

Parkcare Homes (No.2) Limited

Mather Fold House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out a comprehensive inspection of Mather Fold House on 08 and 09 January 2019. The first day was unannounced.

Mather Fold House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to six people. At the time of the visit there were four people who lived at the home.

The registered manager had left the service following our last inspection and a new manager had been appointed and was applying to register with the CQC. 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 the last inspection on 08 and 09 July 2018, we found five breaches of the regulations. This was because there were shortfalls to the safe management of people's medicines, people were not protected against the risk of abuse and improper treatment including the appropriate use of physical restraint. In addition, risks associated with receiving care including, prevention of infections had not been adequately managed and staff had not been adequately supported with supervision and ongoing training. People were not treated with dignity by care staff. The governance and quality assurance systems were not effective in identifying shortfalls to generate improvements to the quality of the service. These were breaches of regulation 10,12,13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection of 08 and 09 July 2018, we met with the provider to discuss what actions they intended to take to improve the quality of the care and address the shortfalls. We asked them to take immediate action to address the shortfalls and regularly submit evidence of their actions to CQC. The provider was also asked by the local authority's contracts monitoring team to complete an action plan under their quality performance and improvement planning process. We have met regularly to monitor their progress.

During this inspection, we reviewed actions the provider told us they had taken to address the breaches in regulations identified at the previous inspection on 08 and 09 July 2018. We also looked to see if improvements had been made in respect of the breaches. We saw that significant work had taken place to improve the safety, effectiveness and quality of care provided. However, we found ongoing shortfalls in relation to the safe management of medicines which meant the service was still in breach of Regulation 12 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The work to improve the service was still in its early stages. There were areas where further improvements

were required to ensure a consistent delivery of safe care and treatment that could be evidenced in the longer term.

People were not adequately supported to ensure they received their medicines safely and as prescribed. We found there had been a number of preventable medicine administration errors and there had been a lack of robust action when people routinely refused their essential medicines. While some people's GPs had been informed and engaged, this was not always consistent. The refusal of medicines was noted to have had an impact on one person living at the home. The management at the home took immediate action to resolve the matter and involved the relevant professionals.

People who lived at the home were not able to share their views with us due to their complex needs. We received mixed feedback from visiting relatives. Some relatives told us that they felt there had been notable improvements in the safety of their family members and that there was sufficient staff available to help people when they needed this. While other relatives felt improvements had been made, they did not think it would be sustained.

Improvements had been made to the management of risks to people receiving care. This included risks associated with abuse and improper treatment, disproportionate use of physical restraint, undignified treatment from care staff and the spread of infections. Staff had received training in the management of behaviours that could challenge and treating people with dignity. The systems for reviewing risk levels and ensuring lessons learnt were shared in the service had also improved. Reflections had been held following incidents to identify what went well and what could be done better in the future.

Management and governance systems in the home had improved. We acknowledged that this was at an early stage. Further improvements were required to ensure that changes made could be fully established and embedded within the staff team and the governance systems in the home. There was a new manager who had been employed since July 2018. We noted an improvement in the systems designed to assess, monitor and improve the service. There was an increased oversight on the service from the provider's representatives and senior leadership.

A significant number of audits and quality assurance processes were in place; they were supported by an action plan. However, action plans had not been signed off to show action had been taken and timescales had not been set to show when actions on any identified shortfalls were expected to be completed. Medicines management was also not robust and needed further improvements. The shortfalls we found indicated the quality assurance and auditing processes needed further improvements. There was a continuing breach of regulation in relation to medicines.

Records showed that staff had been recruited safely and the staff we spoke with understood how to protect people from abuse or the risk of abuse.

There had been improvements to staff training arrangements. Staff had received induction and appropriate training. However, induction records had not always been signed off to show that inductions had been completed.

We observed people being supported in a sensitive and caring manner. Staff and the manager had awareness of people's privacy and dignity. We noted improved outcomes for some individuals in the home, however we also saw further improvements were required to improve other people's outcomes through stimulation and offering a variety of activities to keep them engaged.

Referrals were made to community healthcare professionals where required to ensure that people received

appropriate support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way. The service had taken appropriate action in line with the Mental Capacity Act 2005.

