Premiere Care (Southern) Limited

The Willows Care Centre

Inspection report

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Date of inspection visit:
15 August 2017
16 August 2017

Date of publication:
11 October 2017

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

The Willows Care Centre provides accommodation, personal and nursing care for up to 40 older people, people living with dementia or people with a mental health condition. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. There were 35 people living at the service at the time of our inspection.

At the last inspection, the service was rated Inadequate. The provider took prompt action to reduce the risks at the service. We took enforcement action against the provider and applied a condition to their registration requiring them to send us an action plan twice each month informing us how they were improving the quality and safety of the service. We received these actions plans as required. At this inspection we looked to see if the action taken by the provider had been effective and found that improvements had been made. However, there were continued breaches of four regulations and further improvements were required in other areas.

Before our inspection the provider decided to stop providing nursing care to people. They were working with the people, their families, funding authorities and the local Clinical Commissioning Group to assess each person's needs to make sure they could continue to be met at the service. Plans were in place to support people who required nursing care to find alternative services.

A manager was working at the service. They had applied to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The provider's oversight of the service had improved since our last inspection. The support provided to staff had increased, however nurses had not always been held fully accountable for their responsibilities. A number of checks and audits had been completed; however, action had not always been taken to address any shortfalls found, including medicines errors.

Some staff continued not to follow the provider's medicines procedures and people continued to be at risk from unsafe medicines management, including the safe storage and administration of medicines.

At our last inspection we found that risks to people had not been consistently identified, assessed and

reviewed. At this inspection we found that some risks, including risks to people's skin, continued not to be assessed and reviewed regularly. Care had not been planned to meet people's changing needs, including the correct use of pressure relieving equipment. Other risks, such as the risk of people losing weight or falling had been assessed and action had been taken to keep people safe.

The provider's recruitment procedures had still not been followed for all staff. The Disclosure and Barring Service (DBS) criminal records check for one staff member had not been fully completed and disclosures on another DBS had not be adequately assessed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were not always treated with respect. People continued not to have enough to do during the day on occasions, despite care staff spending more time with people and inviting outside entertainers into the service. We have made a recommendation about activities for people living with dementia.

Some confidential information about people had not been disposed of securely. Some records about people's care had improved. However, detailed and up to date guidance was not available to staff about some people. The management team had recognised this and put plans in place to address the shortfalls. Records were now accessible to staff.

Previously we found that staff did not know the signs of possible abuse and safeguarding risks had not been identified and acted on. Staff had completed training since our last inspection and knew the signs of abuse. Any concerns had been recognised and discussed with the local authority safeguarding team.

Since our last inspection staff had completed training about how to keep people safe in an emergency. Following our last inspection the local Fire and Rescue Service had visited the service and the provider had acted on their advice.

People now received the care they needed to keep them as healthy as possible. Previously people were not always offered foods to help keep them as healthy. At this inspection we found people were offered food and drinks to meet their needs and preferences, including cultural and spiritual preferences.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people were restricted.

Some staff had completed training in relation to the principles of the Mental Capacity Act 2005 (MCA) since our last inspection. Assessments had been completed of people's capacity to make specific decisions and people were supported to make day to day decisions. Further improvements were planned to support people to understand and make choices.

There were now sufficient staff deployed to meet people's needs and people no longer had to wait for the support they needed. Since our last inspection staff had completed training in key areas including dementia care and communication. Staff told us they now felt supported by the management team. Staff had not met regularly with a manager to discuss their role and practice. The management team had identified this shortfall and a plan was in place to address this.

Staff now worked as a team and knew about their roles and responsibilities. Staff told us they felt appreciated by the management team and the provider and were motivated to continue to improve the

service.

Since our last inspection the provider and manager had recognised, investigated and resolved complaints they received. Complaints and concerns had been used to improve the service.

People and their relatives and staff were now involved in planning what happened at the service and had been asked for their feedback. A residents and relatives group had been established and a representative regularly met with the manager and provider.

We have received notifications of significant events that had happened at the service promptly since our last inspection.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of the report. Following our inspection the provider sent us an action plan detailing how they would address the concerns identified during the inspection. We will follow this up at the next inspection.

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

'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.'

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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 always safe.

Medicines were not always managed safely.

Risks to people were not always assessed. Action had not been taken to support some people to be as safe as possible.

Staff had not been recruited safely or in line with the provider's procedure.

Staff knew how to keep people safe if they were at risk of abuse.

There were enough staff to help people when they needed it.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received all the support they needed to improve their practice.
Care had been planned to meet people's health care needs.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff supported people to make their own decisions.

