Only Care Limited

Rosewood Court

Inspection report

175 London Road
Dunstable
Bedfordshire
LU6 3DX

Tel: 01582500820
Website: www.onlycareltd.com

Date of inspection visit:
15 November 2016
17 November 2016

Date of publication:
18 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 17 November 2016 and was unannounced. We had carried out a comprehensive inspection of the service in July 2016 during which we identified that there were numerous breaches of the fundamental standards. These breaches were in respect of person-centred care, consent, dignity and respect, safe care and treatment, nutritional and hydration needs, receiving and acting on complaints, good governance and fit and proper persons being employed. During this inspection we found that improvements had been made in all areas that we had identified.

Rosewood Court is a newly built three storey home. It is well appointed with single rooms, all of which have en-suite wet rooms. It was registered with CQC in April 2016 to provide accommodation for up to 66 people who require nursing or personal care. At the time of our inspection, 27 people were living at the home, some of whom had dementia and some who required 'end of life' care.

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.

People were safe at the home and we found the management to be supportive and approachable. There were mixed opinions about the food and drink that people received and promised changes to the menu had been delayed. However, people received sufficient food and drink to maintain their health and well-being. People were engaged with the activities that had been arranged and had discussed improvements to these at regular resident meetings.

The home had developed policies, systems and processes to enable the needs of people to be assessed and for care plans to be developed to meet those needs. However, people's care plans were not always personalised to reflect the individual's preferences. Management plans had also been developed to minimise the risks associated with the individual's care needs.

The number of staff required to support people had been determined using the dependency levels of the individuals who lived at the home but they were not always deployed in such a way that people's needs were met in a timely manner. This was a breach of Regulation 18 of the Health and Social care Act 2008

(Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The recruitment process for new staff was robust. Staff received an induction programme and on-going training. They were supported to gain relevant qualifications in Health and Social Care and were supported by way of regular supervisions. This meant that people were cared for and supported by staff who had the necessary skills and knowledge to do so safely and effectively. Although staff had an understanding of the requirements of the Mental Capacity Act 2005 they were unaware that authorisations had been received to deprive some people of their liberty for their own safety under the associated Deprivation of Liberty Safeguards. They were unaware of the conditions of the authorisations and people may have had their rights infringed.

Staff were caring and friendly. They knew the people they cared for and supported well. They protected people's dignity, treated them with respect and encouraged them to maintain their independence. Staff understood the need for confidentiality.

There were systems and processes in place to monitor the quality and effectiveness of the service. The provider was actively involved with it and received twice monthly reports on the quality and development of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although there were enough staff to care for and support people, the staff may not have always been deployed effectively in order to prevent delay in people's needs being addressed and reduce the risks posed to them.

A robust recruitment process meant that people were cared for and supported by staff who were suitable for the roles in which they had been employed.

People's medicines were managed safely and people received their medicines as they had been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the specialist training needed to care for an individual effectively.

Staff were unaware that some people living in the home were subject to Deprivation of Liberty authorisations under the Mental Capacity Act 2005.

People had mixed opinions on the food they received. Although the menu was to be reviewed in July 2016 this had not happened. People found the food boring and repetitive.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and knew the people they cared for and supported well.

Staff treated people with dignity and respect.

People were encouraged to maintain their independence and their relationships with family and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans that had been developed were insufficiently detailed to give staff all the information as to how they should deliver the care people needed.

A handover sheet had been devised that was completed for each shift which gave detailed, up to date information about each person who lived at the home.

People were encouraged to maintain their interests and hobbies and join in a variety of activities on a daily basis.

Is the service well-led?

Requires Improvement

The service was not always well led.

Action plans had not always been developed when quality audits had identified areas for improvement.

Although a quality audit had identified that the care plans needed to incorporate a more person centred approach it had failed to identify the level of similarity that existed between care plans.

The registered manager was thought of highly by people, their relatives and staff at the home.

Rosewood Court

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 15 and 17 November 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the local authority, the public or staff. A notification is information about important events which the provider is required to send us by law. We also spoke with members of staff from the commissioning bodies who had arranged for people to be placed at the home. We reviewed the action plans that the provider had sent to CQC following our last inspection. These advised us as to how they would address the concerns that had been identified during that inspection. .

