

Mulberry Court Healthcare Limited

# Mulberry Court Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We carried out an unannounced inspection of the service on 31 January 2017 and 1 February 2017.

We carried out a comprehensive inspection of this service on 19, 21 April 2016 and four breaches of legal requirements were found. These included; medicines not being safely administered, people being unlawfully deprived of their liberty, quality assurance audits were not effective and people were not supported by sufficient numbers of suitably qualified staff. We undertook this inspection to check that they had followed their action plan and to confirm that they now met the legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mulberry Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

Mulberry Court Care Home is registered to provide personal care for up to 43 people. At the time of our inspection there were 21 people using the service. Mulberry Court was newly registered in November 2015.

Mulberry Court Care Home is a two storey home situated in the middle of a housing estate in Bilborough, a suburb of Nottingham city. There are 43 single rooms with shared bathroom facilities. There is a communal lounge and separate dining room. There is a reminiscence area. Outside is a garden area that can be accessed with support from staff.

Since our last inspection there had been a change of management and a new registered manager had been recently recruited and was in post during our inspection. 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.

Staff were aware of the safeguarding adult procedures to protect people from avoidable harm and most had received appropriate training or were booked onto training. Most risks to people's health were known by staff and these were reviewed regularly.

People received their medicines as prescribed and these were managed correctly. However, medicines given 'as required' did not always have the appropriate guidance or protocols that staff needed to follow.

Accidents and incidents were recorded and appropriate action had been taken to reduce further risks. There had been improvements made to the cleanliness and décor of the home.

Safe recruitment practices were followed and only people suitable to work for the service were employed. Staff received an induction, training and appropriate support necessary to carry out their roles.

People received sufficient to eat and drink and their nutritional needs had been assessed and planned for.

People's weight was regularly recorded where needed. People received a choice of meals. People's healthcare needs had been assessed. We observed healthcare professionals visiting people throughout our inspection and records we checked confirmed this was taking place regularly.

The registered manager applied the principles of the Mental Capacity Act 2005 (MCA) and Deprivations of Liberty Safeguards (DoLS), so that people's rights were protected. Best interest decisions had been recorded but records did not always show who had agreed these.

Staff were kind and caring when supporting people. Most care records were up to date and effective in meeting people's needs.

People or relatives were involved as fully as possible in their care and support, however records checked did not always confirm this. There was a complaints policy and procedure available and complaints were responded to effectively. Information was available to inform people of independent advocacy services. There were no restrictions on people visiting the service.

People were supported to participate in activities of their interest. An activities coordinator led group activities which were run daily. Staff supported people with their goals and aspirations that promoted independence.

The provider had made improvements in monitoring the quality and safety of the service. Quality assurance audits had been recently introduced and were being reviewed regularly by the provider and registered manager. These needed to be sustained over a period of time to confirm their effectiveness.

The provider had sent out feedback surveys to clients, relatives and staff.

The provider was aware of their regulatory responsibilities.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good** ●

The service was not consistently safe.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of harm. Most staff had received safeguarding training.

People received their medicines as prescribed and were managed safely. However, some medicines given 'as required' did not always have the appropriate guidance or protocols that staff needed to follow.

Assessments did not always contain sufficient details for staff about how to reduce the risks for people.

Staffing levels were sufficient to meet people's needs. The provider operated safe recruitment practices to ensure suitable staff were employed to work at the service.

The provider had implemented systems that had improved the cleanliness and hygiene at the service.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Staff received an induction and on-going training that was relevant to people's needs. Staff received appropriate and regular opportunities to review their work, training and development needs.

There were behaviour care plans in place to support people who experience periods of high anxiety.

People's rights were protected under the Mental Capacity Act (MCA) 2005, but best interest decisions were not always recorded clearly.

The provider ensured people had a choice of nutritious meals and had sufficient amounts to eat and drink. Monitoring of people who were at nutritional risk was recorded.