People were offered a choice of food to help keep them as healthy as possible.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect.

Staff were kind and caring to people.

Staff understood what people were telling them.

People were given privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives had not always been involved in planning their care.

Guidance was available to staff about how to meet each person's needs.

People did not have regular opportunity to take part in activities they enjoyed.

People's complaints had been investigated and resolved to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some checks completed on the quality of the service were not effective. Action had not always been taken when shortfalls were identified.

The views of people, their relatives and staff were obtained and used to improve the quality of the service.

Records about the care people needed were not consistently accurate. The confidentiality of people's records was not always maintained.

Staff knew and understood their role and responsibilities.

Important information had been shared with CQC, to help us understand what had happened at the service.

The Willows 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 checked 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 was a comprehensive inspection.

This inspection took place on 15 and 16 August 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at action plans and notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We reviewed information we had received from other sources including health and social care professionals.

We spoke to a clinical nurse specialist for older people, continuing health care nurse assessor, local authority commissioners and safeguarding staff who had given the provider and manager guidance about how to improve areas of the service. They all told us the quality and safety of the service people received had improved.

During our inspection we spoke with twelve people living at the service, three people's relatives and friends, the deputy manager, the clinical lead and staff. We visited some people's bedrooms with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at medicines records and observed people receiving their medicines.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk with us.

We last inspected The Willows Care Centre in January 2017 and rated the service Inadequate overall.

Requires Improvement

Is the service safe?

Our findings

At the inspection in January 2017 we found people were not always protected from the risks of unsafe medicines management. At this inspection we found the risks continued.

The provider had a policy in place for the safe management of medicines; nurses had not read the policy since our last inspection and did not know the standards the provider required. The competence of four nurses to manage medicines safely had not been checked effectively and nurses continued to not manage people's medicine safely.

The storage of medicines needed to improve. We observed that the medicines room was dirty and unhygienic. We observed equipment used to administer people's medicines, including medicines pots, had been washed in a dirty sink and were drying on a draining board stained with lime scale. Approximately one litre of water used to prepare medicines was left uncovered in an area that was dirty from maintenance works, including brick dust. This water had been used to prepare people's medicines. There was a risk that water contaminated with dirt and splinters would be used when preparing people's medicines.

Nurse's personal food items were stored inappropriately in the medicines room; we observed a white powder being stored in an unlabelled medicines pot. A nurse told us this was table salt. Some people who were at risk of choking were prescribed powder to thicken their drinks, which looked similar to the salt. There was a risk that the salt could be mistaken for a prescribed thickener.

At our last inspection we observed one person's tablet being crushed and given to them in a yogurt. The provider had not requested advice from the community pharmacist about the administration of the person's medicine and we observed the same practice at this inspection. Dairy products can reduce the absorption of the medicine and there was a continued risk that it would not be effective.

Some people continued to receive their medicines without their knowledge crushed and disguised in food, known as 'covert medicine administration'. Nurses administering medicines continued to be confused about what covert medicine administration was and were not able to tell us why people received their medicines without their knowledge. Three people's assessments for covert medicines were not up to date and had not been reviewed when their medicines changed. There was a risk that medicines which are not suitable to be crushed would be crushed making them less effective. Decisions to administer people's medicines covertly had not been recorded and reviewed to assess any risks to the person and to show who had made the decision in people's best interests.

At our last inspection we found that people did not always receive their medicines at the time prescribed by their doctor. At this inspection we observed that most people received medicines at the time they were prescribed.

Some people's medicine administration records (MARs) did not have photographs of the person on them. Photographs help staff, especially agency staff who do not know people well, administer the right medicine

to the right person. One audit stated that photos of people needed updating on their MAR. This had not been done.

We looked at MARs and associated care records for six people. Nurses recorded on MARs that creams to keep people's skin healthy had been administered by care staff. The cream administration records we looked at had not been completed consistently. Nurses and the provider could not be assured that people's creams had been applied as prescribed and there was a risk that they would not be effective. Guidance had been given to care staff about where to apply each cream.

Homely remedies, over the counter medicines for the treatment of minor ailments, continued not to be managed safely. We were told that homely remedies were no longer held in stock. However, a stock of head lice treatments that were not labelled individually for people was held. The provider's medicines policy had not been updated to reflect the change in the use of homely remedies and there continued to be a risk that they would not be used under the guidance of a person's GP to ensure they did not impact on other areas of people's health, such as their skin health.

The registered persons had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed medicines 'when required', such as pain relief or to help them relax when they were anxious. Guidance had been provided to staff since our last inspection about the 'when required' medicines each person was prescribed. This included when it should be offered and the minimum time needed between doses. People received their 'when required' medicines when they needed them.