During our inspection we spoke with nine people and four relatives of people who lived at the home. We also spoke with five care workers, one senior care worker, a nurse, a housekeeper, the administrator, the deputy manager, the Head of Care, the cook, a representative from a consultancy company that was supporting the home and the registered manager.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for four people. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at two staff recruitment records and reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Our findings

During our last inspection in July 2016, we found that the service was not safe. Staffing levels had not been determined taking into account people's level of need and staff did not have the skills to provide for all people's care and treatment needs. In addition, the recruitment process for staff had not been robust. Risks associated with people's needs had not always been assessed and systems were not in place to mitigate them. There had been no analysis of accidents or incidents to identify any trends and take action to prevent recurrence and contingency plans in the event of an emergency had not been developed. People's medicines were not administered as they had been prescribed and, on a number of occasions, people were not given their medicines due to insufficient stock being held. There was insufficient equipment to meet people's needs. During this inspection we found that improvements had been made in all areas.

Although there were enough staff to care for and support people, the staff may not have always been deployed effectively in order to prevent delay in people's needs being addressed and reduce the risks posed to them. Even though people we spoke with all said that they thought that there was enough staff, even at night, they still felt that they waited too long when they required assistance. One person told us, "The call bell is alright when they actually answer it. Sometimes its two minutes others half an hour. It is mostly longer first thing in the morning when I need them to help me go to the toilet. I often give up and have to go myself. But that's when I fall and my [relative] gets so cross but I need to go in the morning." This person had recently suffered a fall when going to the toilet unassisted. Another person said, "You see when you try to call someone and they take a bit longer than you think they should do for what you want them for, usually for me it's assistance to go to the toilet, it can be distressing. Waiting, waiting 15 minutes or more." A member of staff told us, "Mostly it takes us two minutes to answer a bell unless two of us are involved in hoisting a service user, or providing care where we need to double up. This is when people have to wait. You see the senior stays in the lounge/dining area and oversees care plans, so there are really four carers on each floor, two for each side of the central lounge. But if two of us are involved in hoisting or caring for someone who requires us to double up we need the senior to support by answering the bells."

The registered manager showed us that staffing levels had been determined to take account of people's level of dependency. One member of staff said, "With the staffing ratios here now we have time to care for the residents well." On the day of our inspection there were 11 people living on the first floor being cared for by a nurse and three care workers. Some of the people who lived on the first floor required nursing care. On the ground floor there were 16 people, who did not require nursing care, being supported by four care workers, including a senior care worker. In addition, the clinical lead and the Head of Care were often available in addition to the staff on the rota to support people. The registered manager was also 'hands on'

and available to assist the care workers and we saw evidence of this during the inspection.

That there was either not enough staff or the staff were not deployed effectively to meet people's needs was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of two members of staff who had recently joined the home. We found that the process had been robust and had included carrying out relevant checks with the Disclosure and Barring Service (DBS) to ensure that the applicant was suitable to work in the service. It also included the follow up of employment references. These checks assisted the provider to determine whether the applicant was suitable for the role for which they had been considered. The registered manager told us that there had been on-going recruitment to enable them to reduce the use of agency staff. They planned for more staff to start in January 2017. The robust recruitment process meant that people were cared for and supported by staff who were suitable for the roles in which they had been employed.

The care records we looked at all contained assessments of the risks associated with people's care and support. These had included the risks associated with people's medical conditions as well those associated with people's mobility, their risk of falling, poor nutrition and pressure ulcers. People and relatives told us that they had been involved in discussions about these risks. One risk assessment for a person who used a 'rollator' to assist with their mobility and had been assessed as at significant risk of falls, advised staff to ensure that the person always used the 'rollator' and wore appropriate footwear to reduce the risk. The personalised risk assessments had been reviewed regularly, at least once a month. Risks were documented on handover sheets which were shared twice a day and reviewed daily by the registered manager. These sheets detailed people's capacity, their diagnosis and needs and risks associated with continence, eating and drinking, moving and handling, medicines, charts to be monitored. This meant that staff had access to up to date information about the people they cared for and supported and the risks to which they were exposed.

