Langford Park Ltd

Langford Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 19 and 22 February 2016. The previous inspection of the home was carried out on 17 and 19 August 2015 where we found breaches of regulations. These related to safe care and treatment, safeguarding service users from abuse and improper treatment, and assessing and monitoring the quality of service provision. The service was rated as 'requires improvement' and the provider was required to submit a monthly action plan explaining what they were doing to meet the legal requirement to improve the service.

We carried out this inspection in February 2016 to check whether these improvements had been made. Langford Park is registered to provide accommodation, nursing and personal care support for up to 34 older people, people living with a dementia and younger people with a physical disability. At the time of this inspection there were 29 people living there. 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.

We found significant improvements in all aspects of the management of the service since the last inspection. There had been input from the local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT) since the last inspection. These professionals had closely monitored the home with regular visits and provided training and support to help the provider and management team establish effective care and management systems. This input had been welcomed and the providers and management team had worked closely and constructively with them to keep people safe and improve the quality of the service. However, it was not possible at the time of the inspection to determine whether there was consistency in the effectiveness of the care, treatment and support people received, or whether this would be sustained, as the changes had been so recent. In addition, some improvements had yet to be implemented.

At the last inspection we identified that risks to people's safety had not been fully assessed, recorded or reviewed. At that inspection we found staff did not have access to written information about potential risks or the actions they must take to reduce those risks. At this inspection we found improvements had been made and there were systems in place to minimise risks. However further improvements were needed in relation to the assessment of risk, particularly related to falls and accident and incidents.

At the last inspection we found there was no information to show how people had been involved in the planning and review of their care. Since that inspection a new care plan system had been introduced in the home and staff were writing new care plans for everyone. However not everybody we spoke to had been consulted. The new care plans required additional information, especially about people's history and background. People's end of life wishes had not been consistently discussed with them or their families and had not been recorded. This meant there was a risk they may not receive the care they and their families

wish for at the end of their life.

There had been a large turnover of staff which had made it difficult for people to build relationships with the staff who supported them. One visitor said, "The biggest issue is the turnover of staff. You're never sure who will be here when you visit".

At the time of the inspection staff had not been receiving regular individual support and supervision. Managers recognised they had lost confidence during the safeguarding process and were feeling under scrutiny and demoralised. They wanted to provide constructive and positive support to help them feel more motivated and valued. Formal staff supervision was being reintroduced during the week of the inspection in the form of one to one sessions.

There were some organised activities and the activities organiser visited people who were cared for in their rooms. However, this was not sufficient to meet the social and spiritual needs of everybody at the home. The provider and registered manager were taking steps to address this and a health professional reported some progress had been made. An additional activities co-ordinator had been appointed, and it was planned that staff would support people with more 'person centred' activities on an individual basis. An 'activity care plan' was being developed to identify activities relevant to people and their interests, and direct staff in how to provide them.

At the last inspection the provider did not have adequate systems in place to monitor and review the quality of care and ensure the service continued to meet people's needs effectively. At this inspection we found new quality monitoring systems were in place to ensure the home ran smoothly. However, these had not yet been fully established and therefore we are not yet fully confident that improvements can be sustained on a long term basis.

At the last inspection we found the service did not always manage medicines safely. At this inspection we found systems were now in place to ensure people received their medicines safely. This was confirmed by a health professional who told us, "They do seem to manage their medication very carefully".

At the last inspection we found people's rights were not being fully protected in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. At this inspection we found that improvements had been made. Staff were more familiar with this legislation. Applications had been made for people to be cared for under the Deprivation of Liberty Safeguards where appropriate.

People were protected from the risk of abuse through the provision of policies, procedures, robust recruitment and staff training. The registered manager and provider had worked closely with the local authority, acting promptly and decisively to address concerns and minimise risk.

There were adequate numbers of staff with the knowledge and skills to meet people's physical needs. Communication systems had improved and staff were kept well informed about any changes to people's needs through staff meetings and handover sessions between each shift.

The staffing structure in the home provided clear lines of accountability and responsibility. There was always a registered nurse on duty which made sure people and staff always had access to a more senior staff member to oversee people's health needs and respond to any concerns. Care staff demonstrated a good understanding of people's physical care needs, and completed charts and daily records recording their interventions in line with people's care plans.