People's medicines were now being ordered in plenty of time so they did not run out. No medicines were out of stock. Previously we found that medicines were not always stored safely. The temperature of the medicines fridge and medicine room were now being monitored appropriately.

At our January 2017 inspection we found that risks to people had not been consistently identified, assessed and reviewed, including the risk of developing pressure sores. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe. At this inspection we found that assessments and guidance to staff had improved, but further improvements were required to make sure care was planned to mitigate risks when people's needs changed.

Staff told us some people were at risk of developing pressure ulcers. They told us that one person had a 'red area' and was receiving their care in bed so the pressure on the area could be reduced. The person was assessed in June 2017 as being at high risk of developing skin damage. The risk assessment had not been reviewed since then to identify any change in their needs. Guidance to staff about the support the person needed had not been reviewed since June 2017 or when the person's skin became 'red'. Staff told us they repositioned the person every three hours and did not place them on the red area. We found the person was asleep in bed, lying on the area. They were using a pressure relieving mattress. The nurse on duty was not able to describe the red area to us. An assessment of the red area had not been completed and care had not been planned to meet the person's needs. There was a risk the person would not receive the care they needed to prevent their skin from deteriorating.

At our last inspection we found that people were not always provided with the pressure relieving equipment they needed. At this inspection we found that people were supported to use pressure reliving equipment. The provider's action plan stated the following action had been completed, 'All nurses completing weekly

mattress air pump checks to ensure correct settings, new chart with correct setting with reference to weight to be placed in to every care plan and reviewed'. However, we found that weekly checks had not been completed and guidance continued not to be available to staff about the correct settings for airflow mattresses to make sure that they offered people the maximum benefit. Checks on mattress settings had not been carried out for a month.

We asked staff what setting a mattress used by one person should be at. They told us they did not know. The nurse on duty told us that the mattress should be set according to the person's weight and did not know that alternative measurements were used to assess the person's body mass. We asked the nurse on duty how they would decide the setting for an air mattress. They shrugged their shoulders and told us, "I don't know, it's best to", the nurse mimed pushing down on a mattress. Using pressure relieving equipment that is too firm or soft may not give people the best protection from developing skin damage. The provider could not be assured that pressure relieving equipment was being used correctly.

People's repositioning records showed that they were supported to change their positions regularly to reduce the risk of them developing skin damage.

At our last inspection we found that the provider's recruitment process had not been followed and checks had not been fully completed to make all staff were honest, trustworthy and reliable.

An audit of the Disclosure and Barring Service (DBS) criminal records checks for all staff had been completed following our last inspection. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Further checks had been completed where the provider found shortfalls such as the disclosure of a conviction.

Previously we found that action had not been taken to assess and manage possible risks to people from cautions or convictions some staff had. At this inspection we found that all cautions and convictions had been assessed but a risk assessment had not been completed in relation to one staff member who had spent convictions. The staff member worked alone with people at night and led the shift. There was a reduced level of monitoring by the management team at night.

The registered persons had failed to operate effective recruitment procedures to make sure staff were of good character.

The registered persons had failed to mitigate risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection of January 2017 found that some people were at risk of losing weight and the provider was not managing this risk. At this inspection we found that risks to people had been identified and action had been taken to support people including making referrals to the dietician. One person's eating and drinking care plan review in May 2017 identified that they had lost weight despite receiving nutritional support in accordance with the dietician's recommendations. The dietician reviewed the person's care at the request of staff. Staff had followed their advice, which was available in the kitchen and in the person's records and the person had put on a significant amount of weight.

We observed that people were not always moved safely at our last inspection and guidance had not been provided to staff about the equipment and techniques they should use to move people. At this inspection we observed staff moving people safely. Staff had been retrained and guidance about how to move people had been updated, to included details of the equipment to be used. Staff knew the correct size of sling to

use for each person and we observed people being moved safely.

Some people found it more comfortable not to use the footplates on their wheelchairs. Staff knew there was a risk of the injury to people's feet and ankles and used pillows to keep them as safe as possible. The management team was researching alternative equipment to keep people safe.

Accidents and incidents had been recorded and analysed to identify any trends. Action had been taken to reduce the risk of accidents occurring again. For example, one person had rolled out of their bed. This risk had been assessed and they now used bedrails to reduce the risk of them falling out again. Risks associated with the use of bedrails had been identified, such as the risk of people trapping their limbs between the bedrails. We observed that bedrails bumpers were fitted correctly to the bedrails, covering the gap between the rails to reduce the risk of entrapment.

