Nightingale Group Limited

Guardian Care Centre

Inspection report

Longton Road
Trentham
Stoke On Trent
Staffordshire
ST4 8FF

Tel: 01782644800
Website: www.guardiancare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 14 and 15 November 2016. At our previous inspection we found the provider was in breach of six Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive or well led. We had issued the provider with two warning notices and asked them to improve. At this inspection we found that although some improvements had been made further improvements were required. You can see what action we have asked the provider to take at the end of the report.

The service is registered to provide accommodation and personal care for up to 143 people. People who use the service have complex physical health and/or mental health needs, such as dementia, acquired brain injury and behaviours that challenge. At the time of our inspection 125 people were using the service.

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

Risks of harm to some people were not being minimised as safe infection control procedures were not being followed in relation to their specific conditions and some staff did not know how to keep these people safe. Medicines were not managed safely and put people at risk of not having their prescribed medicines at the times they required them.

The principles of the MCA 2005 were not being consistently followed as some people were not consenting to or being supported to consent to their care. People did not always have their choices and individual preferences met and there were limited opportunities for people to participate in hobbies and interests of their choice.

Systems the provider had in place to monitor and improve the service had not been fully effective in ensuring improvements in people's quality of care were made.

There were sufficient suitably trained staff to meet the needs of most people who used the service in a timely manner, however some specialist training was required to meet all people's needs safely. New staff were employed following safe recruitment procedures and agency staff were checked for their suitability to work with people who used the service.

People were safeguarded from the risk of harm and abuse as staff and the management knew what to do if they suspected someone had been abused. The local safeguarding procedures were being followed.

Staff who cared for people felt supported and received regular supervision and on going training. People felt the staff were competent and effective in their roles.

People received health-care support from other professionals when their needs changed or they became unwell. People were supported to maintain a healthy diet and support was sought if people experienced difficulty in eating and drinking.

People told us and we saw that staff treated them with dignity and respect. People's right to privacy was upheld and they were encouraged to have a say in how the service was run. People and their relatives were involved in their care planning and kept informed of any changes.

The provider had a complaints procedure and people and their relatives felt their complaints were taken seriously and acted upon. Changes to the management structure had created opportunities for staff to develop and had played a part in the improvements made since our last inspection.

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's medicines were not managed safely.

Care for people with tracheostomies was not always safe. Infection control procedures were not always followed.

There were sufficient suitably trained staff to safely meet the needs of people. Staff had been employed through safe recruitment procedures.

People were safeguarded from harm and the risk of abuse as staff and managers were following safeguarding procedures and reporting incidents of suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always consenting to or being supported to consent to their care and treatment.

Staff were receiving support and training to fulfil their role however, further training was required to ensure staff were effective in all aspects of their roles.

People were supported to maintain a healthy diet.

People's health care needs were met when their needs changed or they became unwell.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

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

People's right to their privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual needs and preferences were not always met.

People were not always offered activities to meet their emotional and social needs.

There was a complaints procedure and people were confident that their complaints would be dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems the provider had in place to monitor and improve the quality of the service were not always effective.

The quality of care had improved since our last inspection.

People, their relatives and staff felt the management team were open and approachable.

Guardian Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 November 2016 and was unannounced.

Our inspection team consisted of four inspectors, a pharmacy inspector, two specialist advisors in tracheostomy care and mental health and two expert by experiences. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the action plan the provider had sent us following our last inspection. We looked at notifications the registered manager had sent us of significant incidents. Statutory notifications include information about important events which the provider is required to send us by law. We had discussions with the local authority to gain their views on the quality of service.

We spoke with 26 people who used the service and 16 of their relatives. We spoke with 16 care staff, 6 nurses, and a domestic staff member and training manager. We spoke with the nominated individual, registered manager and a consultant the provider had recently employed. We spoke with two visiting health professionals. Some people were unable to talk to us due to their communication needs so we observed their care. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at 17 people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, staff rotas, recruitment records and training records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment being provided was not always safe. At this inspection we found that although some improvements had been made there were further requirements required.

