The Elms Residential Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 August 2018 and was unannounced. The last inspection was in June 2017, where we found five breaches of regulation relating to governance, staffing, consent, person-centred care and premises and equipment. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. At this inspection in August 2018, we found improvements had been made and the service was no longer in breach of regulations.

The Elms is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 20 people in one adapted building. At the time of this inspection there were 18 people living in the service, most were older people some of whom were living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements had been made to ensure the governance arrangements identified where quality and safety were being compromised. Though further work was necessary to embed new systems and processes, it was clear the provider and registered manager had taken steps to improve and build upon their existing governance arrangements.

People's medicines were generally managed well by staff who were trained to administer people's medicines. However, we found that further improvement was needed with the application of creams, documentation, and more robust auditing processes.

There was a new person centred electronic care planning system in place which was replacing paper records. This system was still quite new and not all information had been transferred over. We found some errors in transfer of risks such as choking, and the registered manager took action to ensure these were put onto the system promptly. We advised them to prioritise those people most at risk to ensure safe delivery of care.

Further work was required to ensure that people's end of life wishes were known. Care records contained only very basic information. However, advance care plans were in the process of being completed.

There was not a dedicated activity co-ordinator working in the service, but staff delivered activities. A schedule of activities had been implemented, but people preferred a less structured approach. Some

people we spoke with indicated that at times they felt bored and would like more to do. We have made a recommendation that the service ensures it is meeting people's individual and specialist needs on a day to day basis.

Staff were seen to be kind and caring towards people, however, our observations and feedback received from people indicated that further work was needed to ensure that the staff and management approach was consistent and people's dignity was respected.

Staffing levels and deployment of staff had been reviewed and new processes implemented which ensured that staff knew their roles and responsibilities.

Staff took appropriate precautions to ensure people were protected from the risk of acquired infections, and the services' cleaning regimes were more robust.

Staff had regular supervision and they had been trained to meet people's individual needs effectively. Staff were encouraged to progress in their roles, and higher level qualifications were offered.

The requirements of the Mental Capacity Act 2005 were being met, and staff understood their roles and responsibilities to seek people's consent prior to care and support being provided. However, further improvements in relation to care planning and documentation will ensure all staff are provided with clear guidance when people's liberty is being restricted and how they should support this aspect of people's lives.

People had been supported to have enough to eat and drink to maintain their health and wellbeing. Further work is required to ensure fluids are recorded accurately and people's nutritional needs are fully reflected in care records.

The provider had an effective system to handle complaints and concerns.

People were supported to access healthcare services when required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks relating to people's care were in place, however, records were being transferred across to a new electronic system and not all had been carried over accurately. The registered manager promptly addressed this and agreed to prioritise transfer of information based on those most at risk.

Improvements were needed in the auditing and documentation relating to medicines.

There were sufficient staffing levels in the service and staff were deployed effectively.

Is the service effective?

Good

The service was Effective.

Deprivation of Liberty Safeguards (DoLS) had been applied for when people who lacked capacity to consent, had their liberty restricted. The service was following the principles of the Mental Capacity Act 2005, however, some further improvements could be made to ensure staff have relevant guidance.

People were supported to maintain good health and had access to healthcare support in a timely manner.

People told us the food was satisfactory and that they had a choice. The dining experience had improved.

People's fluid intake was not always accurately recorded, but plans were in place to address this.

Staff were trained in subjects relevant to the people they were caring for, and had opportunities to increase their learning and qualifications.

Is the service caring?

Good

The service was caring.

Staff were observed to be kind and caring in their interactions with people, however, some feedback indicated the approach of staff could vary.

People were asked for their views in 'resident' meetings.

Relatives and visitors could visit at any time and there were no restrictions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activity provision was still not at a level which would meet the individual and specialist needs of all people using the service.

Care plans were in the process of being transferred to a new electronic system. Information reflected people's needs and how they would like their care to be delivered. The new system will allow for a greater level of detail to be included.

