Coseley Systems Limited

Meadow Lodge Care Home

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the previous inspection in March 2018 we rated the service 'Inadequate' in the areas of Safe, Effective and Well Led. We found the provider had breaches in the regulations under 12, 15, 9, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the service was awarded a rating of 'Inadequate' overall. This was the second time the service had been rated 'Inadequate' overall. At the inspection in November 2017, the provider was rated as 'Inadequate' in all five key questions with breaches in regulations 9, 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As the service was rated 'Inadequate' we placed the service in special measures following the November 2017 inspection. We asked the provider to send us an action plan each month of how they were meeting the regulations. We placed four conditions on the provider's registration, telling the provider that a deep clean of the premises should be undertaken and that no-one should be admitted to the home without CQC's approval, and that sufficient amounts of suitable and nutritious food should always be provided to meet the needs and preferences of service users. In addition, we told the provider they must take immediate action to obtained healthcare support for people with pressure sores or people losing weight.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvements are made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This may lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements and is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

We inspected this service again on the 23 and 24 August 2018. The inspection was unannounced on the first day. On the second day of the inspection the provider and manager were informed we would return to the home. The inspection was to check on whether the provider had made the necessary improvements.

Meadow Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Meadow Lodge is registered to provide care and accommodation to a maximum of 22 older people, younger adults and people with a diagnosis of Dementia.

At the time of the inspection, there were 13 people living at the home. Two people who usually resided at the home were in hospital at the time of our inspection visit.

There was no registered manager in post. 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. A manager had been appointed at the home, and had applied to register with CQC as the registered manager, which was still under consideration by CQC.

We found improvements had been made at the home since our previous inspection. At our previous inspection we found the provider and registered manager did not always manage risks to people's safety, and people were placed at unnecessary risk. At this inspection we found risk assessment procedures had been improved, however, environmental risks continued to be managed inconsistently. Further improvements were required to ensure people were always supported safely.

Infection control practices had improved and the home was cleaner than before. However, we found improvements still needed to be made to ensure people were protected from the risk of infection, especially at weekends when cleaning staff were not on duty. We found at sometimes during the day unpleasant smoke odours continued to disseminate throughout the dining area and hallway.

People had access to sufficient amounts of food to maintain their health and weight. However, we continued to find the meals provided did not always meet people's preferences. Action was taken to refer people to health professionals when needed, to gain treatment when their health needs changed.

Staff were available to take care of people's immediate care needs but did not always have time to spend with people.

Care records had been improved since our previous inspection visit and medicines were managed safely. People were involved in the planning and review of their care. Care records were individual to the person and people's specific communication needs were met.

Staff had received updated training to enable them to support people effectively.

The manager and staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and supported people in accordance with the Act. Staff were aware of who needed support to make decisions about their care and welfare.

People were not always treated with dignity and were not consistently given choices in their daily lives. There continued to be a lack of stimulating activities and support to people, to engage them in hobbies, interests and events that might increase their wellbeing.

The provider had taken action to improve the service and had acted on the concerns raised in previous inspections. However, improvements needed to be sustained and built upon to ensure people always received good quality care that met their needs.

Where the provider was identifying areas that required improvement, action to improve the home and the quality of care people received had been taken.

This service has been in Special Measures since January 2017. Services that are in Special Measures are kept

under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the provider demonstrated to us that improvements had been made and is no longer rated as 'Inadequate' overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

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.

The provider still needed to make some improvements to the cleanliness of the home and in managing environmental risks to ensure people were always supported in a safe environment. People were supported by a consistent staff team that managed the risks associated with their health, care and support. Medicines were managed and administered to people safely. Safeguarding procedures were in place, to investigate any concerns. There were enough staff to support people, and keep them safe.

Is the service effective?

Requires Improvement

The service was not consistently Effective.

People were provided with nutrition that did not consistently meet their preferences. People's rights were protected as staff worked within the principles of the Mental Capacity Act 2005 (MCA). Staff had the relevant training, skills and support to provide people with effective care. People were supported to maintain their health and referred to external healthcare professionals when a need was identified.