People were supported to access external healthcare professionals when needed.

### Is the service caring?

Good ●

The service was caring.

People were supported by staff who were kind and caring. Staff were given the information they needed to understand and support the people who used the service.

The provider had ensured people had helpful and important information available to them such as independent advocacy and support services.

People were asked about their preferences and staff respected these. There were no restrictions on friends and relatives visiting people.

### Is the service responsive?

Good ●

The service was responsive.

Most people's care and support were personalised to their needs, preferences and routines. The service had run successful themed days, alongside supporting people with their hobbies and interests.

People and their relatives were supported to contribute as fully as possible to their assessment and in decisions about the care and support they received.

Complaints were responded to effectively.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well-led

A registered manager had been recently appointed who had made improvements at the service since our last inspection, but this needed to be sustained.

The provider had recently improved their systems and processes that monitored the quality and safety of the service. However, this needed to be sustained.

People, relatives and staff were given opportunities to contribute

to decisions to improve and develop the service.

The provider was aware of their regulatory responsibilities.□

# Mulberry Court 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 31 January 2017 and 1 February 2017 and was unannounced.

Before the inspection we reviewed information we held about the service including the last inspection report and notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service to obtain their views about the care provided by the service. Prior to the inspection we received some information of concern about the care provided to people and we used this information to assist our planning.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

The inspection team consisted of two inspectors 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.

On the days of the inspection we spoke with ten people who used the service. We also spoke with five relatives or visitors who were visiting. Some of the people who used the service had difficulty communicating with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the registered manager, a cook, two domestic staff, two senior care staff, one care staff, the maintenance worker and an activities co-ordinator. We looked at all or parts of the care records and/ or relevant records of seven people who used the service, as well as a range of records relating to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

We spoke with four health professionals who were visiting the service.



# Is the service safe?

## Our findings

During our previous inspection In April 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns that people medicines were not managed safely. This was because safe administration guidance was not followed and this put people at risk. This was because safe medicines administration guidance was not followed. We also had concerns about people's risk plans and these had not been reviewed and recorded effectively.

At this inspection we found that improvements had been made in the management and administration of medicines. People told us staff looked after their medicines. One person said, "Staff keep the medication safe and make sure [relative] has their tablets." A relative also told us that medicines were well managed.

We checked six Medication Administration Records (MAR) and these all had the name of the person, who the medicine was prescribed for, the name of the medicine, dosage and frequency. However, the preferred method of taking medicines was not always recorded. The MAR sheets had all been signed appropriately. We observed a senior staff member administer medicines to people, they did this competently and followed the providers medicine policy and procedure. Regular monthly medicine audits were carried out by the registered manager to confirm medicines were being given safely.

We observed that staff offered people 'as required' medicines and this was documented correctly. However protocols were not always in place for medicines which had been prescribed to be given 'as required'. Protocols would provide information for staff on the reasons 'as required' medicines should be administered.

Staff told us, and records confirmed, that staff had attended training in medicine management. The registered manager told us staff competency was regularly assessed to ensure medicines were administered safely and in line with current best practice guidelines. We checked records which confirmed competency assessments had been completed and signed by staff and their assessor. Our checks on the management and storage of medicines including the medicine policy reflected current professional guidance.

Recent medicine audits completed by Boots Pharmacy and the local Clinical Commissioning Group showed the service managed medicines safely and had scored well which provided further evidence that the service had made improvements in this area.

At our previous inspection we found there were no repositioning charts or any evidence to confirm people were being assisted to change position by staff in order to minimise the risk of pressure ulcers.

At this inspection we found that improvements had been made in this area. Risk assessments had been completed and plans developed to advise staff of the required action to manage these risks. We checked records for people that required support with regular repositioning and these were being carried out effectively. A relative described how their [family member] had fallen out of bed and how the home had assessed the risk and found ways to reduce the risk with minimal impact on the person's freedom. However,

one person's file stated a person was at risk of choking but no guidance was in place to advise staff how to effectively manage this. This showed us that further improvements were still required in this area to ensure that appropriate guidance was in place to support staff to reduce the associated risks.