Previously we had found that people's medicines were not always being managed safely. At this inspection we found that medicine was stored safely in locked trolleys, in a locked temperature monitored room. Medicines that needed cold storage were kept in a fridge and daily records showing temperature monitoring were completed. However, records on one unit showed that the fridge temperature was out of the recommended range and staff told us they had not done anything about it or reported it to an appropriate person to act upon. This could mean that people's medicines were not safe for use as they were not be stored at the correct temperature.

We looked at the records for people who were using medicinal skin patches. Some records showed where the patches were being applied to the body. However, the patches were not being applied and removed in line with the manufacturer's guidance, which could result in unnecessary side effects. We found that tablets and capsules, that were no longer needed, were disposed of appropriately. However, there was no arrangement in place for the disposal of liquid medicines. Staff we spoke with described how they would dispose of liquid by pouring it down the sink and this was not in line with current waste regulations.

Staff did not always have enough information to administer medicines safely. For example, we spoke with two nurses about how to administer a specific medicine to a person who required thickened fluids. We were given two different responses that were not supported by any written information. For another person, we saw a nurse being told by another member of staff that the person needed to have a tablet used for the control of epilepsy cut in half before being administered. This was not recorded anywhere and the information leaflet of the medicine clearly state that the tablet should not be cut. Cutting the tablet would affect its effectiveness and meant that the person was at risk of experiencing an epileptic seizure.

We found that where people needed to have their medicines administered through a tube in the stomach or nose, the necessary safeguards not were in place to administer these medicines safely. There was no recorded evidence of advice from the prescriber or the pharmacist and there were no written protocols in place to inform staff on how to prepare and administer each medicine. Therefore, there was serious risk that people's health and welfare could be affected.

The care staff applied prescribed creams to people's skin. There was information available for staff on where and how often some of the creams should be applied. However, records of administration showed that people were not always getting their cream as prescribed. A person's skin may become dry and sore if creams are not applied as the doctor intended.

On one unit, we asked for an error log of medicines incidents and we were shown one significant event

involving medicines. There was no recent evidence of reporting, shared learning or meaningful action plans in response to near misses or less significant errors to help prevent similar errors occurring again.

We looked at the way people who had tracheostomies were being cared for. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. We found that not all staff knew how to care for people with a tracheostomy safely. One person had a tracheostomy that would require a certain procedure to be undertaken in the event of the tracheostomy becoming blocked. The unit manager and staff caring for this person were not aware of this procedure and told us they would ring for paramedics if the tracheostomy became blocked. This would result in a delay for emergency treatment as the person would have to be taken to hospital before any action would be taken. This put this person at high risk of not being able to breathe and the consequences were fatal.

We found that infection control procedures in relation to caring for people with tracheostomies was not safe. The facilities for the staff to wash their hands in people's rooms were poor. It is essential for staff to wash their hands before and after they undertake tracheal suction, change dressings, clean the inner tube or change the ventilator tubing. The sinks in the ensuite toilets were not adequate for clinical hand washing. Liquid soap for the purpose of staff hand decontamination was not installed in the bathrooms. We saw in one person's ensuite that the paper towel dispenser did not contain paper towels and we observed a member of staff leave one person's bedroom following a procedure without washing their hands. This put people at risk of infection due to cross contamination and poor infection control practises.

We saw that some of the equipment used for people with tracheostomies such as trolleys and ventilator machines were not always clean. We found pockets of dust on people's trolleys and one person's trolley was wet. We asked a domestic member of staff about the cleaning regime for people's room and equipment. They told us the only opportunity to clean behind the trolley was when the person left the room for a bath, which was on a weekly basis. They stated it was care staff's responsibility to clean the machines and the ventilator. This put people at risk as there could be a transfer of bacteria through dust and particles which can result in pneumonia. Thorough cleaning of equipment is necessary to prevent build up of contamination, however this had not been done as dust was evident and there were no records to suggest equipment had been cleaned

We found that the water to flush the tracheostomy tubes was stored in a drinking jug in people's bedrooms. There was no indication of when the water was changed or if tap or sterile water was used. The National Patient Safety Project: Tracheostomy care and NCEPOD recommend that sterile water is used in a sterile jug and the jug is labelled and changed every 12 hours. This put people at risk as stagnant water increases the risk of legionella.

Risk assessments in relation to the care of people with tracheostomies lacked detail and the staff we spoke with did not know all the risks associated with them. We discussed this with the registered manager and consultant who informed us that they would arrange training.