End of life care planning needed improvement, but advance care plans were in the process of being completed.

The service had systems in place for receiving, handling and responding appropriately to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager and provider had responded to the previous concerns identified at the last inspection. They had implemented new systems and processes to support and drive improvement. However some quality checks needed further improvement to ensure all areas for improvement were identified. These needed to be sustained and fully embedded into practice.

The service provided an open culture. People and staff were encouraged to contribute to decisions to improve and develop the service.

The Elms Residential 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 21 August 2018 and was unannounced. 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.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding and quality team prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the time of inspection there were 18 people living at the service. To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with nine people who lived at the service, two relatives, one health professional, the registered manager, and three members of care and catering staff.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2017, we found breaches of regulation in relation to risks in the environment, and staffing. We rated this key question as 'requires improvement' At this inspection we found that improvements had been made, and the service was no longer in breach of these regulations. However, there were other areas we found which needed further work to ensure people were safe. This key question therefore remains as 'requires improvement'.

The service was in the process of changing their paper documentation over to an electronic system. Staff carried an electronic device which they entered notes onto and could see when each person was last attended to. We were informed that all information relating to risks had been entered onto the new system, however, we found that some risks had not been transferred over fully. For example, we found that two people were at risk of choking, but the information from their paper notes had been filed and had not been transferred to the new electronic system, which placed them at risk of harm if staff were not aware of the risks and how to prepare their food and fluids. After we brought this to the attention of the registered manager, they implemented an alert to the handheld devices so staff were reminded of the risks, and updated the electronic system.

Where people were at risk of falls or of developing pressure ulcers, appropriate screening tools were used to calculate the level of risk. However, the corresponding care plan did not always provide information on what was in place to mitigate the risks, for example, pressure relieving mattresses or repositioning schedules which were in place. We brought this to the attention of the registered manager who advised us they would update this on the system.

Some information recorded in the new electronic system was more detailed than the information previously held in paper records. For example, moving and handling records were now much clearer, describing slings types to use and colour coding of sling loops to ensure correct positioning. However, as the service was in the middle of changing over from paper to electronic records, the full effectiveness of the system could not be fully determined. We discussed the risks associated with the transfer of information from one system to another with the registered manager, who was transferring the information alphabetically. We advised to do this in order of those people most at risk. They agreed to do so and check all the information was accurately transferred.

During this inspection we saw that window restrictors had been fitted to windows to prevent the risk of a fall from height. Wardrobes had also been fixed to the walls. Flooring, which had previously constituted a trip hazard, had been replaced and there was new carpeting throughout the entrance to the home, with easy access throughout the ground floor. New internal doors, which were easier to open than the previous ones, had been installed.

Most of the radiators in the service were covered but we noticed one in the living room which was exposed and this presented a risk of scalding if someone were to lean or fall against it. As part of the refurbishment plan, the metal radiator covers in the service were to be replaced by wooden ones. We also noticed some

exposed pipes in bathrooms which also needed to be addressed promptly and brought this to the attention of the registered manager.

We checked the systems in place for manging people's medicines and found some areas for improvement. For example, a current rotation patch chart for one person was not available. These are important to prevent irritation of the skin and ensure the administration site is regularly rotated. The registered manager indicated that daily checks on the position of the patch were recorded by the carers but the entries for the chart we saw indicated that the patch was not being rotated on a seven day basis, as prescribed. The registered manager said this was due to errors in completion of the form. This did not provide reassurance that the patch was being applied and rotated correctly.

Carers used the handheld electronic devices to confirm application of creams but the recording of each separate application with a separate entry was not routinely happening. The registered manager was unable to show us the body map entries so she could not check where the creams had been applied.

There were clear protocols for the use of 'as required' (PRN) medicines for most, but not all of the people who lived at the service. We brought this to the attention of the registered manager who responded to this omission immediately.

