Ranc Care Homes Limited

Orchard House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Orchard House is registered to provide accommodation for up to 64 people who require nursing or personal care. At the time of our inspection there were 41 people using the service. The home has two units. Rivendell unit is on the ground floor and Lothorian unit on the first floor. There is access to the first floor by stairs or lift.

This unannounced inspection took place on 11 May 2016.

At the last comprehensive inspection on 2 and 5 October 2015 this service was placed into special measures by CQC. A breach of seven legal requirements was found and the service was rated as inadequate. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to:

- responding to and reporting allegations of abuse,
- carrying out assessments of, and managing, risks,
- ensuring that the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were met,
- treating people with care, dignity and respect,
- involving people in the assessment of their care and treatment,
- assessment and monitoring of the service.

During this inspection we found that there was sufficient improvement to take the service out of special measures. We found that the provider had followed their plan which they had told us would be completed by 31 March 2016 to show how the legal requirements were to be met. Some improvements were however still needed.

The service did not have a registered manager. The last registered manager left their position in October 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had appointed a new manager but they had not yet registered with CQC.

Staff were knowledgeable about reporting concerns about people. However, information about suspicions and allegations of harm had not always been reported by the management of the service to the appropriate authorities. This put people at risk of harm and limited those organisations responsible for safeguarding people to act in a timely manner.

The administration and management of medicines was not always undertaken in a safe way. Staff had been

assessed as competent but a medication error had taken place prior to this inspection.

The manager and staff understood and worked within the principles of the Mental Capacity Act 2005 and the codes of practice. Appropriate applications had been sought to deprive people of their liberty.

People were cared for by staff who understood them. People were encouraged to be independent and their privacy and dignity was respected by staff. Assessments and management of risks to people, in areas such as falls and medicines administration, were completed.

People were given opportunities to be involved in, and contribute to, how their care needs were met.

People's health care needs were identified by staff and met by a range of health care professionals including a GP, speech and language therapist and an occupational therapist.

People were supported with their nutritional needs and staff ensured people ate and drank sufficient quantities.

Staff were provided with a formal induction and regular training and support to enable them to undertake their roles.

People knew how to make a complaint. We saw the provider investigated any complaints and made changes to improve the service.

The manager had carried out regular audits to assess what improvements needed to be made.

We found one breach 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 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.

Staff were aware of their responsibilities to protect people from harm. However, information about suspicions and allegations of harm had not always been reported by the management of the service to the appropriate authorities. This meant people were not always protected from harm.

People had their risks assessed and managed safely.

People were not always safe when medication was administered because errors had not always been dealt with effectively.

Is the service effective?

Good

The service was effective.

Staff had received training and were acting in accordance with the MCA and DoLS code of practice.

People were cared for by staff who had the right skills and knowledge about each person they cared for.

People were able to access a variety of food and drink of their choice.

Is the service caring?

Good

The service was caring.

People were cared for with dignity and respect by staff who understood the things that were meaningful and important to them.

Staff knew how to support people to access independent advocates to act on their behalf.

People were supported to see their families and friends and maintain those relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People were involved in the assessment of their care so that their needs could be met in the way that they wanted.

People were supported with a range of hobbies, interests and pastimes.

Compliments, suggestions and concerns, were used as a way of recognising what worked well and what improvements were required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People using the service were not always informed of incidents in an open and transparent way. Notifications had not always been sent to the CQC as required by law.

Audits and systems to measure the quality of the service meant that any shortfalls in the service provided to people were identified and acted upon.

Records had not always been completed to ensure people received high quality care.

Orchard House

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 11 May 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection we looked at all of the information that we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements. We looked at other information that we held about the service including notifications, which provide information about events that happen in the service that the provider is required to inform us about by law.

During the inspection we spoke with six people who lived in the service and three visitors. We spoke with the manager, the deputy manager and area manager. We also spoke with four members of care staff, three registered nurses, one team leader and the service's chef.

As part of this inspection we looked at records in relation to keeping people safe from harm and we also looked at the care plans and risk assessments for five people. We looked at records in relation to the management of the service including audits, satisfaction surveys and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in October 2015 we found that the provider was breaching two legal requirements in this area and was rated as inadequate. We found at this inspection that the provider had made some improvements to investigate and respond to allegations of harm. We found that the provider had made significant improvements because risks to people had been assessed and minimised.