These issues constitute a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe when being supported. One person said: "I always feel safe here, you can tell they know what they're doing". We saw that when people had experienced falls or accidents, that action was taken to minimise the risk of further incidents. Falls were recorded and records were checked regularly to look for an increase or a trend to the falls. We saw where a trend had been identified that action was taken to reduce the risk of falls. For example, one person had been identified as being at high risk following several

falls, so a member of staff had been allocated to be with the person on a one to one basis prior to the funding for this member of staff being agreed by the commissioners. We saw that a sensor alarm had been fitted to the person's arm chair and there was a sensor mat available by their bed which was low to the ground to help prevent injury of they fell. We saw that since these precautions had been put in place there had been a reduction in falls and when the sensor alarm had sounded when the person was in bed, they had been found to be safely sitting on the mat with no injury. This meant that this person was being protected from harm and injury from falling.

Previously we had found that the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staff to keep people safe. At this inspection we found that improvements had been made and they were no longer in breach of this regulation. Previously people had told us that they had to wait for their care needs to be met. At this inspection people were more positive about the staffing levels and timeliness of their care. For example one person told us: "I have to wait sometimes, but it's much better than it was" and another person told us: "Yes, I feel they are safe here, there seems to be staff around and never have to wait long to get help". We saw that each month the dependency levels of people using the service were assessed in each area of the service. Staffing levels had been increased in two areas following our previous inspection and new staff roles had been implemented to reduce the need for agency staff. The provider had introduced nurse support assistants who helped the registered nurse with the administration of medicines and other tasks they had been formally trained to complete. Everyone we spoke with about the nurse support assistant role told us it had been of great benefit to the service and was helping to improve care for people. Senior care staff had also been introduced to ensure the basic care tasks were allocated and carried out. We saw the provider responded and increased staffing to meet people's needs when this was required. We saw people who required extra staff support, such as one to one support had their allocated staff with them. The one to one hours were recorded and monitored to ensure that they were in place.

Since our last inspection we found that new checks on 'agency' staff were being undertaken. The provider was seeking assurances from the agencies that the staff employed were eligible to work and of good character by ensuring they had a profile of each agency staff they used. A member of the administration team also visited the agencies to randomly check staff profiles as a quality assurance check. We saw that staff who were employed by the provider were recruited using safe recruitment procedures by carrying out checks to ensure that new prospective staff were of good character and fit to work. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

At our previous inspection we found that the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they were not protecting people from abuse and avoidable harm through the use of restraint. At this inspection we found improvements had been made and they were no longer in breach of this regulation. Previously we had found that records in relation to the use of restraint with people who presented with behaviours that put themselves and others at risk did not contain the information required to ensure that any restraint being used was proportionate and the least restrictive. At this inspection we found that new records had been devised which followed the National Guidance which states that detailed and accurate records of restraint should be maintained. We saw that records now included the names of staff involved, the reason for using the specific type of intervention, the type of intervention used, the date, the duration of the incident and whether the person or anyone else had been injured or distressed. We saw that incidents of restraint were audited on a monthly basis and trends and patterns to the person's behaviour were identified. We saw that one person who had experienced an increase in their behaviour had been urgently referred to a consultant for advice and support. This meant that the risk of harm to people through the use of restraint was being minimised and assessed as being the

least restrictive intervention.

People who used the service told us they felt safe. One person said: "I feel safe all the time". A relative told us: "My mum seems to like to here and they are quite safe". All the staff we spoke with knew what to do if they suspected someone had been abuse. One staff member told us: "If the unit manager didn't do anything I would report it to you (CQC)". Another staff member told us: "If I don't speak up for them, who will. There's no point me being their carer if I'm not going to protect them from abuse". We spoke with the unit managers and registered manager and they were aware of their responsibility to report any allegations of abuse. We are aware of safeguarding referrals which had been raised by the management at the service which demonstrated their knowledge and compliance with safeguarding people.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the principles' of the Mental Capacity Act 2005 (MCA) were being followed. The 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. We found that several people who lacked mental capacity had not been consulted with or supported by a representative in the decision about a Do Not Attempt Resuscitation (DNAR) order being put in place. This meant that people were at risk of not having their wishes adhered to in relation to their end of life care and people were not consenting to or being supported to consent to their end of life care and treatment.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not safeguarding people from unlawful restrictions and decision making. At this inspection we found that improvements had been made and they were no longer in breach of this regulation. We found that when people had been assessed as lacking mental capacity to agree to specific decisions, that a best interest discussion was held. For example, we saw that previously the staff were making decisions for some people about how they took their medicines when they had been refusing to take them. We found that since our last inspection, meetings had been held with people' s GP, pharmacist and family members to discuss whether it was in the person's best interest to covertly administer their medicines to them without their knowledge. The covert plans gave staff clear instructions as to how this should be done in the safest way according to the medicines guidelines.