Is the service caring?

Requires Improvement

The service was not consistently Caring.

Most of the time staff were kind and caring, and knew people well. However, people were not consistently supported by staff to make choices about how they lived their daily lives. People were able to maintain contact with family and friends, and were supported with their communication needs.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

There continued to be limited physical and mental stimulation for people, which did not always meet their needs. People and their families were involved in planning how they were cared for

and supported. People knew how to make a complaint and provide feedback to staff and the manager.

Is the service well-led?

Requires Improvement

The service was not consistently Well Led.

Improvements to quality assurance procedures had been made since our previous inspection, however, these needed to be sustained and embedded into practice. Some of the provider's management systems continued to require improvement to be effective in identifying where improvements were needed. The provider did not always ensure CQC were notified about events at their service.

The manager and provider were approachable and there was a clear management structure in place to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. There were systems in place, so they could share their views about how the home was run.

Meadow Lodge Care Home

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 23 August 2018 and 24 August 2018. The first day of our inspection visit was unannounced. On the first day of our inspection visit three inspectors and an assistant inspector visited the home. On the second day, two inspectors visited with the assistant inspector.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information we had received from other agencies, including commissioners of services. Commissioners are professionals who may place people at the home, and fund people's care. We considered this information when planning our inspection of the home.

This inspection was a follow up visit to check improvements had been made in the management of the service. We asked the manager and the provider, to supply us with information that showed how they managed the service and the improvements they had made. We considered this information along with the action plan they had submitted to us following our inspection March 2018.

The provider had not been asked to complete an update to their Provider Information Return since our previous inspection. 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.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the

experiences of people who could not talk with us.

We observed care and support being delivered in communal areas of the home. To gain people's experiences of living at Meadow Lodge Care Home, we spoke with 13 people and two relatives of people who used the service. We spoke with the manager, the provider, and received feedback from seven care staff and a cleaner.

We looked at 13 people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs and risk assessments. We also looked at a range of documents produced by the manager which demonstrated how quality assurance was undertaken.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in March 2018 we rated Safe as 'Inadequate'. People were not cared for in a way that met their needs, and reduced the risks to their health and wellbeing. Systems required improvement to ensure people were always cared for safely. At this inspection we found systems needed to be embedded and sustained to ensure that people were always cared for consistently and safely. We have rated Safe as 'Requires Improvement'.

At our previous inspections we found significant shortfalls in the provider's systems to ensure risks to people were managed to keep them safe. This resulted in a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. When we visited the service in August 2018 to check whether improvements had been made we found people did not remain at this level of risk, because risks were usually identified and staff acted to mitigate risks. We found there was no longer a breach of Regulation 12. For example, where people were at risk of developing damage to their skin, there was a risk assessment in place for the person that identified that the person should be supported to re-position every two hours. Daily records showed this support had been provided. No-one at the home had developed damage to their skin since our previous inspection. Staff had also been trained in how to recognise the signs of people developing skin damage, to reduce the risks to people.

At our previous inspection we had concerns that the home needed to be cleaner, to protect people from the risk of infection. We saw people's rooms and the communal areas of the home were cleaner than at our last inspection. Staff used protective equipment such as aprons and gloves to prevent the spread of infection around the home, and from person to person. The provider had recruited a dedicated cleaner who worked at the home five days per week, and followed a cleaning schedule (list of cleaning jobs they needed to complete each day). Night staff had also been given some cleaning duties to perform during their normal shift. The manager monitored the cleanliness of the home with regular daily walk rounds, checking of cleaning schedules and a monthly infection control audit. We saw that care staff were responsible for checking the cleanliness of communal toilets throughout the day. One person's relative told us, "It's clean enough now, and they are making an effort to update things."