We observed one staff member supporting a person unsafely under their arms. This person needed to be assessed to see if equipment would be required to move them safely. We were told that this person could independently transfer and mobilise around the home and records checked confirmed this.

Accidents and incidents were recorded and body maps used to detail any injuries. The registered manager, staff and healthcare professionals, where needed reviewed these records to check that incidents were responded to appropriately and that people received the care they needed. The registered manager told us they looked for any patterns or trends to reduce further risks and records checked confirmed this. Where some people were at risk of falls, assistive technology, such as, sensor mats were used to alert staff if a person was mobile in their room. This meant that people were supported effectively when mobilising in their rooms.

During our previous inspection in April 2016 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns about how people were not supported by sufficient numbers of suitably qualified skilled or experienced staff.

People we spoke with confirmed there were sufficient staff available and they responded appropriately when needed. One person said, "Staff came straight away when I fell." Another person said, "There's a button to press if you need help, I have one in my room, but I haven't needed to use it yet." A member of staff said, "Staffing levels are much improved. There's always someone to watch the floor. No-one's waiting to go the bathroom; we can help people when they need it."

We checked the rotas and there were sufficient staff available to meet the needs of the service. The service used a staff dependency tool to maintain sufficient staff numbers across the service and to meet people's individual needs. Agency staff were used to cover staff absences. During our inspection we observed staff were deployed within minutes when people required assistance.

People told us they felt safe at the service. One person said, "I feel safe, if [staff] need to leave the room, they leave a 'knob' [call button] so I can call them." A relative said, "I feel confident in the staff, I feel my [relative] is safe here." Another relative shared, "[My family member] is totally safe in the home."

Staff demonstrated they were aware of the signs of abuse and what their role and responsibility was in protecting people from avoidable harm. A safeguarding policy was in place and staff followed this when reporting any concerns they had, either internally to the registered manager, or to external agencies such as the CQC.

We were aware of the action taken by the registered manager in response to concerns, allegations and potential safeguarding risks. This included informing external agencies and CQC, and working with the relevant organisations responsible for investigating safeguarding allegations. These were now being managed well with the involvement of health and social care professionals.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. Records showed regular servicing of equipment such as hoists, walking aids, gas installations and fire safety and prevention equipment were carried out to ensure they were safe to use.

However, there were some areas that required attention. Not all of the bedrooms were locked when not in use. We accessed one bedroom that was not in use which contained a wardrobe not securely fixed to the wall. This meant someone could access the room and may be at risk of injury from unsecured furniture. At the bottom of one stairway a stand aid and wheelchair were blocking the fire exit. We shared this with the registered manager who took immediate action and cleared the area to make it safe.

The internal and external environment was clean and tidy and well maintained. This was an improvement since our last inspection. One person said, "There's a massive improvement here. It was scruffy before, but the decoration is great now. I think they've done a really good job." Another person said, "When they scrub the floors, they put warning boards; so we don't slip." A relative said, "It is clean and staff are friendly."

One person said, "We can't go out into the garden at the moment." The person explained that it was not secure and people might try to escape. We spoke to the provider and registered manager about this. They explained work was planned for March 2017 to make the garden safe and fully accessible. We received confirmation of the works to be undertaken after our inspection.

We were told people were not restricted in accessing the garden but some people would need support from staff to do this safely. All doors were alarmed and one person explained, "The alarm went off in the lounge; the manager and 'odd job man' came within minutes. It was a latch on the door that was broken, they mended it within minutes." Maintenance records we checked confirmed this had been recorded and actioned.

Personal Emergency Evacuation Plans (PEEP's) were in place. PEEPs contain information that support staff and emergency services in knowing what support a person will need to be safely evacuated from their home. A business continuity plan was in place which recorded the actions that would be taken to protect people in an emergency; such as loss of power, heating or water.