Improvements had been made because nursing and care staff had, after receiving relevant training, gained a full understanding of how to ensure people were protected from harm. They were able to describe what the signs of harm could be, and they were clear about reporting procedures. However, we found that although staff had reported concerns and incidents to senior staff within the home, senior staff had not always reported these in a timely manner to external stakeholders and they had failed to follow the provider's policy.

We found one incident that had affected the health and wellbeing of one person had not been reported or dealt with appropriately to keep the person safe. We also found that there had been six other incidents that should have been reported to the local authority safeguarding team. This put people at risk and did not always ensure they were as protected from harm as they should have been.

The manager stated the referrals would be completed as soon as practicable.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Following the inspection we were informed that the safeguarding referrals had been completed and sent to the local authority safeguarding team.

There had been improvements in relation to the physical and health risks that people were exposed to. This was because the level of risk to people was managed effectively. Areas of risk that had been identified to people included moving and transferring, behaviour that challenged people and others, safe eating and drinking, the development of pressure sores and falls. We saw information in relation to how these risks had been managed. For example one person had been assessed in relation to risks around their behaviour that challenged themselves and others. There were details of how staff should remain calm and offer reassurance to the person. There was also guidance about the techniques that staff should use to distract the person. One member of care staff said, "I have had risk assessment training and this has helped me understand what risks people can take and those they need support with such as going out into the garden." We saw that a process was in place to ensure risks were reviewed regularly. Staff confirmed that the reviews took place and information in people's records was updated where necessary.

People and their relatives told us that when people were supported with their care needs this was done in a safe way. For example, where two staff were required for safe moving and transferring the correct number of staff were always provided. Our observations of people, who were moved and transferred, showed that staff

made sure people were assisted as safely as possible. One person told us, "I have a walking frame and they [staff] always make sure it is right by my side." We saw that this was indeed the case.

People received their prescribed medicines from staff who were trained in the management and administration of medicines. Nursing staff said that they now had the time they needed to administer people's medicines. One nurse said, "It's much less busy now and I have the time to administer medicines without feeling rushed." Our observations showed that staff gave people time to take the medicines they had been administered and that staff recorded medicines administered accurately. We saw that where people had difficulty in communicating that they were in pain, a recognised pain scale was used by nurses. This meant people received pain medication when they needed it.

During the inspection we saw that people were supported to take their prescribed medicines. However, there had been one incident, prior to this inspection, where a person had been given the wrong medication. We found that the nurses had not followed the provider's policy and procedure in medication administration. Management had not followed their protocols in medication error reporting and no advice had been sought from a healthcare professional in relation to the impact that this error could have had on the person's health or wellbeing.

People told us they were happy with how their medicines were administered. One person told us, "I have medicines for all sorts of things. They [staff] tell me what they are for and make sure I take them before then signing my form [medicines administration record [MAR]." Staff told us that information was provided for those people whose medicines had to be taken in a particular way such as 'before food' and 'with water'. Each person's MAR chart contained the level of support, dosage and timings specified by the prescriber. Staff confirmed that they had been trained and assessed as being competent in the safe administration of medicines, and records confirmed this was the case. One person said, "They [staff] get my medicines one or two at a time as this is how I like them. I have them with a drink." Another person said, "I have a nurse come in and she gives me my medicines. I have an extra tablet at lunch time."

Records showed that appropriate equipment maintenance and servicing had taken place. The fire alarm system was tested weekly and fire extinguishers and emergency lighting were checked and serviced regularly by a contractor. There were Personal Emergency Evacuation Plans which were easily available in an emergency. The manager showed us the fire grab box, which contained emergency information, but staff were not aware of it or what it contained. There were detailed contingency plans in place but staff not aware of where these were kept. This meant that in the event of an emergency that staff would not have the appropriate information to act promptly.

Staff told us, and reports were seen, that showed any accidents and incidents were recorded. Care and nursing staff said they discussed and recorded the measures required to help minimise the potential for any recurrence. For example, referrals were made to the local falls team or provision of additional equipment such as bed rails.

The registered provider had a system to establish the staffing levels required to ensure people's needs could be met safely and effectively. People and their relatives told us that there were now sufficient numbers of staff in place to meet people's care needs. One person told us, "I feel safe here as I have my call bell and it is always next to where I sit," and another person said "Having the same girls [staff] and getting to know them helps me feel assured that I am safe."