A recent pharmacist audit had taken place and there was evidence of regular medicines audits by the registered manager. These involved checks on the storage, recording and administration of medicines on the medication administration record (MAR) charts. However, the areas of improvement we found, did not feature in the current medicine audit. Checks on the inclusion of PRN protocols, profile pages, the correct application and recording of patches and creams should be included in the regular medicine audit.

Senior staff were trained to manage medicines and they were competency checked on a six monthly to annual basis. The MAR charts clearly indicated when to administer medicines. A separate record sheet was completed by staff to indicate the precise time medicines were administered, thus removing the risk of any medicines being given within intervals that were too short. This also demonstrated that medicines were given in accordance with people's individual requirements which were detailed on their profile pages. We noted that a profile page for one person, who had recently arrived, had not been created. The registered manager said she would address this promptly.

Staff undertook regular checks on medicine stock levels and apart from one minor discrepancy, we found the stock levels to be correct. Medicines were appropriately labelled and stored. Daily temperature checks on both the fridge used for temperature-sensitive medicines and the room where medicines were stored, were within acceptable levels.

New cleaning schedules were in place and the related documentation demonstrated that these areas were cleaned on a regular basis. Bedding and commode audits took place regularly in addition to wheelchair and walking frame cleaning. The registered provider told us that all that all but two mattresses have been replaced with specialist pressure care mattresses. The communal rooms and peoples' bedrooms looked clean and tidy and generally the home smelt fresh although there were some lingering malodours in certain locations which the registered manager was aware of.

We saw evidence of thorough cleaning schedules in the kitchen, which were regularly audited. The kitchen was due to be fully refurbished by the end of September 2018 and no longer constituted a food hygiene risk. Environmental Health and infection control officers had assessed the home on several occasions since our last inspection. We saw their reports and were satisfied that adequate improvements had been made. The

service received a food hygiene rating in September 2018 which showed it was rated as 'Good'.

External checks and servicing to equipment and facilities in the premises such as gas, electricity, hoists, stand aids, lift, emergency lighting and fire alarms were carried out at the appropriate frequency.

There was a fire risk assessment in place, and we saw that actions listed had been met. The registered manager told us that a fire service inspection was due soon as the last one was carried out in 2015. Staff received training in fire safety, and in March 2018 they carried out a practical evacuation drill which is good practice to ensure staff know the procedures.

There were regular checks on the water temperatures in the service to reduce the risk of legionella bacteria. In addition, water samples were sent for external checks.

At our previous inspection we observed that staffing levels were not sufficient to meet people's needs. The registered manager had implemented two different staffing dependency tools, both of which showed that the staffing levels were within acceptable parameters.

A key development has been the creation of a 'senior shift role', which involves a senior carer providing direction to other staff to ensure that their time is used effectively. The member of staff we spoke to said this new structure was working very well and ensured they maximised their time attending to people's individual needs. Staggering the lunch times had also helped ensure there was adequate support for people who needed assistance to eat. Those people who chose to have their lunch in the dining room were served at 12.00pm, which allowed for up to four carers to be present with them. People who ate in their bedrooms without assistance were served their lunch at 12.30pm. This arrangement ensured that people were given the support needed to eat and drink.

Staff received safeguarding adults training. One staff member told us, "We have safeguarding training, someone comes in, and we do workbooks. I would report abuse to the manager, provider, or CQC. I wouldn't see any harm come to these [people] they are like family."

During a recently introduced residents meeting, people were asked if they felt safe in their environment. Their comments were displayed on a board in the living room, alongside quotes from relatives and visiting health professionals. The comments were positive and indicated that people in the service felt safe and protected. One person told us, "I'm definitely being looked after, they [staff] sit and watch what you do and that makes me feel safe." A relative said, "I was ill and away for a while and I was quite happy knowing [relative] was safe. This year I've sat back more, and I've been happy knowing [relative] is looked after. I don't visit as often as I used to and it's a relief not to worry about [relative]."