Safe recruitment and selection processes were in place. We looked at four staff files which confirmed all the required checks were completed before staff began work. This included checks on criminal records, references and employment history. This process was to make sure, as far as possible, new staff were safe to work with people who may be at risk of harm. This showed that the registered manager followed robust recruitment practices to keep people safe.

## Is the service effective?

### Our findings

During our previous inspection in April 2016 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns that the provider was not providing staff with the required induction, support and training to ensure their competency was maintained.

At this inspection we found that improvements had been made in this area. We spoke to a relative about the staff and they said, "I think that staff are fantastic."

The staff we spoke with were positive about the induction, supervision and training they had received. Records checked confirmed this was taking place. However not all staff had completed the core training. There were many new starters who were going through a period of induction. Inductions included a period of shadowing alongside experienced workers, working in pairs and attending training. Some of the core training included; safeguarding adults, Mental Capacity Act (MCA), moving and handling, medication management, infection control and fire prevention. The registered manager and provider assured us that all core training will be completed by mid February 2017 for all staff.

The registered manager also confirmed that all staff had recently been enrolled onto 'The Care Certificate.' The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers.

A specialist dementia outreach practitioner was visiting the service and confirmed all staff had been on dementia training which was delivered by their team. They were positive about how staff supported the needs of people living with dementia and how any associated behaviours were responded to effectively.

During our previous inspection in April 2016 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns about how people were unlawfully deprived of their liberty. We were not confident that the service was providing care for people in line with the legal requirements of the MCA as staff had insufficient knowledge and use of the MCA legislation. At this inspection we found that the necessary improvements had been made.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS evidence showed these had been made where required.

Most staff had completed MCA training which had improved their understanding of the MCA and its impact

on people living at the service. Staff confirmed they had received training and knew what action to take if they had concerns about a person's ability to consent.

MCA assessments and best interest decisions had been made where appropriate. Where an MCA assessment had been completed that showed a person lacked mental capacity to consent to a specific decision a best interest decision was recorded. Records showed involvement of relatives in best interest decisions but we did not always see evidence of health professionals involvement. This is good practice for decisions about people's health and well-being.

Some people living with dementia had periods of anxiety that affected their behaviour at times. Behavioural charts had been completed when this happened but behaviour care plans were not always in place. This meant staff may not always be aware of how they should respond and incorporate the risk this put people at. The registered manager confirmed these would be reviewed and updated.

People told us they could choose what they wanted for breakfast. We saw people were given both hot and cold options. Most people had the same routine for breakfast and staff were familiar with these. One person changed their mind after trying a spoonful of porridge. They then chose a cooked breakfast. Throughout the inspection hot and cold drinks were offered to people in the lounge. In the morning the cook was observed asking people about their choice of meals for lunch. The cook explained to us how pictures were also shown to people of meals that could be prepared. If people were still unsure small plates were dished up and shown to people so they could make a choice at mealtime. However we did not see this happen. This meant that it was more difficult for people living with dementia to be able to make informed choices about their meal preferences. We did see the cook showing someone a range of fruit to help them choose what they would like to have as a snack.

We observed lunch and noted some people were able to eat independently and where people needed support this was on the whole provided. Some people ate better after being prompted. During lunch two people were not offered clothes protectors until well into their meal. Condiments were not always available on the table. Puddings were brought out before people had finished their main meal. This could have a negative impact on the people's meal time experience as some people may feel rushed or could get confused.

We received positive comments about the food and drink. All meals that were prepared looked appetising, nutritious and portions appeared to be the same size. One person said, "You have a decent scan [food] here. I choose porridge for breakfast, It sets you up for the day."

There were sufficient staff available to support people at mealtimes. One person was observed wandering about in the dining room and into the lounge about four times during their meal. Staff helped this person sit down, but then went off to do other tasks. This person used their hands to eat. Some adaptive cutlery and a little more engagement from staff when supporting people during their meals was needed.