People received care that reflected their individual needs and preferences. Staff told us they knew people well, respected and followed their preferred routines. There had been improvements in involving people, their relatives and professionals in the review of their care. There were improvements in the way care records were maintained and how staff recorded people's outcomes in care records.

People were supported to take part in activities and events. Improvements were required to ensure activities were varied in line with people's needs. There was a policy on how people could raise complaints about care and treatment. This had been followed when complaints were raised.

There had been improvements in the way staff communicated with people. They supported people sensitively and spoke to them appropriately when providing care. The manager had engaged with other health and social care stakeholders such as the local authority, clinical commissioning groups and local health care professionals to improve the quality of care provided to people.

There was a business contingency plan to demonstrate how the provider had planned for unplanned eventualities which may have an impact on the delivery of regulated activities. The equipment and premises had been maintained and improvements had been made to the premises.

The provider had sent notifications to the Care Quality Commission for notifiable incidents, such as allegations and incidents of abuse and significant events that affected the smooth delivery of services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe.

People were not consistently supported to receive their medicines safely and as prescribed.

Accident and incident monitoring had improved, and lessons were learnt and shared with staff on prevention of future incidents.

There had been improvements to the management of risks associated with abuse and improper treatment of people.

Relatives told us they felt their family members were safe in the home and were protected against the risk of abuse.

Safe recruitment practices had been followed. There were sufficient staff available to meet people's needs.

Is the service effective?

Requires Improvement 

The service was not consistently effective.

Improvements were required to ensure induction records were signed off when staff completed their induction. There were significant improvements to staff training. Staff received an appropriate induction and supervisions.

People's capacity to make decisions about their care had been assessed and consent had been considered.

People were supported appropriately with their healthcare and nutritional needs. They were referred appropriately to community healthcare professionals.

Is the service caring?

Requires Improvement 

The service was not consistently caring.

We received mixed feedback from two relatives regarding the care provided and consistence. Improvements were required to how important information was shared with relatives.

Further work was required to enhance people's outcomes and well being.

There had been improvements in the caring ethos and values in the home. Staff knew people well and good relationships had developed between people and the staff.

People were encouraged to maintain relationships with family and friends.

Is the service responsive?

Good ●

The service was responsive.

There had been improvements in treating people in a person-centred way. People and their relatives had been involved in the reviewing of their care plans. Care records had been reviewed and written in a respectful manner.

People were supported to take part in suitable activities inside and outside the home.

Relatives knew who to speak to if they had any concerns or complaints and were confident they would be listened to.

People's relatives were given the opportunity to discuss their end of life needs.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There had been improvements to the governance systems in the home. However, there were shortfalls we identified.

The manager regularly audited and reviewed many aspects of the service. There had been improvement in the oversight provided to the manager. However, audits had not been signed off and timescales had not been set for actions to be completed.

Relatives gave mixed feedback about the management. Staff felt engaged and able to raise any concerns with the manager.

While improvements had been made, it was recognised by the management, staff and relatives that there is still further work that need to be done to raise the quality of care provided and to ensure the standards are embedded in the staff practices.

Mather Fold House

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a comprehensive inspection.

The inspection took place on 08 and 09 January 2019. The first day was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection, we reviewed the information we held about the service, including previous inspection reports, action plans submitted by the manager, safeguarding concerns and notifications we had received from the service. A notification is information about important events which the service is required to send us by law. We contacted healthcare and social care professionals who were involved with the service for their comments. We also contacted Lancashire county council contracts team and safeguarding team for feedback about the service. We completed an inspection plan to guide our inspection visit.

Due to technical problems, the provider was not able to complete a 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 took this into account when we inspected the service and made the judgements in this report

During the inspection, we spoke with three relatives of people who lived at the home. We were unable to speak to people at the home due to their complex needs however we observed their interactions with care staff. We also spoke with three care staff face to face and four care staff via telephone interviews. In addition, we spoke to the manager, two directors and a quality improvement lead. We looked in detail at the care records of three people who lived at the service. We carried out an observation of the environment. In addition, we looked at service records including staff recruitment, supervision and training records, policies and procedures, complaints and compliments records, audits of quality and safety, fire safety and environmental health records.

Is the service safe?