Health questionnaires were completed by all staff as part of the recruitment process. Checks had been made to make sure that reasonable adjustments were made to support staff to properly perform their role. Checks on the identity of staff and the qualifications of nurses had been completed. Nurses' personal identification numbers were checked to make sure they were registered with the Nursing and Midwifery Council.

The provider's disciplinary process was followed when the management team identified that staff had not provided the care or treatment that people required, such as not administering people's medicines. Referrals had been made to the Nursing and Midwifery Council and DBS to protect people from staff members whose practice was not safe.

Our last inspection found that the registered manager had not always adhered to the provider's safeguarding policy and had not reported some instances of alleged abuse. Since the last inspection the management team had reported any concerns they had to the Kent local authority safeguarding team and informed the Care Quality Commission (CQC). Staff had worked with the safeguarding team and health care professionals to reduce the risks of incidents occurring again. There had been a reduction in the number of concerns raised.

Since our last inspection seventeen staff had completed training on keeping people safe from abuse and harm and more training was booked for the remaining staff. Staff knew the signs of possible abuse, such as changes in people's behaviour or bruising. They were confident to raise any concerns they had with the manager or provider. Concerns that had been raised had been acted on.

Risks of people being restrained unnecessarily had not been identified and managed at the last inspection. Strategies were now in place to support the people whose behaviour could challenge to make sure that they were not restrained unnecessarily and any restraint was done in a safe and lawful way. Staff had been trained to restrain people in a safe way and only as a last resort.

Staff had not been clear about the action they needed to take to keep people safe in an emergency at our last inspection. People's personal emergency evacuation plans (PEEPs) had been reviewed and now included guidance to staff about how to move people to keep them safe in an emergency. This included the equipment required to move people and their capacity to understand fire evacuation instructions. Staff knew how to support people in an emergency and had received training to use evacuation equipment. Regular tests were carried out on extinguishers, emergency lighting and fire doors.

Following our last inspection we informed the local Fire and Rescue Service about the risks we found. They

visited and gave the provider advice and guidance about improved fire safety. The provider took the recommended action, including reviewing storage in the cellar and evacuation plans.

At our last inspection we found that staffing levels were reduced at times and people had to wait a long time to receive the care they needed. Nurses and care staff were now deployed to the levels the manager assessed were required to meet people's needs. We observed that staff, including nurses were no longer rushed and people did not have to wait a long time for the care they needed. For example, when one person became anxious staff promptly sat next to them and reassured them.

There had been a change in staff since our last inspection. Recruitment had taken place and the provider was recruiting to two health care assistant vacancies. Vacancies, training and staff leave were covered by other members of the team or regular agency staff. At the last inspection the registered manager told us they were monitoring staff absence. The provider and manager had analysed staff sickness absence to look for patterns and had put strategies in place to manage this. Sickness absence had reduced.

The provider had decided to stop providing nursing care to people. Nurses had been given notices of redundancy and contingency plans were in place to make sure nurses were deployed at all times to meet people's needs until people with nursing needs were moved to more suitable placements.

Requires Improvement

Is the service effective?

Our findings

Nursing staff did not have the skills they needed to meet people's needs. At our last inspection we found that the competency of nurses to manage medicines safely had not been checked. At this inspection we found that only three of the seven registered nurses involved in the management and administration of medicines had been assessed as competent to administer medicines safely. We found medicines were not consistently managed safely by nurses. The service had changed the pharmacy which dispensed people's medicines. The current pharmacy provided an online medicines training module for staff. Although nurses had registered for this training, only one nurse had completed it. Senior health care assistants had begun to complete training so they could administer medicines to people from October when nursing staff were no longer working at the service. Nurses had not identified shortfalls in the management of medicines that we found at the inspection, including using fresh water used to prepare medicines. They were not aware of the National Institute for Health and Care Excellence advice and had not followed good practice guidance.

Previously we found that the provider's induction process for new staff, including working alongside established staff was not being followed. At this inspection we found that the provider's policy in relation to the induction of nurses had not been followed as stated in their action plan. The competency of nurses to complete tasks had not been assessed. For example, one nurse who began working at the service shortly before our inspection had not completed an induction and their competency to complete tasks including supporting people who received their nutrition through a feeding tube had not been assessed. Health care assistants worked alongside experienced staff and their competence had been assessed as part of their induction to check they were providing people's care to the standard required.