The cook as well as other staff, had undertaken a nationally recognised qualification in food hygiene training. The cook had detailed dietary information for each person who used the service. This included information about allergies, food intolerances, likes and dislikes, preparation of food [e.g. soft or pureed diet] and any assistance they required with eating and drinking.

People were weighed regularly to enable the staff to assess whether people's health was at risk as a result of excessive weight gain or loss. Where expert guidance was needed, referrals to Psychiatrists, GPs, dieticians, Speech and Language Therapists (SALT) were made and recommendations implemented.

One person would not eat or drink because they felt they needed to pay for their meals. Even though the service reassured the person and explained their fees included meals this person would still not have meals. The business manager was able to create an innovative plan to develop a meal voucher which the person could hand over at each meal time in exchange for their meal. This intervention directly led to the person coming off end of life care and gaining weight. This was a creative way of respecting a person's independence, dignity and health needs.

## Is the service caring?

### Our findings

People told us the staff were kind and caring. Our observations confirmed this. One person said, "I find them lovely. The staff are sociable, very helpful and would do anything for you." A relative said, "Staff are very caring. They put a lot of time in. No one's ever rushed." Another relative said, "I am really impressed. I can't praise the staff enough."

People were seen to be relaxed within the company of staff, and appropriate exchange of light hearted friendly conversations were observed throughout our inspection. We observed staff had good interaction and communication skills. We observed many interactions between staff and people that were positive and supportive. When people needed support from communal areas to their rooms this was done with positive banter and a caring approach.

Relatives told us they had been involved in decisions about their family members care. They also told us that their family member was as involved in decision-making as they wanted to be. Signatures seen in care plans indicated consent to photographs had been taken. However, we did not always see signatures in relation to care plans or any formal care reviews with the person or their relatives.

We saw people had access to information about independent advocacy services. This was available in the various communal areas around the service. However this was not available in people's service user handbook. Advocacy services act to speak up on behalf of a person, who may need support to make their views and wishes known. The provider confirmed they would add this information to the service user handbook.

A person was wearing nightwear and a dressing gown in the lounge. Staff asked if they wanted to get dressed and the person said no they were comfortable. Staff said, "Okay just tell me if you choose to get dressed later and I will help you."

People told us they felt the staff treated them with dignity and respect and we saw staff doing so throughout the inspection. We observed staff listened to people's requests and spoke respectfully to people. Where people's care needs were being discussed in public, either with the person, or with other staff, this was done so discreetly, which ensured people's dignity was maintained. Information was provided within the home which informed people how they should expect to be treated by staff and how staff would ensure that people's rights were respected. We saw people's right to privacy were respected, with staff listening to people's requests to go back to their bedrooms, or asking to be left alone. Staff would also knock on people's bedroom doors and waited an acceptable length of time before entering. This ensured people's privacy and dignity were not compromised.

People within the home looked clean and well presented. One person said, "Clothes are always clean and well maintained." We visited people in their rooms and they were also well presented. This meant staff treated people with respect by ensuring they were clean and presentable.

One person had a fall in the dining room. Staff responded quickly and effectively. Two staff were observed supporting and reassuring the person in a caring and professional manner. A privacy screen was used to maintain the person's dignity whilst waiting for the paramedics.

Staff we spoke with understood how to promote people's independence and knew their preferences. One person said, "I have help to have a shower, I do a full wash myself the rest of the time." Another person said, "I have a shower about every 3rd day. If I'm not feeling too good, I'll give it a miss. There's a seat so I can do it independently." This told us people were able to maintain their independence by choosing how much support they required.

People's care records were handled respectfully. The importance of confidentiality was understood and respected by staff and confidential information was stored safely. This ensured that people's personal records could not be viewed by others, ensuring their privacy was maintained.