In addition to the personalised risk assessments the registered manager had also carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Checks were also carried out to ensure that equipment had been serviced and portable appliances had been tested. We noted that although the checks carried out on pressure equipment in October 2016 had identified that three units were not in good condition there had been no action plan completed to address this. People may have been left at risk of developing pressure ulcers if they had to use equipment that was not working correctly.

We saw that a system of monthly analysis of accidents and incidents had been introduced. This had enabled the registered manager to identify any trends and causes. It had been identified that one person had suffered a high number of falls and they had used the information to refer the person to the falls clinic.

Each person had a personal emergency evacuation plan (PEEP) that was reviewed regularly to ensure that the information contained within it remained current. This plan provided staff with information on the assistance people may need to leave the home safely. The registered manager showed us the emergency contingency plans that had been developed in September 2016 to ensure the safety of people should an event affect the home and stop it running, which was kept with the PEEPs in the reception area.

Since the previous inspection in July 2016 the home had changed the pharmacy from which they sourced people's medicines. The new pharmacy had revised the medicines administration records (MAR) for the people who lived at the home. We saw that people's medicines records contained a front sheet which held a

current photograph of the person and detailed any known allergies they had. There were protocols in place for medicines that had been prescribed on an 'as needed' basis (PRN). We saw that the medicines that were classified as controlled drugs were stored securely and the administration records for these had been fully completed and audited regularly. When people had their medicines delivered by transdermal patch the position of each patch when it was applied was recorded on a body map to ensure that a different application site was used each time. We looked at the MAR for 16 people and found that these had been completed fully. There were no unexplained gaps. We also reconciled the stock of medicines for two people with their records and found these to be correct. A relative told us that, following discussions with themselves and the staff at the home, the doctor had authorised for their relative to be given their medicines covertly, that is without their knowledge, as they did not co-operate with taking tablets.

People and their relatives told us that they were safe at the home. When asked, one person told us, "Safe here, yes safe enough. There is always someone about to call on." Another person said, "Really safe thank you. I can always get someone even if it takes a little longer than you think it should." A relative told us, "[Relative] is very safe here, I think they look after [them] well. I have no concerns about [their] safety." Another relative said that their relative was, "As safe as houses."

The service had policies and procedures to protect people, including safeguarding and whistleblowing. We saw that these were displayed in the staff room. Posters on safeguarding were on display on notice boards and in the lifts so that people and their relatives were made aware of which organisations they could contact should they have concerns. Staff told us that they had received training on safeguarding and knew the signs to look for. One member of staff told us, "You need to look for changes in behaviour of the service user if you suspect something is not right. Document your doubts to start with and then share your concerns with evidence if possible."

Requires Improvement

Our findings

When we inspected the service in July 2016, we found that staff were poorly trained and did not have supervision with their manager to discuss their performance. We also found that staff had a poor understanding of the requirements of the Mental Capacity Act 2005 or the need for the consent of people to be obtained before care or support was delivered. People had not been involved in planning the menus and their likes and dislikes had not been taken into account. People were also not appropriately supported to eat their meals. During this inspection we found that there had been improvements in all areas.

People told us that the staff were well trained and had sufficient skills to support them. One person told us, "I would say that they are very well trained yes. They know us all individually." Another person said, "Oh they are always doing training here, loads of it." However, not all the relatives we spoke with agreed. One relative told us, "I don't think that they have had enough awareness or catheter training. One or two know and understand what to do the others don't especially the night staff, who put [relative's] bag sometimes on the stand sometimes not."

Staff told us that they had all completed induction training and that there was a programme of on-going training. One member of staff told us, "I did my two weeks induction training back in May, then three weeks ago, I did another weeks training. The training is excellent, especially for me because I had not been a carer before. I [now] have my level 3 diploma in Health and Social care." Another member of staff said, "I did two weeks of training before I started. Then I had to shadow (work alongside an experienced member of staff) for a week before I started on the floor." The registered manager showed us the information they held regarding the training that each member of staff had completed. The registered manager told us that they were awaiting the certificates for training that staff had completed in October 2016 to update the information but all staff were up to date with their training. Additional training had been sourced in respect of diabetes management, infection control, pressure ulcers and end of life care.