The provider told us in their action plan that qualified nurses would receive supervision from the clinical lead nurse. This had not happened and nurses had not been given the opportunity to reflect on their practice and discuss their personal and professional development. Areas of nurses' development highlighted in the provider's action plan, such as the medicines management had not been discussed to check they did not have any further development needs. The provider was not aware that the clinical lead was not offering clinical supervision to nurses as they had required them to.

The registered persons had failed to appropriately support staff to be competent to fulfil their role. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our last inspection the provider had recognised that health care assistants had not received training in key topics and had put a plan was in place to address the shortfalls. This had been effective and staff had completed a number of training courses including report writing and fire safety. A new training provider had been employed in July 2017. They had completed a training needs analysis and had planned training to develop the staff over the next six months. This included training in communicating with people with dementia.

Staff told us they had 'loved' the dementia training they had completed and described how this had

impacted on their practice. One staff member told us they had learnt that people living with dementia could sometimes take two or three minutes to respond to questions, the staff member told us they now gave people much longer to respond to questions they asked them. We observed staff giving people time to consider questions and their answers and responding to what they had been told.

During our previous inspection we observed staff using a 'drag lift' which posed a risk to people and staff. Staff had completed updated moving and handling training since the last inspection. We observed staff moving people safely with the correct equipment and techniques.

At our last inspection we found that staff had not met regularly with a manager or team leader on a one to one basis for supervision and coaching. Health care assistants had met with a manager since our last inspection but meetings were not held as frequently as the provider required. This shortfall had been identified by the management team and a plan had been put in place to meet with all staff in August and September 2017.

Staff had an annual appraisal which included discussing plans for their future development. A schedule was in place and staff knew when the meeting would take place. If meetings did not take place a new date was set.

At our last inspection we found that people's health needs were not fully supported. At this inspection we found that changes in people's health had been identified quickly and support had been obtained from health care professionals such as tissue viability nurses and dieticians. Guidance was now available to staff about the support people needed to manage medical conditions, including the advice of health care professionals.

Guidance from a health care professional about one person's needs advised that if their condition deteriorated to contact their GP. Staff had contacted the person's GP when their condition had not improved and they had prescribed further treatment. This had been administered by staff and the person's condition had improved.

Following our last inspection the provider had worked with health care professionals to reassess people's health needs. Staff had undertaken training and offered people the support they needed to manage their mental health needs. Staff described to us how some people had behaviour that challenged at times and the support they offered them. Staff understood what people were telling them when they behaved in a certain way and planned their support to reduce the risk of people becoming distressed or anxious. For example, staff told us that one person did not like loud noises or groups of people and this caused them to become anxious. They described to us how they anticipated when the person may become anxious, such as celebrations at the service and supported them to move to a quiet area or held the celebrations elsewhere at the service.

A Registered Mental Health Nurse had planned the support people needed and was available to provide support about people's mental health care. Staff had developed relationships with local mental health and safeguarding teams and discussed people's care with them.

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 make 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Previously we found that staff had not completed training on the principles of MCA and people were not supported to make decisions in ways they preferred. At this inspection we found that staff understood the principles of MCA and supported people to make choices in ways they understood. People's ability to make particular decisions had been assessed since our last inspection. When people were not able to make a decision, such as using bedrails, decisions were made in their best interests by people who knew them well, including staff, their relatives and health care professionals.

We observed staff providing information to people in different ways to them to make decisions. For example, showing people items such as food and activities. The chef was taking pictures of all the meals they made and planned to make picture cards and menus to help people make choices. Staff respected people's decisions, including any unwise decisions they made, for example, smoking.

Several people were the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. Applications had been made appropriately and people were supported to move freely about the building. The management team knew when people's DoLS authorisations were due to expire and had submitted new applications where necessary.

At our last inspection we found that meals were not always prepared to meet people's needs. At this inspection we found that staff, including kitchen staff knew about people's preferences and dietary requirements and prepared drinks, food and snacks to meet these. This included allergies and intolerances and people's cultural needs and preferences.

A new chef had been employed and they had met with people and their families to discuss people's likes and dislikes and any suggestions they had for the menu. New menus were in place and included people's suggestions, such as cottage pie and bread and butter pudding. The chef told us, "I am here for the residents. If they want something I will do my best to get it for them".

Soft meals were prepared for people who were at risk of choking. Each food was pureed separately to help people taste the individual flavours and see the colours of foods. The chef prepared birthday cakes for each person on their birthday. They prepared soft puddings and piped decorations on them for people who required a soft diet so they did not miss out.

Meals times were now planned around people's needs and preferences. We observed some people continued to have their breakfast late as they chose to get up later. We also observed people eat their lunch and tea when it was offered. People's food records showed that they had not missed meals. Food was available at all times of the day and night, including sandwiches, yoghurts and cakes. Staff had been trained in safe food handling and were able to make light meals for people when they requested them.