Our findings

At the last comprehensive inspection on 08 and 09 July 2018, we found that people's risks had not always been managed appropriately. Risks associated with abuse and improper treatment of people and the inappropriate use of restraint had not been adequately managed. We found shortfalls in medicines management and infection control practices. These were multiple breaches of Regulation 12 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the action plans sent to us following the inspection of the service in July 2018. We reviewed compliance against regulations 12 and 13 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. Necessary improvements had been made in respect of protecting people from abuse and improper treatment, accident and incident management, infection prevention, and the management of risks to receiving care. The service was compliant with regulation 13 in relation to use of physical restraint.

Improvements had also been made in respect of treating people with dignity. Staff who had acted unprofessionally had been dealt with through the provider's disciplinary procedures and had left the service. Systems for monitoring incidents reports and sharing lessons learnt had also improved. Risks relating to people were shared in records and reviewed. Although some improvement had been made in respect of the management of risks we found there were continuing concerns that the service had not met the required standards in relation to the safe management of people's medicines and was in continued breach of Regulation 12.

At our last inspection we found shortfalls in relation to how people's medicines were managed. This was because the medicines were not stored at the correct temperatures. Medicines errors had occurred, and staff had not received the necessary checks to ensure they were competent to administer medicines.

During this inspection we found some improvements had been made in relation to the monitoring of temperatures for medicines storage and the home had reviewed their medicines practices. An air conditioning unit had been purchased to ensure medicines were stored at the right temperature. Staff had received medicines training and had been competence checked following this. This helped to ensure that the effectiveness of medicines was not compromised. However, before this inspection we had received safeguarding outcomes from the local authority and notifications from the home which showed there had been medicines errors. These errors had resulted in a person not receiving their medicines as prescribed and missing their doses.

We reviewed medicines administration records for one person and found there were numerous instances where they had refused their medicines. While staff had contact the GP on one of the occasions and they had documented the refusal, there was no evidence to demonstrate that the consistent refusals had been reported to the person's GP to ensure these refusals could be reviewed. Our conversation with staff and review of the records showed that there had been a deterioration of the person's behaviour during the period when they were refusing their medicines. This indicated that the lack of consistency had impacted on

the person's welfare. While the person was known to refuse medicines, we would expect the home to proactively consult with the person's GP to ensure a medicines review could be undertaken and consider alternatives. We discussed this with the manager and the directors at the home/service who contacted the GP during the inspection and also informed us they were seeking input from other professionals including specialist nurses for the person.

Records we reviewed also showed a person had experienced a possible allergic reaction which was suspected to be as a result of a specific medicine. However, this incident and the possible risk had not been recorded in the person's medicines records, or medicines risk assessment to alert other staff and ensure these were not prescribed in future. We asked the manager to take action during the inspection and they took action immediately.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made to the management of risks to people's individual safety and well-being. At our last inspection we found individual risk assessments were not properly recorded and regularly reviewed. One person did not have written protocols on how to manage their behaviours to maintain their safety and that of staff. Incidents that had occurred in the home had not been reviewed or analysed to assess what could be done better to reduce the risks to people and risks of re-occurrences. Staff had not always used personal protective equipment to protect them from injuries. At this inspection we noted improvements had been made. In majority of the cases individual risks had been identified and reviewed regularly. The risk assessments included; choking, falls, and behaviours that can cause harm to the person or care staff. Strategies had been drawn up to guide staff on how to monitor and respond to identified risks and any signs of deterioration in people's behaviour. Guidance had been sought from specialist professionals such as speech and language therapists and occupational therapists. Care staff were observed to be following the guidance and wore protective clothing.

We received mixed feedback from relatives. Comments included, "Everything seems fine now. Staff are much better at dealing with the lads [people who used the service] when they become aggressive." However, two relatives raised concerns regarding their family members not receiving medicines as prescribed and the cleanliness of the premises and their family member's bedrooms. They also stated that they did not always feel safe when they visited. We shared their view with the manager who confirmed they would meet with the relatives and discuss their concerns.