We saw that each member of staff had received supervision. The registered manager told us that the consultant's representative had assisted with training the registered manager, clinical lead and the head of care to complete supervisions. The registered manager told us, "They did a couple and we sat in. We are waiting on additional training for the seniors to do the supervisions." The registered manager showed us the supervision documentation which was used. This included information about the member of staff's performance, training needs and the provider's policies as well as giving the member of staff the opportunity to discuss any concerns they may have about any of the people who live at the home. We also saw that there was a plan for ongoing supervision for each staff member.

The registered manager had arranged for a local authority specialist to provide training on the requirements of the Mental Capacity Act 2005. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were able to explain the requirements of MCA and where best interest's decisions were recorded. One member of staff told us, "We do log them on the daily log but we also include all the detail in our handover." Staff were less knowledgeable about DoLS. One member of staff told us that no people who lived at the home were subject to a DoLS. However one of the care records we looked at contained a DoLS authorisation that had been granted in September 2016. The registered manager told us that they had made DoLS applications for a number of people. We saw that an advocate had been appointed to support the person following the initial DoLS assessment in July 2016. As the staff did not know that people were subject to DoLS they would be unaware of the terms of the authorisation and people's rights may not have been protected.

Staff were able to tell us how they gained people's consent to provide care or support. One member of staff told us they gained consent to care by saying, "Good morning how are you? Are you ready to get up yet?" They went on to say, "If they are not ready to get up we will go back and check on them and try again in about 10 minutes." Another member of staff told us, "Where people struggle to communicate, I communicate by looking for facial expressions, look at their body language and I would like to be able to use a picture book but we don't have one yet. We are supposed to be getting picture meal cards. There has been a lot of talk about this but they have not shown up yet. That is difficult, explaining the menu to people without images."

People still had mixed opinions on the food they received. One person told us, "Food is quite good. We do get a choice of main meal. Sometimes the puddings are not great but on the whole okay." Another person said, "It's better than it used to be, I suppose. I would still say it's ghastly. But why do we have to have jelly three days in a row? And we usually joke at our table that they must have a contract with apple growers because we have apple crumble all the time, four days last week." A third person told us, It's okay even though it's mostly the same pudding for three or four days. What irks me the most is the soup and sandwiches for tea every day. I don't like sandwiches anyway but everyday it's terrible." Their relative told us that they were aware that there was the choice of something hot at teatime but their relative forgets to ask. A member of staff said, "We will always go to the kitchen for an alternative if anyone does not like the main course choice."

We spoke with the cook who told us that they were advised of people's likes and dislikes by way of a preferences form completed by the care staff. Although the cook had told us in July that they were revising the menu to take account of people's preferences this had not yet been completed. We saw that the activities co-ordinator was completing questionnaires with people which included asking them about foods they would like to have included on the menu. The cook told us, "Some people just want an omelette at lunch time and we make it for them. We have made a few changes to the menu and tried a few different things but they did not like them." The kitchen assistant asked people each morning if they wanted either of the two choices for their main meal or an alternative. People were offered a choice of food again at lunchtime. One member of staff asked one person, "Would you like chicken pie or macaroni cheese? Would you like new potatoes or mash?" They offered another person a drink by saying, "Orange squash or water?"

Additional meals had been prepared to allow for people to change their mind when the meals were served. If people had special dietary requirements these had been catered for. For example people who were living with diabetes were offered sugar free ice cream.

We observed the lunchtime experience in the dining rooms on both the ground and first floor. Staff were on hand to assist people to eat their meals. Staff knew the people who required assistance to cut their food up and this was done for them as soon as they were given their meal. Staff did not assume that people required their help but asked for their permission before cutting the food up. One person had adaptive cutlery that allowed them to eat their meal without assistance once it had been cut up. We saw that one member of staff was assisting a person to eat whilst standing over them. This did not enhance the experience for the person they were assisting. We brought this to the registered manager's attention and they spoke to the member of staff and arranged for them to sit down next to the person while assisting them to eat their meal.

People were able to help themselves to drinks and snacks throughout the day. There were chocolate bars, crisps and fruit available in the lounge next to trays of blackcurrant and orange squash. Some service users had plates of cut up fruit next to them.