People's individual nutritional requirements were assessed and documented to ensure they received a diet appropriate to their needs and wishes. There were sufficient staff to ensure everybody who needed support with eating received it. The recently appointed chef told us they planned to speak with people about their food preferences and offer an increased range of choices.

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

Some aspects of the service were not safe.

Risks to people's safety were not always fully assessed, recorded and reviewed.

There were sufficient numbers of staff to keep people safe and meet each person's individual needs.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

Systems were in place to ensure people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been receiving regular individual support and supervision, although this was due to be reinstated.

People's rights were protected, because the service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People received effective care and support from staff with the experience, skills and knowledge to meet their needs.

People were effectively supported with nutrition and hydration.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they found it difficult to build relationships with staff because of the high staff turnover.

People's end of life wishes were not consistently discussed with them and their families and recorded.

Staff were committed to promoting people's independence and

supporting them to make choices.

People's privacy and confidentiality was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always consulted about their care plans.

People's social and spiritual needs were not always met.

People felt involved in decisions about their care.

People received the support they required to meet their individual physical care needs.

Is the service well-led?

Requires Improvement

The service was well led but some systems to monitor the quality of the service were still in the process of being fully established and embedded.

People, relatives and staff expressed confidence in the management and felt that any concerns would be addressed.

The manager and providers were committed to developing and improving the service for the benefit of people and staff working there.

Langford Park

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.

At the previous inspection on 17 and 19 August 2015 we found areas that required improvement. For example, risk assessments and risk management plans were not being completed and reviewed regularly and the service was depriving people of their liberty for the purpose of receiving care or treatment without lawful authority. The service did not have effective systems in place to assess, monitor and improve the quality and safety of the service. We rated the service as 'requires improvement' and the provider submitted a monthly action plan explaining what they were doing to meet the legal requirement to improve the service. The service subsequently became part of the local safeguarding process and was supported by the council quality assurance and improvement team. We carried out this inspection to check whether sufficient improvements had been made since August 2015 to ensure that people were safe and their needs were being met.

This inspection took place on 19 and 22 February 2016. It was an unannounced inspection which meant the provider, registered manager and staff did not know we would be visiting. It was carried out by two inspectors and a specialist advisor with expertise in nursing and dementia care.

We reviewed the previous inspection reports before the inspection. We also reviewed the information we held about the home. This included safeguarding and quality assurance reports and feedback from Devon County Council commissioners and community health professionals. Feedback was positive showing that they felt improvements had been made. The safeguarding process was closed following a meeting in April 2016 where significant improvements were found.

At the time of this inspection there were 29 people living at the home. During the inspection we spoke with 16 people who lived at the home, four relatives who were visiting and three health and social care professionals. Some of the people we spoke with were unable to comment on their experiences directly due to living with dementia. We therefore spent time observing care provided in the communal areas and staff

interactions with people. We also spoke with 13 members of staff, the registered manager and two providers. We looked at a sample of records relating to the running of the home and to the care of individuals. This included six care plans, food and fluid monitoring charts, risk assessments; medication administration records (MARS), four staff personnel files and quality assurance tools. We toured the premises, all accommodation and communal areas and the kitchen. We also looked at medicine storage and administration.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we identified that risks to people's safety had not been fully assessed, recorded or reviewed. At that inspection we found staff did not have access to written information about potential risks or the actions they must take to reduce those risks. At this inspection in February 2016 we found improvements had been made. However, further improvements were needed. For example, one care plan we read showed risks associated with the person's behaviour and mental health had been assessed and there were guidelines in place to state how these should be managed. Despite this there was no risk assessment in place which identified risks associated with their physical environment or how these should be minimised by staff. The registered manager advised other forms of risk assessment such as accident and incident and falls reporting and audits had not been completed. This was because the priority had been updating care plans to ensure people received safe care. They reassured us these assessments ` would be completed as a matter of urgency.

A new system of risk assessment documentation had been introduced, focussing on pressure area care, nutrition, falls and moving and handling. These updated assessments were comprehensive and person-centred. We saw that charts, for example relating to fluid and dietary intake, were being correctly completed by staff. People were not experiencing pressure area damage, which indicated relevant risk assessments and care interventions were effective. We saw staff knew how to move and handle people correctly. Repositioning and skin inspection charts were in evidence in people's rooms and being completed. Pressure relieving mattresses were set correctly and checked daily. A member of staff told us most people's records were checked at every shift to ensure interventions had been completed and documented. In their view this had kept people safe. Health professionals confirmed risk assessments and care plans were now in place and effective in ensuring safe and appropriate care.