People on Rivendell unit told us that staff now always had time for a chat and that there were enough staff to ensure that they were safe. One person told us, "I can't get out of bed on my own. When I want to get up

the staff help me and do this very carefully." A relative told us, "Knowing my [family member] is safe means a lot to me. I wouldn't have them living here if I was at all worried, which I am not." Another person said, "If I do ask for any help they [staff] do come quickly. If I have to wait it's a few minutes, tops." On Rivendell unit one nurse told us, "It's much better at the moment as there are less people living here and this gives us time to care without having to be [task driven]."

Our observations on Lothorian unit, where people were unable to tell us about the level of staff, showed that there were enough members of staff available to meet the needs of people in the service. For example we saw that there was one member of staff in the lounge at all times. The staff member sat with people, assisted them with their meals and looked through books and magazines with people. We saw one person was walking in and out of the lounge and they were acknowledged by staff each time.

People were safe because the provider followed robust procedures for the recruitment of staff. Staff confirmed the checks that had been completed. For example, a satisfactory employment history, Disclosure and Barring Service [DBS] check, [This check is to ensure that staff are suitable to work with people who use this service] and proof of previous employment. Staff said that other identity documents they had provided included recent photographic identity and a declaration of their health status.

Good

Is the service effective?

Our findings

At the previous inspection in October 2015 we found that the provider was breaching two legal requirements in this area and was rated as inadequate. We found that at this inspection the provider had made significant improvements in ensuring that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were met and that staff were competent to carry out their roles.

The provider had made improvements in the assessment of people under the MCA and DoLS.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the DoLS. We checked whether the provider was working within the principles of the MCA and DoLS.

Improvements had been made because the manager and all staff had an understanding of the MCA and DoLS. The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests and in the least restrictive manner. We saw evidence in people's files that there was detailed information about capacity assessments and best interest decisions in line with the MCA and DoLS.

We saw that staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement and in line with the MCA and DoLS codes of practice. A member of staff told us that the MCA was, "It's knowing what people are saying and talking their choices through. Letting them [people] choose what they want to do and only putting restrictions such as a bed rail in place where there was no lesser restriction."

We found that appropriate applications to lawfully deprive people of their liberty had been submitted to the supervisory body [local authority]. These were awaiting authorisation. Information about Independent Mental Capacity Assessors (IMCA's) was displayed on notice boards. This was to help those people or families who may wish to request external help and information.

We checked information that had been recorded in relation to any incidents to ensure people were not restrained. We found that no-one had been restrained and staff and management confirmed that was the case. Information in people's care plans and risk assessments showed that staff had details of how to de-escalate situations. For example, by offering reassurance, providing alternative things to do or by conversing with people.

Staff told us that following their induction they were supported with shadow shifts (working with a more experienced member of staff). This continued until the managers were confident the staff member was able to do their job independently. Staff told us that the manager of the service supported them in their role and they could ask for any additional training if they needed this.

People were supported by staff who had the necessary skills and who knew the people they cared for well. All staff had received training in subjects such as the MCA, health and safety, equality and diversity and fire safety. One staff member told us, "I have to do so much training and sometimes I do this at home but I get paid for this. I have done the MCA [Mental Capacity Act 2005] fire safety, dementia care, moving and handling as well as infection prevention and control." Another member of staff said, "I have just completed all my training again to make sure it is up-to-date." Nursing staff told us that they were in progress of completing their revalidation as well as maintaining their professional registration with the Nursing and Midwifery Council [NMC].

People told us they felt the staff had the skills to be able to provide their care. One person told us, "The staff do know what they are doing with me. I never have to tell them. I may be getting more [health condition] but they listen to me and do as I want." A volunteer visitor told us, "If ever [person] needs anything, such as help with eating, the staff do this."

Staff told us that they now received regular supervision and a yearly appraisal. One staff member told us, "I have just had my supervision and that is the second since November [2015]. I had to complete some refresher training on medicines administration as well as the MCA and food hygiene. I am all up to date now." Staff told us that supervision was "a two way conversation where we can now ask for, and receive help; and also where things are going well we are praised".