There had been improvements to the practices for protecting people from abuse, neglect and discrimination. At our last inspection, we found arrangements for protecting people against abuse and improper treatment were not robust. People had been treated in an undignified manner and physical restraint been used inappropriately by some of the care staff. Following the inspection, the provider took action and followed their disciplinary processes. We also noted there had been a reduction in the number of incidents in the home and the use of physical restraint. One staff member told us, "Staff consistency has improved, and this has helped reduced incidents of staff being assaulted."

There was a safeguarding policy which was shared with staff and information on reporting abuse was displayed prominently across the home/service. Staff we spoke with understood the procedures to safeguard adults at risk. Training records showed that staff had completed safeguarding training. Safeguarding concerns had been reported to the local safeguarding authority. Recommendations by safeguarding professionals had been taken on board to improve people's safety. There was a whistleblowing (reporting poor practice) policy which the staff we spoke with were aware of. Conversations

with staff showed they were confident to use the procedure, for example about the conduct of another member of staff.

Relatives told us there were enough staff to meet their needs. On the day of the inspection we observed there were adequate numbers of staff to meet people's needs. We reviewed the staffing rotas for two weeks before the inspection, including the week of our inspection. We found that the staffing levels set by the service had been met on all occasions. Agency staff were used where appropriate to provide cover for any absences. A significant number of staff had been recruited and there had been a reduction in the use of agency staff. This helped to improve consistency and ensure people were cared for by staff who were familiar to them.

Safe staff recruitment procedures had been followed to protect people who used the service. We looked at the recruitment records for three members of staff and found the necessary checks had been completed before they began working at the service. This included an enhanced Disclosure and Barring Service (DBS) check, which is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. A full employment history, proof of identification and two references had been obtained. These checks helped to ensure that staff employed were suitable to provide care and support to people living at the home.

We noted that improvements had been made to ensure people living at the home were protected from the risks associated with the spread of infections. There was an infection control policy and staff had been trained in infection prevention measures and food hygiene. In addition, there was a regular infection control audit as well as environmental audit. Staff had been provided with protective personal equipment such as gloves and aprons. The premises looked clean however, two relatives we spoke with felt that the home was not consistently clean. We spoke to the manager regarding this and they informed us they would increase their monitoring processes.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. Records showed that equipment at the home was inspected regularly to ensure it was safe for people to use, including portable appliances. Checks on the safety of the home environment had been completed, including gas and electrical safety. Hot water temperatures had been checked regularly to reduce risks of scalding. Legionella checks had also been completed and there was an up to date legionella inspection certificate. Legionella bacteria can cause legionnaires disease, a severe form of pneumonia. This helped to ensure that people were living in a safe environment.

Each person had a personal, emergency evacuation plan (PEEP). This included the number of staff they would need support from, any equipment required and the evacuation procedure. Fire safety checks had been undertaken and there was a business continuity plan in place, which provided guidance for staff in the event that the service experienced a loss of amenities including gas, electricity, water, heating or telecommunications. This helped to ensure that people continued to receive support if the service experienced difficulties.

Is the service effective?

Our findings

At the last comprehensive inspection in July 2018, we found there were shortfalls in the provisions in staff training and development. The provider had not ensured that staff providing care to people had the qualifications, competence, skills and experience to do so safely. Staff had not been provided with robust induction and supervisions. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found improvements had been made to ensure all staff had received the training that the provider had deemed necessary for the role. Training records showed that a significant number of staff had updated their training. This included training related to supporting people living with autism and learning disabilities, managing behaviours that can challenge, equality and diversity, the use of physical restraint, dignity and respect, medicines and safeguarding vulnerable adults.

Training records were monitored regularly to check that all staff had attended training arranged for them. All staff spoken with confirmed they had attended training. There was evidence to show that the manager and the provider had reviewed and improved their processes in relation to supporting staff to gain adequate skills and knowledge.

Staff we spoke with confirmed that they had received supervision. Staff had been provided with induction at the start of their employment. However, improvements were required to ensure induction records were signed when completed. This would demonstrate that induction had been completed and that it has been overseen by the manager to ensure staff had gained the required knowledge to undertake their role safely.

Comments regarding staff knowledge and skill was positive. However, the general consensus from all relatives we spoke with was that while improvements were being made, they felt there were still inconsistencies in the home and that improvements had not yet been sustained.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In people's own homes, and in the community, this is usually through MCA application procedures called the Deprivation of liberties Safeguards (DoLS).