We saw the cleaner spent all their time cleaning the home, including communal bathrooms and toilets, people's rooms and the communal areas of the home. However, some people told us they still felt the home could be cleaner. For example, one person told us they felt the bathroom and bath they used could be kept cleaner. One person said, "The bathrooms aren't cleaned until the cleaner gets in." We found that a toilet on the first day of our inspection visit as people were getting up and using the toilet, it was visibly unclean. One person told us they liked to get up early and independently make themselves a snack and a cup of tea. They complained the kitchen was not always cleaned from the previous evening or night time when they went into the kitchen. We raised this with the registered manager who told us they would review the cleaning schedules for staff to address these concerns, as the cleaner did not start to clean until later in the morning.

Cleaning schedules, procedures and the cleanliness of the home still required improvement to ensure cleanliness was sustained and that people were always cared for in a clean environment. We found the

cleaner was not employed more than five days per week, and so some days the home did not have dedicated cleaning staff. In addition, cleaning schedules did not include the cleaning of shared and communal areas of the home. We saw table cloths and tables were not always cleaned after people sat at the table, and before people ate their meal.

At this inspection, we still found environmental risks to people's safety were not always managed effectively. We saw the cleaner did not always protect people from risk, when they were cleaning the home, as some of their cleaning products were accessible to people who lived at the home. This included people with a diagnosis of dementia, who may access and ingest the cleaning products. When we raised this with the cleaner and the provider, action was taken to immediately protect people, and store the items safely.

We found there were still concerns around the home that required action, to ensure people were always supported safely. For example, there were some building materials in one of the communal lounges at the home which had not been stored safely. When we brought this to the attention of the manager and provider, the materials were immediately moved.

At the previous inspection we found people were not always well supported to maintain and manage their catheter, to ensure they were protected from the risk of infection. At this inspection we found staff had all received training in how to support people to maintain their catheter, and catheter care plans had been put in place to reduce the risk to people.

At previous inspections we found some areas of the home required maintenance, this included some broken plaster that had the potential to cause injury and cigarette ends that had not been disposed of safely. When we checked to see if these issues had been improved, we found the broken plaster had been repaired. The outside area where cigarette ends had been left was tidier, and the provider had spoken to all staff about the importance of keeping this area clean.

At our previous inspection visit we found the home had a dedicated smoking room for people who wished to smoke. This room was joined to one of the dining areas, where people could choose to eat their meal. The smoking room did not have adequate ventilation and as a result, smoke odours were being emitted through the dining area and into the hallway leaving an unpleasant smell.

During this inspection we checked how the smoking room was being ventilated. We found the window had been opened, and an extractor fan was available in the room. However, this was not left on following one person having a cigarette. During our inspection visit, on both days, we continued to find unpleasant odours emanating into the dining room next to the smoking area. We raised this with the provider who told us they intended to update the extractor fan in the room to come on automatically several times during the day, to ensure the room was ventilated automatically. The change was due to be made by the end of September 2018. The provider later confirmed this had been implemented.

There was a calm atmosphere in the home and the relationship between people and the staff who cared for them was friendly. People did not hesitate to ask for assistance from staff when they wanted support. This indicated they felt safe around staff members. People told us they felt safe living at the home. One person said, "I feel really safe here, I love it, It's my home."

Staff received training in how to safeguard people from abuse and could tell us what action they would take if they thought a person was at risk of harm. One member of staff told us, "If I saw anything, I would report it to the manager". We saw that where concerns had been raised, these had been reported to the local authority safeguarding team and Care Quality Commission as required.

Staff told us that prior to starting work, they had been required to provide their work history, references from previous employers and complete a check with the Disclosure and Barring Service (DBS). The DBS check indicated if the prospective staff member had a criminal record or had been barred from working with vulnerable adults. Records we looked at showed that these checks had been completed. The provider explained that they had altered their recruitment process following our previous inspection, checks included a DBS, risk assessments if any concerns about the suitability and character of prospective staff, and two references from a previous employer (or character references if these were not available). They also checked identification documents and the person's right to work in the UK. The provider explained that in addition they now intended to renew DBS checks for staff every three years.

The manager and provider was taking action to monitor the accidents and incidents at the home, to see whether risks to people's health and wellbeing could be reduced. For example, each month the manager reviewed accidents and incidents to see whether there were any patterns and trends, and whether anyone needed to have a referral made to health professionals.

