were being met by religious events, and Holy Communion was held at the service on regular occasions.

People's care plans now demonstrated how people were being actively involved in making decisions about their own care and support. For example, records showed how one person had contributed to a meeting about the management of their medicines.

## Is the service responsive?

### Our findings

At our last inspection on 12 and 15 June 2017 we rated this key question as Requires Improvement because, people's care plans were not always reflective of how their care and support needs should be met, and people told us there was not always enough to do socially. During this inspection we looked to see if improvements had been made. We found most action had been taken, but improvements were still ongoing and required more time to demonstrate they continued, and that they could be sustained.

Overall, people now had care plans in place to help provide guidance and direction to staff about how to meet their needs. Staff told us they felt people's records were much more detailed now, and explained how the registered manager had worked hard to make improvements. However, whilst there had been an improvement to the detail contained within people's care plans, changes to people's medicines and mobility had not always prompted a review of related care plans. The provider had also not considered whether care plans were in a suitable format for people to read.

We recommend that the provider takes account of the Accessible Information Standard (AIS) to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Overall, people would be supported respectfully at the end of their life, because staff had received training in palliative care. The registered manager had a good relationship with the community nurses and the GP practice to help ensure, when necessary a co-ordinated approach was taken. However, whilst people's end of life resuscitation wishes were recorded and known, people's end of life care plans were not individualised to help ensure staff knew what people may specifically want. Such as, people who they may want to be present and music they may like played in their final days and hours. The registered manager told us they would take action to gather this information, and create individualised care plans for people.

Staff shared how people's needs were being met and if they had changed during a daily handover and a new handover sheet had been created to help ensure important information was shared consistently and effectively amongst the staff team.

The registered manager helped to reduce people's social isolation by consulting with people about what they wanted to do. On the first day of our inspection people enjoyed a game of bingo. People and relatives commented, "They've had flower arranging", "We go to a pub for lunch once a month and sometimes we have hymn singing here and I enjoy that"; and "A man comes into play the guitar once a month and they have church and hymns here each month. They also had a BodyShop party once. The carers take the residents to a pub once in a while for a meal".

People's comments and complaints were respectfully listened to, and used to help improve the service. People told us, "If I had a concern I would tell the person in charge" and "I know the manager, and would complain to her if I needed to". Since our last inspection there had been no new complaints. However, the registered manager had devised a new complaints log to record when a complaint was received, which



would assist in identifying themes which maybe emerging within the service. The provider's complaints policy was given to people when they moved into the service, and was displayed within the service. However, the policy may not have been in a suitable format for everyone to understand. The manager told us, they would take action to review this.

## Is the service well-led?

### Our findings

At our last inspection on 12 and 15 June 2017 we rated this key question as Inadequate because, the provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. In addition, the provider did not seek and act on feedback from external professionals in order to improve the service. During this inspection we looked to see if improvements had been made. We found action had been taken, but improvements were still ongoing and required more time to demonstrate that they continued, and could be sustained.

Following our last inspection, the Commission considered its enforcement policy, and took enforcement action, which was to impose a condition on the provider's registration. This meant on a monthly basis, the provider was requested to carry out an audit of people's care plans and risk assessments, the management of people's medicines, and equipment and environmental maintenance. Submit a summary of their findings to the Commission, and demonstrate what action was being taken to improve the service and to meet regulation. Since October 2017 the Commission had been receiving and reviewing the provider's monthly returns, which had demonstrated ongoing improvement at the service. However, whilst during this inspection we found improvements within the service, our findings relating to people's care plans, the environment and medicines management determined the information which had been provided had not always been fully accurate. This demonstrated the providers auditing systems had not always been robust in identifying where improvements were required and continued to require adapting.

We recommend the provider researches and implements alternative health and social care auditing tools.

The provider now had a more active and visible involvement within the service, with one person commenting, "The owner comes and mingles with us all. Very nice". The registered manager also confirmed the provider's presence by telling us they were "Always here, checking things". They expressed they felt supported, and received one to one supervision of their practice.

People lived in a service whereby the registered manager and provider were continually learning which helped to adapt and improve the service. Partnership working with other providers was important to the registered manager to help keep on top of ongoing developments and changes in the sector. For example, the registered manager was working with another provider to support them with changes to their governance systems, whereby external audits and checks would be carried out in the future.

The registered manager and provider kept their professional knowledge up to date by attending training courses with the staff team, and by liaising with the local authority quality improvement team. They also told us they kept up to date with regulatory changes by accessing the Commissions website. However, they were not aware of the Accessible Information Standard (AIS). The AIS is to ensure services fully meet people's information and communication needs, in line with the Health and Social Care Act 2012, which came into effect from 01 November 2017.

People lived in a caring service, the ethos of which was reflected by the approaches taken by the registered

manager and provider. Whilst this caring ethos had not been detailed within the provider's statement of purpose or service user guide (the providers brochure and terms and conditions), it was at the heart of the service. With people and families telling us, "They have been so kind, the owner and the manager are excellent" and "I have every faith in what they do here, it's a lovely home...if there is a 'home from home' this is it".

People and staff told us they felt the service was managed well, with one person commenting, "I think it is well organised and led". There was now a whistleblowing policy in place which encouraged staff to confidentially raise concerns about poor conduct and practice. All staff told us that unlike before, they now felt confident to raise concerns, and that they now knew action would be taken.

People and staff's views were now being obtained to help with the development of the service. Monthly and bi monthly questionnaires were being completed, on subjects such as meals, the environment, the care provision and staffing. As a result of one survey one person had received a new bedroom carpet and the menu had been altered.

The provider and registered manager demonstrated an open and transparent approach throughout our inspection, for example showing us what they had identified themselves as already requiring improving. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

The Commission continued to be informed of significant events which had occurred in line with their legal obligations. For example, safeguarding alerts or deaths.