DoLS authorisation requests had been submitted to the local authorities as all people's care involved restrictive practices such as handling belts, one to one supervision and all people were not free to leave the home independently. Handling belts are designed to allow transfers without the care staff or health professional having to hold the person's clothing or body. They can be used to support people who are at

risk of running into the road when walking in the community. The use of the belts requires authorisation from the Court of Protection and the service had obtained the necessary authorisation. All the staff we spoke with were aware of the importance of involving people and their relatives in decision making and offering choices.

Mental capacity assessments and some consent records had been completed to support people in their decisions making processes. We discussed the need to ensure that best interest records were fully completed to include the views of other people consulted in the decisions where people lack capacity to make specific decisions.

We noted that the service provided a variety of information when people were transferred to hospital. People's care records contained a hospital passport. This is a record which contained details about a person's needs including any allergies, communication needs and how they need to be supported. This would assist in ensuring that people would receive effective care and treatment and that relevant information would be shared when they moved between different services.

There was documentation that confirmed pre-admission assessments had been completed. Support plans had been updated to include behavioural support plans for each person. Staff had signed to show they had read the records.

People's needs, and choices were assessed to ensure that care, treatment and support was delivered in line with current legislation and best practice. The care service was aware of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. At our last inspection we found the service had not always lived by these values and expectations. However, we noted some improvements had been made to this and people's outcomes had started to improve. Further improvements were required to fully embed the ethos and enhance people's experiences and outcomes.

People had been referred to and seen by a variety of healthcare professionals, including GPs, community nurses, speech and language therapists, podiatrists and opticians. Care staff had sought medical advice where required or where they had suspected a deterioration in people's health needs.

Improvements had been made to procedures for protecting people against discrimination, including in relation to people's protected characteristics such as race, disability, religion, gender or age. Staff had received training in equality and diversity and there was a policy to protect people against discrimination and harassment. Information on how to report concerns was readily available in prominent places within the home.

Care files were clear in their guidance to support the staff to meet the individual nutritional needs of people. Staff had identified people who required support with their nutritional needs. Nutritional risk assessments had been completed which identified what support people required. Where specialist nutritional support had been identified for example; where there was a risk of choking, care plans and risk assessments had been developed with support from specialist professionals such as speech and language therapists.

At our last inspection we found shortfalls in relation to the maintenance of the property. At this inspection we found improvements had been made and some repairs and renovations had been made ongoing work was underway to improve the premises. Furniture, decorations and perimeter fences were secured to ensure people's safety and privacy.

Is the service caring?

Our findings

At the last comprehensive inspection in July 2018, there were shortfalls in the provisions in staff training and development. We found people using the service were not treated with respect and dignity at all times while they received care and treatment. Care records were not always written in a compassionate or respectful manner and people's routines and preferences were not followed. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found improvements had been made. All staff who had been suspected of unprofessional behaviour including treating people in an undignified manner had been dismissed from the home and some of the incidents had been reported to the police. The remaining care staff had received refresher training which highlighted the importance of treating people with dignity and respect.

Feedback from relatives was mixed however, there were no concerns about the caring nature of the staff. Comments included, "[Name] loves the staff to bits, they [staff] have made a fantastic relationship with him" and "Support staff are lovely. Very kind with my [relative]."

The majority of the relatives were positive about the care provided and improvements made. They said, "There has been improvements however the management of our [relative's] clothing is poor, his clothes are not ironed well and this has an impact on his wellbeing because he is particular about looking smart." Another relative informed us that they did not feel the home was meeting their relatives' needs adequately due to a number of incidents and errors in the care provision of their family member. We spoke to the manager who informed us that they were resolving these concerns by introducing a keyworker policy and key worker meetings. Each person in the home would be allocated a named worker. They confirmed they were dealing with the concerns and undertaking investigations. They also informed us they will address the specific concerns with the relatives.

Staff we spoke with knew people, in terms of their needs, risks and their preferences. They knew majority of people's routines and how people liked to be supported, such as what they liked to eat and drink and how they liked to spend their time. One staff told us, "Everything is ok, its good here now actually."

We observed compassionate and respectful interactions between staff and people throughout the inspection. It was clear that care staff had made an effort to understand people's needs as well as developing positive relationships with them.