People, relatives and staff confirmed relatives and friends were able to visit freely without any unnecessary restriction. We observed relatives, friends and health and social care professionals visit people throughout our inspection.



## Is the service responsive?

### Our findings

People told us the staff supported people with their goals and aspirations. A person said, "(The activities co-ordinator) takes people out. On Thursday I'm going to Asda to buy a telly so I can watch TV in my room." Later the person said that they were going to the, "Chapel for a sing song." A relative said, "[My family member] is encouraged to do what [they] want. [My family member] can get up and go to bed when they want." A person confirmed this by telling us, "Breakfast goes on to 10am, you can have a lie in if you want to."

People and their relatives where appropriate, had been involved as fully as possible in the pre-admission assessment. We saw records that confirmed this. These assessments are important to ensure the provider can meet people's individual needs before admission to the service to enable staff to provide a responsive and personalised service. Care plans were then developed to support staff to understand what people's diverse needs were and how to respond using a person centred approach.

Staff felt that care records were well organised and provided clear guidance. Staff knew and understood how to meet people's care needs. Care records were better organised since our last inspection, but we saw some records did not contain all the information necessary to support people effectively. For example a person with diabetes had information in their care plan about foot and eye checks but no guidance on hypoglycaemia (hypo). Hypoglycaemia is a condition where the level of glucose (sugar) in the blood drops below a certain point. This causes a number of symptoms such as dizziness, sweating, shaking and palpitations, that usually go away 10 to 15 minutes after eating something sweet.

We reviewed care plans for two people that needed support to be turned in the night. Repositioning charts that detailed the frequency of turns were in place for both people. However, the records for one person did not demonstrate that they had received support to change their position as reflected in their care plan. This person had no current skin damage listed on their records.

Another person's care plan contained information about supporting them with continence and stated to refer to the nutrition section of the care plan for a well-balanced diet. When we referred to this section there were no details of food and drinks that could support this person with a well-balanced diet. This showed us that records had not always been updated to reflect people's needs. During our inspection health professionals had been visiting people and no concerns were raised about people not receiving the care they needed. People and their relatives did not raise any concerns about the support received in these areas. We discussed care plans and documentation with the registered manager at the inspection and she confirmed that these records will be reviewed and updated as matter of urgency.

Staff told us another person woke in the morning at a certain time when we checked the person's care plans there was a two hour difference to the time we were told. Records needed to reviewed to reflect people's changing needs. However people did tell us they were able to get up when they chose. We saw people having breakfast in the dining at different times throughout the morning. One person said, "Breakfast goes on to 10am, you can have a lie in if you want to."

A relative said, "[My family member] has gone out shopping. There was a New Year's Eve party and we went to the Burns Night. There's so much to do. They've done cake mixing, skittles; it's really exercised their mind." The relative showed us a film they had made using their phone which showed a bagpiper had been playing at the Burns Night and staff had been dressed in kilts. Picture boards of themed events were visible in various communal areas around the home.

A relative described how their family member is supported to take part in activities and care for themselves. They said, "[Their relative] looks at the photos of all of the things (the relative) has done and staff encourage [relative] to get involved. [Relative] likes doing things for themselves and they [staff] encourage [relative] to do that."

There was a section in people's care plan about socialising and staff used this to provide person centred activities. There was evidence of wide range of activities taking place in the home, people leaving the home to go to pubs, cafes and shopping.

Outside entertainers, schools and churches had visited the home to celebrate festive occasions. The activities coordinator had a good knowledge of activities available for people living with dementia and had plans to improve these further. Activities records reviewed had been completed well and people that took part spoke positively about them.

During our inspection we saw that there were various activities people could choose to take part in. There was a selection of films, some music, people could have a hand and head massage and some people chose to have their nails manicured and painted. People were seen to be comfortable, happy and relaxed when taking part in the activity of their choosing.