At our last inspection we found that people who were at risk of losing weight had not been regularly offered fortified foods and drinks. At this inspection staff explained to us who was at risk of losing weight and required extra calories. Staff knew how people preferred to take these calories such as fortifies foods and supplements. A detailed list was available for all staff, including kitchen staff to refer to. We observed people's meals and drinks being prepared to meet people's needs.

Some people were unable to eat or drink and received their nutrition through a feeding tube directly into the stomach called a percutaneous endoscopic gastrostomy (PEG). People received the support they needed to use the PEG and were offered a choice of staff to support them.

Requires Improvement

Is the service caring?

Our findings

Some people's relatives had complimented the staff on the care they provided to their loved ones. Their comments included, 'I have always felt that the care my relative receives is second to none and it is because the staff care' and 'You are all so caring and lovely. Thank you for the last day, you were a great comfort'.

We found people were not always treated with respect by all staff. We observed a positive interaction between a health care assistant and a person. They sat together, holding hands and chatting in a relaxed way. The staff member spoke with the person kindly and gave them time to respond to questions. The person told the staff member they had a headache and confirmed they would like a pain relief tablet, which was requested promptly from the nurse on duty. Shortly after the nurse told us they had given the person the tablets with a drink of water, but they had not swallowed them. The nurse placed the wet tablets, which were starting to dissolve, in a medicines pot. The nurse told us they would try to administer the same tablets again later. The nurse had not considered that it was not respectful to give the person the same tablets later. We highlighted this to a member of the management team and the medicines were disposed of.

Some information about people's needs was not kept confidential. Guidance given to staff about where to apply people's prescribed creams, including a map of the person's body, was displayed on each person's bedroom wall. The information was available to everyone who entered the person's bedroom including domestic staff and visitors.

People received their care in private. Staff knocked on bedroom and bathroom doors before entering. The privacy of people who chose to receive care or treatment in communal areas was maintained by the use of screens.

At our last inspection we found that staff were not always caring. At this inspection we observed that staff were kind and caring to people. We observed one staff member supporting a person with their breakfast. They sat next to the person and asked, "Would you like to try some breakfast?" The person said they would and the staff member gave them the support they needed to eat it. Staff no longer supported more than one person at a time and people got the attention they needed.

Staff engaged more with people as they walked through the lounges than they had at our last inspection, including as they went about their tasks. Staff stopped and chatted to people, explaining what they were doing. People responded to staff and smiled. Staff held people's hands and spoke to them quietly to reassure them. People responded positively to this and were relaxed and comfortable with the staff.

Previously we found that staff did not consistently support people to remain independent. At this inspection we observed staff encouraging people to complete tasks independently and offering them support only when they needed it. Blue toilet seats had been fitted to help people see them more easily. This had reduced the amount of support people needed and one person was now able to meet their own needs without the support of staff.

Staff used the skills they had learnt during training to understand what people were telling them. All the staff we spoke to told us that one person held staff's wrist when they were anxious and they reassured the person. Previously staff had seen this as a behaviour that challenged. Staff told us they now looked at why people behaved in certain way, including any triggers for the behaviour and planned the support they offered people in each situation. Incidents at the service had reduced.

We observed that one person appeared agitated and was trying to remove an item of clothing. Staff anticipated that the person was telling them they wanted to change their clothes and supported them to do this in the privacy of their bedroom. When we saw the person later they had changed their clothes and were relaxed and smiling.

Previously we found that some people's spiritual needs were not met. People and their families had told staff about their spiritual preferences and this information was now available to staff. People were supported to follow their preferred religion if they wanted to. Religious services were held for people who wanted to attend.

At our last inspection staff told us they did not know about people's likes, dislikes and had not been told about people's lives before they moved into the service. At this inspection we found that staff now knew about people's likes and dislikes. The 'This is me' documents previously completed by people and their relatives were available to staff in their care records. The 'This is me' is a form designed by the Alzheimer's Society to support people to share information about their cultural and family background; events, people and places from their lives; preferences and routines. Staff used this information to plan people's care, including the music people listened to and the films they watched.

People had been asked about if they preferred a female or male carer. . Where people had expressed a preference staff made sure a carer of the person's preferred gender always provided their support.