People's relatives informed us that they had been involved in decisions about the care of their relatives and we also saw evidence of their involvement in person centred care reviews. However, improvements were required as one relative told us they had not been informed of an important hospital appointment which they wanted to be part of.

We observed staff supporting people sensitively and patiently and repeating information when necessary, to ensure that people understood them. They had improved on the use of picture exchange communication

system (PECS). The picture exchange communication system, or PECS, allows people with limited or no communication abilities to communicate using pictures. People using PECS were taught to approach another person and give them a picture of a desired item in exchange for that item. This helped to ensure that communication was effective, and that staff were able to meet people's needs.

People were supported to be as independent as possible. For example, with eating and walking around the home.

Staff we observed and those we spoke with respected people's privacy and dignity. We observed staff knocking on doors before entering bedrooms, actively listening and engaging with people using appropriate touch and explained what was going on and what they were doing in easy to understand language and at a level to ensure eye contact.

People's right to confidentiality was protected. There was a confidentiality policy in place which documented staff responsibilities, and the importance of confidentiality was included in the staff induction. Care records were kept in a secure and only accessible to care staff.

People were supported to maintain important relationships. Some relatives visited during our inspection and we saw that they were made welcome by staff. This meant that people could stay in touch with people who were important to them.

Information about local advocacy services was available at the home and was included in the service user guide. We also saw one person was being supported by an advocate. People can use advocacy services when they do not have friends or relatives to support them or want support and advice from someone other than staff, friends or family members.

Is the service responsive?

Our findings

At the last comprehensive inspection in July 2018, we found the records relating to care and treatment of people were not fit for purpose. They did not reflect people's care needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection in January 2019, we found improvements had been made to how people's care needs were recorded and the state of the records. We noted that there were daily checks to ensure records were completed accurately and respectfully. The support plans had also been audited to ensure information contained in them was correct.

Relatives told us they had noticed improvements being made to ensure people received care that reflected their individual needs and preferences. They also confirmed they had been invited to review the care plans of their family members. Relatives commented, "We are involved in our [relative's] support plan review and communication is good now." However, another relative told us, "Communication improves for a short time and then goes back to being poor. I have asked for staff to record social activities, so I can see what is happening on a daily basis and this is never consistent." We shared these views with the manager and they informed us they will address these concerns with the relatives involved.

Improvements had been made to ensure people's care files were written in a person-centred manner and that they reflected people's needs. Some of the care records had been re-written since our last inspection. The records were comprehensive including people's backgrounds and their physical, social and behavioural needs. Guidance had been provided to staff on how to support people when their behaviour puts them, and others at risk. Some staff had signed to show they had read the care records. However, improvements were required to ensure all staff were familiar with the contents of the care records to ensure they could all support people in a consistent manner.

People were supported with meaningful day time activities of their choice. During the inspection we observed people taking part in different individual activities with care staff. However, we noted people were not supported to choose from a variety of activities. In particular we discussed the need to ensure two people living at the home were adequately supported to ensure they have a variety of activities that are suited to their needs and which are meaningful to them and can offer stimulation. This would enhance their mental well-being and self-esteem. The manager told us they were in the process of updating the activity plans.

The provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We found, people's communication needs had been assessed and documented. A significant number of the care records were supported by pictures to make it easy for people to understand.

The provider had considered the use of technology in the service. People had access to broadband and a telephone system. There were Wi-Fi facilities for people and staff to use should they need to access the internet.

The manager had started conversations with relatives to consider how they could support people to plan for the end of their life. The completion of end of life care plans would assist in ensuring that people received support to ensure a pain free and dignified death. We noted that care staff had not been provided with training around end of life care however the manager said they would be reviewing this to ensure staff were trained in this area.

We looked at how the service managed complaints. There was a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission and external organisations. We noted there was a complaints procedure displayed in the home and included in the service user guide pack. We saw one complaint had been received since the last inspection. The complaint had been dealt with in line with regulations and measures had been put in place to address the complaints satisfactorily.

Is the service well-led?