At the last inspection we found the service did not always manage medicines safely. At this inspection in February 2016 we found systems were now in place to ensure people received their medicines safely. A health professional told us, "They do seem to manage their medication very carefully". The registered manager was proactive in checking medicines had been given safely. This allowed them to identify any medication errors, act to ensure people were safe and address concerns with staff in supervision.

We saw medicines being administered by registered nurses and recorded correctly. People received their medicines at the correct time and consent was obtained before they were given. One person said "They always bring my tablets first thing so they have time to kick in before I get up." Another person said "Nurses bring the tablets, they're very good." Where people required assistance with prescribed lotions or creams there were clear records to show when these had been applied. Care plans had body maps to show where the creams should be applied and staff signed to say when they had been administered. This enabled the effectiveness of creams and lotions to be monitored.

There were appropriate secure storage facilities for all medicines, including those requiring additional security or refrigeration. The temperature of fridges and storage areas for medicines were checked and recorded daily. Medicines entering the home were recorded when received and when administered or

refused. Records were checked against stocks held and found to be correct.

People told us they felt safe at the home and with the staff who supported them. Comments included, "I feel very safe here. They seem to know what I want before I even ask", "I feel safe because of very good staff that care. I trust them", and, "I feel safe. I've got my bell. People come quickly. If I have a concern". A relative said "I can go away knowing they are well looked after and safe." A health professional told us, "It's not just safe. I'd place my Mum there now".

People were supported by adequate numbers of staff to meet their physical needs. People had access to call bells which enabled them to summon assistance when they required it. People told us staff responded quickly to requests for help. One person said "If you ring the bell or pull the emergency cord the staff come pretty quickly. At night they are really quick." Throughout the inspection we saw staff responded to requests for support promptly. We did not hear bells ringing for extended periods of time showing staff responded to requests for help in a timely manner. One person receiving end of life care had a personal call bell system. This alarm was carried by a registered nurse at all times to ensure an emergency response if required.

Risks of abuse to people were minimised because the provider ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

People were protected from the risk of abuse through the provision of policies, procedures and staff training. Staff we spoke to confirmed they had completed safeguarding training and knew how to raise any concerns. They told us,"I would not hesitate to report anything". We saw they had raised concerns about another member of staff delivering unsafe care. A safeguarding process had been initiated and action taken to keep people safe. The registered manager and provider had worked closely with the local authority, acting promptly and decisively to address concerns and minimise risk. They had raised safeguarding alerts, carried out investigations and taken any action necessary to keep people safe, including using the home's disciplinary procedures. Staff meetings were used to reinforce the importance of the whistleblowing policy, and staff were encouraged to use it if necessary.

There were systems in place to make sure the premises and equipment were safe for people. A new door entry system meant people who had capacity to do so could freely choose to come in and out of the building using a personal key fob. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. This was supported by the recent increase in time available for cleaning and the introduction of a quality assurance programme focussing on the maintenance of the environment and infection control. A relative told us, "The cleanliness is marvellous".

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found the service was not always effective. At this inspection we found there have been significant improvements. However because they are so recent, it is not possible to determine whether there is consistency in the effectiveness of the care, treatment and support people receive or whether this will be sustained.

At the time of the inspection staff had not been receiving regular individual support and supervision. Managers recognised they had lost confidence during the safeguarding process and were feeling under scrutiny and demoralised. They wanted to provide constructive and positive support to help them feel more motivated and valued. Formal staff supervision was being reintroduced during the week of the inspection in the form of one to one sessions. The registered manager told us they would talk with staff about their strengths and areas for development, arranging appropriate support as necessary. For example some staff did not have English as a first language, and there were concerns they did not always understand what was being asked of them. In addition the registered manager was clear that staff should speak English while on duty as that was the language used by people living in the home. These staff may therefore need English lessons to be able to support people effectively. In the longer term the registered manager and providers wanted to invest in staff, supporting them to develop specialist knowledge and skills to meet the diverse needs of people living at the home. Staff would identify any particular interests initially and then be trained to become specialists in that area, for example working with people who were living with dementia or a learning disability.