People's weight was monitored and appropriate referrals made if there were any concerns. One member of staff told us, "We have a policy of food first so we will use full fat milk or cream in their mash or add cheese if the person is losing weight. We weigh them monthly. If the weight loss is extreme we will refer to a nutritionist and get advice for the kitchen and staff." Another member of staff said, "We have food and fluid charts and we weigh people monthly. If we have concerns we may weigh them weekly, we refer to dietitians and GP as necessary."

People told us that they were supported to maintain their health and well-being. Staff told us that people were seen regularly by the district nurse. One member of staff said, "We have a list of contact GPs for service users. Unfortunately most like to prescribe over the phone rather than come out but they will speak to us. If we are in doubt we will call the paramedics." People used a chiropodist who visited the home every six weeks. A hairdresser called at the home every Wednesday but several service users used their own hairdresser. An optician called at the home three weeks ago and the staff told us they visited regularly.

Good

Our findings

When we inspected the home in July 2016, people told us that the staff were not always caring and there was insufficient information available to them. During this inspection we found that improvements had been made. People were happier with the attitude of the staff and had greater access to information about the home and local services.

People told us that the staff were kind and caring. One person told us, "The girls are very jolly and pleasant. I like to have a joke with them." Another person said, "The girls are very kind and caring. Good to be around chatting to us." We observed staff having a joke with service users and speaking to them about things they had done in their lives while they were hoisting them. For example, when one service user was being hoisted, to put them at ease staff talked to them about their job as a manager in a shop. The person started to tell the staff about their role and responsibilities. This made them all laugh and the person was quickly and efficiently transferred while still laughing. Another person was being prepared to be transferred by the hoist and the staff talked to them about their travels in the past to America and Australia. The staff linked this flying experience to being hoisted and said as they lifted the person, "Up, up and away [Name]. We are going on our travels again." The person enjoyed this and smiled and laughed as they were swiftly and confidently transferred to their wheelchair to go to lunch.

People felt that the staff knew them well and understood their needs. They told us that the staff chatted with them when they were providing care, at mealtimes and, when they were doing their paper work, they would sit in the lounge and talk with them. We saw that one person liked to spend time in the reception area with the administrator. They were welcomed and made comfortable and provided with refreshments throughout the time they spent there.

People told us that they were encouraged to maintain their independence. One person said, "I am very independent I can look after myself really but these girls are marvellous what they do for people." Another person told us, "They help me get washed and dressed because I can't quite reach around my back. They help me put my socks on as well. They are very good. I feel very well cared for." On the day of our inspection people had been involved in making the cakes that were to be eaten with the afternoon tea.

People said that all the staff treated them with dignity and respect, including the housekeeping staff. One person told us, "They close the door and curtains but now they use a screen when they hoist me in the lounge (and close the curtains there too). They try their best with this with towels and what not." Another person said, "The carers are very good. They have got a lot of patience. They use towels to help keep us

private when we have a shower." A member of staff told us, "During personal care we cover service users with a towel, we knock before we go in and we always close the door and curtains. In the lounge we close the curtains when we are using the hoist, because there is a lot of traffic and people sitting in their cars at the traffic lights looking in. We have a screen now too that we use."

Staff we spoke with were able to explain how they maintained the confidentiality of the people. They did not discuss people outside of the home and did not disclose personal information to anyone who should not be given it. However, a recent complaint had been received from a neighbour who had overheard staff talking about people when they used the smoking area when on their breaks. The registered manager had sent all staff a memo reminding them of the need to maintain confidentiality and not to talk about people where they could be overheard by others.

People were encouraged to maintain their relationships with friends and family. They told us that friends and family could come at any time and they were welcomed by the staff. Relatives said that they were able to make themselves a cup of tea. One relative told us, "I come three times a day. I am always welcome. I have not had lunch here but have been offered it. I have been invited to spend Christmas Day and Boxing Day here." Another relative said, "I come five times a week. The staff bend over backwards to help." Although friends and family acted as advocates on people's behalf we saw that some people also had an independent advocate to support them.