On Rivendell unit we saw that people had access to refreshments and snacks of biscuits and fresh fruit throughout the day. People were supported to eat and drink the foods they liked, how and where they liked to eat them and any particular dietary needs. One person told us, "They [staff] come round and ask what I would like to eat. I like cornflakes soaked in milk for breakfast. I have fish for dinner as I don't like meat." We saw that the person was offered a fish option at lunchtime. Our observations showed that people's meal times were an occasion that was enjoyed with much conversation, laughter and smiles from people who had enjoyed their meal. Another person said, "They [staff] make sure I always have a drink and that it is on my table. If I run out I only have to ring my bell and they bring me a drink."

People were supported to eat their meals if needed. Where people had a soft food or pureed diet we saw that they were assisted (if required) to ensure they had sufficient to eat and drink. We saw that staff, who helped those people to eat their meal, did this at a pace the person was comfortable with whilst making sure the person had eaten each mouthful safely. If people preferred anything else to eat the chef told us, "I now have a better budget and people can have what they want as long as we have it in stock. If not, we can order it for future occasions."

On Lothorian unit we saw that people were offered a choice of drinks and asked if they would like sugar in hot drinks. The team leader on Lothorian unit asked people what they would like for lunch from a choice of chicken nuggets and Cornish pasty. We saw that people did not always understand the choices they were offered. The manager showed us picture menus, which they said staff should have used as visual prompts for people. We saw the pictures, which were clear and large and would have given some people a visual reminder of, for example, what a pasty looked like. However the picture menus were not being used by staff. The manager said she would ensure all staff were made aware of where the pictorial menus were located so that people were able to make choices more easily. A volunteer visitor told us, "My friend is safe here as they

can't eat without help and the staff make sure they do eat and drink."

There was comprehensive information available to staff in one person's eating and drinking plan. The plan stated that if the person was restless at meals and chose to walk with purpose, finger foods could be provided. Staff could walk with the person and offer food and drink at regular intervals (providing this did not cause distress).

Care staff told us that they supported people to access health care professionals including GP's, community psychiatric nurses, dieticians, speech and language therapists and community nurses. People's healthcare records showed that where required, people were supported with their health care needs by the most appropriate health professional. One person told us, "I had a lady doctor come the other day." Another person added, "I asked for my own doctor. They [staff] are quite good at getting a doctor if I need one." This showed that people's healthcare needs were responded to.

Good

Is the service caring?

Our findings

At the previous inspection in October 2015 we found that the provider was breaching one legal requirement in this area and was rated as inadequate. We found that at this inspection the provider had made significant improvements in providing care that supported people with dignity and respect.

Improvements had been made because we saw that people were cared for in a kind and compassionate way by staff and that people's privacy and dignity was respected. We saw that staff on Rivendell unit ensured they only entered people's bedrooms with the person's permission. One person told us, "I like my door open but the staff knock, say hello, and they make sure I agree to them coming into my room." Another person told us, "They [staff] treat me with care and dignity. It can't be easy caring for so many people but they let me know if they can't attend to me straight away." However on Lothorian unit we saw one member of staff walk into people's bedrooms without knocking. The staff member said that they did not knock as the door was open anyway. We informed the manager about these issues at the time of the inspection. The manager told us that this would be acted upon.

Our observations showed us the various ways that staff provided compassionate care. One example was where staff used a privacy screen when moving and transferring a person. The staff engaged in conversation with the person, joined in when the person began to sing and explained each stage of the move. For example, by making sure the person's feet and arms could not be caught on the sling. We saw the use of tabards and napkins at mealtimes, which kept people's clothes clean and respected their dignity. One person told us, "What I like most about living here is they [staff] treat me really well." Another person said, "The girls [staff] brought me a card and a drink for my birthday. The chef made it [a cake] just for me." We saw minutes of a resident's meeting in April 2016 that showed how one person had been able to make a comment about a very personal issue. They had been given positive suggestions by staff on how to address it. The person had commented in the minutes that they would take the advice.

People had care plans that identified how they wanted their care to be provided. On Rivendell unit this included what the person's preferences were such as reading a book, watching TV or spending time in their room. One person told us, "I like my own space. Staff do pop in and say 'hello' but I am more than happy and contented to be on my own." A member of staff was heard saying to one person, "You look nice today with your eye shadow on." We observed how sensitive staff were if people were asleep at lunch time by waking the person gently and asking if they wanted to eat now or later. One staff member said, "Not to worry I'll keep your dinner warm so you can have it later." The person said "thank you" before nodding back off to sleep.