We saw that staff were available throughout our inspection visit in the communal areas of the home and there were enough staff to support people safely with care tasks. Staff and the manager told us they did not usually use any temporary staff at the home. This meant people were supported by a consistent staff team. However, we found staff had limited time to spend with people, spending most of their time on completing care tasks and tasks around the home. Although the provider had recognised this, and had increased staffing levels to employ an activities co-ordinator for some time during each week, we remained concerned that staffing levels did not always meet people's social needs.

The provider used a dependency tool, based on the care needs of people at the home, to assess how many care staff were required to care for them safely. In addition to care staff the manager kept their training and skills up to date, so that they could assist care staff at busy times of the day. Following our previous inspection staffing levels had been adjusted in a number of areas, including the recruitment of a dedicated cleaner. From the rotas and staffing complement we found where staff were on holiday, replacement staff were brought in to cover their duties.

At our previous inspection we found a person was not assisted safely to take their medicine, as a staff member gave the person all of their tablets to take at once, the person was visibly struggling with handling so many tablets at once and could not swallow them. At this inspection we found people received their medicines as they should. Medicines were stored safely in locked cupboards in each person's room. People were happy with the support they were given with their medication. One person told us, "I do have my medication and they [staff] don't forget to give it to me".

We saw that where people required medications on an 'as and when required' basis, there were protocols in place informing staff of when these medications should be given. Staff also used a easy to read 'pain scale' to assist with measuring people's pain levels if they were unable to communication well.

At our previous inspection we found one person had run out of their prescribed pain relief. Since our previous inspection the manager had reviewed the ordering of medicines to ensure people always had an available stock of medicine at the home. The ordering system had been changed, so that medicines were reviewed each month, and were ordered a fortnight before they were needed. In addition, the provider had changed the pharmacy they used, to improve the responsiveness of the ordering system. The manager told us, "We are confident no-one will run out of their medicines now."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2018, we found significant shortfalls in the provider's systems to ensure people received effective care. This resulted in the provider being rated as 'Inadequate' in the key question of Effective. We checked to see if improvements had been made. We found some improvements had been made, which needed to be sustained, and that people's care had improved. However, the provider needed to make further improvements to ensure people always received effective care that sustained their health and wellbeing. We have rated Effective as 'Requires Improvement.'

At our previous inspection we had concerns that people were not being offered enough to eat, to meet their nutritional needs. We were also concerned that the food on offer at the home did not meet people's preferences, and therefore people were reluctant to eat the food at the home. At this inspection we observed two mealtimes. We looked at how much food was on offer for people, and whether the food was meetings people's dietary, cultural and religious needs and preferences. This was so we could be sure people were being given enough food and drink to maintain their health.

We received mixed feedback from people about the food on offer at the home. Comments from some people were; "The food is rubbish", "There is not enough choice", and "The portions are small and we don't get extra." Other people and their relatives had complimentary things to say about the food. Comments were; "The meals are as good as can be expected", "Lunch was nice, and I am full" and, "You get two choices every day, we didn't used to, but we do now".

On the first day of our inspection we saw one person was given food that was cold, and undercooked and so they were unable to eat their meal. Another person commented on the pudding not being appetising, and so they were unwilling to eat it. We saw this was due partly to the absence of the cook, who was on holiday. We saw a member of staff had been brought in to prepare food in their absence, and was unsure of how to prepare some of the food options on offer that day. They chose to prepare a different desert than one on the menu, as they were unsure how to prepare the advertised choice.

On both days of our inspection visit we saw people were offered alternative foods if they did not eat their meal. However, one person said the alternative was not appetising which meant they did not really want to eat. We saw one person decided not to eat their meal, as it was not to their taste, and fed this to the birds outside. This meant they did not eat at that mealtime.