We observed people taking part in a quiz. The activities co-ordinator adapted her communication with each person to encourage everyone to be equally involved and use their skills, for example, asking one person to read the question and asking people by name for their ideas of the answers.

The dining room wall had lots of photographs of activities that people have been supported to take part in including making pumpkin lanterns, cleaning and word-searches. People we spoke with were able to fondly recall taking part in these activities. The activities co-ordinator said, "I put them on the wall to remind people what we have been doing and so relatives can see what we have been up to."

One person's first language was not English. There was a worker on shift who was able to communicate with them and we observed the positive interaction between both. Later we asked the worker about this person's personal preferences and they were able to explain clearly how they supported this person with these. The worker had also prepared some culturally appropriate meals that the person might enjoy which showed us that people's cultural needs and wishes were respected.

When people required support to go the bathroom from communal areas we observed that this was done quickly and respectfully.

All staff were required to attend dementia training and invites were also offered to people living at the home. One person took up the offer and joined the training and received a certificate to confirm they had completed the training. This person proudly showed us their certificate of achievement. This person would also welcome and greet guests who were moving in, or if they were having a look around would share their perspective of living at the home.

When people wanted to go out in the community they were able to. One person said, "If I want to go out I can, I go out on my scooter. If I ask for my scooter to be charged they will do it, but I have to ask." A relative said, "They [the service] make good community links, like going to play bingo at the social club down the road."

People were provided with the information they needed to assist them with making a complaint if they needed to. This information was also in the service user handbook, but this information could be made more visible around the communal areas. People told us they would speak with the registered manager if they had concerns and they would be responded to appropriately.

There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain clearly how they would respond to any complaints raised directly with them.

We viewed the complaints register and saw the registered manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner, in line with the provider's complaints policy. Learning from complaints was shared at staff meetings.

## Is the service well-led?

### Our findings

During our previous inspection In April 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management failed to take action in response to safeguarding concern which could have impacted on people's safety. There was no learning or evaluation from accidents and incidents. Audits were not effective in identifying and rectifying issues found within the service. Care documentation was not adequate in demonstrating an accurate, up to date record for each person using the service. People had not been given opportunities to comment on their views of the service.

At this inspection we found that improvements had been made in the leadership of the service. When a safeguarding incident was raised appropriate agencies had been informed including CQC using the appropriate notification. The service liaised effectively with the local authority when safeguarding concerns were investigated. The registered manager developed learning and good practise from outcomes of investigations for their staff. People and staff confirmed the service had improved since the new registered manager had been in post.

Since the appointment of the new registered manager the service had been working through an action plan to improve the service which had been required by local commissioners and CQC. The provider and registered manager confirmed this had been completed in December 2016. We were told by the provider and registered manager that new quality audits systems had begun in January 2017.

A range of audits were now in place to check on quality and safety. Areas included medicines, care file reviews, health and safety of the premises, equipment and the environment. The registered manager and provider told us that action plans were developed to continually improve the service. The provider needed to sustain and evidence the quality audit processes for a longer period of time to confirm this was effective. As some documents we reviewed had not been picked up as requiring additional information to bring them up to date.

We received positive feedback from external healthcare professionals that visited the service. They said they had seen improvements under the leadership of the new registered manager. This included having good communication and better joined up working to improve people's health and well-being outcomes.

The provider's statement of purpose and service user guide provided information about what people could expect from the service. This included the provider's vision and values. We found staff understood these and demonstrated them in their day to day work.

The provider's representatives visited the service on a weekly basis where they met with the registered manager to discuss how the service was operating and what action was required to further develop the service. We saw records that showed where improvements had been identified plans were in place to make these required changes. This told us that the provider was continually reviewing and improving the service.

Staff spoke positively about the registered manager and staff were clear on expectations required from them. Staff told us the registered manager was approachable and would sort any problems out. A staff member said, "She's very polite and supportive." Another staff member said, "It's definitely improved since she came. It's much better."