We had previously found that some people were being unlawfully restricted of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we found that people identified at our previous inspection had been referred for an authorisation to legally restrict their liberty in their best interest. If people lacked mental capacity to agree to their care and treatment at the service they were referred at the point of their admission.

People we spoke with told us they were asked consent to their care. One person told us: "Yes, the staff always ask me first before they do anything. Even though I choose my clothes the night before they always ask if I still want to wear them as the weather might have changed". Another person said: "The girls ask me what I want, and they do always tell me before they move me". Staff we spoke with had an understanding of the MCA and how it impacted on how they supported people. One staff member said: "You've always got to ask people what they want; they can always show you in their own way even if they can't tell you". Another staff member told us: "I can always tell when a person is happy for me to do things just by the way they look at me, if they don't want me to do something I might leave it a bit and check again later". The provider had

organised further training for all staff on the MCA from the local authority since our last inspection.

We had previously had concerns about the support and training staff received to be effective in their role. We found that some improvements such as more frequent staff practise observations had been put in place by the managers, and new senior staff roles had been introduced which were motivating staff to improve their performance. Staff we spoke with informed us they were receiving on-going, regular training and support. One member of staff told us: "We get good training; I had an induction and some shadowing before I supported anyone on my own". Another member of staff told us: "I've been asked if I would like to do the nurse support worker role and I've said yes as I want to progress in my career". People who used the service and their relatives told us they felt that staff were effective in their role. One relative told us: "The staff know what they are doing and receive regular training". However, some staff were not aware of how to care for people with tracheostomies and this put these people at risk. The registered manager informed us that they would facilitate training in this area.

People were supported to maintain a healthy diet. Some people required the use of a percutaneous endoscopic gastrostomy (PEG). A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that feed, water and medication can be given without swallowing. We observed that people using the PEG looked well-nourished and hydrated. Other people who had been assessed as being at risk of choking were offered a soft or pureed diet to reduce the risks. Snacks were available in between meals and we saw that chocolate was kept at room temperature or melted to ensure that people on a soft diet could enjoy the chocolate also. We saw when people required it, their food and fluid intake was monitored and when weight loss was noted, the appropriate advice was sought. We saw people had their prescribed food supplements when they were required.

People and their relatives told us that the staff supported people to remain healthy and they acted if they became unwell. One relative told us: "The doctor comes every week and the staff recently identified a possible medical problem and quickly notified the GP and they will now be going to hospital for tests". Care records showed that people's health was regularly monitored and prompt action was taken to respond in changes in health needs. People were referred to other health agencies as issues were identified. A visiting health professional told us: "The staff always get in touch as soon as they have spotted a change in people's needs, they are responsive like that".

Good

Is the service caring?

Our findings

At our previous inspection the provider was in breach of Regulation 10 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014 as people were not always being treated with dignity and respect. At this inspection we found that improvements had been made and there was no longer a breach of Regulation.
People and their relatives we spoke with told us that staff treated them well. One person told us: "The staff are much better here than where I used to be, they really care about you here", another person said: "The staff are lovely, they really look after me well here". A relative we spoke with told us: "They are really lovely staff here, always very kind and caring and nothing is too much trouble. They always ask if we want drinks or anything, they're just really thoughtful".

During the two days of our inspection we observed staff interactions with people which were dignified and respectful. We observed that staff were kind, caring and compassionate in their approach to people. Staff we spoke with demonstrated a compassionate value base when speaking about people they cared for. One staff member told us: "We have lovely residents, I really like it here. It can get busy, but I think we all are just trying our best for everyone". Another staff member told us: "The best thing is, the residents and getting to know them. They really rely on us for so much and it's nice when you know them enough to know what they want or how to calm them down if they are anxious".