We saw the second day of the inspection visit the food at lunchtime had been cooked by a different member of staff, and was more appetising. The manager told us the cook was currently on holiday, and so other staff were covering their role. The provider had recognised this as an issue and was recruiting an additional member of qualified and experienced staff to help with holidays and absences in the kitchen.

Staff told us they thought the food options for people had improved since our previous inspection visit, but work was still required to ensure the food met people's preferences. Staff told us the quality of food had improved, with the provider buying a higher quality of pre-prepared food from a local supermarket instead

of from a 'value' range. One member of staff said, "Food and drink is available during the whole day and night." Another member of staff said, "I still have some concerns about the portion sizes, but things have improved."

The provider ordered and sourced the food at the home, which was served each day at the home. We looked at how much food was ordered and delivered on average for each person, each day. The cost of food people received equated to less than £3.00 per person, per day. We found that improvements were still required in the quality and quantity of food people received, to assure us that people were receiving a nutritious and health diet. This was because most foods were pre-prepared meals that required only heating to be served. There was a lack of monitoring of the nutritional content of the food on offer. There was also a lack of fresh fruit and vegetables being prepared each day, to ensure people ate nutritious and healthy food options.

There was a sign on the dining room door encouraging people to ask staff for snacks and drinks when they wished. However, we looked at the availability and quality of the food being provided to people, and in storage at the home. We remained concerned that there appeared to be a lack of fresh food such as fresh vegetables and a variety of different fresh high calorie snacks available to people. Snacks were limited to biscuits, yoghurts and fruit.

We looked at the choices people had on the menu each day. We saw this was limited to one meat dish per day and some lighter alternative meals, for example, jacket potatoes and salads. This meant people who had cultural or religious restrictions on the food they ate had limited choice. The provider explained people were always offered alternatives, even if these were not shown on the daily menu.

There were reduced sugar and low fat options available for people who had diabetes, and there was a vegetarian meal option on the daily menu. The provider explained they were in the process of producing a new menu which would detail a more varied choice of vegetarian meal each day of the week. On the day of our inspection visit the manager also spoke with one person who was still dissatisfied with food choices, to ask them if they would prefer to have their own individualised menu, although the person declined this offer.

People's weights were being monitored and any identified weight loss was being acted upon by referring people to see a doctor as soon as this was identified. People told us that had access to healthcare input where required. Records showed people had been supported to access healthcare services where required to maintain their health. This included referrals to the local nurse practitioner and doctor. People also had access to regular reviews of their eyesight and dental needs. The registered manager confirmed the doctor visited the home each week to conduct a surgery, but also visited the home if they were needed at other times.

The decoration of the home was adequate for people who lived there. We found for people who had a diagnosis of dementia, there was clear signage to support people when moving around the home to indicate where lounge and dining areas were and where people could access toilets and bathrooms.

Since our previous inspection visit the provider had updated their staff training programme. Staff told us they received an induction when they started work which included working alongside an experienced member of staff. One member of staff said, "The induction covered everything I needed to know." The induction training was based on the 'Skills for Care' standards providing staff with a recognised 'Care Certificate'. Skills for Care are an organisation that sets standards for the training of care workers in the UK. The registered manager maintained a record of staff training, so they could identify when staff needed to refresh their skills. The new training programme included (but was not limited to) refresher training in

safeguarding, food hygiene, medicines management, catheter care, and diet and nutrition.
Staff told us they had regular meetings with their manager where they were able to discuss their performance and identify any training requirements. They also participated in yearly appraisal meetings where they set objectives for the next 12 months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked the capacity to make all of their own decisions, the manager was acting in accordance with the MCA. They recorded when someone might require assistance to make a decision, and who should be involved in the decision-making process to act in the person's 'best interests'.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the need to seek consent from people prior to supporting them, and put this into practice. Two people living at the home had a DoLS authorisation in place. Other applications to deprive people of their liberty had been made to the local authority appropriately. Staff were aware of who had these types of restrictions on their care, and how they needed to support people.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2018 we found improvements needed to be made to ensure people were treated in a caring way. We rated the service 'Requires Improvement' in Caring, at this inspection we continue to rate Caring as 'Requires Improvement' because the provider did not always ensure people were always treated in a caring way that respected their choices.