Our observations of the registered manager showed her to be calm when talking with staff. The registered manager was also caring and respectful when speaking with people and their relatives. When incidents occurred the registered manager had confidence in her team to manage the situation. If further support or guidance was required the registered manager would make herself available.

At the previous inspection there were, staff 'Champions' at the service but staff were unclear what this meant for them and the service. These roles now enabled staff to develop their skills and knowledge to support the service in areas of their interest. Some examples of these roles included a; 'Dignity Champion', 'Admissions Champion' and 'Health and Safety Champion'. Staff we spoke with were able to share with us what the role meant to them and how this supported the home, This still needed to be embedded into the service so that people and relatives could fully understand how this benefitted them. Dignity champions believe that dignity is a basic human right, not an optional extra and aim to uphold dignity in care settings such as care homes. This information was visible on the notice board at reception for everyone to view and access.

Staff were aware of the whistle blowing policy and procedure. A whistle-blower is protected by law to raise any concerns about an incident within the work place. Staff said they would not hesitate to use this policy if required.

During the visit where evidence could not be provided clear action was taken to tell us how and when they would do this. We requested some additional information after our site inspection and this was received on time. The registered manager and provider were committed to improving the service. The registered manager's clarity and understanding combined with a caring approach was reflected in the way people and staff spoke about the positive impact she had had since joining the service. However, this effort needed to be sustained by both the registered manager and provider.

We saw that all conditions of registration with the CQC were being met. We had received notifications of the incidents that the provider was required by law to tell us about, such as any restrictions placed on people's liberty, allegations and concerns of a safeguarding nature and any significant accidents or incidents. Appropriate action was described in the notifications and during our visit, records confirmed what action had been taken to reduce further risks from occurring.

We saw records to confirm staff meetings had taken place monthly and these were scheduled in for the year. Records showed that the registered manager used these meetings to discuss areas and actions required to improve the service. For example, records showed that discussions had been had with staff about improving people's experiences for those coming in for a short stay and champions role within the service.

We also noted in the staff survey some negative feedback from staff about support from management. Following this there were clear actions put in place to offer opportunities for staff to meet with management. One example noted was staff were to be consulted on how to deliver a more fairer culture and this to be discussed at the management team meeting.

People and relatives were given opportunities to improve and develop the service by attending residents meetings. Areas discussed included staffing and activities both at the service and in the community.

Relatives were also able to attend these meetings and the registered manager was present to share information and answer questions. Dates of these meetings were on the notice board at reception.

A quarterly newsletter had been produced with pictures of activities and updates of things happening at the home including refurbishment work under way. This was shared with people, relatives and external professionals.

The registered manager told us that they had been reviewing people's care records as a priority. This was an area that required improvement at our last inspection. There had been improvements observed at this inspection but the registered manager still needed to evidence robust and sustained systems for a longer period of time to show that care plan reviews were done effectively. Audits carried out by the registered manager had been in place since January 2017. Prior to this the registered manager and provider were working through an agreed action plan required by the local authority and CQC.

We were told by the provider that they had their own quality assurance audit process which they used to monitor the service. Providers need to show us they or their representatives understand their service and are actively involved in the monitoring of quality and service delivery. An independent consultant carried out regular unannounced spot checks of the service. The provider would visit and do their own spot checks of the overall service. We reviewed these audits and they were thorough and clear but these needed to be sustained and aligned with the registered manager audits for a longer period to evidence their effectiveness.

The registered manager and provider told us they actively sought feedback about the service at meetings and through six monthly questionnaires. This was done by gathering people's views and experiences whether living, visiting or working at the service. Records viewed confirmed questionnaires had been completed. Recommendations were noted and an action plan created with an agreed completion date. One action point noted was that safeguarding awareness sessions were to be run at residents' meetings. This had a named person leading this with an agreed completion date. Findings from surveys were fed back at residents' meetings, next of kin meetings, staff meetings and on the notice board at reception.