Staff recruitment processes were undertaken to ensure staff recruited were safe to work with people living in the service. The registered manager said that they did not have to rely on agency staff, as carers were always willing to take on additional shifts.

We concluded that the re-organisation of the staffing structure and creation of leadership responsibilities served to address the previous concerns around staffing.

The service had ensured that lessons were learned and improvements made when things had gone wrong .The service had responded constructively to the findings of the previous inspection and addressed concerns relating to the safety and cleanliness of the premises. Improvements had been made and planned, including the recent implementation of new and improved audit tools.

Good

Is the service effective?

Our findings

At our last inspection in June 2017, we rated this key question as requires improvement and we found a breach in relation to consent procedures. We also made a recommendation about making mealtimes more of a positive experience. At this inspection, we found that although some further improvements were needed in relation to DoLS, the service was no longer in breach of regulations, and we have rated this key question as 'Good'.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in June 2017, we found that no applications for DoLS had been made, and there were people living in the service who lacked capacity and were under constant control and supervision. At this inspection we found that the appropriate applications had been made by the registered manager. They had also advised relatives of this where relevant. Where people had legal representatives in place, these were listed in people's care records so the service knew who to contact when particular decisions had to be made.

Our observations confirmed staff promoted choice and acted in accordance with people's wishes. One staff member told us, "Its about assessing people every day, some days they can make a decision, some days they cant. I always gain consent before assisting people. Do they need or want help from me? Do they want to choose their own clothes?"

However, further improvements could be made in relations to DoLS applications. For example, although none of the DoLS had yet been authorised, there was no reference to the applications made in people's care plans, such as how people's liberty was being restricted, so staff knew how to support the person more fully. Additionally, not all of the staff we spoke with were aware of who had a DoLS application in place. The registered manager told us they were looking to improve the new care plans in relation to this aspect of people's lives.

At our last inspection in June 2017, we made a recommendation that the service reviews its dining experience to ensure that people received support and that independence was promoted.

At this inspection we found that the dining experience for people had improved. The registered manager had staggered the times that people ate, which enabled staff to provide the support to people who needed

assistance in a respectful and unhurried manner. We observed a much calmer dining experience. People were seated on small tables which had tablecloths, napkins, cutlery and condiments. Independence was also promoted; we observed a member of staff put food on a person's fork and then hand it to them so they could feed themself. We asked people their views on the food. One person told us, "The food is quite good, we get a choice at lunch, soups and different things, breakfast is usually cereal or a poached egg. They make a decent cup of tea." A relative said, "There is nothing wrong with the grub. They are always checking drinks and giving them yogurts."

The service had employed a new chef. They were able to tell us what people's preferences were, and if people were on specialist diets, such as pureed foods. They were aware of foods which would not be suitable to puree and foods that people were allergic to. They told us, "I prepare pureed meals to look as nice as possible, I serve the food separated, not all in one. I make diabetic foods, jellies, custards and cakes. I know what people do and don't like, and I adapt it. I'm going to try pizzas next." External professionals, such as speech and language therapists (SALT) and dieticians, were involved in people's care where there were dietary risks. We found one care plan which needed updating in terms of their input from the SALT team, but the registered manager was already aware of this.

Throughout the day people were offered drinks to ensure they were suitably hydrated as the weather was very warm. There was a variety of drinks and cups close to the main lounge area that people could help themselves to. Some fluid records were not always clearly documented by staff so it was unclear what people had drank. The registered manager told us the new electronic system should improve the accuracy of recording.

People's needs and choices were assessed with input from members of the multi-disciplinary team involved in people's care. Records showed that people had access to healthcare services and received on-going healthcare support. A healthcare professional told us, "This is one of the better homes. [Registered manager] is great. People's weights are always up to date, as is any information I request, and my recommendations are followed 100%. There is a nice vibe about the place, and I always observe good interactions between staff and residents." One person said, "If I need a doctor they'll get me one."