New staff were being recruited, to replace staff who had left and to increase staff numbers overall. An initial two week induction programme introduced them to the home's routines, policies and procedures. They worked alongside more experienced staff to get to know people and about their care and support needs. They were then assessed to ensure they were competent before working unsupervised and completed a six month probation period. This was also an opportunity for them to identify any training needs. The registered manager felt the induction programme needed to be improved and was considering introducing the new national skills for care certificate in the future. This is a more detailed national training programme and qualification for newly recruited staff.

A rolling training programme was in place covering key areas, with the majority of staff having completed mandatory training in moving and handling, safeguarding and the Mental Capacity Act with further training scheduled in subjects such as health and safety and infection control. Additional training was being provided by health professionals as part of the improvement programme, and workshops were running to support the nurses to complete care plans.

At the last inspection we found people's rights were not being protected in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. 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. Some staff we spoke with did not fully understand the principles of the MCA. 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). Several people were eligible for assessment under DoLs but had not been referred.

We checked whether the service was now working within the principles of the MCA, and whether any conditions on approved authorisations to deprive a person of their liberty were being met. At this inspection we found that improvements had been made and staff were more familiar with this legislation. Applications had been made for people to be cared for under the Deprivation of Liberty Safeguards where appropriate. Registered nurses we spoke with had good knowledge of the MCA and how it should be put into practice. They were able to tell us how they acted in accordance with the principles of the act including involving people who knew the person well to make sure any decisions were made in the person's best interests. For example a registered nurse told us about one person who preferred sweet things to eat although they had diabetes. They said they thought they had the mental capacity to make a decision about what they ate at the time but were unsure whether they were able to understand how their diet may affect their health on a more long term basis. The registered nurse told us they thought a best interests decision needed to be made in consultation with family members and health professionals, and this was being arranged.

Staff asked for people's consent before they assisted them with care and support. One member of staff told us how they offered people choices and respected their wishes. They said "If I am helping someone I always tell them what is happening and ask if they are happy for me to help them."

During the inspection we saw people receiving effective care and support from staff with the experience, skills and knowledge to meet their care needs. They demonstrated a good understanding of the importance of regular pressure are care, people's continence needs, food and fluid intake and repositioning. We observed staff referring to and following care plans to ensure the care was being given correctly. We saw they knew what to do if people needed additional support with their physical health. For example if red skin was observed while pressure areas were being checked, it was reported to the registered nurse and prescribed cream applied. This additional care need was documented and evaluated daily. One person told us, "Staff are really good, if you're poorly." A member of staff told us if someone was shouting, "it should not be seen as challenging behaviour, it is the person's way of telling us they require assistance". This showed staff had understanding of how this individual communicated their needs.

There was a registered nurse on each shift who had overall responsibility for monitoring and responding to people's health care needs. We saw they responded effectively to people's requests for support. For example, one person had complained of feeling dizzy and a registered nurse had visited them to take their blood pressure. They explained what they were doing and why, and told the person what the results indicated. The registered nurse informed the person they would take their blood pressure again and arrange for them to see a doctor to make sure they received appropriate treatment if needed.

Care staff demonstrated a good understanding of people's physical care needs, and completed charts and daily records recording their interventions. One member of staff told us they were encouraged to, "Sign it, date it, own it". People in their rooms appeared clean, comfortable and well cared for. Equipment, such as hoists and stand aids, was available to meet people's needs and we saw them being used correctly.

People were referred appropriately to health professionals for specialist support. This was done through the GP and included physiotherapy, speech and language therapists, tissue viability nurses and the community mental health team. The GP visited weekly and reviewed people's physical care needs as required. One

health professional told us staff at the home involved them appropriately and "seem to really care" for the people living there.

Information about people's needs and the care they required was passed to staff during handover meetings. The registered provider and a member of the registered nurse team told us improvements had been made to increase the effectiveness of these meetings. This included ensuring staff had sufficient time to discuss people's needs. In addition a new system had been introduced in which staff were given a daily allocation record sheet, detailing where they would be working and the individual needs of people in their care. This meant staff were clear about their roles and responsibilities and could support people effectively.