People who needed support to share their views were supported by their families, solicitor or their care manager. The management team knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that many people were not offered support to do things during the day. The provider had put a plan in place to improve activities following our last inspection, this had not been fully implemented as one activities coordinator had left and although a replacement was being recruited the post was not being covered by another staff member. We will follow this up at the next inspection. The main role of the activities coordinator was to spend time with people who chose to remain in their bedrooms, to reduce the risk of them becoming lonely and isolated. Other people continued not to be offered opportunities to take part in activities. For example, we observed eight people living with dementia sitting in two lounges during the morning. The people needed encouragement and guidance from staff to take part in activities. They were not offered anything to do by staff and most people fell asleep. Two people painted pictures with staff support and other people read.

The provider had employed outside companies to visit the service to provide activities and entertainment. This included 'music for well-being' which people enjoyed. Staff told us they had seen 'fiddle mats' during their dementia training and purchased some for people to use. We observed people sitting calmly, 'fiddling' with the mats.

People were supported to go out with their families and staff. During our inspection one person opened an outside door on several occasions. Staff told us the person told them they wanted to go out by opening the door and supported the person to go into the back garden. People had been supported to attended local events such as the carnival, which people had enjoyed.

Following our last inspection the provider had stopped taking new admissions into the service for five months while they made improvements. They began taking new admissions into the service in May 2017 and four people with less complex needs had moved in.

Before moving in people and their families had met with staff to complete an assessment of their needs. The preadmission assessment process had improved since our last inspection and important information including how people preferred their care provided was now obtained. This helped the manager make sure staff could provide the care and support the person wanted. People were only offered a service when the management team were confident they could meet the person's needs and they would get along with other people already living at the service.

Further assessments of people's needs, such as their mental health needs were completed once people began to use the service. Assessments were reviewed monthly and were used to plan people's care and support with them.

Basic guidance about how to provide people's care was available to staff in people's care plans. Most people's care plans had been written and reviewed by nurses without the input of people, their relatives and health care assistants who knew people well. The management team recognised that people and others needed to be more involved in planning their care. A plan was in operation to improve the quality of the

information provided to staff. This had been effective and the care plans which had been rewritten included more detailed information about people's preferences and the support they required from staff.

Previously we found that peoples' care plans were not working documents and staff did not refer to them for information about people's needs and preferences. Since our last inspection care plans had been moved from the manager's office to a locked but accessible cupboard in the lounge. All the staff we spoke with had read people's care plans and referred to them during the inspection. Staff no longer relied on each other for information about how to provide people's care. However, a senior carer, nurse and managers were always available to offer further advice and guidance.

At our last inspection we found that detailed guidance was not available to support staff to provide consistent care, such as support to move around. At this inspection we found that guidance to staff had improved and the details of the equipment to be used in different situations was included. For example, if staff were supporting someone to stand from a chair or from the floor.

Reviews of people's care continued to be completed by staff, and some of these now included health care assistants as well as nurses to gain more wide ranging information. Some people and their relatives had been involved in updating their care plan to make sure their views were included. Plans were being implemented to support people and their families to be more involved in planning and reviewing their care.

At our last inspection we found that the registered manager had failed to record, handle and respond to complaints effectively. At this inspection we found that the provider's process to receive and respond to complaints had been followed.

Complaints received had been acknowledged and investigated. People who had made complaints were informed about how their complaint had been investigated and the outcome of the investigations. Everyone was satisfied with the response they received. The provider and manager had apologised for any mistakes made and had used the outcome of complaint investigations to improve practice at the service.

Requires Improvement

Is the service well-led?

Our findings

Following our last inspection we applied a condition to the provider's registration requiring them to regularly send us an action plan detailing the actions being taken to address the shortfalls at the service. We received these action plans as required. Some of the actions the provider had taken and told us were completed were not. This included improvements to medicines management, support for nurses, and the guidance provided to staff about using pressure relieving equipment to mitigate risks.

At our last inspection we found that regular checks had not been completed on all areas of the service to make sure people received good quality care. At this inspection we found that checks on the quality of the service had increased but were not always effective in picking up issues. The shortfalls we found in relation to the management of medicines, including the dirty clinical room, lack of recorded decisions regarding some covert medicine administration and prescribed creams not being recorded, risks and recruitments had not been identified.

Two medicines audits had been completed by community pharmacists since our last inspection. Both audits identified that medicines preparation and storage areas required cleaning. This had not been addressed and we observed that the areas were not clean.

Action had been taken to address some shortfalls the management team found. A week before our inspection the management team's monthly weight audits found that staff were not weighing people and assessing their nutritional needs as required. A weekly check had been put in place to make sure that people's nutritional needs were assessed as required so any changes would be identified quickly. An audit of people's care records had found that some people's care plans and risk assessments had not been reviewed in the past month as required by the provider's review process. A plan had been put into place to address this and care plans and risk assessments were being reviewed at time of our inspection.