The new electronic care planning system was set up to create a 'hospital pack', which provided a summary of key information about people's care. This information could be shared when a person is transferred between services or admitted to hospital. Sharing this information with other professionals less familiar with the person would help them to deliver more effective care which was in line with people's preferences.

When new staff started working in the service they received an induction and worked alongside experienced members of staff whilst getting to know people and learning about how people wanted to be supported. Staff received training that helped them develop the knowledge and skills needed to support people. Records showed that staff had received training in safeguarding adults, first aid, manual handling, infection control, food hygiene, medicines, diabetes, and the Mental Capacity Act 2005. Some staff were also completing National Vocational Qualifications, and there were distance learning opportunities with a local college. One staff member said, "The training here is good, lots of different subjects." One person told us, "I think they [carers] do mostly know what they are doing, they seem to manage alright". A relative said, "I think the care is very good, [relative] always looks good. The carers all seem caring to me. They look after them. I notice that they always come round and talk to residents and check they are okay."

Staff were provided with one to one supervision meetings. Supervision provides staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I have supervision every six to eight weeks, and we discuss training, or any concerns I have." We saw some

supervision records which asked staff's views on the new electronic care system, their well-being, and how they might progress in their role.

At our previous inspection in June 2017, we found that the provider had not considered how to maximise the suitability of the premises for the benefit of people living in the service and those living with dementia.

The provider told us that between March 2015 and June 2017, several projects had been completed which included a new boiler system, a wireless nurse call system, roofing work, and new flooring.

At this inspection we found that signage was improved, old carpets were being replaced, and several doors which were heavy and difficult to open had also been replaced. Further work was planned which demonstrates a commitment from the provider to make the service more visually pleasing for the people who live there, and which improves people's ability to navigate around the service more independently.

Good

Is the service caring?

Our findings

At our previous inspection in June 2017, we rated this key question as 'requires improvement'. This was because we observed some practices which compromised people's dignity.

At this inspection we found some improvements had been made and we have rated this domain as 'Good'. However, some feedback from people and our own observations, indicated that further work was needed to ensure that the staff and management approach was consistent and people's dignity was respected.

We observed that positive and caring relationships had been developed between staff and people. Many of the staff had worked in the service for a long period of time and therefore knew people well. We saw people readily ask for assistance from staff who reassured them.

We received mixed feedback from people on the staff 's approach. One person said, "The carers are alright, not too bad, they are usually very polite. They are very friendly and helpful, and they are quite good in that they know what I like. It's quite pleasant living here, everyone goes out of their way to look after you and ask if you are alright". Another said, "Staff are lovely, beautiful, they come and join in with us, make us laugh, sometimes I have tears in my eyes. When I get up they help me wash and dress. It's a lovely place, the girls treat us with such care, it's just like living in your own home".

Another person said, "You get good and bad staff, it differs and you don't know who's coming. Staff sometimes come and chat, some are good they come and sit with you, as I said they are all different natured people. On the whole they are very caring, you get the odd one, of course they can be run off their feet. You have to accept that sometimes it's different but on the whole it's okay". A fourth person told us, "Most [staff] are polite, one or two are not, they don't stay with me when I'm getting undressed and then they leave me for quite a while. The younger ones are not very nice, they are not very helpful."

We observed one person had a sore mouth, and we were trying to determine the person's name so we could identify them to the registered manager. The registered manager then told us they had asked everyone in the lounge to open their mouths to establish if anyone had oral health concerns. We advised them that this was not a dignified approach to use and to consider how this kind of approach might be mirrored by other staff. They acknowledged their error as soon as we brought it to their attention.

At our last inspection we found that residents meetings weren't taking place to ensure that people's views about the care they received were known. At this inspection we found that residents meetings were now taking place every other month. People were asked relevant questions such as their food choices and snacks they would like to see offered. People were also asked if they felt safe. The registered manager told us that questions will continue to be focussed around CQC's key lines of enquiry.