People's individual nutritional requirements were assessed and documented to ensure they received a diet appropriate to their needs and wishes. The chef was provided with a list of each person's dietary requirements, likes and dislikes. Some people required their food to be served at a specific consistency to minimise the risk of choking. When one person's meal arrived staff checked with the registered nurse if the meal was correct for the person. They looked at the care plan together and established that the meal was at the wrong consistency to meet the person's needs. This meal was then returned to the kitchen and replaced with the correct meal.

The recently appointed chef told us they planned to speak with people about their food preferences and offer an increased range of choices. They were aware of the importance of presentation, for example pureeing foods individually to make them as appetising as possible. The chef spoke individually with people to obtain their choice from the day's menu. However, by lunch time many people could not remember what they had ordered and there was no menu on display or visual reminders for people. Meals were served plated to each individual person meaning they were unable to make choices about accompanying vegetables or portion sizes.

A health professional told us they had raised concerns about some people losing weight. The registered manager and provider had discussed the concerns with kitchen staff and care staff. Better systems were now in place to monitor people's weight. A snack menu and snack trolley had been introduced. The kitchen remained open at all times. This ensured people were encouraged to eat and always had access to food, not just at mealtimes. The health professional was confident people's nutritional needs were now being met, and said, "Cakes are being made all the time. It's like a hotel now, food wise!"

At lunch time people were able to choose where they ate their meal. Care staff said there were enough staff to make sure everyone received the help they needed. Staff told people what was on their plate if they were supporting them to eat. One person was able to eat independently if provided with encouragement and support. A member of staff sat with this person and supported them whilst they ate their main meal. Another person needed a member of staff to physically give them their food. The staff member sat with the person and assisted them at the person's pace. They chatted to the person, which made it a pleasant occasion. The person smiled and was very comfortable with the staff member. Staff had time to chat to people, and the atmosphere at lunchtime on the first floor and in the dining room appeared calm.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us there had been a large turnover of staff, which had made it difficult for them to build relationships with the staff who supported them. One visitor said, "The biggest issue is the turnover of staff. You're never sure who will be here when you visit". One person was very anxious about the amount of new staff at the home. They said "All the best ones have left; the new ones don't know me." However, we saw on more than one occasion during the inspection staff went to this person to chat and offer reassurance to them. One member of staff said "They become anxious when there are changes. I always pop in to make sure they know there are still familiar faces around

One relative said while they were happy with the physical care provided, they found sometimes there was poor communication and staff weren't always as thoughtful as they could be. They told us, "You can't fault the actual care. They are thriving here. But the little things sometimes get missed like making sure they have their glasses and the remote control." This was also the view of a health professional who had found the person they were visiting without their hearing aid and glasses. The provider reassured us this would be addressed with staff.

A health professional we spoke to felt people and their families needed more support with end of life care. They said the home did not offer families the opportunity to discuss this issue or develop an end of life care plan documenting their needs and wishes saying, "Families are asking for it". Care plans reviewed did not record people's end of life wishes. One person at the end of their life, spoke positively about the support they were being given. They had been fully involved in decisions about their care and their wishes taken into account. "On my final journey, my needs are being respected". They felt reassured knowing that staff liaised with their family on a regular basis. They chose how they spent their time, and told us staff supported them to retain as much independence as possible. The registered manager confirmed staff undertook training in end of life care and received guidance and support from the hospice. However unless people's end of life wishes are consistently discussed and recorded, there is a risk they may not receive the care they and their families wish for..

People and their relatives told us the staff were kind and caring. One relative said," I have full admiration for the staff. They are cheerful and upbeat, they are remarkable…My relative is happy here. They are safe. I don't have to worry any more". People commented, "Staff are friendly and helpful, you can have a good laugh with them", "Staff are nice. They are kind. I'm well looked after and comfortable, "and, ""It feels like home. They can't do enough for you."

Long term staff spoken with talked about the importance of listening to what people want, and the recent change at the home from 'task centred', to 'person centred' care. We saw staff working in a person centred way when assisting someone to change position using a stand aid. They were gentle with the person and told them what was happening. They offered reassurance and worked very slowly. A registered nurse told us, "I hear carers talking to residents whilst feeding them and helping them choose the clothes they wish to wear. That makes me feel happy. This is a care home that really takes care of its residents".