Staff demonstrated that they cared for all people who used the service. We saw that people who were in a permanent unconscious state were supported to regularly have a bath. This took three members of staff and a nurse to undertake the task due to the complexity of their needs. We saw that staff talked to people even though they were unresponsive. We saw staff preparing to bathe a person who was on a ventilator. We observed that the staff took great care to ensure the person was to be given access to a bath and ensured their safety. This procedure took careful care planning to ensure the process was safe, and the unit manager told us this only took place when optimum levels of staffing were in place.

People were encouraged to be as independent as they were able to be. We saw that people freely moved around the units when they were able to mobilise themselves. Staff knew people well, and we saw one person had decided to stay in bed until after lunch and they came to the dining room when everything had been put away. Staff knew the person had remained in bed and had kept them a lunch which they were offered. When people were being supported to eat and drink this was undertaken in a kind and caring manner. Staff ensured they were at a height with people where they were able to give eye contact, and were patient and offered encouragement throughout the meal time. We observed one person siting for a long time eating their meal slowly after everyone had finished. Staff did not attempt to rush the person and allowed them to eat their meal in their own time.

Regular meetings for people who used the service and their relatives took place and we saw that the provider had responded following the meetings by actioning their requests. For example, we saw that people had recently requested more garden furniture in one area of the service and this had been purchased. People told us they had enjoyed using the furniture in the summer and when they accessed the

garden to smoke. There was a plan to implement a resident and relative forum and we saw notices throughout the service asking people if they would be interested in being part of this.

We saw that people's right to privacy was upheld. Everyone had their own room which they could access when they wished to. One person told us: "The staff let you have your own space if you want to in your room, and will just come and check on you every now and again to see if you want a drink". Another person whilst describing receiving support with personal care told us: "The staff always use towels to cover me up when I'm having a shower or a wash, they only have me uncovered when they have to".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving care that met their individual needs. At this inspection although we found some improvements had been made further improvements were required.

Improvements had been made to people's individual care plans as they had been reviewed and up dated to reflect people's current care needs. However staff did not always follow the care plans, for example, one person's care plan stated that when they became anxious they should be given the opportunity to walk in the garden as this would help them become calm. We looked through this person's care notes and saw that several times during the summer months this person had become anxious and was not offered the opportunity to access the garden. Instead it was recorded that the person was unsettled with no evidence of them being asked if they would like to go into the garden. It was not recorded how staff supported this person with their anxieties. This meant this person's plan of care was not being followed and their preferences were not being respected.

People's known preferences were not always met. For example, we saw a person was presented with some lunch of lasagne and chips. The person made a sound as if to say they didn't like what was offered, however the staff member walked away. The person ate the chips but didn't eat the lasagne and left the table. We asked a member of staff about this person's preferences and they told us: "[Person's name] doesn't like pasta, they only like what they can put tomato ketchup on that's why they ate the chips". Staff told us that this person would have been asked what they wanted for lunch the previous day and would have agreed to the meal that was offered, however it was known that the person would not eat pasta. The person was eventually offered an alternative meal which they ate. Another person became visibly distressed when being supported to move by a male carer. We looked at this person's care records and saw that they became vocal and anxious whilst being supported and staff should explain what they are doing. We observed that the staff supporting the person did not offer an explanation as to what they planned to do. The person's care records stated that the person preferred female carers; however male carers were supporting them. Staff we spoke with confirmed that the person preferred female carers. This meant that people were not always receiving care that met their individual needs and preferences.

Previously we had concerns that people were not always given the opportunity to engage in meaningful activities. At this inspection we found that some improvements had been made but more were required. We saw a large majority of people throughout the service who were not engaged in meaningful activities. People spent time in the lounges or their bedrooms and though some people had specific staff allocated to them they were not being engaged or interacted with by staff. Several people throughout the service told us they were bored. One person told us: "I'm bored stiff". Another person told us: 'I am very bored, I want to go to a place that has things to do". We saw one person had one to one staffing specifically identified for time to interact and offer a stimulating activity. We saw that when the staff member joined the person at the allocated time they just sat next to the person and did not offer them any conversation or activity. We discussed these issues with the registered manager and consultant who recognised that more needed to be

done to ensure that people's emotional and social needs were met.