Residents had personalised charts of their care needs in their rooms so that staff could see at a glance how people liked their care delivered. To ensure privacy, there was a picture on one side which could be turned over when not in use. Staff were seen to be respectful of people's privacy and discreet when asking people if

they needed the bathroom, and whilst assisting them.

There was a notice board in the entrance hall that was for visitors to be informed of current plans and news.

People's independence was encouraged, One person said, "I'm easy going and I like the independence they allow me". Another said, "I can't forget what I used to be able to do, but they [staff] are good at letting me do what I can." And a third person said, "They help me get up and go to bed, and they are now beginning to tell me to do things myself."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2017, we rated this key question as 'requires improvement'. This was because there was a lack of activity and people were observed at times to be disengaged within their environment. Care plans were also not consistent across the service and held limited information on people's life history, hobbies or interests. This constituted a breach of regulations in relation to person centred care. At this inspection we found that some improvements had been made, and the service was no longer in breach. However, some feedback indicated that further work is needed to ensure that activity provision is meeting people's individual needs.

At this inspection the registered manager told us they had implemented an activity plan, but people did not wish to follow this in such a structured way. There was no dedicated activity co-ordinator working in the service; care staff provided activity from 10am to 11.30am and 2pm to 4pm.

We asked people their views on the activity provision. One person told us, "I do get bored a lot of the time, I potter about, do a bit of drawing now and again, it's something to keep my mind going." Another said, "I just sit here all day, I'm a bit out of the way here but I don't think there is much missing." A third said, "They don't often have a lot of time for chatting." A fourth told us, "I get a newspaper delivered every day. I stay in my room because I can't walk. I'm quite happy looking out and seeing what's going on. I do get lonely. I've got my telly and radio."

The registered manager told us that they discussed activity preferences with people living in the service and from this they devised a plan. They told us that people generally preferred to watch TV and some did not wish to join in with day to day games. We observed some group activity taking place on the day, and several people joining in. Other activity ideas were being discussed such as a 'take away' evening. We saw a staff member playing 'connect 4' with one person in their room. We saw one person went out for the day with family members.

Next year there was a plan to do 'virtual cruise' where they will link food and activity to different countries they discuss on their virtual journey. The registered manager and staff were excited about the project and hoped it would spark interest for most people living in the service.

Though activity provision had been considered more fully, we were still not assured it was meeting everyone's individual needs, as the timings for activity were fixed and the feedback we received indicated that people were at times bored. Day to day stimulation and just chatting with people will avoid people becoming bored, withdrawn and despondent.

We recommend that the service reviews the provision of activity, to ensure it is meeting people's individual and specialist needs on a day to day basis.

Care plans were in the process of being transferred from paper based records to an electronic care system. In the care plans we looked at we could see there was more detail about peoples life history, and their

hobbies and interests. The registered manager told us this was still a 'work in progress'. Where people did not wish to discuss their life history, there was detail explaining that the person had declined, which demonstrated they had attempted to gain the information.

We could see that the new care plan system allowed for far more detail on people's needs, and will be an effective oversight tool for the registered manager as it records detail in 'real time'. People's care plans also contained an area on 'goal setting' and how goals could be achieved. Not all care plans had been transferred to the new electronic system, but those that had provided more detailed guidance for staff to follow. We can review the effectiveness of the new system at our next inspection.

People's care plans held limited information on their end of life wishes and planning. Some just stated if a cremation or burial was preferred. They did not reflect the full scope of people's wishes, such as how people wished to spend their last days. There was no additional information on how staff could provide comfort during these last days such as music the person liked or calming aromas. The registered manager told us they were already looking to improve this aspect of people's care, and had started work on advance care plans. Advance care plans are used to record treatment and care wishes at the end of life so all people involved in a person's care are aware.