Our findings

At the last inspection of July 2018, we found the provider had failed to operate effective systems to monitor and improve the quality and safety of the service. There was a lack of robust governance and oversight regarding the care that people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found improvements had been made to the governance and quality monitoring systems. A new manager had been appointed and senior management had been significantly involved in the monitoring of the service to ensure improvements were made. The provider had carried out audits which were being overseen by the manager. The provider's regional directors and quality improvement personnel visited the home regularly to check the quality of the service. In addition, the provider had carried out their own internal inspections to assess the safety of the care and made recommendations to the manager. While we saw evidence to show that the management team and staff had worked hard to improve the quality of the care provided, there were also some shortfalls which needed further improvements. This meant that the provider's quality assurance systems needed further improvements to ensure they could monitor areas where the quality standards were not being met.

We received mixed feedback from relatives regarding the management of the service. Relatives told us they had noticed improvements since the new manager had been appointed. However, some were doubtful about the sustainability of the changes and did not have confidence with the home and the provider. Comments from relatives included; "[Name removed] the manager is moving things in the right direction", "I can see improvements, but I am still concerned that they will not be sustained", "I can see some small improvements now [name removed] is managing, but I am sick of speaking to them and nothing changes" and "[Name] the new manager and his deputy are much better, I can see an improvement in the overall management."

At our last inspection we found the previous registered manager had not always reviewed care records, monitor the care provided and ensure staff attended training and development as required. During this inspection, we found the manager was undertaking daily walks around the home to observe care delivery and the environment. They also had monthly governance meetings with care staff to discuss people's care and reflect on their practice. This had helped to identify shortfalls and challenges at an early stage and enabled the manager and staff to learn what had gone well and where they needed to improve. One staff member said, "We have a monthly review with the deputy and discuss any concerns and our performance, this has improved the communication for everyone."

There was a governance framework in place to ensure that quality monitoring was reviewed, and regulatory requirements were managed correctly. The provider had introduced various audits to monitor the quality of the care provided. These included audits of the medicines systems, health and safety, infection control and care plan audits. We saw action plans were drawn up to address any shortfalls. However, action plans were not signed off to show the required actions had been completed. They had also not included timescales to show when the required actions should be completed. We also found shortfalls in medicines management

which meant the quality monitoring systems were not robust and needed further improvements. We discussed this with the manager and the directors. They informed us that they will be reviewing their audit processes and will be working with clinical directors in their service to improve medicines management practices.

There was no registered manager in post. The registered manager had left after our last inspection. A new manager had been appointed and was in the process of applying to register with Care Quality Commission.

The manager had responsibility for the day to day operation of the home and was visible and active within the service. They were regularly seen around the home and were observed to interact warmly and professionally with people and staff. All staff we spoke with were positive about the manager and told us they enjoyed working at the home. They all told us they felt supported by the manager. Comments included, "I feel the new manager is very effective and listens", "I can see changes and I think they are a good manager. I think they can pull this care home back to what it used to be" and "The manager listens to us, that has made a huge difference."

We could see that the manager had worked hard to make improvements since their appointment. They acknowledged that further improvements were required to the governance systems and the overall quality assurance processes in the home.

Relatives shared their views and opinions about the service by talking with management and staff and by attending person centred care planning meetings. We could see how people's feedback was responded to. Improvements were required to the communication between people relatives and the management in the home. We spoke to the manager and they informed us they will be meeting relatives. Staff told us staff meetings took place regularly and they could raise concerns and make suggestions. This was confirmed in the records of governance meetings we reviewed.

The service worked with other agencies such as GPs, speech and language therapists, occupational therapists and other health and social care professionals. This helped to ensure that people had support from appropriate services and their needs were met.

The manager had submitted statutory notifications to Care Quality Commission about people using the service, in line with the current regulations. A statutory notification is information about important events which the service is required to send us by law. We noted that the provider was meeting the requirement to display their rating from the last inspection.

The provider and management at the home had actively engaged in dialogue with stakeholders such as the local authority and other health care professionals. They took part in a quality improvement programme led by the local authority and cooperated with the improvement plans and targets set up for them. There was an ongoing action plan to address shortfalls. We observed that the quality of the care provided had improved and outcomes for some people who were at risk of receiving poor care had also improved. There is an acknowledgement that this is still 'work in progress' but there is a commitment to continue making changes at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12(g)