These issues constitute a continued breach of Regulation 9 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People's private rooms were personalised with photographs and personal belongings. There was a plan of redecoration throughout the service which was ongoing. We saw on one unit the carpet had been removed and a more suitable floor covering had been laid. The flooring made it easier for people with mobility problems to get around and was easier to keep clean and odour free. We saw on the same unit that doll therapy had been introduced to people living with dementia. Doll therapy has been proven to be a good way to offer comfort and ease anxiety to some people living with dementia. We saw that a reminiscence room had been created and we were told that one person in particular enjoyed spending time in there when they wanted some quiet time.

Most relatives we spoke with told us they were kept informed and were involved in their relatives care. One relative told us: "I attend regular meetings and if we ask for something it's always done, we asked for new pillows and duvets and that was sorted". People and their relatives told us that they knew how to complain and that their concerns were acted upon. One relative told us: "I complained that people kept going into my relative's room and they put a security gate up, which has stopped people going in". Another relative told us: "It wasn't good here to start with, I kept telling the unit manager and they told me who to write to and they came to see me and it got sorted'. The provider had a complaints procedure and we saw the registered manager followed the procedure when investigating complaints.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found that provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the systems they had in place to monitor and improve the service were not effective. At this inspection we found that although some improvements had been made further improvements were required.

Following our previous inspection the provider sent us an action plan telling us how they planned to improve. We found that some of the actions on the plan had been completed and had improved the quality of the service; however some actions had not been completed and required further improvements. We saw that the provider's action plan stated that no current specialised training was required and the action was recorded as completed. However, we found that some staff were not trained and did not have the correct skills to care for people with tracheostomies. This meant that people could not be sure that the care being delivered was safe and of good quality. Following this inspection the provider informed us that they would no longer be meeting the needs of people who have tracheostomies.

The provider's action plan stated that medication audits were proving effective in driving improvement and the action had been recorded as completed. However, we found that although medication audits were regularly completed they had not identified the issues we found at this inspection. This meant that the audit was not effective in improving the medicines systems and in identifying shortfalls. People were being put at risk as the systems in place to monitor medicine management were not safe.

We saw a monthly infection control audit for the unit in which people who had tracheotomies received care. The recent audit had identified that several staff were not aware of the importance of hand hygiene when caring for people with tracheostomies. This had not been addressed and we observed poor staff practice in relation to hand hygiene and care for people with tracheostomies. This meant that the audit had not been effective in ensuring continuous improvement.

The systems the provider had in place to monitor and improve the quality of service were not always effective in identifying and making improvements in the quality of care to people throughout all area of the service.

These issues were a continuing breach of Regulation 17 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

There was a registered manager in post. Since our last inspection the management structure had changed. Each unit had a unit manager and a clinical lead. New posts had been created which consisted of a nurse support worker and a senior carer. Staff told us that the management were approachable and supportive. One staff member said: "It's much better now with our new unit manager, all the managers are good though and I can approach any of them". People and their relatives told us that things at the service were improving and we observed that a calmer more organised environment was evident throughout the service. Staff we spoke with were honest and transparent and there was a positive culture of openness evident.

Accident and incidents including the use of restraint were monitored and analysed for any trends. We saw that any issues identified were being followed up. For example, one person who had been found to be rolling out of bed regularly had safety mats put in place. Another person who tended to miss their evening does of medication as they were sleeping. We saw that the unit manager asked the GP to review the medicine and change the times of administration.

People, relatives and staff were encouraged to have a say in the way in which the service was run. Regular meetings took place for all people to contribute their ideas for improvement. We saw evidence that people were listened to and action was taken to make the improvements.

The registered manager knew their responsibility in relation to sending us (CQC) notifications and had submitted them as required.

We discussed with the nominated individual, registered manager and consultant the on-going issues with making the improvements. The management were responsive and recognised that further improvements were required. They agreed to discuss with the provider the difficulties they were experiencing in making the improvements due to the number of registered places available across the site.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that met their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not always consent to their care or were supported to consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the service were not always effective.