On Lothorian unit we heard many positive interactions between people and staff. For example, one member of staff said, "Morning [person's name] you look well, would you like to do some reading today?" However, there were times we heard people being spoken about as "soft", which referred to their dietary needs. This meant some people were not treated with respect. The information was given to the manager during the inspection.

Care staff described and people confirmed various methods they used to help support people with their privacy and dignity. This included methods such as closing a door, letting people do as much of their personal care as possible and giving people the time to do it. We saw when a person was having their personal care that the door was closed. When a second member of staff arrived to assist with moving and handling they knocked, waited until the door was opened a little before making sure it was respectful time to enter the person's room. One person told us, "The boys [staff] are good they ask me if I want my curtains closing." A volunteer visitor told us, "I look to see if people are alright. Where they need assistance with eating and drinking that [name] has this provided in a caring and sensitive way." Our observations showed us that care was provided sensitively.

Arrangements were in place to support people and their relatives to be as involved as possible in the person's care. Examples we saw included staff's day to day conversations as well as more formal reviews. Opportunities were taken by staff to give people the explanations they needed such as why staff provided personal care. A relative said, "[Family member] loves it here and I do most of their care [plan] reviews. I don't think my [family member] would know but the staff involve them as much as possible by talking about their past and memories."

People told us that as far as possible they were supported in a way which meant the risk of social isolation was minimised. For example, with visits from relatives, friends, community volunteer and religious groups. The manager and staff also encouraged people to get out into the community as well as into the home's gardens. One person told us, "I love the birds that come, (naming several of these) and being able to go out." Another person told us, "I go out in my wheelchair and I love it now it is getting warmer. In winter I can still watch as they [birds] are right outside my room."

People's care plans recorded any family advocacy arrangements that were in place. We also saw that formal IMCA was available and details were provided on how to contact the service. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. Other advocacy was provided by well-known national organisations.

People were assisted by staff to be as independent as possible. Staff were able to describe what areas people were independent with, as well as how to provide their care. We saw information in one person's care plans that said, 'Encourage independence and dexterity by including [name of person] in activity. Give her a wash cloth and encourage her to clean the areas where she is able'.

We saw that the language used in people's care records was respectful of subjects such as religion, any preference for gender of care staff and what the finer points of people's care were. One person told us, "The boys [staff] are just as nice." One member of care staff said, "I love working here. It is rewarding seeing people smile or feel better after a chat." Our observations and people we spoke with confirmed that this was the case.

Good

Is the service responsive?

Our findings

At the previous inspection in October 2015 we found that the provider was breaching one legal requirement in this area and was rated as inadequate. We found that at this inspection the provider had made significant improvements to involve people with the assessments of their care.

Improvements had been made because people's care needs had been assessed using a combination of methods. As well as a local authority assessment, the manager confirmed that the service made an assessment to ensure the staff could meet each person's needs in a way that was individualised. We saw that further information was being gained about individual likes and dislikes through the use of the 'This is me' form provided by the Alzheimer's Society and Royal College of Nursing.

People's assessments identified what the person's hobbies and interests were. For example, bird watching, reading books, singing karaoke or having a conversation. One person said, "I do like to go outside and help pot up some plants." It also included the time people liked to eat and where, their allergies and food preferences such as low sugar or low fibre content foods. There was also information such as people's favourite films and whether people preferred to listen to the radio recorded. People told us they were encouraged to take part in activities but could choose not to do so. There was a list of activities that had either taken place or were due to. Such as individual time, flower arranging, gardening, hand massage, attending a church service, Banjo music, music and dancing, Pat [Pets as therapy] dog, skittles and baking. People confirmed that there were a lot of things to do and had been involved in several of the activities listed here.

The manager and staff confirmed that people were supported to access the various activities in the service such as reminiscing and musical events including Karaoke. Throughout the day we saw there was something going on to meet each, and every, person's social entertainment requirements. Where people were predominantly cared for in bed we saw that staff spent time with them doing hand massages, having a chat as well as bringing meals and other items that the person needed. This showed that there were measures in place to reduce the risk of people's social isolation. We saw that several people enjoyed sitting in the (downstairs) lounge with staff spending time talking with people having a chat or singing.

We saw how one person requested their daily newspaper. Staff replied with, "[Name of paper] I'll get it for you straight away." We saw that this happened and the person said, "I love my [name of newspaper]." Another person was heard being asked by staff, "Is that your favourite book [person's name]?" The person told us, "I like to read and they [staff] make sure I have my book. I can read or watch TV it's up to me."