Previously we found that records of people's care did not contain information about what each person had done each day or the support staff had provided to them. We also found that important information about people was not recorded and available to staff and visiting professionals. At this inspection we found that the records kept by staff about people's care had improved. The management team had recognised that further improvements were required and had plans in place to rewrite each person's care plan with them and their relatives.

Confidential information about people was not always stored and disposed of safely. Empty medicines boxes had been disposed of in the household waste. Labels with people's names had not been removed to protect their identity. Other information about where people needed cream applied was displayed in view of people, staff and visitors so did not protect people's confidentially.

The registered persons had failed to assess, monitor and improve the quality and safety of the service provided to people. The registered persons had failed to maintain an accurate, complete and secure record in respect of each person, including a record of the care provided to them and of decisions taken in relation

to the care and treatment provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that guidance about the support people needed was not easily available to staff because it was stored in the registered manager's office away from where people received their care. Staff relied on each other to know about how to manage risks to people. People's care records were now stored in a locked cupboard and were accessible to staff at all times to refer to. We observed staff refer to guidance during our inspection.

The manager had been working at the service since March 2017. There were supported by a deputy manager and a 'clinical lead nurse' as the manager was not a registered nurse. The manager had applied to be registered with the Care Quality Commission (CQC).

At our last inspection the registered manager told us they had not taken up offers of support, advice and guidance from visiting professionals, including a clinical nurse specialist for older people. Before this inspection visiting health care staff told us that the management team had asked for support and advice when they needed it, including support with the treatment of people's wounds.

All the staff we spoke with told us the leadership at the service had improved since our last inspection and they felt supported by the provider and management team. They told us the management team provided them with support and guidance when they asked for it and were always available. Staff told us they no longer felt pressured to make decisions and complete tasks without support and guidance. Staff were now clear about their roles and responsibilities and were reminded of these at staff meetings, one to one meetings and promptly if shortfalls were noted in their practice.

One person's relative told us, "There have been huge changes of staff and I find it very disconcerting. It's taking a long time for them to get to know my loved one". The provider had identified that there had been a large change in the staff team and was taking action to increase staff retention. This included rewarding staff for their hard work and dedication to improving the service, for example, during hot weather the provider had purchased cold drinks and cakes for all the staff. Staff told us they appreciated these. Plans were in place to begin other staff rewards.

The previous registered manager had delegated some leadership roles to other staff, including interviewing potential new staff. The manager had taken back these management responsibilities and completed them with support from the deputy manager and provider. The staffing structure had been streamlined and one senior carer allocated tasks and led the shift.

Previously we found that staff did not know about the provider's philosophy of care and did not provide the service in accordance with it. Action had been taken to address this and the principles of the philosophy such as dignity, respect and independence underpinned the training staff completed. At this inspection we found that most staff treated people as the provider and manager required.

Staff told us previously that they did not work as a team and some new staff felt isolated. The management team and provider had improved teamwork and we observed staff working well together. Staff told us they felt part of a team. One new staff member told us the staff team had been welcoming and supportive when they began working at the service.

The provider's process to regularly ask people, their relatives and staff for their views about the quality of the service was now effective. Residents and relative meetings had been held monthly since our last inspection.

The meetings were well attended. At the July 2017 meeting, relatives had commented on staff's enthusiasm and improved care following the completion of dementia training. People and relatives who chose not to attend or were unable to attend were contact for their views and feedback. A relative's representative had been appointed and took forward people's comments and suggestions with the provider.

A staff survey had been completed in March 2017. The responses had been analysed and action had been taken to address the concerns staff raised. A third of the staff had said that senior managers did not act on feedback given to them by staff. The management team now spent more time working alongside staff and speaking to staff. Staff told us their feedback was now listened to and acted on. During our inspection one staff member suggested improvements to the recruitment process to help staff retention. The provider told us they were very pleased the staff member had made the suggestion and they would use the suggestion when recruiting health care assistants in the future. Other improvements implemented at staffs' suggestion included an ice-cream van calling as they had noted people enjoyed ice-creams when they were out. Plans were in place to complete another survey to check the actions the provider and manager had taken were effective.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. At our last inspection we found that notifications of significant events had not been submitted as required. Since our last inspection we have been notified of all significant events at the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception area. Plans were in place to display the rating conspicuously on the provider's website when it was available.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. The registered persons had failed to mitigate risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to assess, monitor and improve the quality and safety of the service provided to people. The registered persons had failed to maintain an accurate, complete and secure record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to appropriately support staff to be competent to fulfil their role.