People gave varied feedback to us about staff and whether they had a caring approach to them. One person told us, "The staff don't care." We saw staff seemed busy with tasks, and were focussed on completing the tasks assigned to them. This meant the systems in place did not support staff to develop caring relationships with people as they did not consistently allow them time to spend with people.

Everyone else we spoke with told us staff were caring. One person said, "The staff are brilliant." We saw some staff made an effort to sit with people, discussing activities and asking how they were.

People provided us with mixed feedback about whether staff supported them to make their own choices and decisions about their care, and their daily routines. One person said, "Sometimes staff do not always ask you before turning on the radio, or changing the TV channel." They felt this didn't support them in feeling like Meadow Lodge was their home. Another person said, "I am fed up and angry, as I am always told to wait until last (for my support)."

The majority of people told us staff assisted them with decision making, and respected their decisions. We saw people were able to spend time in their room, and get up when they liked. Care records showed people's preferences about when they wanted to get up and when they wanted to go to bed.

Staff told us they were happy working at the home, and described their job as satisfying. One member of staff said this was because they felt people were at the centre of what they did, and the home was a caring place.

People appeared clean and well presented. People told us they made choices about what they wanted to wear, and we saw people were dressed in a range of styles to suit their personality. We were invited into two people's rooms to see how their room was arranged. People had personal items, photographs, pictures and ornaments they had chosen to decorate their space and make it personal to them.

People and their relatives told us they were able to meet with family and friends when they wished, as family members and visitors were welcome at the home. This helped people maintain relationships with people who were important to them.

We saw staff respected people's privacy, by knocking on people's doors and asking their permission before entering their room, with the exception of two occasions where staff entered someone's room without knocking first . Some people had locks on their doors, which they operated themselves, where they wished to use these. This restricted people from entering their room without their permission. We saw when one

person requested privacy, this was respected by staff who left the person to spend time in their room. People who shared bedrooms had privacy curtains between beds to ensure they had privacy when they needed it.

Where people had specific communication needs, we saw that alternative methods of communicating were used. For example, we saw that a whiteboard was situated next to one person at all times as this was how they found it easiest to communicate. Staff used this with the person to support them in communicating their needs. Pictorial aids were available for people at mealtimes to support them in understanding their meal choices.

People were offered the use of WiFi at the home to communicate with relatives and friends. The provider was also introducing hand held computer tablets at the home, to increase people's accessibility to the internet and communication methods.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found shortfalls in the provider's systems to ensure personalised care that met people's individual needs and inadequate systems to handle complaints; further improvements were required to ensure people's concerns were acted upon. We rated the service as 'Requires Improvement.' And? found breaches in Regulations 9 and 16. At this inspection we found the provider needed to continue to improve how they responded to people's preferences to ensure they delivered person centred care. We continue to rate Responsive as 'Requires Improvement.' However, we found there was no longer a breach of Regulation 9 and Regulation 16.

We found that people's individual preferences in relation to the meals provided was not always met. We spoke with the provider who was aware of one person's continued dissatisfaction with the meals. They told us they were working with the person to increase their satisfaction levels. During the second day of our inspection visit, following our feedback, the manager spoke with the individual again to assess how their food preferences could be met in the future.

People's preferences regarding the activities and interests on offer at the home were not always met. One person told us they did not take part in the activities on offer at the home, as they were uninterested because they did not stimulate and engage them. Another person told us, "Sometimes you feel remote and on your own. There are not many activities." Staff also told us they felt there could be more on offer to engage and stimulate people.

We saw one person at the home who continually walked around the home and who looked confused. Staff did not always engage with the person in conversation when they passed by them as they were focussed on tasks. Other people sat in the lounge and had little to occupy them, except for watching the television or listening to music. On the second day of our inspection visit we saw some staff did engage people in a game in the afternoon, in the communal lounge area. However, not everyone joined in, and around half of the people at the home stayed in their rooms showing not everyone was interesting in this type of activity. The provider and staff respected people's choice to remain in their room where they wished.