The service had not received any complaints, but had a complaints procedure in place. This was clearly described in the 'service user guide' and the services' statement of purpose. One person told us, "I can complain if I need to, I'd speak with the staff, any of them." Another said, "I've never complained, I don't have to."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2017, we rated this key question as 'requires improvement'. This was because the governance systems in place did not enable the provider to identify where quality and safety was being compromised, and found them to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found that although further work is needed, sufficient improvements had been made and the provider was no longer in breach of this regulation.

The service had responded positively to the concerns raised in our previous inspection of June 2017. There were quality checks and governance mechanisms in place, which identified where quality and safety were being compromised, however further improvements were still needed to ensure that new systems, processes and expectations of responsibilities were fully embedded. Therefore it was too early to see what impact these improvements were having on people and their experience of living in the service.

The registered manager was receptive to our feedback during this inspection and shared our views that quality checks still needed to be improved, notably regarding individual risk assessments and aspects of medicine management.

There were plans to develop the service which involved the creation of two part-time deputy manager roles. These roles had been appointed to internally and will take effect from October 2018. The registered manager will 'back-fill' positions so there is no overall shortfall in capacity. The purpose of the new deputy manager roles was mainly to enable the registered manager to project manage the large-scale service and building development plans.

The registered manager was visible in the service at times although they seemed over-burdened with the transition of care files to the new electronic system and the management of the improvement plans. The appointment of the two part-time deputy managers should alleviate the pressure and enable closer oversight of care delivery. The development of the new leadership structure had helped staff to gain greater clarity on their roles and responsibilities. One staff member said, "Its so much better. Staff know what they are doing. There is a 'senior shift plan' now and everyone knows who is doing what." And, "We [staff] are always able to give our views on things, and these are listened to. The service is very well-led."

There was a strategy in place at provider level to drive improvement within the service. The registered manager showed us a service improvement plan, which was in the process of being created and was informed by the outcome of premises assessments and audits in addition to risk and regulatory requirements. Actions listed in the plan were assigned a risk rating to aide prioritisation of activity.

All areas of the building and equipment had been safety assessed and a formal risk assessment was in the process of being completed. Room maintenance audits were repeated every three months and the outcomes fed into the overall maintenance and refurbishment action plan for the service.

Actions aimed at driving improvement in the delivery of person-centred care had also been introduced. Audits were used to measure operational delivery and feedback on care provision was gathered via meetings and surveys from people, relatives and professionals. The registered manager indicated a desire to provide people with choice and to ensure they were cared for in a safe environment. Further work is needed however on ensuring people's dignity is respected at all times, and ensuring that their own approach is one which reflects high standards that staff can learn from.

The introduction of residents' meetings created a mechanism for obtaining peoples' views and it was noted that people chose the colour of the paint used to decorate the home and the new chairs which were purchased for the living room. It was not clear however whether issues arising from the information obtained from meetings and surveys were always considered and acted upon in a structured way, nor if action taken in response to the feedback was reviewed and, if need be, revised. For example, people were asked for their views on activities they would like to do and changes were made to the activity schedule. However, some people we spoke with still expressed that they were bored at times and lonely in their rooms.

The service invested in the use of the person-centred electronic care plan system. This provides carers with clear and detailed information about peoples' individual care needs and gives a real-time record of interventions. The system should ensure care provision is both pro-active and responsive and enable the registered manager to easily gain closer oversight of the care received. The registered manager had further learning of the system to complete before utilising it to its full potential and it was anticipated that the system would be fully functioning in the coming months. We considered the investment in this equipment to be a positive step, which would likely enhance the safety and well-being of people.

The service provided training for staff and the registered manager demonstrated her commitment to staff personal development when she confirmed the new deputies had obtained their National Vocational Qualifications at Level 5 in Health and Social Care, saying, "It's all about empowering and giving them knowledge."

We saw evidence of a readiness to work with other agencies. The service worked well with other professionals to provide good quality care. The local authority quality assurance team, National Care Association, environmental health and infection control had visited the service recently and their input had been welcomed. The registered manager was also responsive to feedback we provided during our inspection and demonstrated a good awareness of how the service was currently performing.