People's privacy was respected and people were able to spend time alone in their bedrooms if they wished to. They told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private, and there was also a comfortable 'quiet' room for their use. A member of staff told us," "We don't come to work in our work place; we come to work in their home".

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. For example we saw one person being supported to go to the quiet room at lunch time. The member of staff told us they preferred to eat alone because they were self-conscious about eating with others.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found there was no information to show how people had been involved in the planning and review of their care. Since that inspection a new care plan system had been introduced in the home and staff were writing new care plans for everyone. The registered manager was aware the new care plans required additional information, especially about people's history and background and this was in progress. The focus had been on updating care plans to ensure people were safe. They were now planning some 'life story' work with people and their families, to gather this information and help staff to get to know people better.

Although the new care plans were personalised to the individual, not everybody we spoke to had been consulted. One person said, "They did a care plan with me once but not recently."
The registered manager assured us they were in the process of consulting everybody about their care plan. They had written one person's care plan with the person dictating. Some people wanted to complete their care plans themselves and would be supported to do so. A health professional told us staff had, "got really good at writing care plans". While not everybody said they had been involved in writing their care plans, they did feel involved in decisions about their care. A relative told us, "When they moved in they asked all about their likes and dislikes." One person said, "I do feel in control." Another said "You can please yourself what you do really."

There were some organised activities for people to join in with if they wished, and the activities organiser visited people who were cared for in their rooms. However, due to staff changes they had been working alone in this role, with limited time available to meet the diverse needs of everybody at the home. Daily records reflected people's physical health care needs, but there was little reference or assessment of people's social care needs. One person told us a member of staff had taken them into town to buy jigsaw puzzles. They said they would like to go out more. Another person said "I would like just to be able to go to a shop to buy a newspaper and a bar of chocolate. Even if they had a shop here that would do. They have told me to ask a carer but you can't keep doing that." A health professional expressed concern that people's spiritual needs weren't being met. One person, whose religious faith was very important to them, had not had their spiritual needs acknowledged or addressed. Another person commented, "I want to go to church. The church they have here isn't a proper church".

The provider and registered manager were aware that people's social and spiritual needs were not always being met and were taking steps to address this. An additional activities co-ordinator had been appointed, and it was planned that staff would support people with more 'person centred' activities on an individual basis. An 'activity care plan' was being developed to identify activities relevant to people and their interests, and direct staff in how to provide them. A health professional who visited the home confirmed progress was being made and they had seen evidence of the difference this was making to people's quality of life. For example the activity worker had recognised that one person, with limited communication, smiled broadly when sung to. The person's care plan now guided all staff to do this. They had also seen people enjoying two new pets, a rare breed chicken and a bearded dragon.

People told us they liked their room, which was furnished and decorated to their needs, tastes and preferences when they moved in. One person told us the provider had visited after they moved in and asked, "Was I settling in and was there anything they could do to make me more comfortable? I said the toilet was rather small, and the maintenance chap came in and changed the toilet immediately".

Each person had their needs assessed before they moved into the home. Information about the person's needs and history was gathered from the person, their relatives and health and social care professionals. This helped staff to understand the person and their needs, and how they wanted their care to be provided. People could come for lunch and have a look around, to help them decide if the home was right for them.

People received the support they required to meet their individual physical care needs. People told us staff were quick to respond to requests for help. One person had rung their bell and found staff, "coming in like a swarm of bees". Another person said, "You've only got to sneeze and a handkerchief appears". We saw from charts kept in people's bedrooms staff had supported them with personal care. One person told us they had a shower that morning and we saw this was recorded on their chart. They also told us after their shower staff had assisted them to put cream on their legs and feet. This too was recorded on the chart. One person was being nursed in bed and the chart in their room showed staff were assisting them to change position every two hours to minimise the risks of skin damage. The chart showed staff checked the person's skin each time they helped them, to make sure any concerns were quickly identified and passed on to a more senior member of staff for assessment. This showed care plans contained personalised information about people's needs and how staff met them and that needs were being met.