As part of the recent review of people's care the manager had assessed what hobbies and interests people enjoyed before they came to the home, but we could not see how people were being assisted to maintain these previous hobbies. The provider told us they were reviewing how hobbies and interests for people were supported at the home.

There had been improvement in how group activities were being arranged. We saw a recent questionnaire to people had asked for their preferences, and one person had asked for additional outside trips to be organised. Recent activities had been arranged by a designated member of staff, who worked additional hours at the home each week to increase the activities available to people. Trips out to local places such as the park, a band stand, and a local fete had been arranged.

A display board detailing any forthcoming planned trips, and pictures and reminders of recent trips was on

display in the communal corridor for people to see. In addition, a contractor came to the home every fortnight to spend time with people to play games. A staff member said, "We are doing more activities than ever, managers want to do more for people."

Care records showed, and relatives confirmed people had been involved in planning their care. Some people had signed consent to their care plans, where they had the capacity to do so, and records showed assessments had taken place with people in regard to their needs and preferences.

Since our previous inspection all of the people at the home had received a review of their care, and care records had been updated. Records showed personalised information about people such as preferred bedtime drink, hobbies and favourite music.

People and their relatives told us individual staff members were responsive to their requests for assistance. One person said, "Staff are there if you need them", another person told us "[Name] comes when you call."

Staff attended a daily 'handover' meeting at the start of their shift to exchange information about people at the home. Staff told us this assisted them in keeping up to date with people's health and care needs. These handover records were used to communicate important messages and listed key information about each person that lived at the home.

There was information about how to make a complaint or provide feedback about the service available in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. At our previous inspection we saw complaints and feedback was not consistently recorded and investigated, to allow the manager and provider to analyse information and respond to people's concerns consistently. At this inspection we found the systems to record complaints had been improved, and concerns people raised with staff were now also being recorded, responded to and reviewed.

We found around half of the people at the home had some end of life care arrangements in place. The arrangements included decisions that had been made regarding whether people should be resuscitated following a cardiac arrest (DNARCPR). Where people wanted to engage in discussions about end of life arrangements, this facility was on offer. People choose whether to share their wishes with the provider.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in March 2018 we continued to find significant shortfalls in the provider's oversight of the service and their ability to monitor and improve the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We rated the service 'Inadequate' in Well Led. At this inspection we checked to see if improvements had been made and found that there remained shortfalls in the governance systems in place, and that where improvements had been made these needed to be sustained and embedded into practice. We have rated the service 'Requires Improvement' in Well Led. We found there was no longer a breach of Regulation 17.

We had previously rated the service as 'Inadequate' three times in the key question of Well Led. This led to concerns that the provider did not have the skills or knowledge required to make and sustain the required improvements to the care provided. Although at this inspection we found some improvements had now been made to the service, some improvements were still required. We continue to monitor the service to ensure improvements have been sustained and embedded into practice.

Following our previous inspection in March 2018 we had placed four conditions on the provider's registration, telling the provider that a deep clean of the premises should be undertaken and that no-one should be admitted to the home without CQC's approval. We also said that sufficient amounts of suitable and nutritious food should always be provided to meet the needs and preferences of service users. In addition, we told the provider they must take immediate action to obtain healthcare support for people with pressure sores or people who were losing weight. We found these conditions had been met, with the exception of food always being provided to meet the preferences of service users. The provider had also submitted an updated action plan to CQC each month since March 2018, to keep us informed of events and actions taken at the home.

Auditing and monitoring procedures still required some improvement to identify all the actions the provider and manager needed to take, to ensure people were supported safely at all times. For example, auditing and checking procedures had not identified the need for cleaning staff to be employed seven days per week, or the need to keep environmental risks to a minimum. Auditing procedures did not clearly identify the activities and interests people needed to stimulate and engage them each day, in an action plan.