We saw that the provider had produced an information booklet about the service that was available in the seating area of the reception. Details about fees payable were on a separate sheet on the administrator's desk in the reception area. Noticeboards had been put on the walls by the doors to the lounge/dining areas on each floor. A large noticeboard was on the wall in the reception area. These contained information about our previous inspection, safeguarding and how to make a complaint. The administrator's desk was in the reception area and they were available to give people any information that they wanted.

Requires Improvement

Our findings

During our last inspection in July 2016, we found that people had not been involved in the development of their care plans which contained little information about their preferences. We also found that people were not supported to maintain their interests and hobbies. People felt bored and isolated in their rooms. The was also no system to manage complaints. During this inspection we found improvements had been made but further personalisation of people's care plans was needed.

The registered manager showed us the revised documentation that was to be used to assess people's needs before they could be admitted. This was to be used to ensure that the home was able to meet their needs and had all the necessary equipment in place before they joined the home. As the provider had not been able to admit anybody, following conditions placed on them as a result of the findings of our last inspection, this documentation had not yet been tested. However, It appeared to be robust.

People and their relatives had been involved in providing information that had been developed into care plans. This included information on their life history and preferences. One relative told us, "It's all there in [relative]'s care plan. Their likes and dislikes are listed." Another relative told us, "I identified seven areas in the care plans that were incorrect. They have now been corrected." We looked at the care records for three people on the first day of this inspection. We saw that there were care plans that covered all areas of people's lives. These included personal hygiene, sleeping, mobility, skin integrity and continence. Within a care plan we viewed under the heading 'communication' it advised staff, 'If I become confused bear with me and help me to make decisions that are in my best interests.' We found that the care plans within the three care records were very similar in content and were not personalised to the individual. We brought this to the attention of the consultant's representative who had been supporting the service with the development of documentation. We also raised it with the registered manager and the Head of Care, who was responsible for the care plans. On the second day of our inspection the registered manager told us that they had addressed the issue of care plans with all the staff. The care plans in the three care records we had looked at on the first day of the inspection had been re-written. We saw that, although they had been personalised to an extent, more detail was needed in order to provide staff with sufficient information to support people in the way that they wished. The Head of Care showed us care plans in a fourth care record that they had recently revised. One of the care plans within this stated that the person should be offered a hot beverage in the morning. When we discussed this with the Head of Care they told us that the person always had a cup of tea, with milk and sugar and three digestive biscuits. Staff knew this so always gave it to them, even though the care plan did not document that this was what they wanted. The Head of Care told us that they would ensure that all the care plans were re-addressed and personalised to people's

preferences and detailed, such as at night how many pillows the person wanted on their bed. We saw that care plans had been evaluated regularly.

The registered manager had introduced handover sheets for each shift. These sheets detailed people's capacity, their diagnosis and needs and risks associated with continence, eating and drinking, moving and handling, medicines, charts that needed to be monitored, communication and updates. Staff were able to see up to date information at a glance about the needs and capacity of each person who lived at the home and what care and support they needed. One member of staff told us, "I find them very useful because they have all of the up to date information about all of the service users." This enabled them to provide appropriate care and support to the people who lived at the home. The registered manager reviewed each of the completed sheets which enabled them to stay informed of any concerns staff may have about individuals.

The registered manager told us that since our last inspection there had been changes made to the support provided to people to maintain their interests and hobbies. The service now had two activities co-ordinators and the range of activities offered had increased significantly. Activities now included cake baking, as was happening on the day of our inspection, carpet bowls, chair exercises, arts and crafts, manicures and themed nights. People we spoke with all told us that they joined in the organised activities. They told us how much they had enjoyed the recent night of fireworks music and entertainment. They said that this was the first time this had happened and they would like musical evening entertainment to be a regular event. We saw that there was a cinema room in which films were shown regularly. There was also a 'coffee shop' for people and their families to use to sit and chat but unfortunately there were no coffee making facilities in it. Care staff told us that they spent one to one time with people who stayed in their rooms. One member of staff said, "I spend time sitting with [Name] most afternoons. [Name] always tells me stories about their life. I tell them a story about myself. They don't forget."