People said they would be able to complain if they had any concerns. One person said, "The manager is easy to talk to." Another person told us "I would complain if I needed to. I'm pretty confident something would be done." A relative said if they had concerns they would be able to speak with a member of staff or manager if they needed to. There was a complaints policy and procedure which enabled people to make a complaint and receive a response in a timely manner.
Where complaints had been made records showed these had been investigated and responded to. Where investigations had highlighted shortfalls in the service offered action had been taken to make improvements. One response to a complaint outlined the action the provider had said they would take to improve. We checked if these actions had been put into practice and found they had been.

Requires Improvement

Is the service well-led?

Our findings

We found significant improvements in all aspects of the management of the service since the last inspection. There had been input from the local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT). These professionals had closely monitored the home with regular visits, and provided training and support to help the providers and management team establish effective care and management systems. This input had been welcomed and the providers and management team had worked closely and constructively with the local authority to keep people safe and improve the quality of the service. However this was still a 'work in progress'.

At the last inspection we found the provider did not have adequate systems in place to monitor and review the quality of care and ensure the service continued to meet people's needs effectively. At this inspection in February 2016 the provider had begun to implement a range of quality assurance measures, including a newly developed audit tool. For example, the registered manager was proactively monitoring staff effectiveness and competency through observation, discussion and reviewing paperwork. Daily records, including food and fluid charts were audited twice daily and feedback given to staff where improvement was needed. A medication audit was in place. There were questionnaires for people, staff and visiting professionals to complete, asking for their view of the service. However, some audits, such as those monitoring accidents and incidents and the environment had yet to be implemented. The registered manager told us their focus had been on writing care plans and keeping people safe saying, "Our next mission is to improve the audit system". Although our findings have shown that significant improvements have been made since the last inspection in all aspects of the management of the home, systems to monitor the quality of the service were therefore still to be fully established and embedded.

The home was managed by a person who was newly registered with the Care Quality Commission as the registered manager for the service. People, relatives and staff were complimentary about them. One person told us they thought the manager was "easy to get on with". A relative described them as, "very focussed". Comments from staff included, "I have faith in the manager and feel supported", "I could go to them if I wasn't happy" and, "[Manager's name] is very transparent and very honest".

The registered manager told us, "I am excited and passionate about my job and the people we care for". In a mission statement their vision was, "To consistently deliver the highest quality Person Centred Care to our residents - We place quality first in everything we do for our residents, relatives and staff. We aspire to be the most respected and successful care provider within the southwest of England".

The registered manager was supporting staff through a period of fundamental change, including changes to the staff team, the care planning system and roles and responsibilities, through the introduction of a key worker system. Staff meetings were held every six to eight weeks where the registered manager and providers updated staff on the progress being made, provided reassurance and an opportunity for staff to ask questions.

Staff we spoke to were optimistic about the changes that were occurring in the home. One member of staff

said "There's been a lot of changes, but for the better I think." Another member of staff said "I have every confidence we will come through better".
There was a staffing structure in the home which provided clear lines of accountability and responsibility. There was always a registered nurse on duty which made sure people always had access to a senior staff member to oversee and monitor their health and respond to any concerns. In addition to registered nurses there were team leaders who were responsible for overseeing the care provided to people and allocating staff to make sure people received appropriate support to meet their needs. We saw that people's needs were being met.

The providers were very involved in the changes taking place at the home. They told us, "We have taken a long, hard look at ourselves". They were proactive in learning more about the way in which care was provided. They said, "How can we possibly know if care plans are effective if we don't understand them ourselves?" They had taken a more active role in supporting the registered manager, relocating to an office in the home so they were accessible on a daily basis, and appointing a deputy manager. Issues were also discussed at a formal weekly meeting. The providers and registered manager were undertaking training courses to improve their management skills and help them to build an effective staff team. They said," We constructively want to help people succeed. We want to get away from a 'blame culture', and be a place where people want to come and work". People and staff spoke positively about the providers. Comments included, "They are very nice. They're lovely. They always come to see me when they come in" and "They are first class. They're lovely they are". Staff told us the providers were 'coming up with the goods', for example, purchasing new equipment to support them in caring effectively for people.

There were plans to reinstate community links that had been put on hold. For example, with a fund raising group, which had organised the summer fete and had raised money to improve the gardens. The providers hoped this group would become more involved in supporting people at the home with activities. They also planned to network with other providers and attend events which would support their own learning and development and further improve the quality of service provision at the home.