There continued to be no registered manager at the home. However, the current acting manager had been working in their role since late 2017. They told us that although they had been appointed in their role before our last inspection in March 2018, they felt they had not been in their post long enough to make an impact on how the home should be improved and run. This manager had made an application to register with CQC and was waiting to hear if this had been successful. They said, "I have had time to make an impact in my role now."

Since our March 2018 inspection the provider and manager told us they had made significant changes to the way the home was run. Relatives and staff also told us this was the case. Improvements included having a designated activities co-ordinator a few hours per week, improvements in infection control procedures and

the recruitment of trained cleaning staff, the introduction of new training for staff, and an increase in food provision.

An external organisation had been appointed by the provider to conduct monthly audits of the service, and to inspect the home. This was to identify improvements that were needed and to support the learning of the provider and manager in quality assurance procedures and systems. This included the review of all care records in the home, and the introduction of new paperwork and systems to provide clear information for staff on how they could manage the risks to people's health and wellbeing. Care staff and health professionals were also now involved in reviewing people's care records and needs, to ensure they were cared for effectively and changes in their health was recorded. We saw the care records we reviewed were up to date and detailed how staff could mitigate risks to people.

The provider had reviewed and updated their auditing and monitoring systems, based on the advice of the external auditors. The manager conducted regular daily, weekly and monthly checks and audits in a number of areas including medicines administration, infection control, care records, premises and staff performance. Quality checks also included gathering the views of people and staff. Where any actions or areas of improvement were identified, either by the manager, provider or external auditor, these were written into an action plan, which was monitored each month by the external auditors to review the actions completed and what still required action. An ongoing improvement plan of the home was then updated with any changes.

Staff were supported by the manager and provider on a daily basis, as they were based at the home and worked on site five or six days each week. Staff told us that the manager and provider both operated an 'Open Door' policy, which meant they could speak with them whenever they wished. The manager worked alongside staff up to five days per week, and conducted regular walk rounds of the home, so was visible and accessible to people who lived at the home and their relatives. Comments from staff included; "The manager is lovely and very approachable", "The service is better now (with the new manager) who is more understanding", "The manager is always here, walking around and listening to people. She helps the staff out at busy periods."

Staff told us they had regular team meetings and supervision with their manager in order to discuss the service. They told us the manager and provider listened to their feedback, and acted on this to make improvements. One staff member gave us an example of where this had happened saying, "Senior staff used to do night shifts here, but they are now not asked to cover as many nights due to staff changes. This is helping with our work life balance and stress levels."

We saw that people were given an opportunity to provide feedback on their experience of the service in quality assurance surveys each year. People were also encouraged to offer feedback to staff through a complaints and feedback form, which was displayed in the reception area of the home. A relative explained there were also regular relative's meetings organised at the home where they were encouraged to make suggestions. We saw that comments in the feedback we reviewed, regarding the quality of food, remained mixed. Some action had been taken. For example, menus were under review and some food items had already been changed on the menu.

We examined the ongoing improvement plan to assess the improvements that were planned at the home in the forthcoming months. Improvements planned included conducting the next quality assurance satisfaction survey of people who used the service and their relatives in September 2018. The provider was also reviewing staffing levels at the weekends, and was undertaking a renovation of the premises and décor at the home. We saw a painter and decorator working during our inspection visits, some bedrooms and

bathrooms had been decorated and re-furbished and flooring was being reviewed.

The provider told us, "We know we have more work to do, but we are making changes." During our inspection the provider responded straight away to our feedback. For example, we found that a floor was uneven and might increase the risk of people falling at the home, this was changed immediately following our inspection visit.

The provider sent us notifications regarding specific incidents and other events that occurred at the home, as required by CQC. However, we found that there was a lack of understanding around whether the provider was required to notify CQC of authorisations to deprive people of their liberty. This meant the provider had not notified us of two such authorisations. They did so immediately following our inspection visit.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any website run by the provider in relation to this home. We saw that the provider had displayed their rating in the reception area of the home and so had met this requirement. The provider told us they were re-configuring their website at the time of our inspection visit so it was currently in-active, and would be sure to include their rating on their website when this was re-activated.