The registered manager showed us the provider's complaints system and the record of complaints and compliments that had been introduced following our last inspection. Relatives had mixed opinions as to the effectiveness of the complaints system. One relative told us, "I had problems with both laundry going missing and the nursing care. They have addressed the laundry and the nursing care." However, another relative said, "I have made complaints about my [relative]'s catheter care and the cleanliness of the commode. The catheter is no better and the commode is cleaned straight away but a few days later the same happens again. You don't feel you are getting anywhere. It all depends which staff are on." We looked at the record of complaints which showed that the registered manager carried out full investigations of the complaints received and had responded to the complainant in accordance with the provider's complaints policy. A recent compliment received commented, "Thank you for being so wonderful and kind to [relative]. She adores you and does all what you ask."

We saw that, on the first day of the inspection, one of the activities co-ordinators was completing questionnaires with people which asked their opinions on the food, the activities and the care that they received. This information was to be reflected in the revised menus and care plans.

Requires Improvement

Our findings

During our last inspection in July 2016, we identified that there were no systems in place to monitor or manage the quality of the service provided and the documentation was not always up to date or accurate. Following that inspection the provider had employed a consultancy company to support the registered manager in establishing the required systems. The consultancy company's participation in the service had been reduced over a period of time. They had initially been a full time presence at the home in July 2016, assisting with the development of documentation, policies and processes and as support for the registered manager. By the time of our inspection this had been reduced to two visits a month, during which they carried out audits of the home for the provider. We saw the most recent audit completed by the consultant. Although this had identified that the care plans needed to incorporate a more person centred approach the consultant had failed to identify the level of similarity that existed between the care plans. The registered manager told us that the provider had now employed a compliance manager who would be completing audits of the home for the provider and was also available to support them in meeting the fundamental standards.

In addition the provider had made changes to the support mechanisms for the registered manager within the home. The deputy manager was also the clinical lead for the home and a new role of Head of Care had been created. The provider's regional manager continued to provide support to the registered manager as well.

We found that a number of regular audits had been introduced at the home to monitor the quality of the service provided. These included audits of infection control, health and safety, the kitchen, the dining experience and equipment. In addition spot checks of the service provided at night time and at weekends had been completed by the registered manager. Documentation of a weekend check made in October 2016 showed that the registered manager had spoken with the staff on duty, two people and two relatives of people who lived at the home. An audit of mobility equipment had identified that three walking frames needed new feet. The registered manager showed us that action had been taken to address this, although no action plan had been completed.

We saw that there had been a considerable improvement in the quality of the documentation that was being used. This was, on the most part, up to date and correctly completed. We discussed ways in which this could be further improved with the registered manager during the inspection as we found any errors or omissions.

People and relatives spoke highly of the registered manager and told us that they knew them well. They saw them as they walked around the building and they stopped to speak with people as they did so. People, relatives and staff all told us that the registered manager was very approachable. One relative said of the registered manager, "[Name] is unbelievable. She knows her job and can always be relied on."

People and their relatives were invited to monthly meetings at which they were able to discuss any issue about the service. At one recent meeting people had asked for protected mealtimes to be introduced and we saw that friends and families had been asked to respect mealtime so that people could eat their meal uninterrupted. People had also asked for the menu to be revised as they found it to be boring. The cook had told us in July that they were to look at the menu again but this does not appear to have happened. However, the questionnaire that was being completed by the activities co-ordinator included information about people's food preferences to inform the menu changes to be made. People had also discussed the care staff, the call bell system and entrance to the building, which they felt was too easy, even though it is protected by a key pad entry system. People and their relatives were able to influence how the service developed by participation in the regular meetings and questionnaires.

Staff were also able to contribute to the development of the service during supervision and by participating in the regular staff meetings held. Minutes of a meeting held in September 2016 showed that the care staff had discussed areas such as confidentiality, following the complaint raised by a neighbour, rotas, the use of social media, personal protective equipment and the kitchens. The kitchen staff held their own meetings at which cleaning schedules and food first had been discussed as well as safer food handling. People were supported by staff who were committed to improving the service that they provided.

Staff were asked for their understanding of their roles and responsibilities. One member of staff said it was to, "Provide independence where possible, keep everyone safe, and understand it is their home." Another member of staff said it was to, "Just look after the residents. Give them what they need, not what we want to give them." This showed that staff were committed to putting people who lived at the home first.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed in a way that enabled them to respond to people's needs in a timely manner.