Staff were knowledgeable about each person they cared for. People's care plans prompted staff as to how best meet each person's expectations in maintaining their independence whilst living at the service. Examples included the support people wanted and also information about what people wanted to do and the type of things they wished to do on their own. Staff told us that the new format care plans were easy to follow. One relative told us, "Since the [CQC] inspection last year the manager and nurses went through [family member's] care plan to make sure it met [family member's] needs, which it now does."

One person told us, "They [staff] know me so ever so well. I have been here [several] years. There has been some new staff but there are still the [more experienced] ones and they know me so well I rarely have to tell them anything other than how I am feeling. If I don't feel well I tell them and they always see what they can do." Another person explained to us, "If I need anything I just have to ask. I kept asking for condiments which I now have my own in my room."

Relatives' views and comments were considered as part of the assessment so that staff understood what worked best for the person such as events to be avoided. For example one person did not like to be got up too early and another who preferred certain staff to provide their care.

On Lothorian unit we saw that people's care plans were followed by staff. We saw that one person had a communication care plan. The staff were to 'ensure that you allow [person's name] time to talk and process the information that is given'. We saw and heard how staff followed the plan and spent time explaining things with the person. For one person who displayed behaviour that challenged them and others, staff told us they stayed with the person whilst they were distressed, which could be up to one and a half hours. However, there was nothing in the person's care plan that showed this was an agreed action for staff nor was there evidence that the manager had been informed about the level of need for that person. When the manager was informed they stated that this had not been agreed by the purchasing authority and she had not been aware of this level of staff input. This meant that people's changing needs had not been recorded or agreed.

People were involved in the home and had attended a residents' meeting where they had decided that they wanted a pet cat. The regional manager told us that the initial thoughts were for a guinea pig but after weighing up the pros and cons a cat was to be obtained.

People told us they knew about the complaints process but all the people said they had no cause to complain. The service had up-to-date complaints policies and procedures contained in the service user guide. This included details on how to contact other organisations such as the Local Government Ombudsman. People told us that staff gave them opportunities to raise concerns about their care and that action was taken where required. One care staff told us, "If ever people suggest things I always record this and if I am not able to resolve the matter quickly I raise it with the manager." For people who preferred information in an alternative format such as written down or in a larger font then this was provided. One person told us, "I can't hear as well as I used to but they [staff] make sure I understand what they ask or tell me. I can lip read a bit but by you [CQC inspector] writing the questions down for me makes it easier for me to communicate." Staff also wrote things down for this person. We saw that complaints had been investigated and where necessary care plans had been updated and changed.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in October 2015 we found that the provider was breaching one legal requirement in this area and was rated as inadequate. We found that at this inspection the provider had made significant improvements to assess and monitor the quality and safety of the service.

Although the manager said the service was open and transparent, we found that was not always the case. This was because people were not told when incidents had occurred, what investigations into the event had been made or an apology given. There was no written record that the person had been spoken with although the deputy manager said they had informed the person verbally. At the time of the incident the person was unwell but there was no information as to whether their ill health was due, in part, to the medication error or other health issues.

People were not always protected on Rivendell unit because records such as food and fluid charts had not been fully or accurately completed. This limited the provider's ability to recognise if any person had or had not had sufficient food to eat or fluid to drink. However, on Lothorian unit the food and fluid charts were being completed more accurately. Fluid charts were totalled at the end of the day but the fluid goal was not recorded on the chart. The manager was informed during the inspection. They were aware there were some recording issues and further training and information at staff meetings were to be provided.

Improvements had been made since our last inspection because people were involved in improving and developing the service through residents' meetings. Minutes of the last meeting in April 2016 showed there had been discussions about whether people wanted individual face to face or group meetings. Nine people said they wanted a resident's meeting once a month but on a face to face basis. People's comments at the meeting in April 2016 had been requests for real fruit in crumble rather than tinned (which had been addressed) as well as more requests for visiting musicians.

Staff team meetings were held regularly and staff said they were expected to attend. They said they were encouraged to discuss general themes such as any changes to the service people received. We saw the minutes of the last staff meeting held on 28 April 2016 which provided information for staff about internal procedures and staff training reminders.

Health and safety meetings were held, the last was 12 April 2016, which discussed the use of hoist slings that had not been checked. An action plan was put in place. Meeting minutes from the managers meeting on 26 February 2016 and a night staff meeting on 5 May 2016 showed staff were provided with the opportunity to raise issues or for management to ensure improvements to the service were discussed.

There had been an activities survey so that staff were aware of what sort of activities people in the service wanted. These activities had included shopping, going to the beach, bingo and for some staying in their room and enjoying the company of individual staff members were the things they enjoyed.

There had been satisfaction surveys sent to all people living in the service, relatives and staff in February

2016. We saw that three people, six relatives and ten staff had returned the surveys. Information from the survey was used to create an action plan which, for example, talked about using the garden more and people planting seeds and growing vegetables, more cooking, trips out and cinema days in the service. People told us that some of the activities, such as working in the garden, had already taken place. Some relatives had requested that they would appreciate seeing the management at weekends. This was in the process of being discussed. Staff had indicated the service was good in many aspects such as training, staffing levels and the provider. Areas of improvement for staff were using less agency staff, better communication and improving poor staff morale. The manager said that the comments made were in the process of being actioned so that improvements to the service could be made.

All staff said there had been many improvements over the last six months which had meant that people had more choices. All staff we spoke to said that they found the new management team supportive and they could go to them with any issues or concerns. One nurse said that a manager was always on call and when they had needed to phone they had got hold of someone straight away.

All staff told us how much more relaxed and calm the atmosphere was since our inspection in November 2015. One said, "We now have the support we never had before. As well as the manager there is a regional manager who we can contact at any time. It has been difficult but we knew things couldn't go on as they did before." One relative told us, "When you ask for a change to [family member's] care it now happens. The service seems to be better managed now. I hope it stays that way."

The manager maintained good communication with people, relatives and staff as well as health professionals such as a GP. This meant that an open and honest culture was being fostered and the manager was more aware of what was going on. One person said, "I know the [deputy] manager now as he is often out and about. He asks me how I am and gets things done. I don't have anything bothering me." One relative said, "I have no qualms about my [family member] living here. I can speak with [name of manager and deputy manager] at any time. They listen and act on my comments."

A nurse told us, "The previous [registered] manager let things slip and now it is much better. The manager and deputy manager are both very approachable and open to suggestions." The chef said, "Morale is now much better. The manager pops into the kitchen every day to see if everything is okay or if I need anything."

All staff commented very positively about the support that management provided. One member of staff said, "I have the manager's and deputy manager's mobile numbers and I can call them at any time. I am much happier knowing that they are there if I need them. One person told us, "Everyone [staff] is nice and I am happy." Another said, "They [management] are very good here and I see them quite often. Even the boss [regional manager] comes for a chat." We saw that was the case and that the regional manager listened to what people enjoyed and the things that had made a difference to the person's life.

Care staff told us about the service provider's values. These included respecting each person as a human being, respecting their human rights and to be cared for as a person. We heard an example where one member of staff said, "We can get you up today [name] if you are feeling up to it?" Another staff member said, "If someone is unhappy about the quality of their care I ask what they would like such as a different meal."

Observations on staff's performance were undertaken frequently. We saw that these checks were to help ensure that people's care was provided to the required standards. One member of staff said, "[Name of manager and deputy manager] are approachable managers. We can ask anything we want. They come and do spot checks on food and fluid charts, bed rails checks, assistive technology being used correctly and care

plans." These checks also included staff's adherence to any changes such as those to people's moving and handling practices. The manager said they liaised with the regional manager for any advice or guidance needed as well as providing praise on the things staff did well. The regional manager told us, "Getting the right manager has been a challenge. I am now confident in their ability, with my and the owner's support, to turn this service around and get it back to being good."

Staff said they were confident of how they would report any poor standards of care. One nurse said, "I would not hesitate to report any poor standards of care. I have done this and actions are now in progress. People are here to be safe and it is all our jobs to make sure this happens. Mistakes do happen but this is rare. [By] being open and honest to report [any events, it] means that the manager can then take the most appropriate action."

The service did not have a registered manager. The last registered manager left the service in October 2015. The provider is required, by law, to notify the CQC of certain important events that occur at the service. From records viewed we found that they and the manager had notified us about the majority but not all events where this had been required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Although appropriate systems and processes were in place, the managers in the service had not followed the provider's procedure in protecting people from harm. Regulation 13 (2)